LOS ANGELES COUNTY
COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140, Los Angeles, CA 90010
TEL. (213) 738-2816 · FAX (213) 637-4748
WEBSITE: http://hiv.lacounty.gov | EMAIL: hivcomm@lachiv.org

COMMISSION ON HIV MEETING

Thursday, September 12, 2019
9:00 AM – 12:15 PM

St. Anne's Conference Center, Foundation Room
155 North Occidental Blvd.
Los Angeles CA 90026

Join the movement in ending the HIV/AIDS epidemic in Los Angeles County, once and for all.
Visit ***www.LACounty.HIV***

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VISION

A comprehensive, sustainable, accessible system of prevention and care that empowers people at-risk, living with or affected by HIV to make decisions and to maximize their lifespans and quality of life.

MISSION

The Los Angeles County Commission on HIV focuses on the local HIV/AIDS epidemic and responds to the changing needs of People Living With HIV/AIDS (PLWHA) within the communities of Los Angeles County.

The Commission on HIV provides an effective continuum of care that addresses consumer needs in a sensitive prevention and care/treatment model that is culturally and linguistically competent and is inclusive of all Service Planning Areas (SPAs) and Health Districts (HDs).

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CODE OF CONDUCT

We welcome commissioners, guests, and the public into a space where people of all opinions and backgrounds are able to contribute. We create a safe environment that celebrates differences while striving for consensus and is characterized by consistent, professional, and respectful behavior. Our common enemies are HIV and STDs. We strive to be introspective and understand and clarify our assumptions, while appreciating the complex intersectionality of the lives we live. We challenge ourselves to be self-reflective and committed to an ongoing understanding. As a result, the Commission has adopted and is consistently committed to implementing the following guidelines for Commission, committee, and associated meetings.

All participants and stakeholders should adhere to the following:

1) **We strive for consensus and compassion in all our interactions.**
2) **We respect others' time by starting and ending meetings on time, being punctual, and staying present.**
3) **We listen, don't repeat what has already been stated, avoid interrupting others, and allow others to be heard.**
4) **We encourage all to bring forth ideas for discussion, community planning, and consensus.**
5) **We focus on the issue, not the person raising the issue.**
6) **We give and accept respectful and constructive feedback.**
7) **We keep all issues on the table (no "hidden agendas"), avoid monopolizing discussions and minimize side conversations.**
8) **We have no place in our deliberations for homophobic, racist, sexist, and other discriminatory statements and "-isms" (including transphobia, ableism, and ageism).**
9) **We give ourselves permission to learn from our mistakes.**

Approved (11/12/1998); Revised (2/10/2005; 9/6/2005); **Revised (4/11/19)**

1. APPROVAL OF THE AGENDA:

A. Agenda **(MOTION #1)**
B. Code of Conduct
C. Membership Roster
D. Committee Assignments
E. Commission Member Conflict of Interest
F. September - December 2019 Commission Meeting Calendar
G. Geographic Maps

LOS ANGELES COUNTY
COMMISSION ON HIV

AGENDA FOR THE **REGULAR** MEETING OF THE
LOS ANGELES COUNTY COMMISSION ON HIV (COH)

(213) 738-2816 / FAX (213) 637-4748
EMAIL: hivcomm@lachiv.org WEBSITE: http://hiv.lacounty.gov

Thursday, September 12, 2019 | 9:00 AM – 12:15 PM

St. Anne's Conference Center
Foundation Room
155 N. Occidental Blvd., Los Angeles CA 90026

Notice of Teleconferencing Site:
California Department of Public Health, Office of AIDS
1616 Capitol Ave, Suite 74-616
Sacramento, CA 95814

AGENDA POSTED: September 6, 2019

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

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

Servicios de interpretación para personas con impedimento auditivo y traducción para personas que no hablan Inglés están disponibles sin costo. Para pedir estos servicios, póngase en contacto con Dina Jauregui al (213) 738-2816 (teléfono), o por correo electrónico á djauregui@lachiv.org, por lo menos 72 horas antes de la junta.

SUPPORTING DOCUMENTATION can be obtained at the Commission on HIV Website at: http://hiv.lacounty.gov. The Commission Offices are located in Metroplex Wilshire, one building west of the southwest corner of Wilshire and Normandie. Validated parking is available in the parking lot behind Metroplex, just south of Wilshire, on the west side of Normandie.

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

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

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

	Call to Order and Roll Call		9:00 A.M. – 9:02 A.M.
	I. ADMINISTRATIVE MATTERS		
1.	Approval of Agenda	**MOTION #1**	9:02 A.M. – 9:04 A.M.
2.	Approval of Meeting Minutes	**MOTION #2**	9:04 A.M. – 9:06 A.M.
	II. REPORTS		
3.	Executive Director/Staff Report		9:06 A.M. – 9:30 A.M.
	A. Welcome and Introductions		
	B. Recognition of Service		
	(a) Bradley Land, Commissioner		
	(b) Kyle Baker, Division of HIV/STD Program (DHSP)		
	C. The Wall Las Memorias Project | AIDS Monument Renovation		
4.	Co-Chair Report		9:30 A.M. – 9:40 A.M.
	A. Meeting Management Reminders		
	B. COH Co-Chair Open Nominations		
	C. United States Conference on AIDS (USCA) Follow-Up		
5.	Housing Opportunities for People Living with AIDS (HOPWA) Report		9:40 A.M – 9:45 A.M.
6.	Ryan White Program Parts C, D and F Report		9:45 A.M – 9:50 A.M.
7.	California Office of AIDS (OA) Report		9:50 A.M. – 10:00 A.M.
	A. California HIV Planning Group Update		
8.	LA County Department of Public Health Report		10:00 A.M. – 10:45 A.M.
	A. Division of HIV/STD Programs (DHSP) Report		
	(a) Molecular Surveillance Program Presentation		
	III. ANNOUNCEMENTS		10:45A.M. – 10:50 A.M.
9.	Opportunity for members of the public to announce community events, workshops, trainings, and other related activities.		

IV. REPORTS

10. Standing Committee Reports 10:50 A.M. – 11:45 A.M.

A. Operations Committee
  (1) Membership Management
    (a) 2019 Renewing Membership Slate Update
    (b) Noah Kaplan | SBP Committee-Only Membership Application **MOTION #3**
  (2) Policies and Procedures
    (a) Policy #08.1104: Commission and Committee Co-Chair Elections and Terms **MOTION #4**
    (b) Policy #08.2301: Voting Procedures **MOTION #5**
  (3) Training
    (a) 2019 COH Mandatory Member Training| October 10, 2019

B. Planning, Priorities & Allocations (PP&A) Committee
  (1) Ryan White Program (RWP) Program Year (PY) 30 Service Category Rankings **MOTION #6**
  (2) RWP PY 30 Service Category Allocations **MOTION #7**

C. Public Policy Committee
  (1) County, State and Federal Legislation & Policy
    (a) Ending the Epidemic: A Plan for America Update

D. Standards and Best Practices (SBP) Committee
  (1) Revised HIV Continuum Framework **MOTION #8**
  (2) Universal Standards of Care **MOTION #9**

11. Caucus, Task Force and Work Group Reports 11:45 A.M. – 12:00 P.M.

A. Assessment of the Administrative Mechanism (AAM) Work Group
B. Aging Task Force
C. Black African American Community (BAAC) Task Force
D. Consumer Caucus
E. HIV Service Awards Work Group
F. Women's Caucus
G. Transgender Caucus

12. Cities, Health Districts, Service Provider Area (SPA) Reports 12:00 P.M. – 12:05 P.M.

VII. MISCELLANEOUS

13. Public Comment 12:05 P.M. – 12:10 P.M.

Opportunity for members of the public to address the Commission
On items of interest that are within the jurisdiction of the Commission

14. Commission New Business Items 12:10 P.M. – 12:13 P.M.

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

15. Announcements 12:13 P.M. – 12:15 P.M.

Opportunity for members of the public to announce community events, workshops, trainings, and other related activities

16. Adjournment and Roll Call 12:15 P.M.

Adjournment for the meeting of September 12, 2019

PROPOSED MOTION(S)/ACTION(S)	
MOTION #1:	Approve the Agenda order, as presented or revised.
MOTION #2:	Approve the Minutes, as presented or revised.
MOTION #3:	Approve Noah Kaplan's SBP Committee-Only Membership Application, as presented or revised.
MOTION #4:	Approve Policy #08.1104: Commission and Committee Co-Chair Elections and Terms, as presented or revised.
MOTION #5:	Approve Policy #08.2301: Voting Procedures, as presented or revised.
MOTION #6:	Approve the RWP PY 30 service category rankings, as presented or revised.
MOTION #7:	Approve the RWP PY 30 service category allocations, as presented or revised, and provide DHSP the authority to make adjustments of 10% greater or lesser than the approved allocations amount, as expenditure categories dictate, without returning to this body.
MOTION #8:	Approve Revised HIV Continuum Framework, as presented or revised.
MOTION #9:	Approved Universal Standards of Care, as presented or revised.

COMMISSION ON HIV MEMBERS:			
Al Ballesteros, MBA, Co-Chair	Grissel Granados, MSW, Co-Chair	Susan Alvarado, MPH	Traci Bivens-Davis, MA
Jason Brown	Danielle Campbell, MPH	Raquel Cataldo	Pamela Coffey (Alasdair Burton, Alternate**)
Michele Daniels (Craig Scott, Alternate**)	Erika Davies	Susan Forrest (Alternate*)	Aaron Fox, MPM
Jerry D. Gates, PhD	Felipe Gonzalez	Bridget Gordon	Joseph Green
Karl Halfman, MA	Diamante Johnson (Kayla Walker-Heltzel, Alternate**)	William King, MD, JD, AAHIVS	Lee Kochems, MA
David P. Lee, MPH, LCSW	Abad Lopez	Miguel Martinez, MSW, MPH	Anthony Mills, MD
Carlos Moreno	Derek Murray	Katja Nelson, MPP	Jazielle Newsome (LoA) (Miguel Alvarez, Alternate**)
Frankie Darling-Palacios	Raphael Peña (Thomas Green, Alternate**)	Mario Pérez, MPH	Juan Preciado
Joshua Ray (Eduardo Martinez, Alternate**)	Ricky Rosales	Nestor Rogel (Alternate*)	LaShonda Spencer, MD
Martin Sattah, MD	Kevin Stalter	Maribel Ulloa	Justin Valero
Amiya Wilson	Greg Wilson	Russell Ybarra	
MEMBERS:	**43**		
QUORUM:	**22**		

LEGEND:
LoA= Leave of Absence, not counted towards quorum
Alternate*= Occupies Alternate seat adjacent a vacancy, counted toward quorum
Alternate**= Occupies Alternate seat adjacent a filled primary seat; counted towards quorum in the absence of the primary seat member

LOS ANGELES COUNTY COMMISSION ON HIV

2019 MEMBERSHIP ROSTER| UPDATED 9/04/19

APPROVED BY COH ON 7/12/19

SEAT NO.	MEMBERSHIP SEAT	Commissioners Seated	Committee Assignment	COMMISSIONER	AFFILIATION (IF ANY)	TERM BEGIN	TERM ENDS	ALTERNATE
1	Medi-Cal representative			***Vacant***		July 1, 2019	June 30, 2021	
2	City of Pasadena representative	1	SBP	Erika Davies	City of Pasadena Department of Public Health	July 1, 2018	June 30, 2020	
3	City of Long Beach representative	1	PP&A	Susan Alvarado	City of Long Beach Department of Health and Human Services	July 1, 2019	June 30, 2021	
4	City of Los Angeles representative	1	PP	Ricky Rosales	AIDS Coordinator's Office, City of Los Angeles	July 1, 2018	June 30, 2020	
5	City of West Hollywood representative	1	PP&A	Derek Murray	City of West Hollywood	July 1, 2019	June 30, 2021	
6	Director, DHSP	1	EXC|PP&A	Mario Pérez, MPH	DHSP, LA County Department of Public Health	July 1, 2018	June 30, 2020	
7	Part B representative	1	PP&A	Karl Halfman, MA	California Department of Public Health	July 1, 2018	June 30, 2020	
8	Part C representative	1	EXC|PP	Aaron Fox, MPM	Los Angeles LGBT Center	July 1, 2018	June 30, 2020	
9	Part D representative	1	PP&A	LaShonda Spencer, MD	LAC + USC MCA Clinic, LA County Department of Health Services	July 1, 2019	June 30, 2021	
10	Part F representative	1	PP	Jerry D. Gates, PhD	Keck School of Medicine of USC	July 1, 2018	June 30, 2020	
11	Provider representative #1			***Vacant***		July 1, 2019	June 30, 2021	
12	Provider representative #2	1	SBP	David Lee, MPH, LCSW	Charles Drew University	July 1, 2018	June 30, 2020	
13	Provider representative #3	1	EXC/PP&A	Miguel Martinez, MSW, MPH	Children's Hospital Los Angeles	July 1, 2019	June 30, 2021	
14	Provider representative #4	1	PP&A	Raquel Cataldo	Tarzana Treatment Center	July 1, 2018	June 30, 2020	
15	Provider representative #5			***Vacant***		July 1, 2019	June 30, 2021	
16	Provider representative #6	1	PP&A	Anthony Mills, MD	Southern CA Men's Medical Group	July 1, 2018	June 30, 2020	
17	Provider representative #7	1	PP&A	Frankie Darling-Palacios (LoA)	Los Angeles LGBT Center	July 1, 2019	June 30, 2021	
18	Provider representative #8	1	PP	Martin Sattah, MD	Rand Shrader Clinic (SPA1), LA County Department of Health Ser	July 1, 2018	June 30, 2020	
19	Unaffiliated consumer, SPA 1	1	EXC/OPS	Michele Daniels	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	Craig Scott (OPS/PP)
20	Unaffiliated consumer, SPA 2	1	PP&A	Abad Lopez	*Unaffiliated Consumer*	July 1, 2018	June 30, 2020	
21	Unaffiliated consumer, SPA 3	1	EXC|PP&A	Jason Brown	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	
22	Unaffiliated consumer, SPA 4	1	EXC|SBP	Kevin Stalter	*Unaffiliated Consumer*	July 1, 2018	June 30, 2020	
23	Unaffiliated consumer, SPA 5			***Vacant***		July 1, 2019	June 30, 2021	
24	Unaffiliated consumer, SPA 6	1	PP	Pamela Coffey	*Unaffiliated Consumer*	July 1, 2018	June 30, 2020	Alasdair Burton (PP)
25	Unaffiliated consumer, SPA 7	1	PP&A	Raphael Pena	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	Thomas Green (PP&A/SBP)
26	Unaffiliated consumer, SPA 8			***Vacant***		July 1, 2018	June 30, 2020	Susan Forrest (PP&A/OPS)
27	Unaffiliated consumer, Supervisorial District 1	1	OPS	Carlos Moreno	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	
28	Unaffiliated consumer, Supervisorial District 2			***Vacant***		July 1, 2018	June 30, 2020	Nestor Rogel (PP)
29	Unaffiliated consumer, Supervisorial District 3	1	SBP	Joshua Ray	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	Eduardo Martinez (SBP/PP)
30	Unaffiliated consumer, Supervisorial District 4			***Vacant***		July 1, 2018	June 30, 2020	
31	Unaffiliated consumer, Supervisorial District 5	1	PP&A	Diamante Johnson	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	Kayla Walker-Heltzel (PP&A/OPS)
32	Unaffiliated consumer, at-large #1	1	PP&A	Russell Ybarra	*Unaffiliated Consumer*	July 1, 2018	June 30, 2020	
33	Unaffiliated consumer, at-large #2	1	OPS	Joseph Green	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	
34	Unaffiliated consumer, at-large #3	1	SBP	Felipe Gonzalez	*Unaffiliated Consumer*	July 1, 2018	June 30, 2020	
35	Unaffiliated consumer, at-large #4	1	EXC/OPS	Bridget Gordon	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	
36	Representative, Board Office 1	1	EXC	Al Ballesteros, MBA	JWCH Institute, Inc.	July 1, 2018	June 30, 2020	
37	Representative, Board Office 2	1	EXC|OPS	Traci Bivens-Davis	Community Clinic Association of LA County	July 1, 2019	June 30, 2021	
38	Representative, Board Office 3	1	EXC|PP|SBP	Katja Nelson, MPP	APLA	July 1, 2018	June 30, 2020	
39	Representative, Board Office 4	1	SBP	Justin Valero	California State University, San Bernardino	July 1, 2019	June 30, 2021	
40	Representative, Board Office 5			***Vacant***		July 1, 2018	June 30, 2020	
41	Representative, HOPWA	1	PP&A	Maribel Ulloa	City of Los Angeles, HOPWA	July 1, 2019	June 30, 2021	
42	Behavioral/social scientist	1	PP	Lee Kochems	*Unaffiliated Consumer*	July 1, 2018	June 30, 2020	
43	Local health/hospital planning agency representative			***Vacant***		July 1, 2019	June 30, 2021	
44	HIV stakeholder representative #1	1	EXC	Grisset Granados, MSW	Children's Hospital Los Angeles	July 1, 2018	June 30, 2020	
45	HIV stakeholder representative #2	1	EXC/OPS	Greg Wilson	In the Meantime Men's Group	July 1, 2019	June 30, 2021	
46	HIV stakeholder representative #3	1	EXC|OPS	Juan Preciado	Northeast Valley Health Corporation	July 1, 2018	June 30, 2020	
47	HIV stakeholder representative #4			***Vacant***		July 1, 2019	June 30, 2021	
48	HIV stakeholder representative #5	1	OPS	Danielle Campbell, MPH	UCLA/MLKCH	July 1, 2018	June 30, 2020	
49	HIV stakeholder representative #6	1	SBP	Amiya Wilson	Unique Women's Coalition	July 1, 2019	June 30, 2021	
50	HIV stakeholder representative #7	1	PP&A	William D. King, MD, JD, AAHIVS	W. King Health Care Group	July 1, 2018	June 30, 2020	
51	HIV stakeholder representative #8	1	SBP	Jazielle Newsome (LoA)	*Unaffiliated Consumer*	July 1, 2018	June 30, 2020	Miguel Alvarez (SBP/OPS)
	TOTAL:	41						

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

LOA: Leave of Absence

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COMMISSION ON HIV

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COMMITTEE ASSIGNMENTS

Updated: September 11, 2019 | Information Subject to Change

EXECUTIVE COMMITTEE

Regular meeting day: 4th Thursday of the Month
Regular meeting time: 1:00-3:00 PM
Number of Voting Members= 13 | Number of Quorum= 7

COMMITTEE MEMBER	MEMBER CATEGORY	AFFILIATION
Grissel Granados, MSW	**Co-Chair, Comm./Exec.***	**Commissioner**
Al Ballesteros, MBA	**Co-Chair, Comm./Exec.***	**Commissioner**
Traci Bivens-Davis, MA	Co-Chair, Operations	Commissioner
Jason Brown	Co-Chair, PP&A	Commissioner
Michele Daniels (Craig Scott, Alternate)	At-Large Member*	Commissioner
Erika Davies	Co-Chair, SBP	Commissioner
Aaron Fox, MPM	Co-Chair, Public Policy	Commissioner
Bridget Gordon	At-Large Member*	Commissioner
Miguel Martinez	Co-Chair, PP&A	Commissioner
Katja Nelson, MPP	Co-Chair, Public Policy	Commissioner
Mario Pérez, MPH	DHSP Director	Commissioner
Juan Preciado	Co-Chair, Operations	Commissioner
Kevin Stalter	Co-Chair, SBP	Commissioner
Greg Wilson	At-Large Member*	Commissioner

OPERATIONS COMMITTEE

Regular meeting day: 4th Thursday of the Month
Regular meeting time: 10:00 AM-12:00 PM
Number of Voting Members= 11 | Number of Quorum= 6

COMMITTEE MEMBER	MEMBER CATEGORY	AFFILIATION
Traci Bivens-Davis, MA	**Committee Co-Chair***	**Commissioner**
Juan Preciado	**Committee Co-Chair***	**Commissioner**
Miguel Alvarez	**	Alternate
Danielle Campbell, MPH	*	Commissioner
Michele Daniels (Craig Scott, Alternate)	*	Commissioner
Susan Forrest	**	Alternate
Bridget Gordon	*	Commissioner
Joseph Green	*	Commissioner
Kayla Walker-Heltzel	**	Alternate
Carlos Moreno	*	Commissioner
Greg Wilson	*	Commissioner

PLANNING, PRIORITIES & ALLOCATIONS (PP&A) COMMITTEE		
Regular meeting day: 3rd Tuesday of the Month Regular meeting time: 1:00-4:00 PM Number of Voting Members= 16 | Number of Quorum= 9		
COMMITTEE MEMBER	**MEMBER CATEGORY**	**AFFILIATION**
Jason Brown	Committee Co-Chair*	Commissioner
Miguel Martinez, MPH, MSW	Committee Co-Chair*	Commissioner
Susan Alvarado	*	Commissioner
Raquel Cataldo	*	Commissioner
Susan Forrest	*	Alternate
Karl Halfman, MA	*	Commissioner
William D. King, MD, JD, AAHIVS	*	Commissioner
Abad Lopez	*	Commissioner
Anthony Mills, MD	*	Commissioner
Derek Murray	*	Commissioner
Diamante Johnson (Kayla Walker-Heltzel, Alternate)	*	Commissioner
Frankie Darling Palacios	*	Commissioner
Raphael Pena (Thomas Green, Alternate)	*	Commissioner
LaShonda Spencer, MD	*	Commissioner
Maribel Ulloa	*	Commissioner
Russell Ybarra	*	Commissioner
TBD	DHSP staff	DHSP

PUBLIC POLICY (PP) COMMITTEE		
Regular meeting day: 1st Monday of the Month Regular meeting time: 1:00-3:00 PM Number of Voting Members= 10 | Number of Quorum= 6		
COMMITTEE MEMBER	**MEMBER CATEGORY**	**AFFILIATION**
Aaron Fox, MPM	Committee Co-Chair*	Commissioner
Katja Nelson, MPP	Committee Co-Chair*	Commissioner
Pamela Coffey (Alasdair Burton, Alternate)	*	Commissioner
Jerry Gates, PhD	*	Commissioner
Lee Kochems, MA	*	Commissioner
Eduardo Martinez	**	Alternate
Nestor Rogel	*	Alternate
Ricky Rosales	*	Commissioner
Martin Sattah, MD	*	Commissioner
Craig Scott	**	Alternate

STANDARDS AND BEST PRACTICES (SBP) COMMITTEE

Regular meeting day: 1st Tuesday of the Month
Regular meeting time: 1:00-4:00 PM
Number of Voting Members = 10 | Number of Quorum = 6

COMMITTEE MEMBER	MEMBER CATEGORY	AFFILIATION
Kevin Stalter	**Committee Co-Chair***	**Commissioner**
Erika Davies	**Committee Co-Chair**	**Commissioner**
Thomas Green	**	Alternate
Felipe Gonzalez	*	Commissioner
David Lee, MPH, LCSW	*	Commissioner
Katja Nelson, MPP	**	Commissioner
Jazielle Newsome (LoA) **(Miguel Alvarez, Alternate)**	*	Commissioner
Joshua Ray (Eduardo Martinez, Alternate)	*	Commissioner
Justin Valero	*	Commissioner
Amiya Wilson	*	Commissioner
Wendy Garland, MPH	DHSP staff	DHSP

CONSUMER CAUCUS

Regular meeting day: 2nd Thursday of Each Month
Regular meeting time: Immediately following Commission Meeting
Open membership to consumers of HIV prevention and care services*

CAUCUS MEMBER	MEMBER CATEGORY	AFFILIATION

AGING TASK FORCE (ATF)

Regular meeting day: 4th Thursday of Each Month
Regular meeting time: 10am-12:00pm
Open membership*

TASK FORCE MEMBER	MEMBER CATETORY	AFFILIATION
Al Ballesteros, MBA	Member	Commissioner
Jason Brown	Member	Commissioner
Alasdair Burton	Member	Commissioner
Mark McGrath	Member	Community
Craig Pulsipher, MPP, MSW	Member	Community

BLACK/AFRICAN AMERICAN COMMUNITY (BAAC) TASK FORCE

Regular meeting day/time: Contact Commission Office
Open membership

TASK FORCE MEMBER	MEMBER CATETORY	AFFILIATION
Traci Bivens-Davis, MA	Member	Commissioner
Danielle Campbell, MPH	Member	Commissioner
Bridget Gordon	Member	Commissioner
William D. King, MD, JD, AAHIVS	Member	Commissioner
Greg Wilson	Member	Commissioner
LaShonda Spencer, MD	Member	Commissioner
Jeffrey King	Member	Community

TRANSGENDER CAUCUS

Regular meeting day/time: TBD; Contact Commission Office
Open membership

WOMEN'S CAUCUS

Regular meeting day: 3rd Wednesday of Each Month
Regular meeting time: 10am-12:00pm
Open membership

CAUCUS MEMBER	MEMBER CATETORY	AFFILIATIO
Danielle Campbell, MPH	Member	Commissione
Bridget Gordon	Member	Commissioner
Grissel Granados, MSW	Member	Commissioner
Natalie Sanchez	Member	Community
LaShonda Spencer, MD	Member	Commissioner

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 9/11/19

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ALVARADO	**SUSAN**	Long Beach Dept. of Health and Human Services	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			HIV Biomedical Prevention
			Medical Care Coordination (MCC)
			HIV and STD Prevention
ALVAREZ	**Miguel**	No Affiliation	No Ryan White or prevention contracts
BROWN	**Jason**	Unaffiliated consumer	No Ryan White or prevention contracts
BALLESTEROS	**Al**	JWCH, INC.	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Case Management, Transitional
			Health Education/Risk Reduction (HERR)
			HIV Counseling and Testing (HCT)
			Medical Care Coordination (MCC)
			Mental Health, Psychotherapy
			Mental Health, Psychiatry
			Oral Health
			Biomedical Prevention
BIVENS-DAVIS	**Traci**	Community Clinic Association of LA County	No Ryan White or prevention contracts
BURTON	**Alasdair**	No Affiliation	No Ryan White or prevention contracts
CAMPBELL	**Danielle**	UCLA/MLKCH	HIV/AIDS Oral Health Care (Dental) Services
			HIV/AIDS Medical Care Coordination Services
			HIV/AIDS Ambulatory Outpatient Medical Services
			HIV/AIDS Medical Care Coordination Services
			nPEP Services

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
CATALDO	Raquel	Tarzana Treatment Center	Case Management, Home-Based
			Case Management, Transitional - Jails
			Housing Services
			Medical Transportation
			Mental Health, Psychotherapy
			Oral Health
			Substance Abuse, Residential
			Substance Abuse, Transitional
			Substance Abuse, Detox
			Biomedical Prevention
			Medical Nutrition Therapy
COFFEY	Pamela	Unaffiliated consumer	No Ryan White or prevention contracts
DANIELS	Michele	Unaffiliated consumer	No Ryan White or prevention contracts
DARLING-PALACIOS	Frankie	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			Health Education/Risk Reduction (HERR)
			HIV Counseling and Testing (HCT)
			Housing Services
			Medical Care Coordination (MCC)
			Mental Health, Psychiatry
			Mental Health, Psychotherapy
			Non-Occupational HIV PEP
			Biomedical Prevention
			STD Screening and Treatment
DAVIES	Erika	City of Pasadena	HIV Counseling and Testing (HCT)
FORREST	Susan	Office of Division and Reenry, Departmet of Health Services, County of Los Angeles	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
FOX	Aaron	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			Health Education/Risk Reduction (HERR)
			HIV Counseling and Testing (HCT)
			Housing Services
			Medical Care Coordination (MCC)
			Mental Health, Psychiatry
			Mental Health, Psychotherapy
			Non-Occupational HIV PEP
			Biomedical Prevention
			STD Screening and Treatment
GATES	Jerry	AETC (Part F)	No Ryan White or prevention contracts
GONZALEZ	Felipe	Unaffiliated consumer	No Ryan White or prevention contracts
GORDON	Bridget	Unaffiliated consumer	No Ryan White or prevention contracts
GRANADOS	Grissel	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			Case Management, Transitional - Youth
			Health Education/Risk Reduction (HERR)
			HIV Counseling and Testing (HCT)
			Medical Care Coordination (MCC)
			Biomedical Prevention
GREEN	Joseph	Unaffiliated consumer	No Ryan White or prevention contracts
GREEN	Thomas	APAIT	HIV Counseling and Testing (HCT)
HALFMAN	Karl	California Department of Public Health, Office of AIDS	Part B Grantee
JOHNSON	Diamante	Bonnie's House	No Ryan White or prevention contracts
KOCHEMS	Lee	Unaffiliated consumer	No Ryan White or prevention contracts
KING	William	W. King Health Care Group	No Ryan White or prevention contracts
LEE	David	Charles R. Drew University of Medicine and Science	HIV/AIDS Benefits Specialty Services
			HIV Counseling, Testing, and Referral Prevention Services
LOPEZ	Abad	Unaffiliated consumer	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MARTINEZ	**Eduardo**	AIDS Healthcare Foundation	Ambulatory Outpatient Medical (AOM) Benefits Specialty Medical Care Coordination (MCC) MH, Psychiatry MH, Psychotherapy Medical Specialty Oral Health HIV Counseling and Testing (HCT) STD Screening and Treatment
MARTINEZ	**Miguel**	Children's Hospital, Los Angeles	Ambulatory Outpatient Medical (AOM) Case Management, Transitional - Youth Health Education/Risk Reduction (HERR) HIV Counseling and Testing (HCT) Medical Care Coordination (MCC) Biomedical Prevention
MILLS	**Anthony**	Southern CA Men's Medical Group	Biomedical Prevention Medical Care Coordination (MCC)
MORENO	**Carlos**	Unaffiliated consumer	No Ryan White or prevention contracts
MURRAY	**Derek**	City of West Hollywood	No Ryan White or prevention contracts
NELSON	**Katja**	APLA Health & Wellness	Benefits Specialty Case Management, Non-Medical (LCM) Case Management, Home-Based Health Education/Risk Reduction (HERR) HIV Counseling and Testing (HCT) Mental Health, Psychotherapy Nutrition Support Oral Health Biomedical Prevention Medical Care Coordination (MCC)
NEWSOME	**Jazielle**	Illumination Foundation	No Ryan White or prevention contracts
PEÑA	**Raphael**	Unaffiliated consumer	No Ryan White or prevention contracts
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
PRECIADO	**Juan**	Northeast Valley Health Corporation	Mental Health, Psychotherapy
			Benefits Specialty
			Mental Health, Psychiatry
			Oral Health
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
RAY	**Joshua**	Unaffiliated consumer	No Ryan White or prevention contracts
ROGEL	**Nestor**	Alta Med	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Case Management, Home-Based
			HCT Mobile Testing
			HIV Biomedical Prevention
			Medical Care Coordination (MCC)
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Promoting Healthcare Engagement Among Vulnerable Populations
ROSALES	**Ricky**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Mental Health, Psychiatry
SCOTT	**Craig**	Unaffiliated consumer	No Ryan White or prevention contracts
SPENCER	**LaShonda**	LAC & USC MCA Clinic	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
STALTER	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
ULLOA	**Maribel**	HOPWA-City of Los Angeles	No Ryan White or prevention contracts
VALERO	**Justin**	California State University, San Bernardino	No Ryan White or prevention contracts
WALKER	**Kayla**	No Affiliation	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
WILSON	**Amiya**	Unique Wome's Coalition	No Ryan White or prevention contracts
WILSON	**Gregory**	In the Meantime Men's Group, Inc.	HIV/AIDS Health Education/Risk Reduction Prevention Services
YBARRA	**Russell**	Capitol Drugs	No Ryan White or prevention contracts

HIV Calendar

September 2019

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1 Week 36	2 8:00 AM - 5:00 PM HOLIDAY - LABOR DAY | COH Office Closed 1:00 PM - 3:00 PM Public Policy Committee [CANCELLED]	3	4	5	6	7
8 Week 37	9	10 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	11	12 9:00 AM - 1:00 PM Commission Meeting 1:00 PM - 3:00 PM Consumer Caucus Meeting	13	14
15 Week 38	16 10:00 AM - 12:00 PM Transgender Caucus Meeting 1:00 PM - 3:00 PM Women's Caucus	17 1:00 PM - 3:00 PM Planning, Priorities & Allocations (PP&A)	18	19	20	21
22 Week 39	23	24	25	26 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	27	28
29 Week 40	30 10:00 AM - 12:00 PM Goals and Objectives Meeting	1 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	2	3	4	5

HIV Calendar

October 2019

Sun	Mon	Tue	Wed	Thu	Fri	Sat
29 Week 40	30 10:00 AM - 12:00 PM Goals and Objectives Meeting	1 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	2	3	4	5
6 Week 41	7 1:00 PM - 3:00 PM Public Policy Committee	8	9	10 9:00 AM - 1:00 PM Commission Meeting 1:00 PM - 3:00 PM [CANCELLED] Consumer Caucus Meeting 1:00 PM - 4:00 PM Member Orientation	11	12
13 Week 42	14 8:00 AM - 5:00 PM HOLIDAY - COLUMBUS DAY | COH Office Closed	15 1:00 PM - 3:00 PM Planning, Priorities & Allocations (PP&A)	16	17	18	19
20 Week 43	21	22	23	24 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	25	26
27 Week 44	28	29	30	31	1	2

HIV Calendar

November 2019

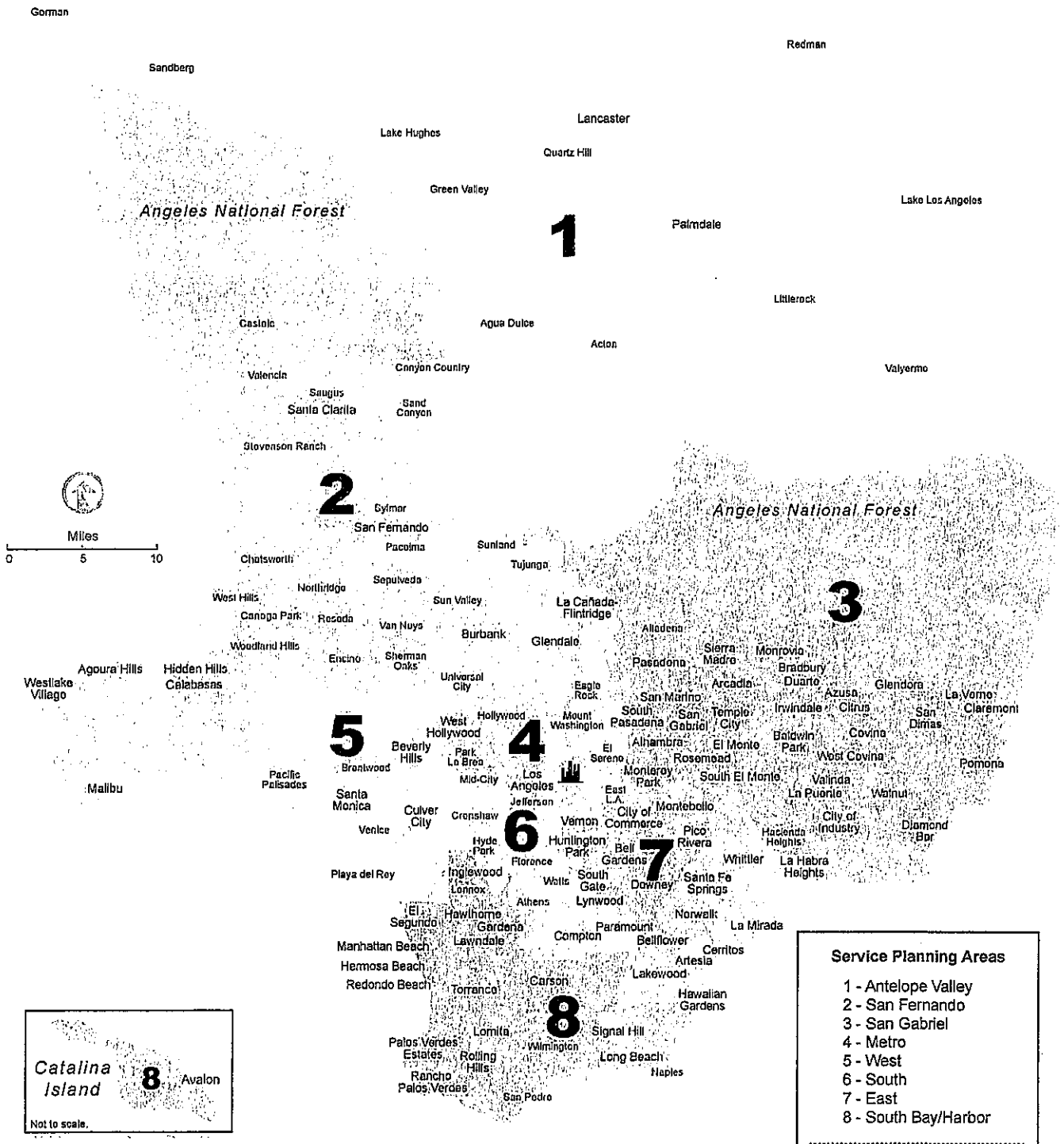
Sun	Mon	Tue	Wed	Thu	Fri	Sat
27 Week 44	28	29	30	31	1	2
3 Week 45	4 1:00 PM - 3:00 PM Public Policy Committee	5 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	6	7	8	9
10 Week 46	11 8:00 AM - 5:00 PM HOLIDAY - VETERANS DAY | COH Office Closed	12	13	14 9:00 AM - 1:00 PM Commission Meeting 1:00 PM - 3:00 PM Consumer Caucus Meeting	15	16
17 Week 47	18 10:00 AM - 12:00 PM Transgender Caucus Meeting	19 1:00 PM - 3:00 PM Planning, Priorities & Allocations (PP&A)	20 9:30 AM - 11:30 AM Women's Caucus	21	22	23
24 Week 48	25	26	27 8:00 AM HOLIDAY - THANKSGIVING DAY | COH Office Closed	28 HOLIDAY - THANKSGIVING DAY | COH Office Closed 10:00 AM - 12:00 PM Operations Committee Meeting (CANCELLED) 1:00 PM - 3:00 PM Executive Committee Meeting (CANCELLED)	29	30

HIV Calendar

December 2019

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1 Week 49	**2** 1:00 PM - 3:00 PM Public Policy Committee	**3** 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	**4**	**5**	**6**	**7**
8 Week 50	**9**	**10**	**11**	**12** 9:00 AM - 1:00 PM Commission Meeting 1:00 PM - 3:00 PM Consumer Caucus Meeting	**13**	**14**
15 Week 51	**16**	**17** 1:00 PM - 3:00 PM Planning, Priorities & Allocations (PP&A)	**18**	**19**	**20**	**21**
22 Week 52	**23**	**24**	**25** 8:00 AM - 5:00 PM HOLIDAY - CHRISTMAS DAY | COH Office Closed	**26** 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	**27**	**28**
29 Week 1	**30**	**31**	1	2	3	4

Los Angeles County
Service Planning Areas



Service Planning Areas

1 - Antelope Valley
2 - San Fernando
3 - San Gabriel
4 - Metro
5 - West
6 - South
7 - East
8 - South Bay/Harbor

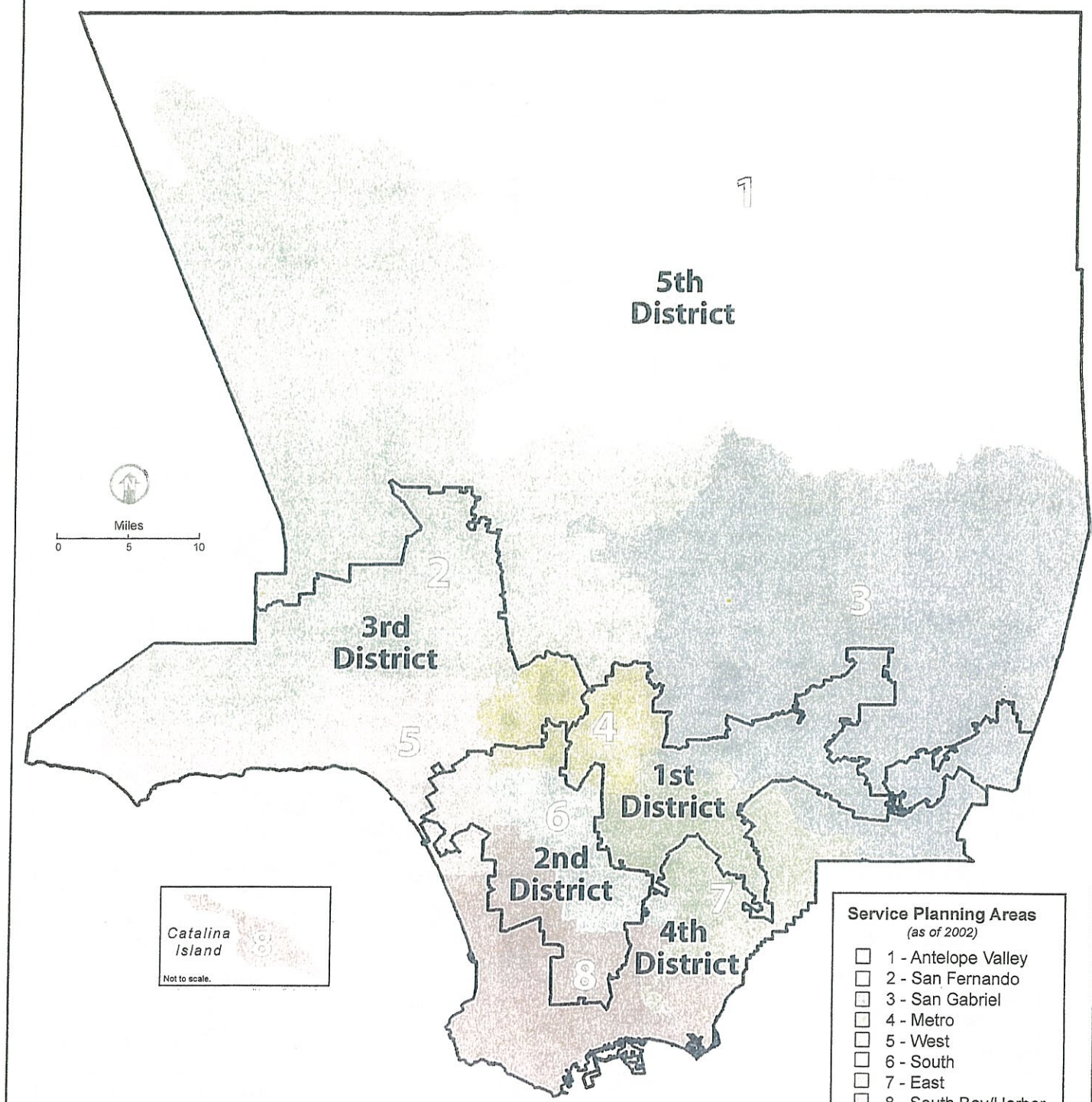
American Indian Children's Council covers all SPAs

Los Angeles County
Children's Planning Council
Improving Children's Lives

Note: City names are shown in **BLACK**.
Communities are shown in **GRAY**.

August, 2002
Los Angeles County
Children's Planning Council
Data Partnership (213) 893-0421

Los Angeles County Service Planning Areas by Supervisorial District



Los Angeles County
Children's Planning Council
Improving Children's Lives

August, 2002
Los Angeles County
Children's Planning Council
Data Partnership (213) 893-0421

3. EXECUTIVE DIRECTOR/STAFF REPORT:

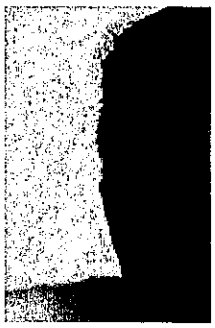
C. The Wall Las Memorias Project | AIDS Monument Renovation

RENOVATION PROJECT

We are proud to announce the renovation of the Las Memorias AIDS Monument, the first AIDS monument of its kind in the nation.

As the AIDS epidemic continues to impact communities across the country the Las Memorias AIDS Monument in Lincoln Park (Los Angeles) continues to anchor the work of The Wall- Las Memorias Project in local communities and across the country.

Be the first of you



The AIDS monument Renovation Project will be funded in part by Proposition A, the Sage Neighborhoods Park Tax that is set to expire in 2019. In March 2015, the Los Angeles County Board of Supervisors approved a motion to initiate the Countywide Comprehensive Parks and Recreation Needs Assessment, which found The Wall Las Memorias AIDS Monument in dire need of rehabilitation. The Los Angeles County Board of Supervisor President Hilda Solis made this possible by including the request in her motion to allocate funding for priority parks projects for the First Supervisorial District.

In allocating the funds, Supervisor Solis expressed support of The Wall Las Memorias AIDS Monument as it is the only one of its kind in the nation and resides in the first supervisorial district of Los Angeles County. The monument has and will continue to serve as a catalyst for social change and as a place for our community to remember those who were lost to this epidemic that claimed so many lives.

The Wall las Memorias Project is now seeking a landscaping architect (see RFQ below) to meet with community members to assist in the new design, with construction projected to begin within the year. Additional funding will be sought to compete the $500,000 estimated worth of renovations. Los Angeles City Councilmember Gilbert Cedillo has pledged to seek additional funding for the project. In addition, the organization looks forward to reclaiming the $100,000 of a security deposit that was part of the initial payment of the monument's construction.

As part of its renovation, the site of the monument will seek anticipated improvements including **new landscaping, updated irrigation systems, new pedestrian level lighting, security cameras, interpretive signage** and **landscape/walkway improvements.**

The monument was originally dedicated on December 1st, 2004 in Lincoln Park before a crowd of more than 1,500 community members. It was designed by architect David Angelo and public artist Robin Brailsford. A community advisory board selected the site in 1993, based upon its rich cultural and artistic history with the Latino community and its proximity to the local AIDS Treatment Center at County USC Hospital, the Rand Schrader AIDS Clinic.

LEARN MORE ABOUT:

> Press Release: TWLMP AIDS Monument Renovation Funds Approved

> History of the Las Memorias AIDS Monument

> Monument Site Plan

> Request For Qualifications Application

> Press Release: TWLMP Selects Lead Architect

> 3D Renderings of Proposed Changes

> DONATE to the Renovation Project

For inquires about the project, please contact Erika Reyes at erika.reyes@twlmp.org or (323) 257-1056 ext. 29

For any press or media opportunities, please contact our Community Engagement Manager Andres Magaña at andres.magana@twlmp.org or (323) 257-1056 ext. 28

4. CO-CHAIR REPORT:

B. COH Co-Chair Open Nominations – Duty Statement

C. United State Conference on AIDS (USCA) Follow Up

LOS ANGELES COUNTY
COMMISSION ON HIV

DUTY STATEMENT

COMMISSION CO-CHAIR

(APPROVED 3-28-17)

In order to provide effective direction and guidance for the Commission on HIV, the two Commission Co-Chairs must meet the following demands of their office, representation and leadership:

ORGANIZATIONAL LEADERSHIP:

① Serve as Co-Chair of the **Executive Committee**, and leads those monthly meetings.

② Serve as ex-officio member of all standing Committees:
- attending at least one of each standing Committee meetings annually or in Committee Co-Chair's absence

③ Meet monthly with the Executive Director, or his/her designee, to prepare the Commission and Executive Committee meeting agendas and course of action,
- assist Commission staff in the preparation of motions, backup materials and information for meetings, as necessary and appropriate.

④ Lead Executive Committee in decision-making on behalf of Commission, when necessary.

⑤ Act as final Commission-level arbiter of grievances and complaints

MEETING MANAGEMENT:

① Serve as the Presiding Officer at the Commission, Executive Committee and Annual meetings.

② In consultation with the other Co-Chair, the Parliamentarian, the Executive Director, or the senior staff member, lead all Commission, Executive and special meetings, which entail:
- conducting meeting business in accordance with Commission actions/interests;
- maintaining an ongoing speakers list;
- recognizing speakers, stakeholders and the public for comment at the appropriate times;
- controlling decorum during discussion and debate and at all times in the meeting;
- imposing meeting rules, requirements and limitations;
- calling meetings to order, for recesses and adjournment in a timely fashion and according to schedule, or extending meetings as needed;
- determining consensus, objections, votes, and announcing roll call vote results;
- ensuring fluid and smooth meeting logistics and progress;
- finding resolution when other alternatives are not apparent;
- apply Brown Act, conflict of interest, Ryan White Program (RWP) legislative and other laws, policies, procedures, as required;
- ruling on issues requiring settlement and/or conclusion.

③ Ability to put aside personal advocacy interests, when needed, in deference to role as the meetings' Presiding Officer.
④ Assign and delegate work to Committees and other bodies.

REPRESENTATION:
In consultation with the Executive Director, the Commission Co-Chairs:
① Serve as Commission spokesperson at various events/gatherings, in the public, with public officials and to the media after consultation with Executive Director
② Take action on behalf of the Commission, when necessary
③ Generates, signs and submits official documentation and communication on behalf of the Commission
④ Participate in monthly conference calls with HRSA's RWP Project Officer
⑤ Represent the Commission to other County departments, entities and organizations.
⑥ Serve in protocol capacity for Commission
⑦ Support and promote decisions resolved and made by the Commission when representing the Commission, regardless of personal views

KNOWLEDGE/BACKGROUND:
① CDC HIV Prevention, RWP, and HIV/AIDS and STI policy and information
② LA County Comprehensive HIV Plan and Comprehensive HIV Continuum
③ LA County's HIV/AIDS and STI, and other service delivery systems
④ County policies, practices and stakeholders
⑤ RWP legislation, State Brown Act, applicable conflict of interest laws
⑥ County Ordinance and practices, and Commission Bylaws
⑦ Topical and subject area of Committee's purview
⑦ **Minimum of one year active Commission membership prior to Co-Chair role**

SKILLS/ATTITUDES:
① Sensitivity to the diversity of audiences and able to address varying needs at their levels.
② Life and professional background reflecting a commitment to HIV/AIDS and STI-related issues.
③ Ability to demonstrate parity, inclusion and representation.
④ Multi-tasker, action-oriented and ability to delegate for others' involvement.
⑤ Unintimidated by conflict/confrontation, but striving for consensus whenever possible.
⑥ Capacity to attend to the Commission's business and operational side, as well as the policy and advocacy side.
⑦ Strong focus on mentoring, leadership development and guidance.
⑧ Firm, decisive and fair decision-making practices.
⑨ Attuned to and understanding personal and others' potential conflicts of interest.

COMMITMENT/ACCOUNTABILITY TO THE OFFICE:

① Put personal agenda aside and advocate for what's in the best interest of the Commission
② Devote adequate time and availability to the Commission and its business
③ Assure that members' and stakeholders' rights are not abridged
④ Advocate strongly and consistently on behalf of Commission's and people living with and at risk for HIV, interests
⑤ Always consider the views of others with an open mind
⑥ Actively and regularly participate in and lead ongoing, transparent decision-making processes
⑦ Respect the views of other regardless of their race, ethnicity, sexual orientation, HIV status or other factors

USCA 2019

The theme for this year's USCA was ENDING THE EPIDEMIC IN THEIR MEMORY, which highlighted the many folks whose stories of living with HIV have significantly impacted the world of HIV in the public eye. This theme echoed throughout the conference as there was a strong emphasis on storytelling and hearing directly from those who are living with HIV and their experiences with the services they are accessing, and empowering them to be voices in their own communities. *Leveling up: An intentional conversation about power, privilege and accountability* was a workshop highlighted the impact of privilege and power in the professional work space and how to address and hold people in power accountable for making sure that there is diversity in not only the voices in administration but as well as the front line staff. Some key points were for those who are in power to not feel specifically threatened when receiving input from staff or the community, and having a responsibility to commit to addressing those specific concerns. In the *Connecting the Dots: Uprooting Social Determinants and HIV* session, there were talks of how and what social determinants are preventing folks from accessing HIV care and prevention services. There was an emphasis on HIV Criminalization and HIV Surveillance and mistrust in the medical systems and the communities, and how they perpetuate negative viewpoints from those attempting to access services. *Voices Heard: HOPWA Safe House or House of Pain?* was another particularly interesting workshop that showcased the real stories of people who are accessing HOPWA and housing services and what factors prevent them from obtaining services such as internal self stigma and blame, external stigma from social workers, to income and substance use. In my own recommendation for the commission, it would be wise to engage our communities and encourage those to not only get involved with the local commission, but to get involved with national campaigns such as AIDSWATCH, the nation's largest HIV advocacy event happening in 2020. In regards to service standards development and for organizations funded, but more importantly not funded by the CDC, taking advantage of trainings from the National HIV Classroom Learning center on how to implement standard HIV care and prevention services. There are also many ways to increase the commission's community HIV communication through social media with the help of FHI360 and the training services they provide to help build effective HIV related social marketing. Overall, the USCA conference did a wonderful

job at making sure that the presenters and their workshops were centered and focused on the side of people living with HIV who are both providing and accessing the services alike, allowing folks outside of the experience who are providing care to really get a deeper understanding of how they can better serve these populations.

LOS ANGELES COUNTY
COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
HIVCOMM@LACHIV.ORG • https://hiv.lacounty.gov

UNITED STATES CONFERENCE ON AIDS (USCA 2019)
REPORT FROM ABAD LOPEZ, UNAFFILIATED CONSUMER
Service Planning Area (SPA) 2

Highlights from Selected Workshops

How do you say U=U? Undetectable = Untransmittable. People living with HIV on effective treatment cannot sexually transmit the virus. You may know it, but in the United States, most people living with HIV, providers, policy makers and the public still don't. This radical fact can transform lives and the field when communicated properly. When describing the "risk" from one human being to another in the most intimate moments of their lives, it's important to be impeccable with words and attitudes. When speaking with people living with HIV, their sexual partners, and the wider community, it is important to describe U=U in a way that inspires confidence and does not promote unnecessarily doubts or fear. Below are few pointers gathered from the U.S. and around the world. U=U belongs to everyone!
The phrase "U=U" is now being communicated at the highest levels in the field:

- NIH Director Dr. Francis Collins recently wrote a blog supporting U=U.
- NIAID Director Dr. Anthony S. Fauci and Director of the Division of AIDS at NIAID Dr. Carl Dieffenbach recently wrote an article in JAMA supporting U=U.
- NIH OAR Director Dr. Maureen Goodenow wrote a blog about why U=U is game changer.
- CDC Director Dr. Robert Redfield referred to U=U in a recent speech.
- Over 850 organizations from nearly 100 countries have signed on to the U=U campaign.

Another important topic for me was: Essential Roles of the Ryan White HIV/Program

1) Access to HIV Care: The program ensures access to lifesaving HIV care to uninsured and underinsured people living with HIV.
2) Integrated Care: The Program provides insurers and providers with models and evidence for how to provide integrated care, bringing together physical and mental health services that support lifelong engagement in HIV care.
3) Monitoring HIV Outcomes: The Program supports state and local health departments to innovate in building data and monitoring systems that enable medical and non-medical providers, health plans, health departments and others to work together to improve patient outcomes.

4) Equipping Workforce to Stay Current: The Program trains medical and non-medical providers to provide current HIV medical and supportive care to the diverse HIV population.
5) Nationwide Capacity to Provide High Quality Care: The Program ensures that capacity to deliver HIV medical care exists in all parts of the U.S.

The U.S Response to HIV has come a long way. We have an array of effective and well-tolerated treatments. We know that "U=U" or "undetectable equals untransmittable", meaning that when people with HIV are durably virally suppressed, they cannot transmit HIV to their sexual partners. We also know that if someone is newly diagnosed with HIV, they can expect to live an essential normal lifespan. The demands of people and communities affected by HIV, however, were never exclusively about managing the virus. Rather, they were about building the environment where all people with HIV can live long, happy, and healthy lives. These goals require creating social environments that support people with HIV- and it means addressing co-occurring health conditions that can threaten the benefits of effectively treating HIV.

Last topic that was important for me was: Policy Action can increase community support for HIV Cluster Detection.

Responding to clusters of HIV transmission has been a component of federal and state HIV prevention activities for years, but technological advancements enabling the use of HIV molecular data can enhance the ability to identify and respond to clusters. Using this new cluster detection tool is a central pillar of the Administration's Ending the HIV Epidemic (EHE) Initiative. To maximize its success and utility, however, affected communities and policy makers must work together to maximize the prevention potential of clusters detection while working to ensure that people and communities are not harmed in the process.

6. RYAN WHITE PROGRAM PARTS C, D AND F REPORT

LOS ANGELES COUNTY
COMMISSION ON HIV

Ryan White HIV/AIDS Program Parts

The Ryan White HIV/AIDS Program is divided into five Parts, following from the authorizing legislation. Note that all Parts utilize the same service categories.

- **PART A** provides grant funding for medical and support services to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs). EMAs and TGAs are population centers that are the most severely affected by the HIV/AIDS epidemic.

- **PART B** provides grant funding to states and territories to improve the quality, availability, and organization of HIV health care and support services. Grant recipients include all 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and the 5 U.S. Pacific Territories. In addition, Part B also includes grants for the AIDS Drug Assistance Program (ADAP).

- **PART C** provides grant funding to local community-based organizations to support outpatient HIV early intervention services and ambulatory care. Part C also funds planning grants, which help organizations more effectively deliver HIV care and services.

- **PART D** provides grant funding to support family-centered, comprehensive care to women, infants, children, and youth living with HIV.

- **PART F** provides grant funding that supports several research, technical assistance, and access-to-care programs. These programs include:

  - **The Special Projects of National Significance Program**, supporting the demonstration and evaluation of innovative models of care delivery for hard-to-reach populations;

  - **The AIDS Education and Training Centers Program**, supporting the education and training of health care providers treating people living with HIV through a network of eight regional centers and three national centers;

  - **The Dental Programs**, providing additional funding for oral health care for people with HIV through the HIV/AIDS Dental Reimbursement Program and the Community-Based Dental Partnership Program; and

  - **The Minority AIDS Initiative**, providing funding to evaluate and address the impact of HIV/AIDS on disproportionately affected minority populations.

Retrieved from: https://hab.hrsa.gov/about-ryan-white-hivaids-program/about-ryan-white-hivaids-program.
October 2016.

7. CALIFORNIA OFFICE OF AIDS (OA) REPORT:

the OA Voice

Issue: September 2019

This newsletter is organized to align the updates with Strategies from the ***Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention, and Care Plan*** (Integrated Plan). The Integrated Plan is available on the Office of AIDS' (OA) website at www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/IP_2016_Final.pdf.

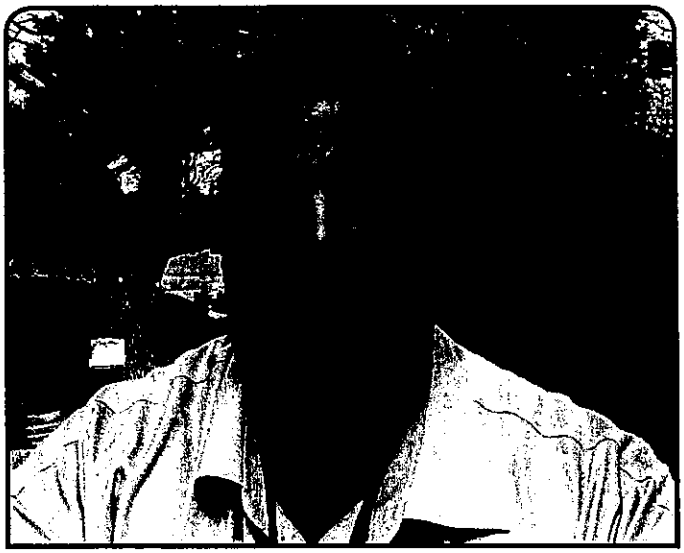
In This Issue:

Staff Highlight:

OA is pleased and excited to announce that Adrian Barraza has accepted the Office of AIDS Division Assistant Chief position. He will start his new position on Friday, August 30th.

Adrian has been with the AIDS Drug Assistance Program (ADAP) Branch since November 2015 during which time he served as the ADAP Unit 3 Chief for a little over a year and the ADAP Program, Policy, and Fiscal Section Chief since 2017.

Adrian is lead on the ADAP Estimate Package for inclusion in the Governor's Budget and has led implementation of the PrEP Assistance Program and the Access, Adherence, and Navigation Program to assist in navigating ADAP clients to comprehensive health coverage and achieving and maintaining viral suppression.



Strategy A: Improve Pre-Exposure Prophylaxis (PrEP) Utilization

PrEP Assistance Program (PrEP-AP):

As of August 20, there are 181 PrEP-AP enrollment sites covering 100 clinics that currently make up the PrEP-AP Provider Network. As of August 20, there are 2,461 clients enrolled in the PrEP-AP.

A comprehensive list of the PrEP-AP Provider Network can be found at https://cdphdata.maps.arcgis.com/apps/webappviewer/index.html?id=6878d3a1c9724418aebfea96878cd5b2.

Gilead, the sole manufacturer of Truvada® for PrEP, recently made a change that may affect individuals who are currently enrolled in the Gilead Copay Coupon Card Program. The Gilead Copay Coupon Card Program has changed vendors. Data from some accounts did not fully transfer to the new vendor and as a result, some individuals may be unable to pick up Truvada® at their pharmacy. Individuals that are experiencing issues with obtaining Truvada® at their pharmacy should have their pharmacist call one of the following numbers for updated Rx, BIN, and/or other needed numbers: (877) 505-6986 or (888) 358-0398.

ADAP Insurance Assistance Program	Number of Clients Enrolled	Percentage Change from July
Employer Based Health Insurance Premium Payment (EB-HIPP) Program	579	+5%
Office of AIDS Health Insurance Premium Payment (OA-HIPP) Program	4,615	-0.6%
Medicare Part D Premium Payment (MDPP) Program	1,748	+2%
Total	**6,942**	**+0.4%**

Individuals who have general questions regarding the Gilead Copay Coupon Card Program may call the main program number at (800) 226-2056.

Strategy G: Improve Availability of HIV Care

The California Department of Housing and Community Development (HCD) will release its draft of the 2018-19 Consolidated Annual Performance and Evaluation Report (CAPER) for public comment prior to submittal to the Department of Housing and Urban Development on September 30, 2019. The CAPER reports on specified federal housing and economic assistance allocated by the state, which includes the Housing Opportunities for Persons with AIDS (HOPWA) program, for the period July 1, 2018, through June 30, 2019. The draft will be available on HCD's website at http://www.hcd.ca.gov/policy-research/plans-reports/index.shtml#caper, for a 15-day public comment period between September 4 and September 18, 2019. The HCD website will also provide details on how to submit public comments closer to the public comment period.

Strategy J: Increase Rates of Insurance/Benefits Coverage for PLWH or on PrEP

ADAP's Insurance Assistance Programs:

As of August 27, the number of ADAP clients enrolled in each respective ADAP Insurance Program are shown in the chart above.

Strategy K: Increase and Improve HIV Prevention and Support Services for People Who Use Drugs

The California Budget Act of 2019 included $15.2 million in funding for syringe services programs (SSPs) staffing, to be spent over four years. The initiative also includes funds for technical assistance to SSPs and to the organizations SSPs work with to provide comprehensive services to people who use drugs.

The funding will roll out in two stages: first OA will release an RFA for a grants manager/technical assistance (TA) provider. The awarded organization will then issue an RFA to SSPs. They will also provide TA, and evaluate the impact of the project.

The Harm Reduction Unit has completed thirty interviews with stakeholders interested in providing input into the RFA, and on July 16th hosted a webinar with stakeholders to discuss next steps for funding. To sign up for an interview, or receive the recording of the webinar, contact Leslie Knight (Leslie.Knight@cdph.ca.gov.)

CDPH's Opioid Overdose Surveillance Dashboard has been updated with new indicators and data, found at https://bit.ly/33ZkmQb. It now includes

morbidity and mortality indicators for opioids combined with other drugs and other drug poisonings, both for benzodiazepines, amphetamines, and cocaine. Full-year 2018 emergency department data are also available.

Harm Reduction Coalition has produced a simple 1-page guide to safer drug use that includes strategies, safer injection practices, and information on skin and soft tissue infections. The guide can be found at https://bit.ly/2MBz76t.

Strategy N: Enhance Collaborations and Community Involvement

Ending the HIV Epidemics in the United States:

Responding to the national "Ending the HIV Epidemic in the United States" plan, the CDC and HRSA have issued notice of funding opportunities (NOFOs) targeted to the 50 counties and eight states that have the highest burden of HIV in the United States. In California, designated counties include Alameda, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, and San Francisco.

The CDC NOFO deadline has past and notification of awards will be announced by September 30, 2019. This NOFO was a one-year grant for accelerated planning and updating of Getting to Zero plans. Los Angeles and San Francisco submitted applications specifically for their counties. The NOFO directed the State Office of AIDS to submit an application on behalf of the other six counties. It is anticipated that a second NOFO will be issued by the CDC for a four-year period to implement the plan developed in year one.

The HRSA NOFO was released on August 13, 2019 and applications are due October 15, 2019 (HRSA-20-078). Per NOFO instructions, the designated Part A counties can submit applications directly. The funding is to be used in specified counties rather than for the entire Eligible Metropolitan Areas or Transitional Grant Areas. California designated Part A eligible counties include Los Angeles County, Oakland (Alameda County), Orange County, Riverside and San Bernardino Counties, Sacramento County, San Diego County and San Francisco City/ County. Funding from this award will be used to implement strategies, interventions, approaches, and core medical and support services to reduce new HIV infections in the United States. Unique to this NOFO is not requiring clients to meet all Ryan White HIV/AIDS Program (RWHAP) eligibility requirements, only that there is a documented HIV diagnosis. Therefore, these monies may reach people ineligible for RWHAP programs. As always, the State Office of AIDS is happy to collaborate and coordinate services between all California local health jurisdictions.

AIDS2020:

The International AIDS Conference will convene in San Francisco and Oakland, July 6 – 10, 2020. Registration for the conference opens October 1, 2019. The local planning committee is developing an abstract mentor program to assist local organizations who want to submit abstracts for presentation at the conference. Follow the resources being developed by the local AIDS2020 committee at http://aids2020local.org.

Strategy O: Further Leverage Existing Resources to Better Meet the Needs of People at Risk for and Living with HIV in California

California Planning Group (CPG):

OA and CPG members will convene for their fall in-person meeting October 21 – 23, 2019 in San Diego, CA. The meeting will provide CPG members an opportunity to share updates, exchange ideas and conduct CPG business. Additional information about this meeting can be found at https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_CPG.aspx.

For questions regarding this report, please contact: angelique.skinner@cdph.ca.gov.

8. LA COUNTY DEPARTRMENT OF PUBLIC HEALTH REPORT:

A. Division of HIV/STD Programs (DHSP) Report

(a) Molecular Surveillance Program Presentation

County of Los Angeles Public Health

Advancing HIV Prevention through Cluster Detection and Response in Los Angeles County: An Emerging Model

Sophia F. Rumanes, MPH, Chief, Direct Community Services
Kathleen Poortinga, MPH, Epidemiologist, HIV Surveillance

September 12, 2019
Los Angeles County Commission on HIV

1

County of Los Angeles Public Health

I. Introductions
II. Evolution of HIV Prevention and Ending the Epidemic
III. HIV/STD Partner Services
  – What is HIV/STD Partner Services
  – Who conducts HIV Partner Services
IV. HIV Molecular Epidemiology
  – What is a molecular cluster?
  – Molecular data analysis and limitations
V. HIV Molecular Cluster Response
  – What can we do when a cluster is detected?
  – Response: Local and state health departments, CDC, Providers
VI. How is HIV Molecular Cluster Detection and Response being implemented in LA County?
VII. Next Steps

Evolution of HIV Prevention

- We are at an exciting time in HIV prevention:

Testing is faster and can detect infection earlier

Better treatment and prevention options than ever

Treatment saves lives AND prevents transmission

Pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP)

Improved strategies and interventions to reach populations in need of prevention, care, and related services

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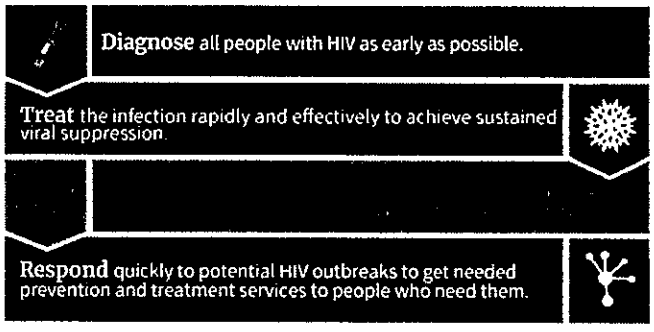
Ending the HIV Epidemic: A Plan for America

GOAL:

75% reduction in new HIV infections in 5 years and at least 90% reduction in 10 years.

HHS will work with each community to establish local teams on the ground to tailor and implement strategies to:



County of Los Angeles Public Health

What is HIV/STD Partner Services?

Partner Services reduces the spread of HIV and STDs by helping people inform their partners.

The goals of Partner Services include the following:

- Provide services to persons infected with HIV or other STDs, including providing them risk-reduction counseling, linking them to medical care, and making referrals to other services (e.g., psycho-social support and prevention interventions).
- Ensure that sex and drug-injection partners of persons with HIV or other STDs are notified of their exposure, provided counseling and testing, treated or linked to medical care if needed, and provided other appropriate referrals.
- Reduce future rates of transmission by aiding in early diagnosis treatment regimen.

5

County of Los Angeles Public Health

Public Health Investigator (PHI) role in Los Angeles County

Mandated functions of the Health Officer related to communicable disease

Enforcement public health laws (i.e. quarantine, legal orders)

Locate cases and contacts to disease and refer for medical care

Educates clients (progression of disease, risk reduction)

Motivates compliance (discuss long term health risks)

Remove threats to the public's health (e.g., acute communicable disease)

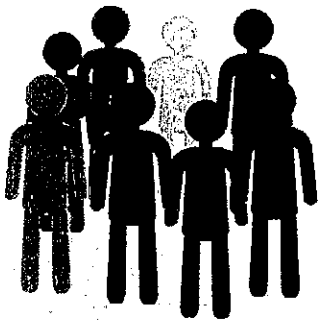
County of Los Angeles Public Health

What do PHIs in LA County follow up on?

- Sexually transmitted diseases
- HIV
- Tuberculosis (TB)
- Acute communicable diseases (ACD)
- Marine biotoxin monitoring
- Home births
- Response to public health emergencies (eg. measles outbreak)

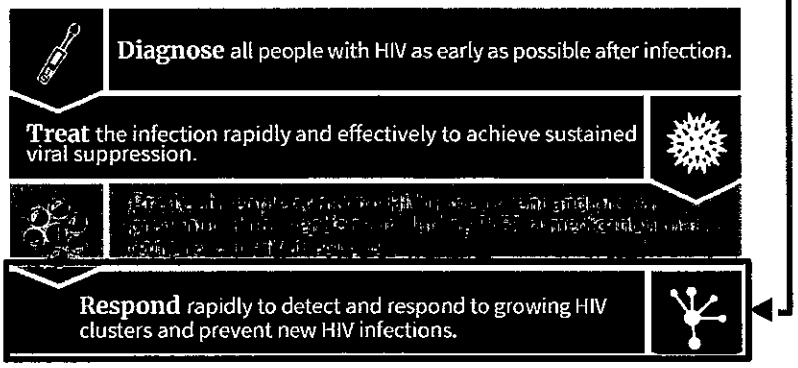
County of Los Angeles Public Health

HIV/STD Public Health Investigator (PHI) activities



- Conduct record searches (e.g., medical records, STD CaseWatch look up, HIV Surveillance look-up etc.)
- Contact Providers
- Conduct locating activities to find clients
- Interview clients and conduct partner elicitation
- Locate contacts/sex or needle sharing partners and people who can benefit from testing ("clusters")
- Refer or transports contacts or "clusters" to clinic for testing/epi-Rx.
- Interview sex partners/clusters with positive labs.
- Education/referrals/PrEP offer and referral
- Training: 12 month Trainee program, continuous training, confidentiality and security trainings.

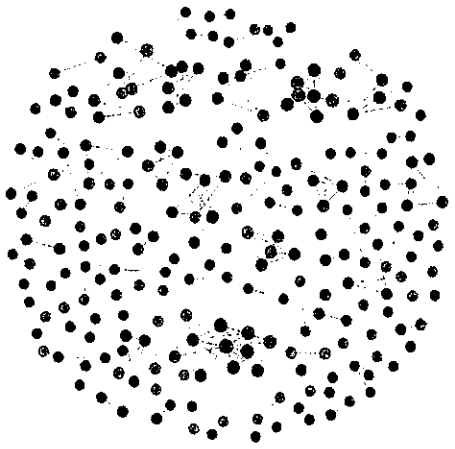
Molecular data highlighted in federal End the HIV Epidemic plan



- In 2018, molecular epidemiology required in CDC integrated funding
- In 2019, molecular data highlighted as one of the four federal strategies

What is an HIV molecular cluster?

- Drug resistance testing generates HIV nucleotide sequence data of the virus (*molecular HIV data*)
- A **molecular cluster** is a group of persons with diagnosed HIV infection who have genetically similar HIV sequences
- Analysis can identify if there are large groups of similar sequences indicating rapid HIV transmission
- We use this information to focus prevention efforts



HIV Molecular evolution

- HIV mutates/evolves over time
- People living with HIV infection whose viral strains are genetically similar may be more closely related in transmission

LA LA LA LA LA LA LA LA	LA LA LA LA LA LA LA LA
LA LA LA **RA** LA LA LA LA	LA LA LA **RA** LA **MA** LA LA **YA**

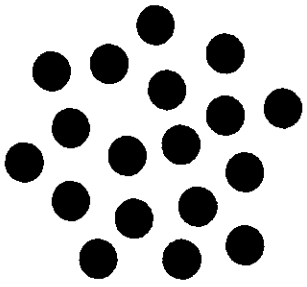
- Analysis: compares nucleotide sequences to determine relatedness

ACCGGATAACGGTTATCCG	ACCGGATAACGGTTATCCG
ACTGGATAACGGTTATCCG	ACCGAATCACGGAAATCCG

Adapted from presentation by J Gardy

Routine molecular analysis to detect large groups with genetically similar viruses

- Secure HIV-TRACE program analyzes HIV pol sequences
- Prioritize those groups with <u>recent and rapid</u> transmission
  - Within the most recent 3 years
  - Highly related viral sequences (≥ 99.5% similar)
  - At least 5 persons with HIV diagnosed within the past 12 months



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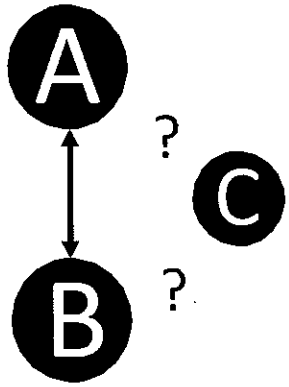
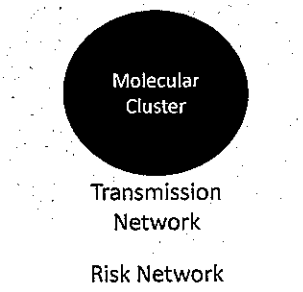
Molecular analysis with Secure HIV Trace:

Does:	Does not:
Identify a group of people with similar forms of HIV	NOT determine direct links or directionality of transmission between people
Indicate recent and rapid HIV transmission	NOT indicate that an outbreak has necessarily been detected
Provide a data source to inform and enhance current HIV prevention activities	NOT replace partner services or community outreach
Depend on how many HIV positive diagnoses have genetic sequence data in our surveillance database	NOT identify all cases in the risk network



The possibilities of using molecular clusters to identify underlying transmission cluster and risk network



Can include persons with diagnosed HIV infection who
- Entered HIV care
- Had HIV genetic sequence transmitted to DPH

Can include
- Persons with undiagnosed HIV infection
- Persons with diagnosed HIV with no genetic sequence available

Can include
- Persons who are not HIV-infected but may be at risk for infection

What can the local HD do when a molecular cluster is identified?

Ensure rigorous precautions to protect client confidentiality

- Individuals
  - Molecular cluster cases - prioritize their retention in care; conduct partner services to ask for risk network members who could benefit from testing or PrEP
  - Named contacts - Provide education, HIV/STD testing, linkage to PrEP, link/re-link to care (if HIV positive)
- Groups
  - Identify networks with unusual or shared risk factors (e.g., IDU)
  - Understand missed opportunities for HIV prevention and linkage to care within the associated transmission/risk network
- Community
  - Identify communities experiencing rapid HIV transmission and deliver targeted testing and prevention efforts

15

What can providers/CDC do for cluster detection and response?

Providers can:

- Order genotypic HIV drug resistance testing when a patient tests positive for HIV
- Remain alert to increases in HIV transmission and unusual patterns in risk behaviors

CDC can:

- Confirm the geographic limits of clusters, allowing jurisdictions to target resources to areas of high need
- Take the lead on rapidly responding to clusters that involve multiple states
- Provide guidance to states on response and effective prevention interventions
- Monitor whether efforts are successfully preventing the spread of infection

16

LA County: Cluster Detection and Response

- Run HIV-TRACE every 2 weeks to identify new clusters/new cases associated with existing clusters
  - Identify whether they appear to be in care and virally suppressed
    - If not, refer to our Linkage Re-engagement Program
    - If yes, check to see if they received HIV Partner Services after diagnosis
      - If no, then refer to our Partner Services staff to interview
        - » If any partners or contacts identified, follow-up to educate, link to testing, PrEP
  - Identify any common venues for meeting partners or shared risk factors (e.g., IDU, people experiencing homelessness)
- Coordinate with SOA/CDC when clusters have links outside of LAC

17

LA County: Issues Requiring Additional Discussion/Review

- How to message to clients?
  - What if they already received PS or are in care?
  - What if significant time has lapsed since diagnosis?
- What other ways can this information be used?
  - Any role for their HIV medical provider?
  - Explain DPH role and plan to contact?
  - Coordinate interview?
- How can these services be conducted in a culturally sensitive and non-coercive manner?
  - Importance of community engagement

18

LA County: Next Steps

- Integrate into existing Partner Services activities while exploring how to enhance program
- Partner engagement/education
- Data protections/enhancing policies and procedures
- Assessing legal implications
- Engage community and stakeholders
- Developing collaborations
- Developing capacity
- Assessing prevention portfolio and fiscal mechanisms needed for response
- Submit plan to CDC (in 2020)

19

Los Angeles County HIV Strategy Goals

- Reduce annual HIV incidence to 500 by 2022
- Increase the proportion of Persons Living with HIV (PLWH) who are diagnosed to at least 90% by 2022
- Increase the proportion of diagnosed PLWH who are virally suppressed to 90% by 2022

20

County of Los Angeles Public Health

Acknowledgements:

Sonali Kulkarni, MD, MPH
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Wendy Garland, MPH
Sameh Mansour
Office of AIDS

County of Los Angeles Public Health

10. STANDING COMMITTEE REPORTS:

A. Operations Committee
   (1) Membership Management
      (b) Noah Kaplan | SBP Committee-Only Membership Application **MOTION #3**
   (2) Policies and Procedures
      (a) Policy #08.1104: Commission and Committee Co-Chair Elections and Terms **MOTION #4**
      (b) Policy #08.2301: Voting Procedures **MOTION #5**
   (3) Training
      (a) 2019 COH Mandatory Member Training Flyer

B. Planning, Priorities and Allocations (PP&A) Committee:
   (1) Ryan White Program (RWP) Program Year (PY) 30 Service Category Ranks **MOTION #6**
   (2) RWP PY 30 Service Category Allocations **MOTION #7**

C. Public Policy (PP) Committee

D Standards and Best Practices (SBP) Committee
   (1) Revised HIV Continuum Framework **MOTION #8**
   (2) Universal Standards of Care **MOTION#9**

10. STANDING COMMITTEE REPORTS (cont'd):

A. Operations Committee

(1) Membership Management

(b) Noah Kaplan | SBP Committee-Only Membership Application **MOTION #3**

(2) Policies and Procedures

(a) Policy #08.1104: Commission and Committee Co-Chair Elections and Terms **MOTION #4**

(b) Policy #08.2301: Voting Procedures **MOTION #5**

(3) Training

(a) 2019 COH Mandatory Member Training Flyer

LOS ANGELES COUNTY
COMMISSION ON HIV

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HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov

POLICY/PROCEDURE #08.1104	Commission and Committee Co-Chair Elections and Terms	Page 1 of 8

MOTION #4:
9/12/19 COH MEETING

SUBJECT: **The process and scheduling for Commission and Committee Co-Chair elections.**

PURPOSE: **To outline the steps and timing for the Commission's and standing committees' Co-Chair elections.**

BACKGROUND:

- Federal Ryan White legislation mandates that all Part A jurisdictions establish local HIV planning councils to develop a comprehensive ~~care~~ HIV plan, rank priorities and determine allocations, create standards of care, and to carry out a number of other responsibilities. The Los Angeles County Commission on HIV serves as the local Ryan White Part A HIV planning council for the Los Angeles County.

- In accordance with Ryan White rules and Ordinance 3.29 of the Los Angeles County Charter, the Commission on HIV comprises 51 voting members, meets monthly, and fulfills its various responsibilities through an open, transparent meeting process. The meetings comply with appropriate provisions of California's Ralph M. Brown Act, and are run according to Robert's Rules of Order.

- Elected leadership is necessary to represent the planning council, facilitate the meetings, and oversee planning council work, among other responsibilities. The Health Resources and Services Administration (HRSA), the federal agency responsible for administering the Ryan White Program, recommends that planning councils elect Co-Chairs for these functions. The Commission on HIV has adopted HRSA's guidance with two Co-Chairs elected by the membership.

- The Commission on HIV relies on a strong committee structure to discharge its work responsibilities. Consistent with the Commission's By-Laws, the Commission organizational structure comprises five standing committees: Executive, Public Policy (PP), Operations, Priorities, Planning, and Allocations (PP&A), and Standards and Best Practices (SBP). Except for the Executive Committee (where the Commission Co-Chairs serve as the Committee Co-Chairs), the standing committees are led by two Co-Chairs elected by the Committee membership.

- The Commission Co-Chairs' duties, responsibilities, rights and expectations are detailed in *Duty Statement, Commission Co-Chair*). The Committee Co-Chairs' duties, responsibilities, rights and expectations are detailed in *Duty Statement, Committee Co-Chair*.

POLICY:

1. The Commission Co-Chairs are elected to two-year terms, and each Co-Chair seat expires in December of alternate years. Except for the Executive Committee, each of the standing committees annually elects two Committee Co-Chairs to one-year terms that expire in February. There are no limits to the number of terms to which a Commission or committee Co-Chair can be re-elected. Co-Chairs elected to fill mid-term vacancies are elected for the remaining duration of the term, until it expires.

2. The Commission Co-Chairs are considered members of all committees, and also serve as Executive Committee Co-Chairs. Committee Co-Chairs cannot serve as Co-Chair to more than one committee at a time.

3. Nominations for the vacant Commission Co-Chair seat are normally opened in ~~November~~August, unless unexpected circumstances arise (meeting cancellations, absence of quorum, etc.) prevent it. Nominations for the Committee Co-Chair seats are usually opened in January, following election of the Commission Co-Chairs and final committee assignments, unless otherwise delayed. Members can nominate themselves or can be nominated by other stakeholders throughout the period in which the nominations are open.

Comment [MD1]: Per By Laws, Co Chair elections are to be conducted at least four months prior to end of the year/term.

4. Except for immediate vacancies in both Co-Chair seats, nominations must be open at the monthly meeting prior to the Co-Chair elections. Unless delayed or postponed, the Co-Chair elections are held at following month's regular meeting.

5. Commission Co-Chair candidates must have at least a year's service on the Commission. At least one of them must be HIV-positive and at least one of them must be a person of color. Only Commissioners can serve as the Co-Chairs. Only Commissioners serving in their primary committee assignment may serve as Committee Co-Chairs, but at least one of the Committee Co-Chair seats must be filled by a Commissioner. Unaffiliated HIV-positive consumers are highly encouraged to seek leadership roles and run for a Commission or Committee Co-Chair seat whenever possible.

6. Co-Chairs are elected through a sequential voting process until there are only one or two candidates remaining, as need dictates. The Commission/committee must approve the final candidate(s) through a consent vote of approval or through individual roll call votes. All Co-Chairs must be elected by a majority of the voting membership. A Co-Chair candidate's failure to earn a majority vote disqualifies that member as a Co-Chair candidate for that term, closes the election for that meeting, extends the nominations period, and postpones the election to the subsequent meeting.

7. Commission and Committee Co-Chair terms are allowed to be extended to accommodate delayed meeting schedules, lack of suitable candidates, or when the body cannot determine definitive, final Co-Chair candidates. A single Co-Chair may also continue to serve, when needed, until a second Co-Chair candidate is identified and elected.

PROCEDURE(S):

1. **Terms of Office**: The Commission Co-Chairs are elected to office for staggered two-year terms. Aside from the Executive Committee, standing committee Co-Chairs are elected for two-year terms.
   a. Commission Co-Chair terms expire in alternate years to ensure leadership continuity. The Commission Co-Chairs also serve as Co-Chairs of the Executive Committee, and serve in those roles for the duration of their tenure as Commission Co-Chairs.
   b. The four, remaining standing committees [Public Policy (PP), Operations, Priorities Planning and Allocations (PP&A) and Standards and Best Practices (SBP)] elect their Co-Chairs for one-year terms that expire concurrently.
   c. Commission Co-Chair terms expire in December of the calendar year, unless the November and/or December monthly Commission meeting(s) are cancelled, quorum is not achieved at the meeting at which the Co-Chair is scheduled to be elected, or by majority vote of the Commission to accommodate an extension of the Co-Chair election process.
   d. Committee Co-Chair terms expire in February of the calendar year, but may be extended, if needed, until new Co-Chairs are elected to fill the leadership positions.
   e. In the case of a mid-term vacancy in one of the Commission Co-Chair seats, the Commission Co-Chair is subsequently elected to fill the unfinished term resulting from the vacancy. Likewise, committee Co-Chairs elected to fill mid-term vacancies are elected for the respective unfinished terms.
   f. Commission Co-Chairs are considered voting members of all Committees and subcommittees, but are not counted towards quorum unless present.
   g. ~~The Commission Co-Chairs cannot be elected as Committee Co-Chairs. A Committee Co-Chair can only serve in that capacity for one Committee at a time. Once a Commission or Committee Co-Chair term has ended, they must wait one year before running for a Co-Chair seat.~~

Comment [MD2]: This has not been the practice; we have had co chairs who have served multiple consecutive terms.

2. **Commission Co-Chair Election Process:** Normally—unless adjusted for unexpected circumstances—the Commission Co-Chair elections proceed according to the following schedule:
   a. 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.
   b. 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.
   c. The Co-Chairs delegate facilitation of the Co-Chair election to the Parliamentarian, Executive Director or other designated staff.
   d. Commission members who have been nominated, meet the qualifications, and who accept their nominations are presented for Commission vote.
   e. The Parliamentarian (or Executive Director/staff) leads Commission voting to elect the new Commission Co-Chair.
   g. Following the new Co-Chair's election, the Commission Co-Chairs and the Executive Director must determine Commission members' final committee assignments by the end of December in order to open committee Co-Chair nominations the following month.

3. **Committee Co-Chair Election Process:** Normally—unless adjusted for unexpected circumstances—the committee Co-Chair elections proceed according to the following schedule:
   a. Aside from the Executive Committee (the Commission Co-Chairs serve as the Executive Committee Co-Chairs), the standing committees open candidate nominations for both Co-Chair seats at their January meetings (following final committee assignments).
   b. Nominations are closed the following month when Committee Co-Chair elections are opened under the Co-Chair reports.
   c. The current Co-Chairs delegate facilitation of the Co-Chair election to the Executive Director or another assigned staff representative.
   d. Committee members who have been nominated, meet the qualifications, and who accept their nominations are presented for Committee vote.
   e. The Executive Director (or other designated staff) leads Committee voting to elect the new Co-Chairs.
   f. The newly elected Co-Chairs begin service at the following committee meeting.

g. As per Robert's Rules of Order, The Commission Co-Chairs should maintain a position of neutrality and not vote in Committee co-chair elections unless there is a tie vote for a position, then they may (but are not required to) vote to break the tie

4. **Co-Chair Qualifications/Eligibility**: Only voting Commissioners may serve as Commission Co-Chairs. In order to ensure leadership diversity and representation, eligible Commission Co-Chair candidates must have at least one year of service and experience on the Commission. Among the two Commission Co-Chairs, at least one of the Co-Chairs must be HIV-positive, and at least one of them must be a person of color. Additionally, it is strongly preferred that at least one of the two Co-Chairs is female.

   The Commission does not impose eligibility or qualification requirements for Committee Co-Chairs, although it is strongly encouraged that nominees acquire at least one year's experience with the Committee before standing as a Co-Chair candidate.
   a. Any Committee member nominated as a Co-Chair candidate must be serving on that Committee in his/her primary Committee assignment.
   b. Only Commissioners may serve as Co-Chairs.
   b. Alternates, members serving on the committee in secondary Committee assignments, and BOS-appointed non-Commission committee members may not serve as Co-Chairs.

5. **Co-Chair Nominations**: Outside the rare possibility of immediate vacancies in both Commission Co-Chair seats, all Commission and Committee Co-Chair elections must follow a nominations period opened at the respective body's prior regular meeting. The nominations period is designed to give potential candidates the opportunity to consider standing for election and the responsibility of assuming a leadership position. Candidates may nominate themselves or participants may nominate other members. Any stakeholder may nominate Co-Chair candidates.

   Candidates can be nominated in public when the nominations are opened or any time prior to the closure of the nominations—including just prior to when the Co-Chair elections are opened at the subsequent meeting—or by contacting the Executive Director through phone, email and/or in writing at any time during the period in which nominations are open. Nominations are formally closed when the eligible candidates begin making their statements.

   All Commission Co-Chair candidates nominated prior to the meeting of the Co-Chair election are given the opportunity to provide a brief (single paragraph, single page) statement about their candidacy. All Co-Chair candidates should be given the opportunity to make a short oral statement about their candidacy prior to the election.

6. **Co-Chair Election Voting Procedures:** Co-Chairs are elected by a majority vote:
   a. Roll call voting for elections requires each voting member to state the name of the candidate for whom he/she is voting, or to abstain, in each round of votes.
   b. If there are more than two candidates nominated for Commission Co-Chair, voting will proceed in sequential roll calls until a final candidate earns a majority of votes and is elected by a consent or roll call vote. If no candidates earn a majority of votes in a single round, the candidate earning the least number of votes will be eliminated from the subsequent round of roll call voting. The process continues until there is a majority vote for one candidate, or only one candidate remains and the others have been eliminated. Once the final candidate has been selected, the Commission must approve that candidate for the Co-Chair seat in a consent or roll call vote.
   c. When there is only one Commission Co-Chair candidate, the vote serves as approval or rejection of the nominated candidate.
      1) A consent vote may be used to approve the final candidate(s) for the Co-Chair seat(s). A roll call vote is not necessary for a final candidate unless there are objections to the election of the candidate.
   d. If there are two Commission Co-Chair vacancies to fill, voting adheres to the process outlined above except that the final two candidates are identified as the final Co-Chair candidates. A consent vote may be used to approve both final candidates, but a subsequent roll call vote is necessary to identify which candidate will fill the longer term; the candidate earning more votes fills the seat with the longer term.
      1) A roll call vote to approve both candidates to fill the Co-Chair seats is not necessary unless there are objections to the election of one or both of the candidates.
      2) When there are objections to the election of one or both of the candidates, each candidate must be approved by a majority through an individual roll call vote.
   e. If there are three or more candidates nominated for the two Committee Co-Chair seats, the same process described for Commission Co-Chair election voting (Procedure #4a) is followed. If there are only two Committee Co-Chair candidates, the Committee is entitled to unanimously accept the "slate of Co-Chair nominees"; otherwise an individual roll call vote is necessary to approve the election of each candidate to a Co-Chair seat.
   f. In the case of a tie during the final vote, the body can re-cast its vote to accommodate changes in voting. If the body cannot resolve the tie after a new vote, the current Co-Chair(s) remain in office, voting is closed, nominations remain open until the subsequent meeting, and a new election is resumed at that meeting. The process will repeat monthly until a clear majority vote-earner is identified.

g. If a majority of the voting members oppose a final candidate's/final candidates' nominations, the current Co-Chair(s) retain their seat until the subsequent meeting, nominations remain open, and a new election is held at the next meeting. The final candidates' whose nominations were opposed are no longer eligible to fill the seat in the current term. The process will repeat monthly until the body finds majority support for a final candidate(s).

7. **Co-Chair Election Contingencies:** A number of factors may impede the normal Co-Chair election timelines outlined in Procedures #2, #3 and #6. Following are potential challenges that can result in process delays, and how those challenges should be resolved:

   a. **Inadequate Number of Qualified Co-Chair Candidates:** The Co-Chair whose term has expired may continue in the seat with the term extended until a new Co-Chair is elected. If the Co-Chair does not choose to continue, or has resigned, a Commission or Committee Co-Chair may temporarily serve as a single Co-Chair until a second Co-Chair can be identified and elected. Co-Chair nominations will remain open indefinitely until qualified candidate(s) are identified and elected.

   b. **Cancelled Meeting(s) or Quorum(s) Not Realized:** Nominations can be opened at a subsequent meeting and/or extended to accommodate the cancelled meeting(s) or absence of quorum(s). If the meeting for which the election is scheduled is cancelled or a quorum is not present, nominations remain open an additional month and the election proceeds the following month.

NOTED AND APPROVED: Cheryl A Barrit **EFFECTIVE DATE:** December 9, 2010; 9/29/16

Original Approval: *Revision(s):10/19/16; 7/24/17; Proposed Revisions 7/25/19*

LOS ANGELES COUNTY
COMMISSION ON HIV

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POLICY/PROCEDURE #08.2301	Voting Procedures	Page 1 of 3

MOTION #5:
9/12/19 COH MEETING

SUBJECT: The process for formally supporting or opposing Commission, committee or subcommittee actions.

PURPOSE: To describe the procedures for formally determining specific actions proposed at formal Commission or committee meetings.

BACKGROUND:

- Article V *(Meetings)*, Section 8 *(Robert's Rules of Order)* of Policy/Procedure #06.1000 *(Bylaws of the Los Angeles County Commission on HIV)* ~~says~~ states the following: "All meetings of the Commission shall be conducted according to the current edition of 'Robert's Rules of Order, Newly Revised', except where superceded by the Commission's Bylaws, policies/procedures, and/or -applicable laws."

- All Commission member voting is subject to the conditions and provisions of state and federal conflict of interest requirements as detailed in Article VII *(Policies and Procedures)*, Section ~~4~~5 *(Conflict of Interest Procedures)* of Policy/Procedure #06.1000 *(Bylaws of the Los Angeles County Commission on HIV)* -and Policies/Procedures #08-.3108 *(Adherence to State Conflict of/-Interest Rules ~~and~~ Requirements-).*

POLICY:

1) Specific actions by the Commission or a committee can be taken as a result of co-chair instruction or following a successful motion by a quorum of a voting body in attendance.
    a. In accordance with Commission Bylaws, and/or Robert's Rules of Order, certain votes are required of the body in spite of broad agreement.
    b. All allocation decisions require motions and roll call votes.

2) All Commissioners (or their alternates in their absence) who are appointed by the Board of Supervisors may vote on matters before the Commission, unless they have recused themselves. All members assigned to or appointed to committees (or their alternates in their absence) may vote on motions before those committees, unless they have recused themselves.
    a. "Recusal" is dictated by Policies/Procedures#08.3108 (*Adherence to State Conflict of Interest Rules and Requirements).*
3) The Commission or its committee may vote on a motion in one of two ways:
    a. Unanimous voice vote (with abstentions as noted), commonly called "consensus," or
    b. Roll call vote
    c. While they do not count as votes, nor count in the vote tally, abstentions will be recorded and noted in meeting and motion summaries and minutes.

PROCEDURES:

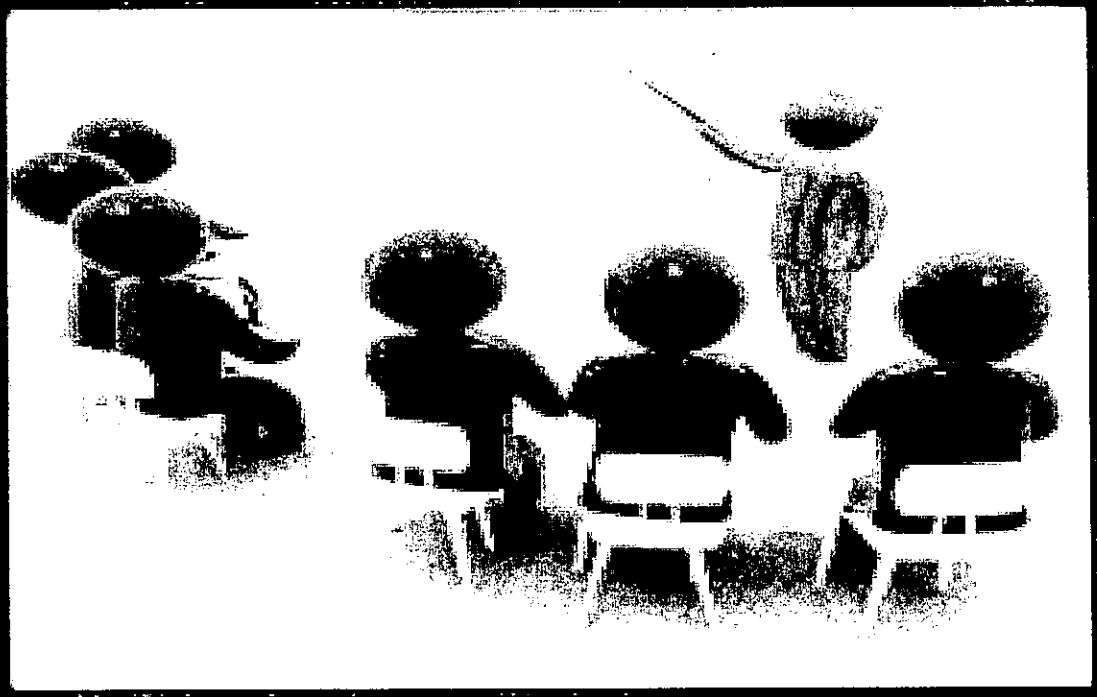
1. **Co-Chairs' Prerogative**: If all in attendance are in agreement, and there is no motion on the floor, it is the co-chairs' prerogative to direct that an action be taken without a specific vote.
2. **Content of Motions:** Motions are made by members of the body and must be acted on for one of three reasons:
    a. They are "procedural" in nature: required by law or rule, such as the Ralph M. Brown Act or Robert's Rules of Order (e.g., approving the agenda, minutes);
    b. They are "Action" in nature: either to lend credibility and/or formality to an action already agreed upon by the body; or to determine an action in a way about which there may be varied opinion/disagreement among the members and/or those in attendance.
3. **Submission of Motions:** In accordance with Policy/Procedure #08.1102 *(Subordinate Commission Working Units*), motions are made and acted on in several ways, subject to Robert's Rules of Order:
    a. They can be included on the agenda in advance of the meeting by a formal subunit of the body (e.g., committee, subcommittee or task force). Motions on the agenda are deemed "moved" by adoption of the agenda, and do not require a second, for a vote.
    b. They can be made at the meeting in response to a specific agendized item of discussion. There motions require an individual to "move" the action, and a "second" from a person who agrees that the motion should be placed "before the body".
    c. They can be moved to the agenda by action at a previous meeting and treated appropriately as agendized.
4. **Voting Privileges:** Motions can only be voted when there is a quorum of the members of the body with voting privileges present:
    a. All Commissioners (or their Alternates when they are not present) appointed by the Board of Supervisors have voting privileges at Commission meetings;
    b. All Commission members assigned or appointed to a committee, or their Alternates when they are not present, have voting privileges at the respective committee meetings;
    c. All members with voting privileges at the Commission or committee meetings who have not recused themselves may vote on any motion "before the body";
    d. In accordance with Policies/Procedures #08.3108 *(Adherence to State Conflict of Interest Rules and Requirements)*, members must recuse themselves when they have an appropriate conflict of interest.

5. **Action Following a Motion**: Once a motion is made, any discussion may follow, unless prohibited by Robert's Rules of Order. The motion can be amended, postponed or referred, etc., by vote, in accordance with Robert's Rules of Order.
6. **Consensus on a Motion**: When the body is ready to vote on a motion, it is the Co-Chairs' responsibility to poll the body by voice, and ask if there is any objection. If there is objection from at least one member of the body, a roll call must be taken (*see Procedure #7*).
    a. After the co-chair determines if there are no objections, the co-chair will call for abstentions.
    b. Abstentions are not considered objections, do not count in the final vote, and, thus, do not affect the decision of whether or not the vote is considered unanimous or if a roll call vote must be taken. Abstentions will be noted in the public record.
    c. If there are no objections, the motion is considered "passed by consensus".
7. **Roll Call Votes:** A roll call vote is taken by a staff member of non-voting member reading the members' names aloud who are present and entitled to vote, and recording the members' votes for the public record.
    a. The roll call can be taken in alphabetical or reverse alphabetical order.
    b. Co-Chairs' votes are taken at the end of the roll call vote; Co-Chairs are not required to vote unless there is a tie in voting ("Co-Chair Prerogative").
8. **Motion Pass or Fail**: At the end of the roll call, the Parliamentarian or reader tallies the supporting and opposing votes cast and gives the number to the Co-Chair to announce whether the motion has passed or failed according to which vote has the greater number.
    a. A motion passes if there are a greater number of supporting votes than opposing votes.
    b. A motion fails if there are a greater number of opposing votes than supporting votes, or if there is a tie between opposing and supporting votes.
9. **Final Decision:** All votes and abstention notes are final when a Co-Chair announces the decision.

NOTED AND APPROVED: Cheryl A Barnett **EFFECTIVE DATE:** 01/20/17

Original Approval: 7/13/2006	Revision(s): 3/14/2012; Updated: 01/20/17; **Revisions Proposed 07/25/19**

LOS ANGELES COUNTY



10. STANDING COMMITTEE REPORTS (cont'd):

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

(1) Ryan White Program (RWP) Program Year (PY) 30 Service Category Ranks **MOTION #6**

(2) RWP PY 30 Service Category Allocations **MOTION #7**

MOTION #6:
09/12/19 COH MEETING

LOS ANGELES COUNTY
COMMISSION ON HIV

Planning, Priorities and Allocations Committee
Service Category Rankings for PY 30 (FY 2020-21)

COH 2020-21 Ranking		Commission on HIV (COH) Service Categories	HRSA Core/ Support Service	Core and Support Services Defined by Health Resources and Services Administration (HRSA)
PY 30[1]	PY 29			
1	1	Ambulatory Outpatient Medical Services	C	Outpatient/Ambulatory Health Services
		Medical Subspecialty Services		
		Therapeutic Monitoring Program		
2	2	Housing	S	Housing
		Permanent Support Housing		
		Transitional Housing		
		Emergency Shelters		
		Transitional Residential Care Facilities (TRCF)		
		Residential Care Facilities for the Chronically Ill (RCFCI)		
3	3	Mental Health Services	C	Mental Health Services
		MH, Psychiatry		
		MH, Psychotherapy		
4	4	Medical Care Coordination (MCC)	C	Medical Case Management (including treatment adherence services)
5	5	Outreach Services	S	Outreach Services
		Engaged/Retained in Care		
6	6	Health Education/Risk Reduction	S	Health Education/Risk Reduction
7	7	Early Intervention Services	C	Early Intervention Services
8	8	Emergency Financial Assistance	S	Emergency Financial Assistance
9	9	Medical Transportation	S	Medical Transportation
10	10	Non-Medical Case Management	S	Non-Medical Case Management Services
		Linkage Case Management		
		Benefit Specialty		
		Benefits Navigation		

COH 2020-21 Ranking		Commission on HIV (COH) Service Categories	HRSA Core/ Support Service	Core and Support Services Defined by Health Resources and Services Administration (HRSA)
		Transitional Case Management		
		Housing Case Management		
11	11	Oral Health Services	C	Oral Health Care
12	12	Psychosocial Support Services	S	Psychosocial Support Services
13	13	Nutrition Support	S	Food Bank/Home Delivered Meals
14	19	Child Care Services	S	Child Care Services
15	14	Substance Abuse Residential	S	Substance Abuse Treatment Services (Residential)
16	15	Home Based Case Management	C	Home and Community Based Health Services
17	16	Home Health Care	C	Home Health Care
18	17	Substance Abuse Outpatient	C	Substance Abuse Outpatient Care
19	18	Referral	S	Referral for Health Care and Support Services
20	20	Health Insurance Premium/Cost Sharing	C	Health Insurance Premium and Cost-Sharing Assistance for Low-income individuals
21	21	Other Professional Services	S	Other Professional Services
		Legal Services		
		Permanency Planning		
22	22	Language	S	Linguistics Services
23	23	Medical Nutrition Therapy	C	Medical Nutrition Therapy
24	24	Rehabilitation Services	S	Rehabilitation Services
25	25	Respite	S	Respite Care
26	26	Local Pharmacy Assistance	C	AIDS Pharmaceutical Assistance
27	27	Hospice	C	Hospice

[1]PY30: The first column represents PY 30 Planning, Priorities and Allocations Committee recommendations.
PY 29: Represents the service category ranking approved by the Commission on April 11, 2019 for PY 29

FY 2020 (PY 30) RWP Allocation Recommendation 07.23.19

Row		Service Category	Recommended Part A Allocations	Recommended Part A %	Approved PY29	Approved PY 29 Part A%	Recommended MAI Allocations	Recommended MAI %	Approved PY 29 MAI	Approved PY 29 MAI %	Recommended Total Part A/MAI %	Approved PY29 Total Part A/MAI%
1	CORE SERVICES	Outpatient/Ambulatory Health Services	$ 11,274,409	30.77%	$ 9,810,822	28.28%	$ -	0.00%	$ -	0.00%	28.29%	25.85%
2		AIDS Drug Assistance Program (ADAP) Treatments	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ -	0.00%	0.00%	0.00%
3		AIDS Pharmaceutical Assistance (local)	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ -	0.00%	0.00%	0.00%
4		Oral Health	$ 7,592,236	20.72%	$ 6,300,000	18.16%	$ -	0.00%	$ -	0.00%	19.05%	16.60%
5		Early Intervention Services	$ 500,000	1.36%	$ 500,000	1.44%	$ -	0.00%	$ -	0.00%	1.25%	1.32%
6		Health Insurance Premium & Cost Sharing Assistance	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ -	0.00%	0.00%	0.00%
7		Home Health Care	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ -	0.00%	0.00%	0.00%
8		Home and Community Based Health Services	$ 2,355,345	6.43%	$ 2,290,552	6.88%	$ -	0.00%	$ -	0.00%	5.91%	6.30%
9		Hospice Services	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ -	0.00%	0.00%	0.00%
10		Mental Health Services	$ -	0.00%	$ 300,000	0.86%	$ -	0.00%	$ -	0.00%	0.00%	0.79%
11		Medical Nutritional Therapy	$ 21,000	0.06%	$ 21,000	0.06%	$ -	0.00%	$ -	0.00%	0.05%	0.06%
12		Medical Case Management (MCC)	$ 10,547,194	28.79%	$ 10,569,206	30.42%	$ 278,397	8.68%	$ -	0.00%	27.17%	27.85%
13		Substance Abuse Services Outpatient	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ -	0.00%	0.00%	0.00%
14	SUPPORT SERVICES	Case Management (Non-Medical) BSS/TCM/CM for new positives/RW clients	$ 1,368,850	3.74%	$ 1,751,458	5.05%	928,627	28.96%	$ 752,024	28.96%	5.77%	6.60%
15		Child Care Services	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ -	0.00%	0.00%	0.00%
16		Emergency Financial Assistance	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ -	0.00%	0.00%	0.00%
17		Food Bank/Home-delivered Meals	$ 2,098,496	5.73%	$ 1,299,557	3.74%	$ -	0.00%	$ -	0.00%	5.27%	3.42%
18		Health Education/Risk Reduction	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ -	0.00%	0.00%	0.00%
19		Housing Services RCFCI/TRCF/Rental Subsidies with CM	$ -	0.00%	$ 500,000	1.44%	2,000,000	62.36%	$ 1,455,000	62.36%	5.02%	5.15%
20		Legal Services	$ 274,872	0.75%	$ 197,436	0.57%	$ -	0.00%	$ -	0.00%	0.69%	0.56%
21		Linguistic Services	$ -	0.00%	$ 17,976	0.05%	$ -	0.00%	$ -	0.00%	0.00%	0.05%
22		Medical Transportation	$ 607,006	1.66%	$ 1,148,939	3.31%	$ -	0.00%	$ -	0.00%	1.52%	3.03%
23		Outreach Services (LRP)	$ -	0.00%	$ -	0.00%	-	0.00%	$ 1,000,000	0.00%	0.00%	2.63%
24		Psychosocial Support Services	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ -	0.00%	0.00%	0.00%
25		Referral	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ -	0.00%	0.00%	0.00%
26		Rehabilitation	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ -	0.00%	0.00%	0.00%
27		Respite Care	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ -	0.00%	0.00%	0.00%
28		Substance Abuse Residential	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ -	0.00%	0.00%	0.00%
29		Treatment Adherence Counseling	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ -	0.00%	0.00%	0.00%
30		Overall Total	$ 36,639,408	100.00%	$ 34,748,746	100.00%	3,207,024	100.00%	$ 3,207,024	100.00%	$ 39,846,432	$ 37,955,770

10. STANDING COMMITTEE REPORTS (cont'd):

C. Public Policy (PP) Committee

LOS ANGELES COUNTY
COMMISSION ON HIV

2019-2020 Legislative Docket
Updated 9/6/19

POSITIONS: SUPPORT | OPPOSE | SUPPORT w/AMENDMENTS | OPPOSE unless AMENDED | WATCH | County bills noted w/asterisk

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
*AB 4 (Arambula) See SB 29	Medi-Cal: eligibility	This bill would additionally extend eligibility for full-scope Medi-Cal benefits to individuals of all ages, if otherwise eligible for those benefits, but for their immigration status. The bill would delete provisions delaying eligibility and enrollment until the director makes the determination described above. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB4	**Support** County position: Watch	07/02/19 In Senate committee: Set, second hearing. Hearing canceled at the request of author.
*AB 36 (Bloom)	Residential tenancies: rent control	This bill would modify the provisions of the Costa-Hawkins Rental Housing Act and allow local governments to apply rent stabilization measures to specified housing units. This bill would authorize an owner of residential real property to establish the initial and all subsequent rental rates for a dwelling or unit that has been issued its first certificate of occupancy within 20 years of the date upon which the owner seeks to establish the initial or subsequent rental rate, or for a dwelling or unit that is alienable separate from the title to any other dwelling unit or is a subdivided interest in a subdivision and the owner is a natural person who owns 10 or fewer residential units within the same jurisdiction as the dwelling or unit for which the owner seeks to establish the initial or subsequent rental rate, subject to certain exceptions. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB36	**Support** County position: Support	04/25/19 Assembly - Rules
AB 53 (Jones-Sawyer)	Rental housing unlawful housing practices: applications: criminal records	This bill would make it an unlawful housing practice for the owner of a rental housing accommodation to inquire about, or require an applicant for a rental housing accommodation to disclose, a criminal record during the initial application assessment phase, as defined, unless otherwise required by state or federal law. The bill would permit an owner of a rental housing accommodation, after the successful completion of the initial application assessment phase, to request a criminal background check of the applicant and consider an applicant's criminal record in deciding whether to rent or lease to the applicant. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB53 *Note: What does this mean for sex offenders? How does this affect individuals that move to California from out of state?*	**Support with more info**	04/24/19 In committee: Set, first hearing. Hearing canceled at the request of author.

COMMISSION APPROVED 6/13/19

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
AB 174 (Wood)	Health care coverage: financial assistance	This bill would require the board to administer enhanced premium assistance to individuals with household incomes below 400% of the federal poverty level, reduce premiums to zero for individuals with household incomes at or below 138% of the federal poverty level, reduce premiums for individuals with household incomes at or between 401% and 800% of the federal poverty level and who are ineligible for federal advanced premium tax credits so their premiums do not exceed a specified percentage of their household incomes, and administer specified additional cost-sharing financial assistance for individuals with household incomes below 400% of the federal poverty level and who are eligible for premium tax credits. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB174	**Support**	09/09/19 Senate amendments concurred in. To Engrossing and Enrolling.
*AB 302 (Berman)	Parking: homeless students	This bill would require a community college campus that has parking facilities on campus to grant overnight access to those facilities facilities, on or before July 1, 2020, to any homeless student who is enrolled in coursework, has paid any enrollment fees, fees that have not been waived, and is in good standing with the community college, and for the purpose of sleeping in the student's vehicle overnight. The bill would require the governing board of the community college district to determine a plan of action to implement this requirement. requirement, as specified. By imposing additional duties on community college districts, this bill would impose a state-mandated local program. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB302	**Support** County position: Support	09/05/19 Ordered to inactive file at request of Senator Hill
*AB 307 (Reyes)	Homeless youth: grant program	This bill would require the council to develop and administer a grant program to support young people experiencing homelessness and prevent and end homelessness. It is the intent of the Legislature to prevent do both of the following: (a) Prevent or reduce the incidence of substance use disorders among homeless youth by providing services in the most efficient and effective way, including housing, if appropriate, and to reduce the exposure to trauma as a result of homelessness that has been shown to be a precursor to substance use disorders. (b) Address the needs of lesbian, gay, bisexual, transgender, and queer (LGBTQ) youth, who account for up to 40 percent of the homeless youth population nationwide and experience substance abuse risk factors, including homlessness and family rejection, more than than their non-LGBTQ peers. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB307	**Support** County position: Support	08/30/19 In Senate committee: Held under submission.
AB 318 (Chu)	Medi-Cal materials: readability	This bill would require the department and managed care plans, commencing January 1, 2020, to require field testing of all translated materials released by the department or the managed care plans, respectively, to Medi-Cal beneficiaries, except as specified. The bill would define "field testing" as a review of translations for accuracy, cultural appropriateness, and readability. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB318	**Support**	09/09/19 Senate amendments concurred in. To Engrossing and Enrolling.

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
AB 362 (Eggman)	Controlled substances: overdose prevention program	This bill would, until January 1, 2026, authorize the City and County of San Francisco to approve entities to operate overdose prevention programs that satisfy specified requirements, including, among other things, the provision of a hygienic space supervised by healthcare health care professionals, as defined, where adults who use drugs can consume preobtained drugs, use sterile consumption supplies, and access to referrals to substance use disorder treatment. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB362	**Support**	06/19/19 In Senate committee: Set, first hearing. Hearing canceled at the request of author.
*AB 414 (Bonta) See SB 175	Healthcare coverage: minimum essential coverage	This bill would require a California resident to ensure that the resident and the resident's dependents are covered under minimum essential coverage for each month beginning after 2019. The bill would impose a penalty for the failure to maintain minimum essential coverage (i.e. individual mandate). https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB414	**Support** County position: Watch	09/10/19 File notice suspended
AB 493 (Gloria)	Teachers: in-service training: lesbian, gay, bisexual, transgender, queer, and questioning pupil resources	This bill commencing with the 2021–22 school year, would require each school operated by a school district or county office of education and each charter school to annually provide in-service training to teachers of pupils in grades 7 to 12, inclusive, and to all other certificated employees at that school, on schoolsite and community resources for the support of lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) pupils as well as strategies to increase support for LGBTQ pupils and thereby improve overall school climate, as specified. By imposing additional duties on public schools and local educational agencies, the bill would impose a state-mandated local program. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB493	**Support**	09/10/19 In Assembly. Concurrence in Senate amendments pending. May be considered on or after September 12
AB 526 (Petrie Norris)	Medi-Cal: California Special Supplemental Nutrition Program for Women, Infants, and Children	This bill would delete existing provisions relating to the automated enrollment gateway system and would instead require the State Department of Health Care Services, in collaboration with the same designated entities, to design and implement policies and procedures for an automated enrollment gateway pathway, operational no later than May 1, 2020, designating the WIC Program and its local WIC agencies as Express Lane agencies and using WIC eligibility determinations to meet Medi-Cal eligibility requirements. The bill would require the pathway to perform specified functions to streamline Medi-Cal enrollment and maximize health care coverage. The bill would require that benefits for applicants enrolling in the Medi-Cal program using the pathway be provided immediately through accelerated enrollment for children and presumptive eligibility for pregnant women. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB526	**Support**	08/30/19 In Senate committee: Held under submission.

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
AB 537 (Wood)	Medi-Cal managed care: quality improvement and value-based financial incentive program	This bill would require, commencing January 1, 2022, a Medi-Cal managed care plan to meet a minimum performance level (MPL) that improves the quality of health care and reduces health disparities for enrollees, as specified. The bill would require the department to establish both a quality assessment and performance improvement program and a value-based financial incentive program to ensure that a Med-Cal managed care plan achieves an MPL. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB537	**Support**	05/16/19 In Assembly committee: Held under submission.
*AB 650 (Low)	Violent death: data	This bill would require the Attorney General to direct local law enforcement agencies to report quarterly, by January 1, 2021, to the Department of Justice data, on the sexual orientation and gender identity of a victim of a violent death. The bill would require the Attorney General to convene, by July 1, 2020, a stakeholder workgroup, including staff who administer the CEVDRS, local law enforcement agencies, and advocates for members of the lesbian, gay, bisexual, transgender, and queer community, to develop specified standards, such as data reporting requirements and forms, and would authorize the Department of Justice to use established policies and practices on reports on hate crimes. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB650	**Support** County position: Watch	05/16/19 In Assembly committee: Held under submission.
AB 683 (Carrillo)	Medi-Cal: eligibility	This bill would require the department to disregard specified assets and resources, such as motor vehicles and life insurance policies, in determining the Medi-Cal eligibility for an applicant or beneficiary whose eligibility is not determined using MAGI, subject to federal approval and federal financial participation. The bill would prohibit the department from using an asset and resource test to make a Medi-Cal eligibility determination for an applicant or beneficiary who is enrolled in the Medicare Shared Savings Program. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB683	**Support**	05/16/19 In Assembly committee: Hearing postponed by committee.
AB 711 (Chiu)	Pupil records: name and gender changes	This bill would require a school district to update a former pupil's records if the school district receives government-issued documentation, as described, demonstrating that the former pupil's legal name or gender has been changed. The bill would require the school district to reissue specified documents conferred upon, or issued to, the former pupil with the former pupil's updated legal name or gender, if requested by the former pupil. By imposing a new duty on a school district, the bill would create a state-mandated local program. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB711	**Support**	08/30/19 Approved by the Governor

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
~~AB 715 (Wood)~~	~~Medi-Cal: program for aged and disabled persons~~	~~Existing law requires an individual under these provisions to satisfy certain financial eligibility requirements, including, among other things, that the individual's countable income does not exceed an income standard equal to 100% of the applicable federal poverty level, plus an income disregard of $230 for an individual, or $310 in the case of a couple, except that the income standard determined shall not be less than the SSI/SSP payment level for a disabled individual or couple, as applicable. This bill would instead require, upon receipt of federal approval, all countable income over 100% of the federal poverty level, up to 138% of the federal poverty level, to be disregarded, after taking all other disregards, deductions, and exclusions into account for those persons eligible under the program for aged and disabled persons.~~ https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB715 *Note: Bill changed to Richard Paul Hemann Parkinson's Disease Program*	~~**Support**~~	~~07/10/19 Senate – Appropriations~~
AB 731 (Kalra)	Health care coverage: rate review	Existing law requires a health care service plan or health insurer offering a contract or policy in the individual or small group market to file specified information, including total earned premiums and total incurred claims for each contract or policy form, with the appropriate department at least 120 days before implementing a rate change. This bill would expand those requirements to apply to large group health care service plan contracts and health insurance policies. The bill would require a plan or insurer to disclose with a rate filing specified information by geographic region, including annual medical trend factor assumptions by aggregate benefit category and the top 25 procedures in each benefit category. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB731	**Support**	09/09/19 Senate amendments concurred in. To Engrossing and Enrolling
*AB 816 (Quirk-Silva)	California Flexible Housing Subsidy Pool Program	This bill would establish the California Flexible Housing Subsidy Pool to fund grants, for a city, county, city and county, or continuum of care, for eligible activities including, among other things for rental assistance, operating subsidies in affordable or supportive housing units, and specified outreach services. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB816	**Support** County position: Support	05/16/19 In Assembly committee: Held under submission
AB 824 (Wood)	Business: preserving access to affordable drugs	This bill would provide that an agreement resolving or settling, on a final or interim basis, a patent infringement claim, in connection with the sale of a pharmaceutical product, is to be presumed to have anticompetitive effects if a non-reference drug filer receives anything of value from another company asserting patent infringement and if the non-reference drug filer agrees to limit or forego research, development, manufacturing, marketing, or sales of the non-reference drug filer's product for any period of time, as specified. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB824 *Note: "Pay for Delay" bill*	**Support**	09/04/19 Senate - Read second time and amended. Ordered to third reading.

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
AB 890 (Wood)	Nurse practitioners: scope of practice: unsupervised practice	This bill would establish the Advanced Practice Registered Nursing Board within the Department of Consumer Affairs, which would consist of 9 members. The bill would authorize a nurse practitioner who holds a certification as a nurse practitioner from a national certifying body recognized by the board who practices in certain settings or organizations to perform specified functions without supervision by a physician and surgeon, including ordering and interpreting diagnostic procedures, certifying disability, and prescribing, administering, dispensing, and administering controlled substances. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB890	**Support**	05/16/19 In committee: Hearing postponed by committee.
AB 929 (Luz Rivas)	California Health Benefit Exchange: data collection	This bill would require the board, if it requires or has previously required a qualified health plan to report on cost reduction efforts, quality improvements, or disparity reductions, to make public plan-specific data on cost reduction efforts, quality improvements, and disparity reductions. The bill would require the board to post that data to the internet website of the Exchange no less than annually. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB929	**Support**	09/09/19 Senate amendments concurred in. To Engrossing and Enrolling.
AB 993 (Nazarian)	Health care coverage: HIV specialists	This bill would require a health care service plan contract or health insurance policy that is issued, amended, or renewed on or after January 1, 2019, to permit an HIV specialist, as defined, to be an eligible primary care provider, as defined, if the provider requests primary care provider status and meets the plan's or the health insurer's eligibility criteria for all specialists seeking primary care provider status. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB993 *Note: AB 1534 two years ago, vetoed by Governor*	**Watch** COH Position two years ago: Oppose (changed from Watch)	09/10//19 Senate amendments concurred in. To Engrossing and Enrolling.
AB 1063 (Petrie Noris)	Healthcare coverage: waivers	This bill would require the American Health Benefit Exchange to obtain statutory authority before seeking a state innovation waiver from the United States Department of Health and Human Services. The bill would also make related findings and declarations. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB1063 *Note: SB 1108 last year, re-worked for this year.*	**Support**	06/10/19 Senate - Read second time and amended. Ordered to third reading.
AB 1246 (Limon)	Healthcare coverage: basic health care services	This bill would require large group health insurance policies, except certain specialized health insurance policies, issued, amended, or renewed on or after January 1, 2020, to include coverage for medically necessary basic health care services and, to the extent the policy covers prescription drugs, coverage for medically necessary prescription drugs. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB1246	**Support**	08/30/19 In Senate committee: Held under submission.

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
AB 1309 (Bauer-Kahan)	Health care coverage: enrollment periods	This bill would additionally require a health care service plan and a health insurer, for policy years beginning on or after January 1, 2020, to provide a special enrollment period to allow individuals to enroll in individual health benefit plans through the Exchange from December 16 of the preceding calendar year, to January 31 of the benefit year, inclusive. The bill would also require, with respect to individual health benefit plans offered outside of the Exchange, that the annual open enrollment period for policy years beginning on or after January 1, 2020, extend from October 15 of the preceding calendar year, to January 31 of the benefit year, inclusive. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB1309	**Support**	09/05/19 Senate amendments concurred in. To Engrossing and Enrolling.
*AB 1481 (Grayson)	Tenancy termination: just cause	This bill would, with certain exceptions, prohibits a landlord of residential property from terminating the lease without just cause, as defined, stated in the written notice to terminate. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB1481	**Support** County position: Watch	06/03/19 Ordered to inactive file at the request of Assembly Member Grayson.
AB 1483 (Grayson)	Housing data: collection and reporting	This bill would authorize the department to require a planning agency to include in that annual report specified additional information that this bill would require, as described below. The bill would require the department, if requested, to provide technical assistance in providing this additional information to the local public entity that is required to include this additional information in the annual report. The bill would also authorize the department to assess the accuracy of the information submitted as part of the annual report and, if it determines that any report submitted to it by a planning agency contains inaccurate information, require that the planning agency correct that inaccuracy. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB1483 *Note: Creates housing production database*	**Support**	09/10/19 From committee: That the measure be returned to Senate Floor for consideration.
AB 1486 (Ting)	Surplus land	The bill would, with regard to disposing of surplus land for the purpose of developing low- and moderate-income housing, only require the local agency disposing of the surplus land to send a specified notice of availability if the land is located in an urbanized area. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB1486	**Support**	07/03/19 Withdrawn from Committee, Re-referred to Appropriations
AB 1611 (Chiu)	Emergency hospital services: costs	This bill would require a health care service plan contract or insurance policy issued, amended, or renewed on or after January 1, 2020, to provide that if an enrollee or insured receives covered services from a noncontracting hospital, the enrollee or insured is prohibited from paying more than the same cost sharing that the enrollee or insured would pay for the same covered services received from a contracting hospital. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB1611	**Support**	09/09/19 In Senate committee: Read second time. Ordered to third reading.

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
AB 1683 (Arambula)	Sexually transmitted diseases: prevention and control	Existing law requires the State Department of Public Health to develop and participate in a program for the prevention and control of venereal disease. Existing law authorizes the department to establish, maintain, and subsidize clinics, dispensaries, and prophylactic stations for the diagnosis, treatment, and prevention of venereal disease. The bill would delete this authority and, instead, would authorize the department to provide medical, advisory, financial, or other assistance to organizations. The bill would require the department, to the extent funds are appropriated by the Legislature, to allocate grants to local health jurisdictions for sexually transmitted disease outreach, screening, and other core services. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB1683	**Watch**	02/25/19 Read first time
*AB 1702 (Rivas)	Homeless Coordinating and Financing Council	This bill would require the agency to provide 6 additional full-time staff positions for the State's Homeless Coordinating and Financing Council to promote and improve service integration of the State's homelessness resources, benefits, and services. The bill would require the council to report to the Legislature recommendations for statutory changes to streamline the delivery of services and effectiveness of homelessness programs in the state, by January 1, 2021. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB1702	**Support** County position: Support	09/10/19 In Assembly. Concurrence in Senate amendments pending. May be considered on or after September 12
*SB 29 (Durazo) See AB 4	Medi-Cal: eligibility	This bill would extend eligibility for full-scope Medi-Cal benefits to individuals of all ages who are otherwise eligible for those benefits but for their immigration status. The bill would also delete provisions delaying implementation until the director makes the determination described above. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB29	**Support** County position: Watch	09/04/19 In Assembly. Read second time. Ordered to third reading.
SB 65 (Pan) See AB 174	Health care coverage: financial assistance	This bill would require the Exchange, notwithstanding the provision establishing the California Health Trust Fund and only to the extent that the Legislature appropriates funding for these purposes, to administer financial assistance to help low-income and middle-income Californians access affordable healthcare coverage by requiring the Exchange to implement specified maximum premium contributions and to reduce copays and deductibles for individuals who meet specified income requirements. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB65	**Support**	08/14/19 August 14 set for first hearing canceled at the request of author.

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
SB 132 (Wiener)	Corrections	This bill would require the Department of Corrections and Rehabilitation to, during initial intake and classification, ask each individual entering into the custody of the department to specify the individual's gender identity, sex assigned at birth, preferred first name, gender pronoun, honorific, and preferred gender identity of any officer who may conduct a lawful body search of the individual. The bill would require the department to issue identification with a gender marker consistent with the gender identity the individual most recently specified, and would prohibit disciplining a person for refusing to answer or not disclosing in response to these questions. The bill would require the department to only conduct a search of that person by an officer of the gender identity of the person's preference. The bill would additionally require housing the person in a correctional facility designated for men or women consistent with the incarcerated individual's gender identity, except as specified. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB132	**Support**	09/06/19 In Assembly. Ordered to third reading.
SB 145 (Wiener)	Sex offenders: registration	Existing law, the Sex Offender Registration Act, amended by Proposition 35, requires a person convicted of one of certain crimes, as specified, to register with law enforcement as a sex offender while residing in California or while attending school or working in California, as specified. A willful failure to register is a misdemeanor or felony, depending on the underlying offense. This bill would authorize a person convicted of certain offenses involving minors to seek discretionary relief from the duty to register if the person is not more than 10 years older than the minor and if that offense is the only one requiring the person to register. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB145 *Note: Per Equality CA, addresses discriminatory practice of treating LGBTQ young people differently than non-LGBTQ peers when engaging in voluntary sexual activity.*	**Support**	08/30/19 In Assembly. August 30 hearing postponed by committee.
SB 159 (Wiener)	HIV: pre-exposure and post-exposure prophylaxis	Existing law generally supports HIV/AIDS prevention and the awareness of HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) medication. This bill would state the intent of the Legislature to enact legislation to reduce barriers to HIV biomedical prevention by removing insurance preauthorization requirements and authorizing pharmacists to furnish pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) without a prescription in an effort to lower the rates of HIV transmission. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB159	**Support**	09/10/19 In Senate. Concurrence in Assembly amendments pending.

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
*SB 175 (Pan) See AB 414	Healthcare coverage: minimum essential coverage	Patient Protection and Affordable Care Act (PPACA) requires individuals, and any dependents of the individual, to maintain minimum essential coverage, as defined, and, if an individual fails to maintain minimum essential coverage, PPACA imposes on the individual taxpayer a penalty. This provision is referred to as the individual mandate. This bill would require a California resident to ensure that the resident, and any dependent of the resident, is covered under minimum essential coverage for each month beginning after 2019. The bill would impose a penalty for the failure to maintain minimum essential coverage. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB175	**Support** County position: Watch	05/29/19 Ordered to inactive file on request of Senator Pan.
SB 233 (Wiener)	Immunity from arrest	Existing law specifies a procedure by which condoms may be introduced as evidence in a prosecution for various crimes, including soliciting or engaging in lewd or dissolute conduct in a public place, soliciting or engaging in acts of prostitution, loitering in or about a toilet open to the public for the purpose of engaging in or soliciting a lewd, lascivious, or unlawful act, or loitering in a public place with the intent to commit prostitution. This bill, instead, would prohibit the possession of a condom as evidence with the intent to commit prostitution, or for maintaining a public nuisance. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB233	**Support**	07/30/19 Approved by Governor.
SB 260 (Hurtado)	Automatic health care coverage enrollment	This bill would require the California Health Benefit Exchange, beginning no later than July 1, 2020, to enroll an individual in the lowest cost silver plan or another plan, as specified, upon receiving the individual's electronic account from a county, or upon receiving information from the State Department of Health Care Services regarding an individual terminated from department-administered health coverage. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB260	**Support**	09/10/19 In Senate. Concurrence in Assembly amendments pending.
SB 329 (Mitchell)	Discrimination: housing: source of income	Existing law prohibits housing discrimination, including discrimination through public or private land use practices, decisions, or authorizations, based on specified personal characteristics, including source of income. Existing law defines the term "source of income" to mean lawful, verifiable income paid directly to a tenant or paid to a representative of a tenant. This bill would instead define the term for purposes of those provisions, to mean verifiable income paid directly to a tenant, or paid to a housing owner or landlord on behalf of a tenant, including federal, state, or local public assistance and housing subsidies, as specified. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB329	**Support**	09/10/19 In Senate. Concurrence in Assembly amendments pending.

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
SB 343 (Pan)	Healthcare data disclosure	This bill would eliminate alternative reporting requirements for a plan or insurer that exclusively contracts with no more than 2 medical groups or a health facility that receives a preponderance of its revenue from associated comprehensive group practice prepayment health care service plans and would instead require those entities to report information consistent with any other health care service plan, health insurer, or health facility, as appropriate. The bill would also eliminate the authorization for hospitals to report specified financial and utilization data to Office of Statewide Health Planning and Development (OSHPD), and file cost data reports with OSHPD, on a group basis. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB343	**Watch**	09/05/19 Approved by the Governor.
SB 464 (Mitchell)	California Dignity in Pregnancy and Childbirth Act	This bill would make legislative findings relating to implicit bias and racial disparities in maternal mortality rates. The bill would require a hospital that provides perinatal care, and an alternative birth center or a primary clinic that provides services as an alternative birth center, to implement an implicit bias program for all health care providers involved in perinatal care of patients within those facilities. The bill would require the health care provider to complete initial basic training through the program and a refresher course every 2 years thereafter, or on a more frequent basis if deemed necessary by the facility. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB464	**Support**	09/10/19 Assembly amendments concurred in. Ordered to engrossing and enrolling.
SB 673 (Morrell)	Comprehensive sexual health education and human immunodeficiency virus (HIV) prevention education	This bill reverses the CA Healthy Youth Act's opt-out process by requiring, for a pupil in a grade lower than grade 7, an active parental ("opt-in") with a signature for sexual health education and HIV prevention education. The act requires each school district to notify parents and guardians about its plan to provide sexual health education and HIV prevention instruction for the upcoming school year and to inform them, among other things, that written and audiovisual educational materials used in this instruction are available for inspection. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB673	**Oppose**	04/22/19 April 24 set for second hearing canceled at the request of author.
SB 689 (Moorlach)	Needle and syringe exchange programs	Existing law authorizes the State Department of Public Health to authorize certain entities to apply to the department to provide hypodermic needle and syringe exchange services in any location where infections are spread through the sharing of used hypodermic needles and syringes, and requires a period of public comment at least 45 days before approval of the application. This bill would instead allow the department to authorize an entity pursuant to these provisions only if the city, county, or city and county in which the entity will be operating has adopted an ordinance or resolution approving that authorization or reauthorization. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB689	**Oppose**	04/24/19 April 24 set for first hearing. Failed passage in committee. Reconsideration granted.

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
SB 741 (Galgiani)	Change of gender	Existing law authorizes a person to file a petition with the superior court in any county seeking a judgment recognizing the change of gender to female, male, or nonbinary. The judgment is required to include an order that a new birth certificate be prepared for the person reflecting the change of gender and any change of name that was ordered in specified jurisdictions. This bill would authorize a person, as part of a proceeding on a petition for a judgment recognizing the change of gender, to also seek an order to revise a marriage certificate of the petitioner or a birth certificate of the petitioner's child to reflect the petitioner's change of gender. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB741	**Support**	07/09/19 In Assembly. July 9 set for first hearing canceled at the request of author.
HR 1384 (Jayapal)	Medicare for All Act of 2019	This bill establishes a national health insurance program that is administered by the Department of Health and Human Services (HHS). Among other requirements, the program must (1) cover all U.S. residents; (2) provide for automatic enrollment of individuals upon birth or residency in the United States; and (3) cover items and services that are medically necessary or appropriate to maintain health or to diagnose, treat, or rehabilitate a health condition, including hospital services, prescription drugs, mental health and substance abuse treatment, dental and vision services, and long-term care. The bill prohibits cost-sharing (e.g., deductibles, coinsurance, and copayments) and other charges for covered services. Additionally, private health insurers and employers may only offer coverage that is supplemental to, and not duplicative of, benefits provided under the program. Health insurance exchanges and specified federal health programs terminate upon program implementation. However, the program does not affect coverage provided through the Department of Veterans Affairs or the Indian Health Service. https://www.congress.gov/bill/116th-congress/house-bill/1384	**Support**	03/13/2019 Sponsor introductory remarks on measure
HR 3222 ~~(Harris)~~ Chu	~~Do No Harm Act~~ No Federal Funds for Public Charge Act of 2019	~~This bill makes the Religious Freedom Restoration Act of 1993 (RFRA) inapplicable to certain federal laws (or implementations of laws) in order to protect civil rights and prevent meaningful harm to third parties (e.g. employment discrimination, denial of services to LGBTQ individuals)~~ ~~https://www.congress.gov/bill/115th-congress/house-bill/3222~~ To provide that no Federal funds may be used to carry out the proposed rule of the Department of Homeland Security entitled "Inadmissibility on Public Charge Grounds", and for other purposes. *Note: Bill changed on 6/12/19*	~~**Support**~~	~~08/03/2017 House - Referred to the Subcommittee on the Constitution and Civil Justice~~
*S 1106 (Harris)	Rent Relief Act of 2019	This bill would create a new, refundable tax credit for taxable years beginning after December 31, 2018, for individuals who pay more than 30 percent of income towards rent (including utilities). The bill would also allow the credit to be accessed every month, if the family or individual elects to do so. https://www.congress.gov/bill/116th-congress/senate-bill/1106/text	**Support** County position: Support	04/10/2019 Read twice and referred to the Committee on Finance.

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
S 1653 ~~(Booker)~~ (Sullivan)	~~Real Education for Healthy Youth Act (REHYA)~~ A bill to amend section 3063 of title 18, United States Code, and for other purposes.	~~This bill supports the health and well-being of young people by providing the comprehensive education they need to make informed, responsible, and healthy decisions, including the promotion of lifelong sexual health and healthy relationships.~~ ~~https://www.congress.gov/bill/115th-congress/senate-bill/1653/text~~ *Note: Bill changed on 5/23/19*	~~**Support**~~	~~07/27/2017 Senate - Read twice and referred to the Committee on Health, Education, Labor, and Pensions.~~
ACA 1 (Aguiar-Curry)	Local government financing: affordable housing and public infrastructure: voter approval	This measure would create an additional exception to the 1% limit that would authorize a city, county, or city and county, or special district to levy an ad valorem tax to service bonded indebtedness incurred to fund the construction, reconstruction, rehabilitation, or replacement of public infrastructure, affordable housing, or permanent supportive housing, or the acquisition or lease of real property for those purposes, if the proposition proposing that tax is approved by 55% of the voters. Ballot measure that will allow bonds for housing and infrastructure to pass with a 55% majority. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200ACA1	**Support**	08/19/19 Read third time. Refused adoption. Motion to reconsider made by Assembly Member Aguiar-Curry.
SCA 1 (Allen and Wiener)	Public housing projects	The California Constitution prohibits the development, construction, or acquisition of a low-rent housing project in any manner by any state public body until a majority of the qualified electors of the city, town, or county in which the development, construction, or acquisition of the low-rent housing project is proposed approve the project by voting in favor at an election, as specified. This measure would repeal these provisions. http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SCA1	**Support**	09/10/19 In Assembly. Read first time. Held at Desk.

ITUP
Insure the Uninsured Project

» *Fact Sheet*

Final Federal Rule on Immigrants and Public Charge

UPDATED AUGUST 2019

Overview

Under federal law, an individual seeking admission to the U.S., or seeking to become a permanent resident (obtain a green card), is "inadmissible" if the individual at the time of application for admission or adjustment of status, is found to be likely at any time to become a "public charge." Public charge is a term used in current federal immigration law to refer to a person who federal officials determine is likely to become primarily dependent on the government for support.

Immigration officials must consider specified public health and social services in a public charge determination. Currently, the only two public programs to be considered are income cash assistance and long-term care in an institution. As the summary below details, the final rule adds certain housing and nutrition assistance programs and non-emergency Medicaid (Medi-Cal in California) to the determination of public charge.

Importantly, the rule does not include as relevant public benefits the Medi-Cal services undocumented immigrants are currently eligible to receive, including federally supported *emergency* Medi-Cal and *state-funded comprehensive* Medi-Cal coverage for undocumented children and undocumented young adults age 19-25. For more information on Medi-Cal benefits available to immigrants, read the ITUP publication, *Health Care Programs for California Immigrants*.

This updated ITUP fact sheet reviews the final rule, existing federal law related to public charge and health care programs, and potential impacts on immigrant access to health care programs in California.

Federal Law on Public Charge and Public Benefits

The Immigration and Nationality Act (INA) identifies groups of immigrants that are ineligible to enter the U.S. or obtain lawful permanent resident (LPR) status if they are determined to be a "public charge."[1] The INA outlines the minimum factors immigration officials must consider to determine whether an immigrant is likely to become a public charge. As part of a public charge assessment, an immigration officer must consider the applicant's:

- Age;
- Health;
- Family Status;
- Assets, resources, and financial status; and
- Education and skills.

Existing Immigration and Naturalization Service (INS) rules require immigration officials to examine all the applicant's circumstances. Immigration officials are prohibited from finding that an individual is likely to become a public charge because of the existence or the absence of any one factor. For example, an immigration official could not deny lawful entry to a low-income immigrant as a public charge based solely on income. The immigration official would also need to review the immigrant's history of

employment, resources, education, etc. The existing rule requires the "totality of the individual's circumstances" to be considered in a prospective evaluation.[2]

Current Policy on Public Charge and Public Benefits. In 1999, INS issued interim *Field Guidance on Deportability and Inadmissibility on Public Charge Grounds.* This guidance sought to ease growing public confusion over the meaning of the term "public charge" and its relationship to the receipt of federal, state, or local public benefits. Under the 1999 policy guidance, INS defined public charge to mean "the likelihood of a foreign national becoming primarily dependent on the government for subsistence." The guidance listed two public benefits as evidence of an immigrant's likelihood of becoming a public charge:

1. Receipt of public cash assistance for income maintenance; or
2. Institutionalization for long-term care at government expense."[3]

Under the guidance, immigration officials are required to consider past use of these two public benefits, and only these two public benefits, in a public charge determination. Immigration officials must also consider all other circumstances, not just the use of these two public benefits, in determining whether an individual may become a public charge.

Immigrants <u>Excluded</u> from Public Charge Determinations. Under existing law, some immigrants are not subject to public charge determinations, including:

- Naturalized citizens,
- Refugees,
- Asylees,
- Survivors of trafficking or domestic violence, and
- Most LPRs.

Summary of the Final Rule

New Policy on Public Charge and Public Benefits. The final rule revises and broadens the definition of public charge. Under the final rule, an immigration official will continue to weigh all factors (age, health, etc.) relevant to the immigrant applicant for adjustment of status to determine whether the immigration official believes that at any time in the future:

1. The applicant is *more likely than not* to receive one or more specific public benefits, listed below; and
2. The applicant will *more likely than not* receive the public benefit(s) for more than 12 months in the aggregate within any 36-month period.

If an immigration official believes the applicant, based on the totality of their circumstances, will more likely than not receive the specific benefit(s) for the indicated length of time, the applicant will be considered a public charge and denied the opportunity to legalize or adjust their status.

The final rule rejects the existing public charge definition that requires immigration officials to evaluate the likelihood of an applicant becoming <u>primarily</u> dependent on the government for subsistence.

Public Benefits Considered in a Public Charge Determination. The final rule adds to the list of public health care programs and benefits that must be considered in a public charge determination. The final rule specifies that the following cash aid and noncash medical care, housing, and food benefit programs must be considered along with other factors in a public charge determination:

- Receipt of public cash assistance for income maintenance;
- Supplemental Nutrition Assistance Program (SNAP);
- Section 8 Project-Based Rental Assistance and certain other forms of subsidized housing; and
- *Receipt of non-emergency Medicaid by non-pregnant adults* (see next section for exemptions).

Under the final rule, an immigrant's reliance on the listed public benefits must meet specific thresholds to be considered as a "heavily weighted negative factor" in a public charge determination. For example, an immigrant needs to receive non-emergency Medicaid benefits for more than 12 months in the aggregate within a 36-month period to be a heavily weighted negative factor in a public charge determination. However, unless specifically exempted in the final rule, an immigration official can consider past use of the listed public benefits in the totality of circumstances evaluation, regardless of whether the threshold has been met.

Non-emergency Medicaid Exemptions. In addition to exempting *emergency* Medicaid services from a public charge determination, the final rule excludes the use of non-emergency Medicaid from a public charge determination for the following populations and under the following circumstances:

- Medicaid benefits received by an immigrant under 21 years of age;
- Medicaid benefits received by a pregnant person, during pregnancy and 60 days postpartum;
- Direct receipt of public benefits, including non-emergency Medicaid, by a member of an immigrant applicant's household, so long as the applicant for adjustment of status is not listed as a direct beneficiary of the public benefit;
- School-based Medicaid services or benefits provided to individuals at or below the maximum eligible age for secondary education, as determined by State law;
- Services funded by Medicaid but provided under the Individuals with Disabilities Education Act (IDEA), a program providing free and appropriate public education to eligible children with disabilities;
- Public benefits, including non-emergency Medicaid, provided to foreign-born children of U.S. parents in the adoption process;
- Public benefits, including non-emergency Medicaid, used by immigrants (and their dependents) while enlisted in the U.S. Armed Forces and serving in active duty or in the Ready Reserve; and
- Any public benefit (such as state-funded Medi-Cal) that is not listed in the final rule.

In addition, the final rule excludes from a public charge determination public benefits that were also excluded under the 1999 policy guidance, if received before the effective date of the final rule.

Types of Immigrants Affected by the Final Rule. The final rule primarily impacts undocumented immigrants applying for lawful residency status through the sponsorship of family members. These immigrants are subject to public charge determinations under existing law. In addition, LPRs that leave the U.S. for more than six months and reenter the U.S. may be subject to a public charge determination.

Under the final rule, additional groups would be subject to public charge determinations for the first time, including certain non-immigrants seeking to extend their current period of authorized stay in the U.S. or those seeking to transition to another non-immigrant status. For example, an individual

authorized to study in the U.S and then return to their country of origin, if their studies take longer than anticipated, this individual may seek an extension of their stay and would be subject to a public charge determination under the final rule.

Impact of the Final Rule

Most immigrants subject to public charge determinations are already ineligible to receive the health benefits that would designate them as a public charge. Most undocumented immigrants are ineligible for federally-funded Medicaid services; except for emergency Medicaid services, which are exempt from a public charge determination. Therefore, the inclusion of non-emergency Medicaid in public charge assessments should not have a significant impact on immigrants seeking to legalize their status.

The final rule may apply to LPRs that leave the U.S. for more than six months and then reenter the U.S. For these immigrants, prior enrollment in non-emergency Medicaid may be included in a public charge determination. In evaluating the proposed rule, the National Immigration Law Center (NILC) prepared materials to support the few immigrant categories subject to public charge determinations and who are eligible for federally funded, non-emergency Medicaid and other impacted programs. For more information, visit the *NILC* website. In addition, the California Department of Social Services (CDSS), Immigration Branch funds qualified nonprofit organizations to provide services to immigrants who reside in the state of California. For more information visit the *CDSS* website.

State Funded Medi-Cal Programs. Currently, California provides comprehensive Medi-Cal coverage to low-income undocumented children up to age 19, using primarily state-only funding, offset in part by federal funds used to cover emergency Medi-Cal services. The final rule does not allow for the inclusion of Medi-Cal coverage for undocumented children in a public charge determination for either the parent or the child. First, the final rule states that immigration officials will not consider direct receipt of public benefits by the child of an applicant as a factor in a public charge determination. The final rule also excludes Medicaid use by individuals under age 21 from being considered in a public charge determination. ***Therefore, Medi-Cal coverage for undocumented, lawfully residing, or U.S. citizen children will not be considered in a parent's or an undocumented child's public charge determination.*** Second, the final rule states that the term "public charge" would only include receipt of any public benefit specifically listed in the final rule. State-funded medical programs are not listed in the final rule; therefore, these programs will not be included in a public charge determination.

The expansion of comprehensive Medi-Cal coverage to low-income undocumented young adults age 19-25 in 2020 will also rely primarily on state funds, offset in part by federal funds to cover emergency Medi-Cal services. ***Similar to the Medi-Cal expansion for undocumented children, the receipt of Medi-Cal by undocumented young adults through a state-funded medical program will not be included in a public charge determination under the final rule.***

Health Status and Private Health Insurance Programs. While health is a factor in public charge determinations under existing law, the final rule changes how this factor is considered. Under the final rule, immigration officials will consider in a public charge determination any medical condition, including a disability, that effects an immigrant's ability to attend school or work, or otherwise care for themselves. The final rule also adds an evaluation of an immigrant's financial status as part of the evaluation of health and requires officials to evaluate the potential costs of treatment for the medical condition and whether an applicant has the resources to cover the anticipated future medical needs.

As part of an assessment of assets, resources, and financial status, the final rule includes, for the first time, private health insurance or the financial resources to pay for medical costs as a heavily weighted positive factor in a public charge determination. Conversely, the lack of private health insurance or the lack of financial resources to pay for medical costs is a negative factor under the final rule.

The final rule will take effect on October 15, unless implementation is stopped by one of the many legal challenges to the rule. The final rule will only apply to public benefits used after the effective date. For public benefits used prior to this date, the public charge policy outlined in the 1999 field guidance, described above, will remain in effect.

Notes

[1] Section 212 of the Immigrant and Nationality Act (INA), Title 8 United States Code Section (U.S.C.) 1182.
[2] Title 8 Code of Federal Regulations (CFR) 245a.3
[3] 64 Federal Register 28689, (May 26, 1999)

About ITUP

Insure the Uninsured Project (ITUP) is a Sacramento-based nonprofit health policy institute that for more than two decades has provided expert analysis and facilitated convenings for California policymakers and decisionmakers focused on health reform.

The mission of ITUP is to promote innovative and workable policy solutions that expand health care access and improve the health of Californians, through policy-focused research and broad- based stakeholder engagement.

ITUP is generously supported by the following funders:

- California Community Foundation
- The California Endowment
- California Health Care Foundation
- The California Wellness Foundation
- Kaiser Permanente

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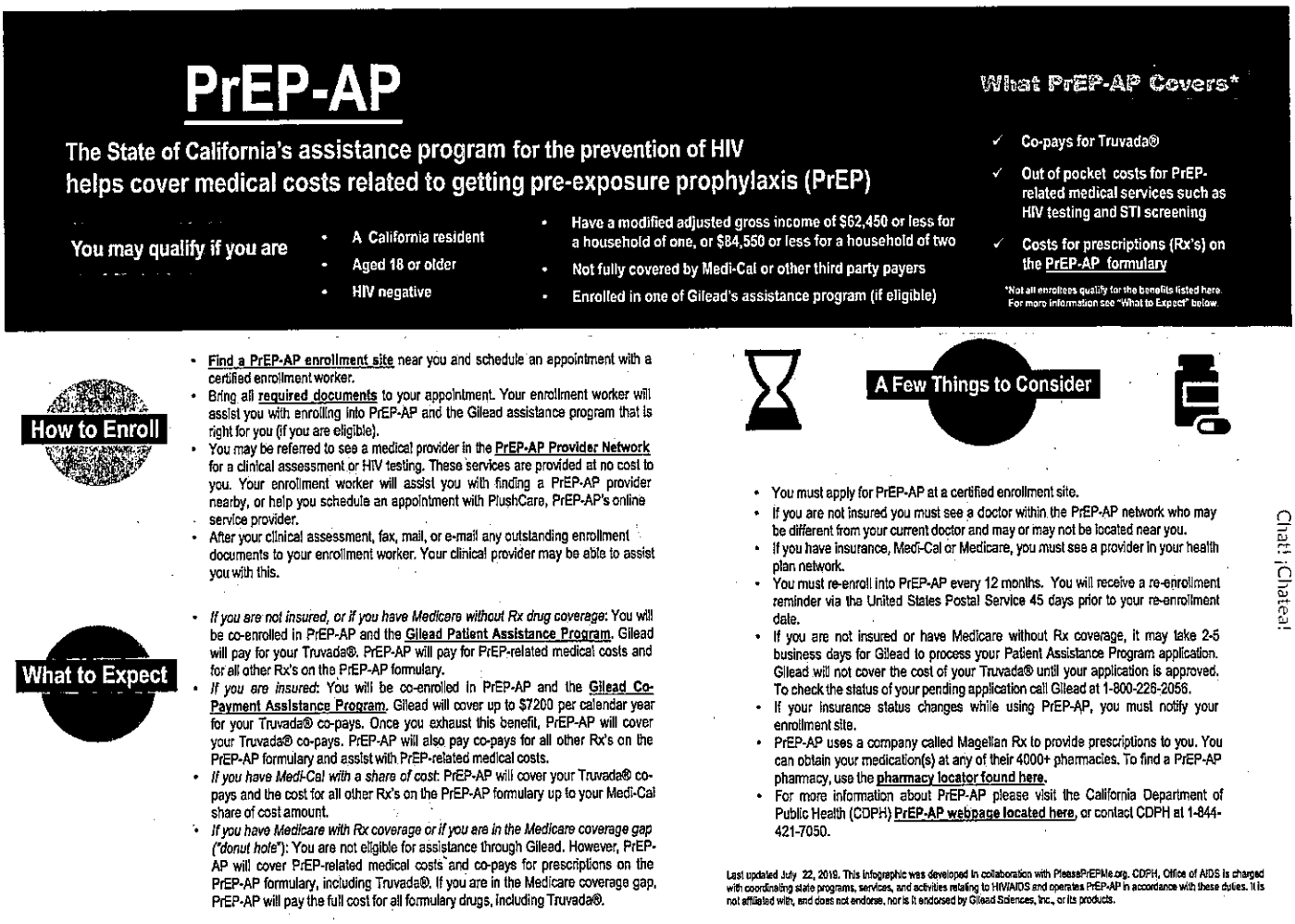
California PrEP Assistance Program (PrEP-AP)

Click here to download this infographic about the California PrEP Assistance Program as a hyperlinked PDF. (/sites/default/files/file-attachments/PrEP-AP_Infographic_07302019.pdf) *(Last updated: 7.22.2019)*



In order to qualify for the California PrEP Assistance Program (PrEP-AP) (https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_adap_resources_prepAP.aspx#) you must:

- Be 18 years or older
- Be a California resident
- Be HIV negative
- Have an annual Modified Adjusted Gross Income that does not exceed 500% of the Federal Poverty Level (https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/2018%20Federal%20Poverty%20Level%20Guidelines.pdf) based on family size and household income
- Not be *fully* covered by Medi-Cal or another third party payer

Please note that uninsured clients must be seen at a contracted clinical provider, which includes the telemedicine service PlushCare (https://www.plushcare.com/), after enrolling in PrEP-AP. Find a contracted location at this link (https://cdphdata.maps.arcgis.com/apps/webappviewer/index.html?id=6878d3a1c9724418aebfea96878cd5b2). Or, click the chat bubble on the right and PleasePrEPMe can help you find one.

Kaiser Permanente (KP) members: The CA PrEP-AP is also available to members in need of financial assistance with out-of-pocket PrEP costs. As of 3/1/19 the Gilead copay card is no longer required. KP members can apply at ANY certified CA PrEP-AP enrollment site but will still be required to see their KP provider for PrEP services and pick-up prescriptions at KP pharmacies. **Find a contracted enrollment location at this link (https://cdphdata.maps.arcgis.com/apps/webappviewer/index.html?id=6878d3a1c9724418aebfea96878cd5b2).**

If you do not qualify for PrEP-AP you can check out other Payment Assistance Programs (https://fairpricingcoalition.org/medication-assistance-program-and-co-pay-programs-for-prep/) which you may be able to apply for, or simply click on the chat bubble to the right to talk to a knowledgeable agent about your options!

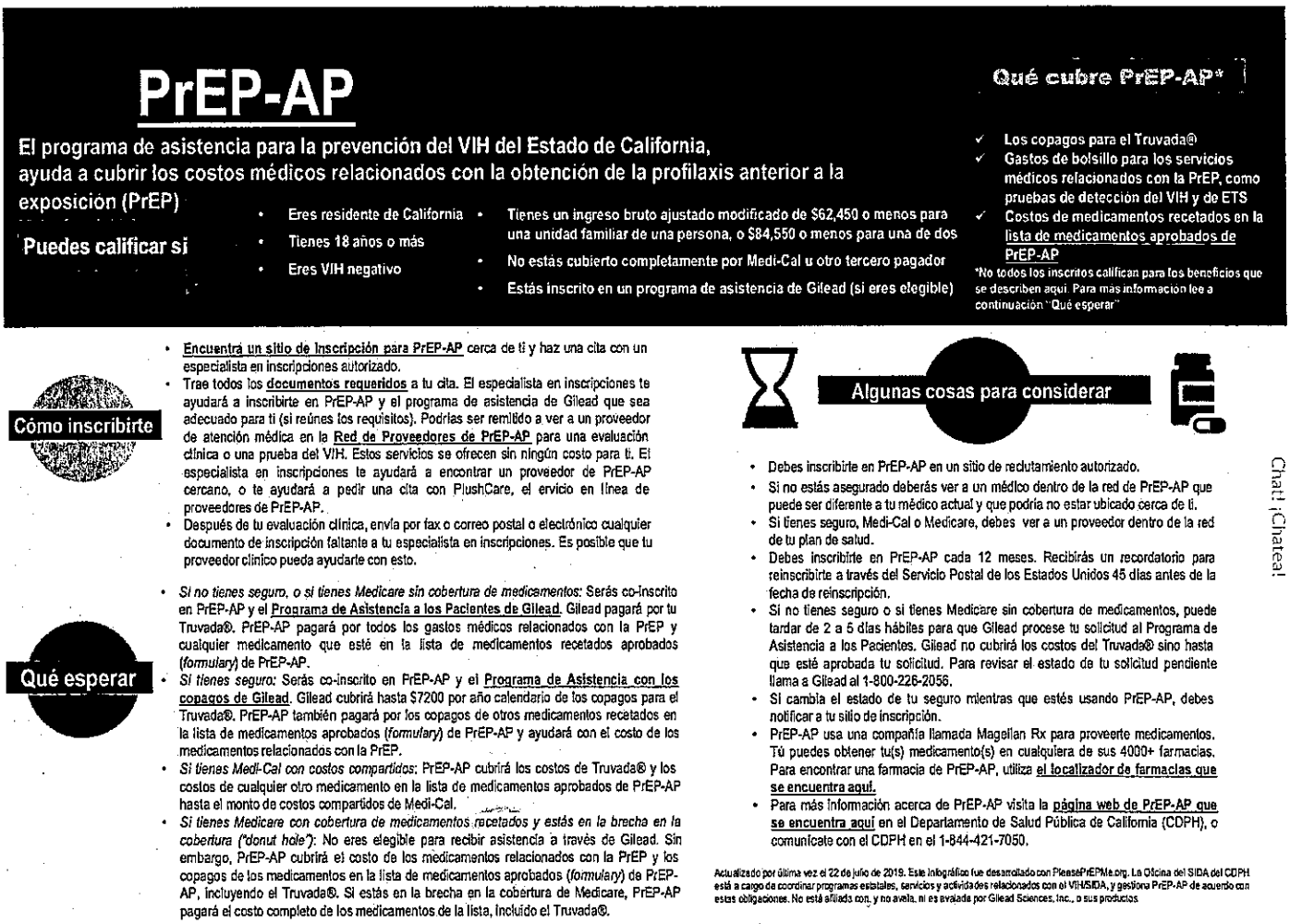
Are you interested in becoming a PrEP-AP contracted clinical provider? You can find the application form at this link (https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph8735.pdf).

Please contact us (/contact) if you would like help with completing this form.

(https://www.facebook.com/PleasePrEPMe) (https://www.youtube.com/channel/UCktcH_57wWV3oQKnVS0-4_A)
(https://www.instagram.com/PleasePrEPMe) (https://www.twitter.com/pleaseprepme)

Programa de asistencia del estado de California para la profilaxis antes de la exposición (CA PrEP-AP)

Haz clic aquí para descargar esta infografía sobre el Programa de asistencia para la profilaxis preexposición (PrEP-AP) con un enlace PDF. (/sites/default/files/file-attachments/PrEP-AP_Infographic_07222019_SP.pdf) *(Última actualización: 7.22.2019)*



Para calificar para el Programa de asistencia para la profilaxis preexposición (PrEP-AP) (https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_adap_resources_prepAP.aspx#), tu debes:

- Tener 18 años o más
- Ser un residente de California
- Ser VIH negativo
- Tener un ingreso bruto ajustado anual que no pase mas de 500% del nivel federal de pobreza (https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/2018%20Federal%20Poverty%20Level%20Guidelines.pdf) según el tamaño de la familia y el ingreso familiar
- No estar *completamente* cubierto por Medi-Cal u otro pagador tercero.

Toma en cuenta que los clientes no asegurados deben ser atendidos por un proveedor clínico contratado después de inscribirse en el programa de PrEP-AP, que incluye el servicio de telemedicina PlushCare (https://www.plushcare.com/). Encuentra un lugar contratado en este enlace (https://cdphdata.maps.arcgis.com/apps/webappviewer/index.html?id=6878d3a1c9724418aebfea96878cd5b2). O, tambien puedes darle un clic a la burbuja de chat a la derecha y PleasePrEPMe te ayudara a encontrar one.

Chat! ¡Chatea!

Miembros de Kaiser Permanente (KP): CA PrEP-AP también está disponible para los miembros que necesitan asistencia financiera con los costos de la PrEP y de bolsillo. A partir del 3/1/19 ya no se requiere la tarjeta de copago de Gilead. Los miembros de KP pueden aplicar en CUALQUIER sitio certificado de inscripción de PrEP-AP en CA, pero aún así se les solicitará que consulten a su proveedor de KP para obtener los servicios de la PrEP y recoger las recetas de medicamento en las farmacias de KP. **Encuentra un centro de inscripción contratado en este enlace (https://cdphdata.maps.arcgis.com/apps/webappviewer/index.html?id=6878d3a1c9724418aebfea96878cd5b2).**

Si no calificas para el PrEP-AP puedes consultar otros Programas de Asistencia de Pago (https://fairpricingcoalition.org/medication-assistance-program-and-co-pay-programs-for-prep/) y aplicar o simplemente haz clic en la burbuja de chat a la derecha para hablar con uno de nuestros expertos sobre tus opciones.

¿Estás interesado en convertirse en un proveedor clínico contratado por el programa de PrEP-AP? Puedes encontrar el formulario de solicitud en este enlace. (https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph8735.pdf)

Pónte en contacto con nosotros (/contact) si deseas ayuda para completar este formulario.

(https://www.facebook.com/PleasePrEPMe) (https://www.youtube.com/channel/UCktcH_57wWV3oQKnVSO-4_A)
(https://www.instagram.com/PleasePrEPMe) (https://www.twitter.com/pleaseprepme)

10. STANDING COMMITTEE REPORTS (cont'd):

D. Standards and Best Practices (SBP) Committee

(1) Revised HIV Continuum Framework **MOTION #8**

(2) Universal Standards of Care **MOTION #9**

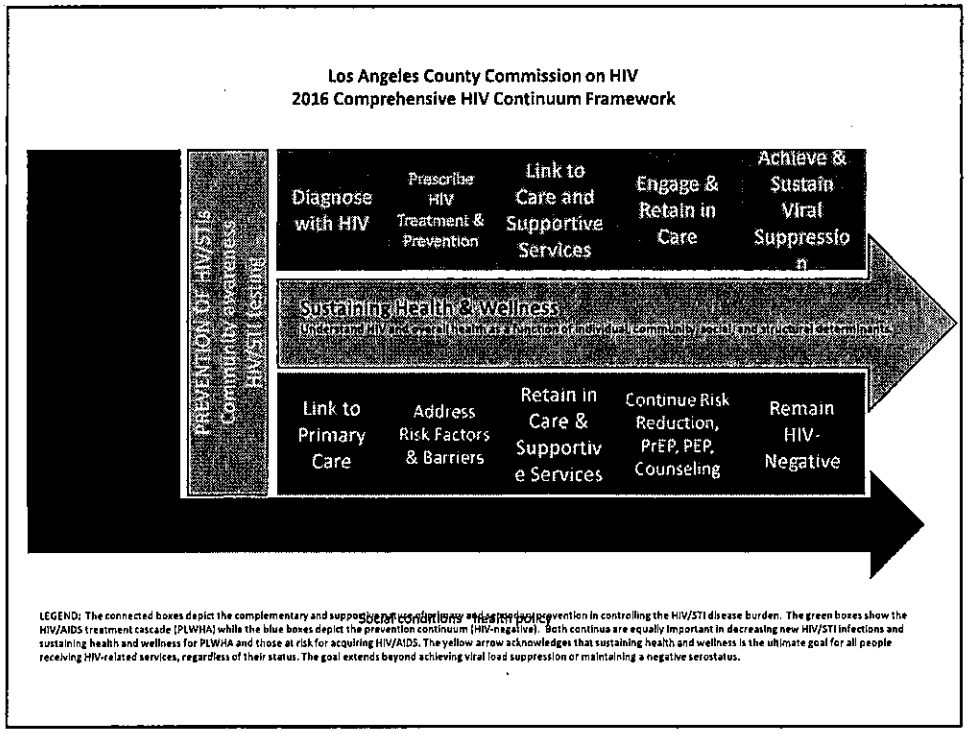
LOS ANGELES COUNTY COMMISSION ON HIV

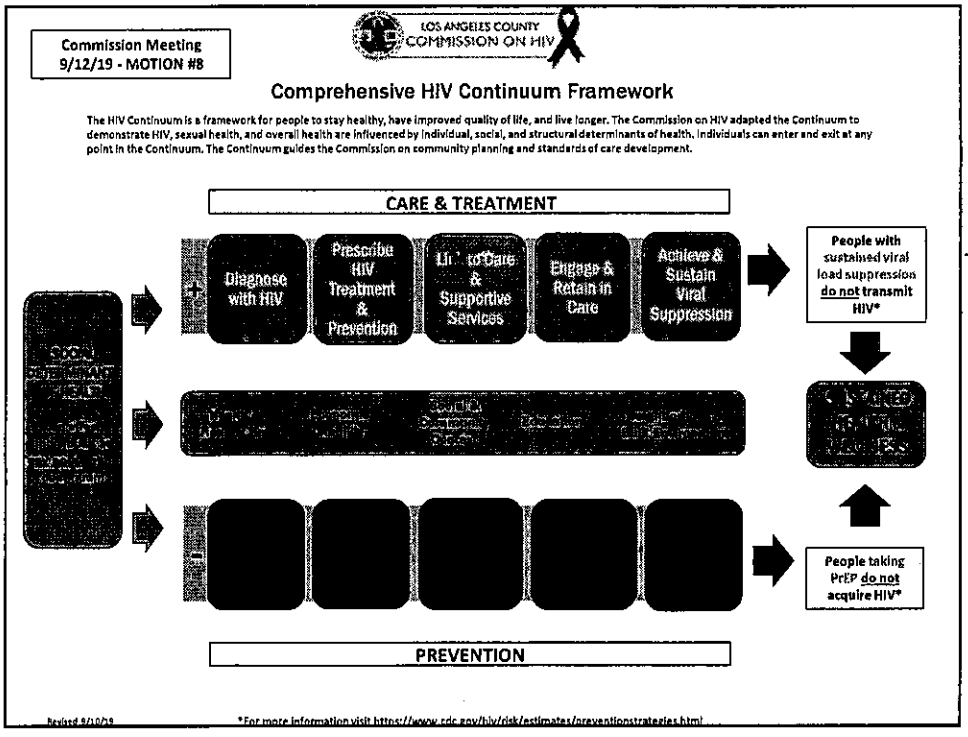
STANDARDS & BEST PRACTICES COMMITTEE

Commission Meeting
September 12, 2019

HIV Continuum Framework – Motion #8

- Aspirational framework for people to stay healthy, have improved quality of life, and to live longer
- Serves as a guide for community planning and developing Standards of Care
- SBP made a commitment to conduct an annual review and update if necessary
- Began review in April, presented the updated draft to the Commission and Executive Committee


Los Angeles County Commission on HIV
2016 Comprehensive HIV Continuum Framework
PREVENTION OF HIV/STIs
Community awareness
HIV/STI testing
Diagnose with HIV
Prescribe HIV Treatment & Prevention
Link to Care and Supportive Services
Engage & Retain in Care
Achieve & Sustain Viral Suppressio n
Sustaining Health & Wellness
Link to Primary Care
Address Risk Factors & Barriers
Retain in Care & Supportiv e Services
Continue Risk Reduction, PrEP, PEP, Counseling
Remain HIV-Negative
LEGEND: The connected boxes depict the complementary and supportive relationship between prevention in controlling the HIV/STI disease burden. The green boxes show the HIV/AIDS treatment cascade (PLWHA) while the blue boxes depict the prevention continuum (HIV-negative). Both continua are equally important in decreasing new HIV/STI infections and sustaining health and wellness for PLWHA and those at risk for acquiring HIV/AIDS. The yellow arrow acknowledges that sustaining health and wellness is the ultimate goal for all people receiving HIV-related services, regardless of their status. The goal extends beyond achieving viral load suppression or maintaining a negative serostatus.


Commission Meeting
9/12/19 - MOTION #8
LOS ANGELES COUNTY
COMMISSION ON HIV
Comprehensive HIV Continuum Framework
The HIV Continuum is a framework for people to stay healthy, have improved quality of life, and live longer. The Commission on HIV adapted the Continuum to demonstrate HIV, sexual health, and overall health are influenced by individual, social, and structural determinants of health. Individuals can enter and exit at any point in the Continuum. The Continuum guides the Commission on community planning and standards of care development.
CARE & TREATMENT
Diagnose with HIV
Prescribe HIV Treatment & Prevention
Engage & Retain in Care
Achieve & Sustain Viral Suppression
People with sustained viral load suppression do not transmit HIV*
People taking PrEP do not acquire HIV*
PREVENTION
Revised 9/10/19
*For more information visit https://www.cdc.gov/hiv/risk/estimates/preventionstrategies.html

Universal Standards of Care – Motion #9

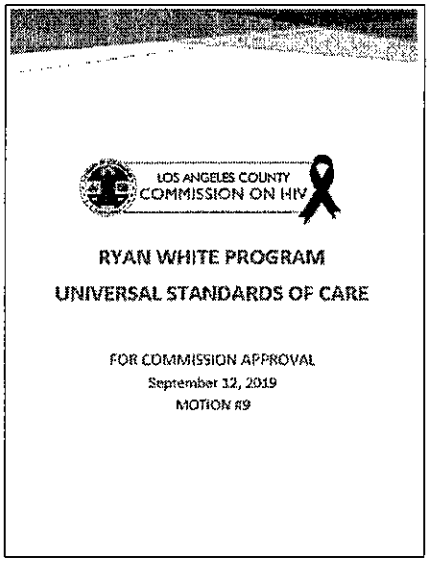
- Main guiding document for Ryan White Part A services in Los Angeles County
- Ensures consistent quality care is offered to clients
- Received guidance from the HRSA technical assistance team
- Two rounds of public comment

Key Updates

- Ensured the standards were measurable and supporting documentation was reasonable for agencies
- Moved language into tables/charts to make them more concise
- Removed the Assessment section to allow for different assessment guidance in across service categories
- Added strong anti-discrimination language
- Included the Patient & Client Bill of Rights as an appendix
- Developed a robust Cultural Competency section to ensure the needs of vulnerable populations are met

Standards available here:

http://hiv.lacounty.gov/Standard-Of-Care


LOS ANGELES COUNTY COMMISSION ON HIV

RYAN WHITE PROGRAM

UNIVERSAL STANDARDS OF CARE

FOR COMMISSION APPROVAL
September 12, 2019
MOTION #9

Thank you!

Standards & Best Practices Committee

- Meets every first Tuesday of the month at the Commission Office 10am-12pm

LOS ANGELES COUNTY
COMMISSION ON HIV

RYAN WHITE PROGRAM

UNIVERSAL STANDARDS OF CARE

FOR COMMISSION APPROVAL

September 12, 2019

MOTION #9

LOS ANGELES COUNTY
COMMISSION ON HIV

TABLE OF CONTENTS

INTRODUCTION

Standards of Care outline the elements and expectations a Ryan White service provider follows when implementing a specific service category. Standards of Care are available for each service category to set the minimum level of care Ryan White funded agencies should offer to clients.[1] The Standards are intended to help Ryan White Part A funded agencies meet the needs of their clients. Providers are encouraged to exceed these standards.

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

UNIVERSAL STANDARDS OVERVIEW

The objectives of the Universal Standards are to ensure agencies:

- Provide services that are accessible and non-discriminatory to all people living with HIV in Los Angeles County with a focus on highly impacted populations
- Educate staff and clients on the importance of receiving care, treatment as prevention, and how people who are completely, durably suppressed will not sexually transmit HIV.
- Protect client rights and ensure quality of care
- Provide client-centered, age appropriate, culturally and linguistically competent care
- Provide high quality services through experienced and trained staff
- Meet federal, state, and county requirements regarding safety, sanitation, access, and public health.
- Guarantee client confidentiality, protect client autonomy, and ensure a fair process of addressing grievances
- Inform clients of services, establish eligibility, and collect information through an intake process
- Effectively assess client needs and encourage informed and active participation
- Address client needs through coordination of care and referrals to needed services

1. GENERAL AGENCY POLICIES

All agencies offering Ryan White services must have written policies that address client confidentiality, release of information, client grievance procedures, and eligibility. Agency policies and procedures facilitates service delivery as well as ensures safety and well-being of clients and staff.

[1] Appendix A: List of Ryan White Part A Service Categories

1.0 GENERAL AGENCY POLICIES	
Standard	**Documentation**
1.1 Agency develops or utilizes an existing client confidentiality policy in accordance with state and federal laws to assure protection of client HIV status, behavioral risk factors, and/or use of services.	1.1 Written client confidentiality policy on file.
1.2 Client determines what information of theirs can be released and with whom it can be shared.	1.2 Completed *Release of Information Form* on file including: • Name of agency/individual with whom information will be shared • Information to be shared • Duration of the release consent • Client signature For agencies and information covered by the Health Insurance Portability and Accountability Act (HIPAA), form must be HIPAA disclosure authorization compliant.
1.3 Agency develops or utilizes an existing grievance procedure to ensure clients have recourse if they feel they are being treated in an unfair manner or feel they are not receiving quality services.	1.3 Written grievance procedure on file that includes, at minimum: • Client process to file a grievance • Information on the Los Angeles County Department of Public Health, Division of HIV & STD Programs (DHSP) Grievance Line 1-800-260-8787. [2] Additional ways to file grievances can be found at http://publichealth.lacounty.gov/dhsp/QuestionServices.htm DHSP Grievance Line is posted in a visible location on site.

[2] http://publichealth.lacounty.gov/dhsp/QuestionServices.htm

Standard	Documentation
1.4 Agency provides eligibility requirements for services available upon request. Eligibility requirements must follow guidance from Division of HIV & STD Programs (DHSP) and HRSA under Policy Clarification Notice #16-02.[3]	1.4 Written eligibility requirements on file.
1.5 All client files are stored in a secure and confidential location, and electronic client files are protected from unauthorized use.	1.5 Client files must be locked and/or password protected with access provided only to appropriate personnel.
1.6 Agency maintains progress notes of all communication between provider and client.	1.6 Legible progress notes maintained in individual client files that include, at minimum: • Date of communication or service • Service(s) provided • Recommended referrals linking clients to needed services (See Section 7: Referrals and Case Closure)
1.7 Agency develops or utilizes an existing crisis management policy.	1.7 Written crisis management policy on file that includes, at minimum: • Mental health crises • Dangerous behavior by clients or staff
1.8 Agency develops a policy on utilization of Universal Precaution Procedures.[4] a. Staff members are trained in universal precautions.	1.8 Written policy or procedure on file. a. Documentation of staff training in personnel file.
1.9 Agency ensures compliance with Americans with Disabilities Act (ADA) criteria for programmatic accessibility (e.g. building and design accessibility, parking, etc.). For agencies with multiple sites, all sites must be in compliance.	1.9 ADA criteria on file at all sites.

[3] https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf
[4] https://www.cdc.gov/niosh/topics/bbp/universal.html

Standard	Documentation
1.10 Agency complies with all applicable state and federal workplace and safety laws and regulations, including fire safety.	1.10 Signed confirmation of compliance with applicable regulations on file.

2. CLIENT RIGHTS AND RESPONSIBILITIES

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

2.0 CLIENT RIGHTS AND RESPONSIBILITIES	
Standard	**Documentation**
2.1 Agency ensures services are available to any individual who meets the eligibility requirements for the specific service category.	2.1 Written eligibility requirements on file. Client utilization data made available to funder.
2.2 Agency includes input from people living with HIV/AIDS in the design and evaluation of services to ensure care is client-centered.	2.2 Written documentation of how input was received to inform service planning and evaluation in regular reports. Lists may include: • Consumer Advisory Board meetings • Participation of people living with HIV in HIV program committees or other planning bodies • Needs assessments • Satisfaction surveys • Focus groups

Standard	Documentation
2.3 Agency provides each client a copy of the *Patient & Client Bill of Rights*[5] document that informs them of the following: • Confidentiality policy • Expectations and responsibilities of the client when seeking services • Client right to file a grievance • Client right to receive no-cost interpreter services • Client right to access their file (if psychotherapy notes cannot be released per clinician guidance, agency should provide a summary to client within 30 days) • Reasons for which a client may be discharged from services and the process that occurs during involuntary discharge	2.3 *Patient & Client Bill of Rights* document is signed by client and kept on file.

3. STAFF REQUIREMENTS AND QUALIFICATIONS

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

3.0 STAFF REQUIREMENTS AND QUALIFICATIONS	
Standard	**Documentation**
3.1 Staff members meet the minimum qualifications for their job position and have the knowledge, skills, and ability to effectively fulfill their role and the communities served.	3.1 Staff resumes on file.

[5] Appendix B: Patient & Client Bill of Rights

Standard	Documentation
3.2 If a position requires licensed staff, staff must be licensed to provide services.	3.2 Copy of current license on file.
3.3 Staff will participate in trainings appropriate to their job description and program a. Required education on how a client achieving and maintaining an undetectable viral load for a minimum of six months will not sexually transmit HIV.	3.3 Documentation of completed trainings on file
3.4 New staff will participate in trainings to increase capacity for fulfilling the responsibilities of their position. a. Required completion of an agency-based orientation within 6 weeks of hire b. Training within 3 months of being hired appropriate to the job description. c. Additional trainings appropriate to the job description and Ryan White service category.	3.4 Documentation of completed trainings on file

4. CULTURAL AND LINGUISTIC COMPETENCE

Ryan White funded agencies must provide services that are culturally and linguistically competent based on the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. As noted in the CLAS Standards, ensuring culturally and linguistically appropriate services advances health equity, improves quality, and helps eliminate health care disparities by establishing a blueprint for health and health care organizations. For the purpose of these standards, culture is defined as the integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics.[6] The standards below are adapted directly from the National CLAS Standards.

[6] National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice. Office of Minority Health, US Department of Health and Human Services. April 2013. https://www.thinkculturalhealth.hhs.gov/clas/standards

Agencies should also strive towards acknowledging implicit bias, how it plays a role in service delivery, and how it can be addressed and countered. Agencies must provide services that align with strategies to reduce implicit bias by the Institute for Healthcare Improvement.[7] For the purpose of the standards, implicit bias refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. These biases, which encompass both favorable and unfavorable assessments, are activated involuntarily and without an individual's awareness or intentional control. Residing deep in the subconscious, these biases are different from known biases that individuals may choose to conceal for the purposes of social and/or political correctness.[8]

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

Federal and State language access laws require health care facilities that receive federal or state funding to provide competent interpretation services to limited English proficiency patients at no cost, to ensure equal and meaningful access to health care services.[9] Interpretation refers to verbal communication where speech is translated from a speaker to a receiver in a language that the receiver can understand. Translation refers to the conversion of written material from one language to another.

4.0 CULTURAL AND LINGUISTIC COMPETENCE	
Standard	**Documentation**
4.1 Recruit, promote, and support a culturally and linguistically diverse workforce that are responsive to the population served.	4.1 Documentation of how staff demographics reflect the demographics of clients served on file (e.g. race, gender identity, age, sexual orientation, etc.)

[7] http://www.ihi.org/communities/blogs/how-to-reduce-implicit-bias

[8] http://kirwaninstitute.osu.edu/research/understanding-implicit-bias/

[9] Title VI of the Civil Rights Act of 1964 and California's 1973 Dymally-Alatorre Bilingual Services Act

Standard	Documentation
4.2 Agency develops or utilizes existing culturally and linguistically appropriate policies and practices. a. Agency educates and trains workforce on culturally and linguistically appropriate practices on an ongoing basis.	4.2 Written policy and practices on file a. Documentation of completed trainings on file.
4.3 Provide resources onsite to facilitate communication for individuals who experience impairment due to a challenging medical condition or status (e.g. augmentative and alternative communication resources or auxiliary aids and services)	4.3 Resources on file b. Checklist of resources onsite that are available for client use. c. Type of accommodations provided documented in client file.
4.4 Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.	4.4 *Signed Patient & Client Bill of Rights* document on file that includes notice of right to obtain no-cost interpreter services.
4.5 Ensure the competence of individuals providing language assistance a. Use of untrained individuals and/or minors as interpreters should be avoided b. Ensure quality of language skills of self-reported bilingual staff who use their non-English language skills during client encounters	4.5 Staff resumes and language certifications, if available, on file.
4.6 Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area in clinic points of entry (e.g. registration desks, front desks, reception, waiting rooms, etc.) and areas where work with client is performed (e.g. clinic rooms, meeting rooms, etc.)	4.6 Materials and signage in a visible location and/or on file for reference.

5. INTAKE AND ELIGIBILITY

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

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

6. REFERRALS AND CASE CLOSURE

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

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

Standard	Documentation
6.4 Agency has a transition procedure in place that is implemented for clients leaving services to ensure a smooth transition for clients who no longer want or need services.	6.4 Completed transition summary in file, signed by client and supervisor (if possible). Summary should include reason for discharge; and a plan for transition to other services, if applicable, with confirmation of communication between referring and referral agencies, or between client and agency.
6.5 Agency develops or utilizes existing due process policy for involuntary discharge of clients from services; policy includes a series of verbal and written warnings before final notice and discharge.	6.5 Due process policy on file as part of transition, discharge, and case closure policy described in the *Patient & Client Bill of Rights* document. (Refer to Section 2).

ACKNOWLEDGEMENTS

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7. APPENDICES

APPENDIX A

RYAN WHITE PART A SERVICE CATEGORIES

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

Core medical services include the following categories:

- AIDS Drug Assistance Program
- AIDS pharmaceutical assistance
- Early intervention services
- Health insurance premium and cost sharing assistance for low-income individuals
- Home and community-based health services
- Home health care
- Hospice services
- Medical case management, including treatment-adherence services
- Medical nutrition therapy
- Mental health services
- Oral health
- Outpatient and ambulatory medical care
- Substance abuse outpatient care

Support services include the following categories:

- Case Management (Non-Medical)
- Childcare Services
- Emergency Financial Assistance
- Food Bank/Home Delivered Meals
- Health Education/Risk Reduction
- Housing Services
- Legal Services
- Linguistic Services
- Medical Transportation
- Outreach Services
- Psychosocial Support Services
- Referral
- Rehabilitation
- Respite Care
- Substance Abuse Residential
- Treatment Adherence Counseling

APPENDIX B

PEOPLE WITH HIV/AIDS BILL OF RIGHTS AND RESPONSIBILITIES

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

A. Respectful Treatment

1. Receive considerate, respectful, professional, confidential and timely care in a safe client-centered environment without bias.
2. Receive equal and unbiased care in accordance with federal and State laws.
3. Receive information about the qualifications of your providers, particularly about their experience managing and treating HIV/AIDS or related services.
4. Be informed of the names and work phone numbers of the physicians, nurses and other staff members responsible for your care.
5. Receive safe accommodations for protection of personal property while receiving care services.
6. Receive services that are culturally and linguistically appropriate, including having a full explanation of all services and treatment options provided clearly in your own language and dialect.
7. Look at your medical records and receive copies of them upon your request (reasonable agency policies including reasonable fee for photocopying may apply).
8. When special needs arise, extended visiting hours by family, partner, or friends during inpatient treatment, recognizing that there may be limits imposed for valid reasons by the hospital, hospice or other inpatient institution.

B. Competent, High-Quality Care

1. Have your care provided by competent, qualified professionals who follow HIV treatment standards as set forth by the Federal Public Health Service Guidelines, the Centers for Disease Control and Prevention (CDC), the California Department of Health Services, and the County of Los Angeles.
2. Have access to these professionals at convenient times and locations.
3. Receive appropriate referrals to other medical, mental health or other care services.

C. Make Treatment Decisions

1. Receive complete and up-to-date information in words you understand about your diagnosis, treatment options, medications (including common side effects and complications) and prognosis that can reasonably be expected.

2. Participate actively with your provider(s) in discussions about choices and options available for your treatment.
3. Make the final decision about which choice and option is best for you after you have been given all relevant information about these choices and the clear recommendation of your provider.
4. Refuse any and all treatments recommended and be told of the effect not taking the treatment may have on your health, be told of any other potential consequences of your refusal and be assured that you have the right to change your mind later.
5. Be informed about and afforded the opportunity to participate in any appropriate clinical research studies for which you are eligible.
6. Refuse to participate in research without prejudice or penalty of any sort.
7. Refuse any offered services or end participation in any program without bias or impact on your care.
8. Be informed of the procedures at the agency or institution for resolving misunderstandings, making complaints or filing grievances.
9. Receive a response to a complaint or grievance within 30 days of filing it.
10. Be informed of independent ombudsman or advocacy services outside the agency to help you resolve problems or grievances (see number at bottom of this form), including how to access a federal complaint center within the Center for Medicare and Medicaid Services (CMS).

D. Confidentiality and Privacy

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

E. Billing Information and Assistance

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

F. Patient/Client Responsibilities

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

1. Participate in the development and implementation of your individual treatment or service plan to the extent that you are able.
2. Provide your providers, to the best of your knowledge, accurate and complete information about your current and past health and illness, medications and other treatment and services you are receiving, since all of these may affect your care. Communicate promptly in the future any changes or new developments.
3. Communicate to your provider whenever you do not understand information you are given.
4. Follow the treatment plan you have agreed to and/or accepting the consequences of failing the recommended course of treatment or of using other treatments.
5. Keep your appointments and commitments at this agency or inform the agency promptly if you cannot do so.
6. Keep your provider or main contact informed about how to reach you confidentially by phone, mail or other means.
7. Follow the agency's rules and regulations concerning patient/client care and conduct.
8. Be considerate of your providers and fellow clients/patients and treat them with the respect you yourself expect.
9. Refrain from the use of profanity or abusive or hostile language; threats, violence or intimidations; carrying weapons of any sort; theft or vandalism; intoxication or use of illegal drugs; sexual harassment and misconduct.
10. Maintain the confidentiality of everyone else receiving care or services at the agency by never mentioning to anyone who you see here or casually speaking to other clients not already known to you if you see them elsewhere.

For More Help or Information

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

For patient complaints/grievances call (800) 260-8787
8:00 am – 5:00 pm
Monday – Friday

15. ANNOUNCEMENTS

Training of Consumers on Quality

Improving Care for People Living with HIV

Congress has mandated a focus on the quality of services provided under Ryan White legislation. The Ryan White HIV/AIDS Program (RWHAP) distributed $22 billion between 1991 – 2007. Each year 540,000 people living with HIV are reached through Ryan White funded programs

Ryan White Qualtiy Programs are focused on improving the care, sfaction, and health outcomes of those living with HIV. The New Hampshire Quality Program is dedicated to fostering active consumer engagement in all quality improvement efforts.

Toney Hodnett
Tonyhodnettc@gmail.com
Phone #(909)764-1460

Christopher Alcala
Calcala9@gmail.com

Erica Washington

09-243-9976

Please call one of us to RSVP.

- Are you a problem solver?
- Do you have ideas to solve challenges in HIV healthcare?
- Would you like to build a stronger relationship with your health care team?
- Would you like to give back by having a positive impact on healthcare in your community?

COME JOIN US!

Date: September, 20th 2019

Time: 9:30am-4:00pm

(Lunch will be provided)

HOSTED BY: TruEvolution

4164 Brockton Ave Suite A,
Riverside, CA 92501

Help us establish working relationships between consumers of care and Ryan White funded entities while increasing your confidence in quality improvement efforts.

McClendon, Dawn

From: HealthHIV <circe@healthhiv.org>
Sent: Monday, September 09, 2019 11:52 AM
To: McClendon, Dawn
Subject: "State of Aging with HIV" Webinar Sept. 18

HealthHIV's POZITIVELY AGING

Webinar on

"The State of Aging with HIV"

held on National Aging with HIV Day

September 18, 2019

2pm EST

Findings from HealthHIV's Inaugural Aging with HIV National Survey will be presented.

Topics include:

Mental Health

Care Coordination

Adherence

Substance Use

Discussion of the analysis of and implications from the survey findings.

Register

at: https://event.on24.com/wcc/r/2087382/B3517D9771E36C3F63873D52F4DDE896

Pozitively Aging is a program supported by

HealthHIV

2000 S Street NW | Washington, District of Columbia 20009

202-232-6749 | info@healthhiv.org

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The LA County Commission on HIV is pleased to announce HIV Connect, an online tool for community members and providers looking for resources on HIV and STD testing, prevention and care, service locations, and housing throughout LA County.