LOS ANGELES COUNTY COMMISSION ON HIV
3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
http://hiv.lacounty.gov

COMMISSION ON HIV MEETING

Thursday, April 13, 2017
9:00 AM – 1:30 PM

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

Los Angeles County Commission on HIV

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).

LOS ANGELES COUNTY COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140, Los Angeles, CA 90010 · TEL. (213) 7382816 · FAX (213) 637-4748
www.hiv.lacounty.gov

GUIDELINES FOR CONDUCT

The Los Angeles County Commission on HIV has played an active role in shaping HIV services in this County and in the State for over a decade. The dedication to providing quality services to people with and at risk of HIV/AIDS by people who are members of this body, both past and present, is unparalleled.

In order to encourage the active participation of all members and to address the concerns of many Commissioners, consumers and other interested members of the community, it is important that meetings take place in a "safe" environment. A "safe" environment is one that recognizes differences, while striving for consensus and is characterized by consistent professional and respectful behavior. As a result, the Commission has adopted and is consistently committed to implementing the following Guidelines for Conduct for Commission, committee and associated meetings.

Similar meeting ground rules have been developed and successfully used in large group processes to tackle difficult issues. Their intent is not to discourage meaningful dialogue, but to recognize that differences and even conflict can result in highly creative solutions to problems when approached in a respectful and professional manner.

The following should be adhered to by all participants and stakeholders:

1) Be on Time for Meetings
2) Stay for the Entire Meeting
3) Show Respect to Invited Guests, Speakers and Presenters
4) Listen
5) Don't Interrupt
6) Focus on Issues, Not People
7) Don't just Disagree, Offer Alternatives
8) Give Respectful, Constructive Feedback
9) Don't Judge
10) Respect Others' Opinions
11) Keep an Open Mind to Others' Opinions
12) Allow Others to Speak
13) Respect Others' Time
14) Begin and End on Time
15) Have All the Issues on the Table and No "Hidden Agendas"
16) Minimize Side Conversations
17) Don't Monopolize the Discussion
18) Don't Repeat What Has Already Been Said
19) If Beepers or Cell Phones Must Be On, Keep Them on Silent or Vibrate

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

LOS ANGELES COUNTY COMMISSION ON HIV
3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
http://hiv.lacounty.gov

2. APPROVAL OF AGENDA:

A Agenda
B Membership Roster
C Committee Assignments
D Commission Member Conflict of Interest
E Geographic Maps
F April – July 2017 Meeting Calendar

LOS ANGELES COUNTY COMMISSION ON HIV
3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
www.hiv.lacounty.gov

Los Angeles County Commission on HIV
[REVISED] MEETING AGENDA

Thursday, April 13, 2017
9:00am – 1:30pm
St. Anne's Conference Center
Foundation Conference Room
155 North Occidental Boulevard, 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

All Commission meetings will begin at their appointed times.
Participants should make every effort to be prompt and ready.

All agenda items are subject to action. Public comment will be invited for each item.

All "action" (non-procedural) motions are included on the consent calendar and are approved when the consent calendar is approved.
A motion can be "pulled" from the consent calendar if there are objections to it, or if it is to be presented or discussed later in the meeting.

Members/Visitors: Remember that the agenda order (and the scheduled times for items) can be changed or significantly delayed during and at a meeting.	**Motions**, public comment periods, dates/times/venues of future activities.	**Who** addresses the issue, reports on it, and/or who follows-up after that.	**Agenda Times** are best estimates, but are subject to change at any time.
AGENDA ORDER/AGENDA ITEMS	**MOTIONS/ACTIONS**	**PARTY(IES) RESPONSIBLE**	**SCHEDULED TIMES**
1. Call to Order		**B Land/R Rosales** Co-Chairs	9:00 am — 9:03 am
A Roll Call			
2. Approval of Agenda	**MOTION #1**	**Commision**	9:03am — 9:05 am
3. Approval of Meeting Minutes	**MOTION #2**	**Commission**	9:05 am — 9:07 am
4. Consent Calendar	**MOTION #3**	**Commission**	9:07am — 9:09 am

AGENDA ORDER/AGENDA ITEMS	MOTIONS/ACTIONS, DATES and LOGISTICS	PARTY(IES) RESPONSIBLE	SCHEDULED TIMES
5. Executive Director's Report		**C Barrit, MPIA,** Executive Director	9:09am — 9:30am
A. Director of Dept of Public Health Introduction		**B Ferrer, PhD, MPH, MEd** DPH Director	
6. Co-Chairs Report		**B Land/R Rosales,** Co-Chairs	9:30am -- 9:45am
A Commissioner Welcome & Service Recognition			
B Meeting Management			
C Presidential Advisory Committee on HIV/AIDS (PACHA) Update		**G Granados,** PACHA member	
D Integration Advisory Board (IAB) COH Rep Election	**MOTION #4**		
E California Planning Group (CPG) COH Rep Election	**MOTION #5**		
F Formation of Long Beach Task Force	**MOTION #6**		
7. Colloquia Series:	**Ask Me About PrEP: A 3-part Digital Campaign to Increase PrEP Uptake**		9:45am — 11:00am
8. Break			11:00am — 11:15am
9. County's Health Department Integration Advisory Board (IAB) Report Report		**A Ballesteros, MBA/B Gordon** COH IAB Representatives	11:15am — 11:17am
10. Housing Opportunities for People Living Wlith HIV/AIDS (HOPWA) Report		**R Ronquillo** Housing + Community Investment Dept City of Los Angeles	11:17am — 11:19am
11. Department of Public Health, Immunization Program Report		**F Pratt, MD, MPHTM, FACEP** Medical Director, Immunization Program Dept of Public Health	11:19am — 11:22am
12. Division of HIV/STD Programs (DHSP) Report		**M Peréz, MPH, Director,** DHSP	11:22am — 11:37am
13. California Office of AIDS (OA) Report		**State Office of AIDS**	11:37am — 11:52am
A California Planning Group (CPG)		**E Cockrell,** CPG At-Large Rep	
B OA Work/Information		**M Arnold, MS-HAS,** Chief, Care Branch, OA	
14. Standing Committee Reports			11:52am — 12:45pm
A Planning, Priorities & Allocations (PP&A) Committee		**A Ballesteros, MBA/J Brown,** Co-Chairs	
(1) Comprehensive HIV Plan (CHP) Review and Update			
(2) Prevention Planning			
B Standards and Best Practices (SBP) Committee		**J Cadden, MD/G Granados, MSW,** Co-Chairs	
(1) Standards of Care			
(a) Universal Service Standards for HIV Care Services	**MOTION #7**		
(b) Standards of Care Updates for HIV Substance Use Residential and Treatment Services	**MOTION #8**		
(c) Incarcerated/Post-Release Transitional Case Management Services	**MOTION #9**		
(d) Youth Transitional Case Management Services	**MOTION #10**		
(2) Prevention Standards and Best Practices			
(3) Housing Eligibility and Service Standards			

AGENDA ORDER/AGENDA ITEMS	MOTIONS/ACTIONS, DATES and LOGISTICS	PARTY(IES) RESPONSIBLE	SCHEDULED TIMES
14. Standing Committee Reports (cont'd)			11:52am — 12:45pm
C Operations Committee (1) Policies and Procedures (2) Membership Management (a) 2017 Member Cohort (b) Application: Juan Preciado | HIV Stakeholder #3 **MOTION #11** (3) Training/Orientation		**T Bivens-Davis/K Stalter**, Co-Chairs	
D Public Policy Committee (1) Healthcare Landscape (2) 2017 COH Legislative Docket Development		**A Fox, MPM/W Watts, Esq.**, Co-Chairs	
15. Caucus,Task Force and Work Group Reports		**Caucus, Task Force and Work Group Co-Chairs**	12:45pm — 12:50pm
16. City/Health District Reports		**City/Health District Representatives**	12:50pm — 12:53pm
17. SPA/District Reports		**SPA/District Representatives**	12:53pm — 12:56pm
18. AIDS Education/Training Centers (AETCs)		**J Gates, PhD**, AETC	12:56pm — 12:59pm
19. Public Comment (*Non-Agendized or Follow-Up*)		**Public**	12:59pm — 1:11pm
20. Commission Comment (*Non-Agendized or Follow-Up*)		**Commission Members/Staff**	1:11pm — 1:23pm
21. Announcements		**Commission/Public**	1:23pm — 1:30pm
22. Adjournment			1:30pm

PROPOSED MOTION(S)/ACTION(S)

PROCEDURAL MOTION(S):

MOTION # 1:	Adjust, as necessary, and approve the Agenda Order.
MOTION # 2:	Approve minutes from the Commission on HIV meetings, as presented or revised.
MOTION # 3:	Approve the Consent Calendar.

CONSENT CALENDAR:

MOTION #4:	Approve Integration Advisory Board (IAB) representative, as presented.
MOTION #5:	Approve California Planning Group (CPG) representative, as presented
MOTION #6:	Approve Formation of Long Beach Task Force, as presented.
MOTION #7:	Approve Universal Service Standards for HIV Care Services, as presented.
MOTION #8:	Approve Standards of Care Updates for HIV Substance Use Residential and Treatment Services, as presented.
MOTION #9:	Approve Incarcerated/Post-Release Transitional Case Management Services Standards of Care, as presented.
MOTION #10:	Approve Youth Transitional Case Management Services Standard of Care, as presented.
MOTION #11:	Approve recommendation for Juan Preciado to HIV Stakeholder #3 representative seat, as presented.

COMMISSION ON HIV MEMBERS

Bradley Land, *Co-Chair*	**Ricky Rosales**, *Co-Chair*	**Majel Arnold, MA-HSA**	**Traci Bivens-Davis**
Al Ballesteros, MBA	**Jason Brown**	**Joseph Cadden, MD**	**Danielle Campbell, MPH**
Raquel Cataldo	**Edd Cockrell**	**Deborah Owens Collins, PA, MSPAS, AAHIVS**	**Michele Daniels**
Kevin Donnelly	**Matthew Emons, MD**	**Michelle Enfield**	**Aaron Fox, MPP**
Jerry D. Gates, PhD	**Joseph Green**	**Terry Goddard, MA**	**Bridget Gordon**
Grissel Granados, MSW	**Lee Kochems, MA** *Eduardo Martinez (Alternate)*	**Abad Lopez**	**Eric Paul Leue**
Miguel Martinez, MSW, MPH	**Anthony Mills, MD**	**José Munoz**	**Derek Murray**
John Palomo	**Raphael Péna**	**Mario Peréz, MPH**	**Thomas Puckett, Jr.**
Ace Robinson, MPH	**Maria Roman/** *Juan Preciado (Alternate)*	**Rebecca Ronquillo**	**Sabel Samone-Loreca**
Martin Sattah, MD	**Terry Smith, MPA**	**LaShonda Spencer, MD**	**Kevin Stalter**
Yolanda Sumpter	**Susan Forrest (Alternate)**	**Will Watts, Esq**	**Terrell Winder**
Octavio Vallejo, MD, MPH			

MEMBERS: 45
QUORUM: 23

for 51 Seats

LEGEND:: **Commissioner/** *Alternate*

All agenda items are subject to action ▣ Public comment will be invited for each item

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. Interpretation services for the hearing impaired and translation services for languages other than English are available free of charge upon request. To arrange for these services, or for additional information about this committee, please contact Dina Jauregui at (213) 738-2816 or 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 fax al (213) 637-4748, por lo menos cinco días antes de la junta.

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.

COMMISSON ON HIV MEMBERSHIP ROSTER

Updated 04-11-2017

MEMBERSHIP SEAT #	MEMBERSHIP SEAT	Commissioners Seated	Committee Assignement	COMMISSIONER	AFFILIATION *(if any)*	TERM BEGINS	TERM ENDS	Alternates Seated	Pending Appointment (Alternates)	ALTERNATE
1)	Medi-Cal representative			*Vacant*		July 1, 2015	June 30, 2017			
2)	City of Pasadena representative	1	OPS	John Palomo	Pasadena Public Health, City of Pasadena	July 1, 2016	June 30, 2018			
3)	City of Long Beach representative	1	PP&A	Deborah Owens Collins, PA, MSPAS, AAHIVS	Dept. of Health and Human Services, City of Long Beach	July 1, 2015	June 30, 2017			
4)	City of Los Angeles representative	1	EXC	Ricky Rosales	AIDS Coordinator's Office, City of Los Angeles	July 1, 2016	June 30, 2018			
5)	City of West Hollywood representative	1	PP&A	Derek Murray	City of West Hollywood	July 1, 2015	June 30, 2017			
6)	Director, DHSP	1	PP&A	Mario Pérez, MPH	DHSP, LA County Department of Public Health	July 1, 2016	June 30, 2018			
7)	Part B representative	1	PP&A	Majel Arnold,MHA	CA Office of AIDS	July 1, 2016	June 30, 2018			
8)	Part C representative	1	PP	Aaron Fox, MPM	Los Angeles Gay and Lesbian Center (LAGLC)	July 1, 2016	June 30, 2018			
9)	Part D representative	1	PP&A	LaShonda Spencer, MD	LAC + USC MCA Clinic, LA County Department of Health Services	July 1, 2015	June 30, 2017			
10)	Part F representative	1	PP	Jerry D. Gates, PhD	Keck School of Medicine of USC	July 1, 2016	June 30, 2018			
11)	Provider representative #1	1	SBP	Joe Cadden, MD	Rand Shrader Clinic (SPA1), LA County Department of Health Services	July 1, 2015	June 30, 2017			
12)	Provider representative #2	1	PP	Maria Roman	APAIT Health Center	July 1, 2016	June 30, 2018	1		Juan Preciado
13)	Provider representative #3	1	PP&A	Miguel Martinez, MSW, MPH	Children's Hospital Los Angeles	July 1, 2015	June 30, 2017			
14)	Provider representative #4	1	EXC|OPS	Raquel Cataldo	Tarzana Treatment Center	July 1, 2016	June 30, 2018			
15)	Provider representative #5	1	PP	Terry Goddard, MA	Alliance for Housing and Healing	July 1, 2015	June 30, 2017			
16)	Provider representative #6	1	PP&A	Anthony Mills, MD	Southern CA Men's Medical Group	July 1, 2016	June 30, 2018			
17)	Provider representative #7	1	SBP	Terry Smith, MPA	AIDS Project Los Angeles (APLA), Health and Wellness	July 1, 2015	June 30, 2017			
18)	Provider representative #8	1	PP	Martin Sattah, MD	Rand Shrader Clinic (SPA1), LA County Department of Health Services	July 1, 2016	June 30, 2018			
19)	Unaffiliated consumer, SPA 1	1	PP&A	Michele Daniels	*unaffiliated consumer*	July 1, 2015	June 30, 2017			
20)	Unaffiliated consumer, SPA 2	1	PPA	Abad Lopez	*unaffiliated consumer*	July 1, 2016	June 30, 2018			
21)	Unaffiliated consumer, SPA 3	1	PPA	Jason Brown	*unaffiliated consumer*	July 1, 2015	June 30, 2017			
22)	Unaffiliated consumer, SPA 4			*Vacant*	*unaffiliated consumer*	July 1, 2016	June 30, 2018	1		Susan Forrest
23)	Unaffiliated consumer, SPA 5	1	PPA	Yolanda Sumpter	*unaffiliated consumer*	July 1, 2015	June 30, 2017			
24)	Unaffiliated consumer, SPA 6	1	SBP	Octavio Vallejo	*unaffiliated consumer*	July 1, 2016	June 30, 2018			
25)	Unaffiliated consumer, SPA 7	1	PPA	Raphael Péna	*unaffiliated consumer*	July 1, 2015	June 30, 2017			
26)	Unaffiliated consumer, SPA 8	1	PP	Lee Kochems, MA	*unaffiliated consumer*	July 1, 2016	June 30, 2018	1		Eduardo Martinez
27)	Unaffiliated consumer, Supervisorial District 1	1	PP	Jose Muñoz	*unaffiliated consumer*	July 1, 2015	June 30, 2017			
28)	Unaffiliated consumer, Supervisorial District 2			*Vacant*	*unaffiliated consumer*	July 1, 2016	June 30, 2018			
29)	Unaffiliated consumer, Supervisorial District 3			*Vacant*		July 1, 2015	June 30, 2017			
30)	Unaffiliated consumer, Supervisorial District 4	1	EXC|OPS	Kevin Donnelly	*unaffiliated consumer*	July 1, 2016	June 30, 2018			
31)	Unaffiliated consumer, Supervisorial District 5	1	SBP	Thomas Puckett, Jr.	*unaffiliated consumer*	July 1, 2015	June 30, 2017			
32)	Unaffiliated consumer, at-large #1	1	PP	Edd Cockrell, Jr.	*unaffiliated consumer*	July 1, 2016	June 30, 2018			
33)	Unaffiliated consumer, at-large #2	1	EXC|OPS	Joe Green	*unaffiliated consumer*	July 1, 2015	June 30, 2017			
34)	Unaffiliated consumer, at-large #3	1	OPS	Kevin Stalter	The Brotherhood IMPACT Fund	July 1, 2016	June 30, 2018			
35)	Unaffiliated consumer, at-large #4	1	OPS	Bridget Gordon	*unaffiliated consumer*	July 1, 2015	June 30, 2017			
36)	Representative, Board Office 1	1	PPA	Al Ballesteros, MBA	JWCH Institute, Inc.	July 1, 2016	June 30, 2018			
37)	Representative, Board Office 2	1	PP	Will Watts, Esq.	Public Counsel	July 1, 2015	June 30, 2017			
38)	Representative, Board Office 3			*Vacant*		July 1, 2016	June 30, 2018			
39)	Representative, Board Office 4	1	SBP	Ace Robinson, MPH	Long Beach C.A.R.E Program	July 1, 2015	June 30, 2017			
40)	Representative, Board Office 5	1	EXC	Brad Land	*unaffiliated consumer*	July 1, 2016	June 30, 2018			
41)	Representative, HOPWA	1	PP	Rebecca Ronquillo	City of Los Angeles, HOPWA	July 1, 2015	June 30, 2017			
42)	Behavioral/social scientist	1	OPS	Terrell Winder	REACH LA	July 1, 2016	June 30, 2018			
43)	Local health/hospital planning agency representative	1	SBP	Matthew Emons, MD, MBA	LA Care	July 1, 2015	June 30, 2017			
44)	HIV stakeholder representative #1	1	SBP	Grissell Granados, MSW	Children's Hospital Los Angeles	July 1, 2016	June 30, 2018			
45)	HIV stakeholder representative #2			*Vacant*		July 1, 2015	June 30, 2017			
46)	HIV stakeholder representative #3			*Vacant*		July 1, 2016	June 30, 2018			
47)	HIV stakeholder representative #4	1	PP	Eric Paul Leue	Free Speech Coaltion	July 1, 2015	June 30, 2017			
48)	HIV stakeholder representative #5	1	OPS	Danielle Campbell	UCLA/MLKCH	July 1, 2016	June 30, 2018			
49)	HIV stakeholder representative #6	1	OPS	Traci Bivens-Davis	N/A	July 1, 2015	June 30, 2017			
50)	HIV stakeholder representative #7	1	OPS	Sabel Samone-Loreca	*unaffiliated consumer*	July 1, 2016	June 30, 2018			
51)	HIV stakeholder representative #8	1	PPA	Michelle Enfield	AIDS Project Los Angeles (APLA), Health and Wellness	July 1, 2015	June 30, 2017			
	TOTAL	44	0	44				3	0	

COMMITTEE ASSIGNMENT LEGEND: EXC (Executive) OPS (Operations) PPA (Planning, Priorities & Allocations) PP (Public Policy) SBP (Standards and Best Practices)

LOS ANGELES COUNTY COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140, Los Angeles, CA 90010 · TEL. (213) 7382816 · FAX (213) 637-4748
www.hiv.lacounty.gov

COMMITTEE ASSIGNMENTS
(Updated 04/12/17)

Committee Member Name/ Alternate	Member Category	Affiliation	Notes
* = *Primary Committee Assignment*	** = *Secondary Committee Assignment*		

EXECUTIVE COMMITTEE

Regular meeting day: Fourth Monday of the month ***Regular meeting time***: 1:00pm–3:00pm

Number of Voting Members: 14 ***Number of Quorum***: 8

Bradley Land	**Co-Chair, Comm./Exec.***	Commissioner
Ricky Rosales	**Co-Chair, Comm./Exec.***	Commissioner
Traci Bivens-Davis	Co-Chair, Operations	Commissioner
Kevin Stalter	Co-Chair, Operations	Commissioner
Al Ballesteros, MBA	Co-Chair, PP&A	Commissioner
Jason Brown	Co-Chair, PP&A	Commissioner
Aaron Fox, MPM	Co-Chair, Public Policy	Commissioner
Will Watts, Esq.	Co-Chair, Public Policy	Commissioner
Joseph Cadden, MD	Co-Chair, SBP	Commissioner
Grissel Granados, MSW	Co-Chair, SBP	Commissioner
Raquel Cataldo	At-Large Member*	Commissioner
Kevin Donnelly	At-Large Member*	Commissioner
Joseph Green	At-Large Member*	Commissioner
Mario Pérez, MPH	DHSP Director	Commissioner

OPERATIONS COMMITTEE

Regular meeting day: Fourth Monday of the month ***Regular meeting time***: 10:00am-12:00pm

Number of Voting Members: 8 ***Number of Quorum***: 5

Traci Bivens-Davis	**Committee Co-Chair***	Commissioner
Kevin Stalter	**Committee Co-Chair***	Commissioner
Danielle Campbell, MPH	*	Commissioner
Kevin Donnelly	*	Commisisoner
Bridget Gordon	*	Commissioner
Joseph Green	*	Commissioner
Sabel Samone-Loreca	*	Commissioner
John Palomo	*	Commissioner

Committee Member Name	Member Category	Affiliation	Notes
* = *Primary Committee Assignment*	** = *Secondary Committee Assignment*		

PLANNING, PRIORITIES and ALLOCATIONS (PP&A) COMMITTEE

Regular meeting day: 3rd Tuesday of the month ***Regular meeting time***: 1:00pm-4:00pm

Number of Voting Members: **13** ***Number of Quorum***: **7**

Al Ballesteros, MBA	**Committee Co-Chair***	Commissioner
Jason Brown	**Committee Co-Chair***	Commissioner
Majel Arnold, MHA	*	Commisioner
Michele Daniels	*	Commissioner
Abad Lopez	*	Commissioner
Miguel Martinez, MPH, MSW	*	Commissioner
Anthony Mills, MD	*	Commissioner
Derek Murray	*	Commissioner
Debi Collins Owens, MPA, MSPAS, AAHIVS	*	Commissioner
Raphael Péna	*	Commissioner
LaShonda Spencer, MD	*	Commissioner
Yolanda Sumpter	*	Commissioner
TBD	DHSP staff	DHSP Staff

PUBLIC POLICY COMMITTEE

Regular meeting day: 1st Monday of the month ***Regular meeting time***: 1:00 pm-3:00pm

Number of Voting Members: **14** ***Number of Quorum***: **8**

Aaron Fox, MPM	**Committee Co-Chair***	Commissioner
Will Watts, Esq.	**Committee Co-Chair***	Commissioner
Raquel Cataldo	*	Commissioner
Edd Cockrell	*	Commissioner
Jerry Gates, PhD	*	Commissioner
Joe Green	*	Comimssioner
Terry Goddard, MA	*	Commissioner
Lee Kochems, MA	*	Commissioner
Eric Paul Leue	*	Commissioner
José Munoz	*	Commissioner
Maria Roman/Juan Preciado	*	Commissioner
Rebecca Ronquillo	*	Commissioner
Martin Sattah, MD	*	Commissioner
Kyle Baker	DHSP staff	DHSP representative

Committee Member Name	Member Category	Affiliation	Notes
* = *Primary Committee Assignment*	** = *Secondary Committee Assignment*		

STANDARDS AND BEST PRACTICES (SBP) COMMITTEE

Regular meeting day: 1st Thursday of the month ***Regular meeting time***: 10:00am-12:00pm

Number of Voting Members: **8** ***Number of Quorum***: **5**

Grissel Granados, MSW	**Committee Co-Chair***	Commissioner
Joseph Cadden, MD	**Committee Co-Chair***	Commissioner
Matthew Emons, MD, MPH	*	Commissioner
Angelica Palmeros, MSW	*	Committee member
Thomas Puckett, Jr.	*	Commissioner
Terry Smith, MPA	*	Commissioner
Octavio Vallejo, MD, MPH	*	Commissioner
Wendy Garland, MPH	DHSP staff	DHSP representative
Ace Robinson, MPH	*	Commissioner

CONSUMER CAUCUS

Regular meeting day: Following Comm. mtg. ***Regular meeting time***: 1:30pm–3:00pm

Open Membership

Kevin Donnelly	**Co-Chair**	Commissioner
Joseph Green	**Co-Chair**	Commissioner
Sabel Samone-Loreca	**Co-Chair**	Commissioner
Al Ballesteros, MBA	Member	Commissioner
Jason Brown	Member	Commissioner
Edd Cockrell	Member	Commissioner
Michele Daniels	Member	Commissioner
Grissel Granados, MSW	Member	Commissioner
Bridget Gordon	Member	Commissioner
Lee Kochems, MA	Member	Commissioner
Brad Land	Member	Commissioner
Abad Lopez	Member	Commissioner
Eduardo Martinez	Member	Alternate
Anthony Mills, MD	Member	Commissioner
José Munoz	Member	Commissioner
Raphael Péna	Member	Commissioner
Thomas Puckett	Member	Commissioner

Committee Member Name	Member Category	Affiliation	Notes
* = *Primary Committee Assignment*	** = *Secondary Committee Assignment*		

CONSUMER CAUCUS (CONT'D)		
Maria Roman	Member	Commissioner
Terry Smith, MPA	Member	Commissioner
Kevin Stalter	Member	Commissioner
Yolanda Sumpter	Member	Commissioner
Octavio Vallejo, MD, MPH	Member	Commissioner

TRANSGENDER CAUCUS		
3rd Monday of the month	***Regular meeting time***:	10:00am-12:00pm
Open Membership		
Destin Cortez	**Co-Chair**	Community Member
Maria Roman	**Co-Chair**	Commissioner
Michelle Enfield	Member	Commissioner
Susan Forrest	Member	Commissioner
Jaden Fields	Member	Community
Kimberly Kisler, PhD	Member	Community
Sabel Samone-Loreca	Member	Commissioner

WOMEN'S CAUCUS		
3rd Wednesday of the month	Regular meeting time:	10:00am-12:00pm
Open Membership		
Bridget Gordon	**Co-Chair**	Commissioner
Yolanda Salinas	**Co-Chair**	Commissioner

YOUTH CAUCUS		
Regular meeting time: TBD		
Open Membership		
Grissel Granados, MSW	**Chair**	Commissioner
Edd Cockrell	Member	Commissioner
Dahlia Ferlito	Member	Community
Eric Paul Leue	Member	Commissioner

LOS ANGELES COUNTY COMMISSION ON HIV
3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
http://hiv.lacounty.gov

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

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
ARNOLD	Majel	California State Office of AIDS	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	No Affiliation	No Ryan White or prevention contracts
CADDEN	Joseph	Rand Schrader Health & Research Center	Ambulatory Outpatient Medical (AOM) Medical Care Coordination Mental Health, Psychiatry

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
CAMPBELL	Danielle	UCLA/MLKCH	TBD
CATALDO	Raquel	Tarzana Treatment Center	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Health Education/Risk Reduction (HERR)
			HIV Counseling and Testing (HCT)
			Medical Care Coordination (MCC)
			Case Management, Home-Based
			Case Management, Transitional - Jails
			Medical Transportation
			Mental Health, Psychotherapy
			Oral Health
			Substance Abuse, Residential
			Substance Abuse, Transitional
			Substance Abuse, Detox
			Biomedical Prevention
			Medical Nutrition Therapy
COCKRELL	Edd	Unaffiliated consumer	No Ryan White or prevention contracts
DANIELS	Michele	Unaffiliated consumer	No Ryan White or prevention contracts
DONNELLY	Kevin	Unaffiliated consumer	No Ryan White or prevention contracts
EMONS	Matthew	LA CARE	No Ryan White or prevention contracts
ENFIELD	Michelle	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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
			Medical Care Coordination (MCC)
FORREST	Susan	Behavioral Health Services, Inc.	Substance Abuse, Residential Substance Abuse, Detox
FOX	Aaron	Los Angeles Gay & Lesbian Center	Ambulatory Outpatient Medical (AOM)
			Health Education/Risk Reduction (HERR)
			HIV Counseling and Testing (HCT)
			Medical Care Coordination (MCC)
			Mental Health, Psychiatry
			Mental Health, Psychotherapy
			Non-Occupational HIV PEP
			Biomedical Prevention
			STD Screening and Treatment
GATES	Jerry	Keck School of Medicine of USC	No Ryan White or prevention contracts
GODDARD II	Terry	Alliance for Housing and Healing	Residential Care Facilities for the Chronically Ill (RCFCI)
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
			Mental Health, Psychotherapy
GREEN	Joseph	Unaffiliated consumer	No Ryan White or prevention contracts
KOCHEMS	Lee	Unaffiliated consumer	No Ryan White or prevention contracts
LAND	Bradley	Unaffiliated consumer	No Ryan White or prevention contracts
LEUE PAUL	Eric	Free Speech Coalition	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
LOPEZ	Abad	Unaffiliated consumer	No Ryan White or prevention contracts
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)
			Mental Health, Psychotherapy
			Biomedical Prevention
MILLS	Anthony	Southern CA Men's Medical Group	Biomedical Prevention
			Medical Care Coordination (MCC)
MUNOZ	Jose	Unaffiliated consumer	No Ryan White or prevention contracts
MURRAY	Derek	City of West Hollywood	No Ryan White or prevention contracts
OWENS COLLINS	Deborah	Long Beach Department of Health & Human Services	Benefits Specialty
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
PALOMO	John	City of Pasadena	HIV Counseling and Testing (HCT)
PENA	Raphael	Unaffiliated consumer	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
PERÉZ	Mario	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
PRECIADO	Juan	Northeast Valley Health Corporation	Mental Health, Psychotherapy Benefits Specialty Mental Health, Psychiatry Oral Health Ambulatory Outpatient Medical (AOM) Medical Care Coordination (MCC)
PUCKETT, JR.	Thomas	Unaffiliated Consumer	No Ryan White or prevention contracts
ROBINSON	Ace	Long Beach C.A.R.E Program	Ambulatory Outpatient Medical (AOM) Medical Case Management (MCC) *Additional Contracts TBD*
ROMAN	Maria	APAIT Health Center	Case Management, Non-Medical (LCM) Language Services Mental Health, Psychotherapy Health Education/Risk Reduction (HERR) HIV Counseling and Testing (HCT)
RONQUILLO	Rebecca	City of Los Angeles, HOPWA	No Ryan White or prevention contracts
ROSALES	Ricky	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
SÃMONÉ-LORECA	Sabél	Unaffiliated consumer	No Ryan White or prevention contracts
SATTAH	Martin	Rand Schrader Clinic LA County Dept of Health Services	Ambulatory Outpatient Medical (AOM) Medical Care Coordination (MCC) Mental Health, Psychiatry

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SMITH	Terry	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)
SPENCER	LaShonda	LAC & USC MCA Clinic	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
STALTER	Kevin	The Brotherhood IMPACT Fund	No Ryan White or prevention contracts
SUMPTER	Yolanda	Unaffiliated consumer	No Ryan White or prevention contracts
VALLEJO	Octavio	No affiliations	No Ryan White or prevention contracts
WATTS	Will	Public Counsel	Legal Services
WINDER	Terrell	REACH LA	Health Education/Risk Reduction (HERR) HIV Counseling and Testing

HIV Calendar

April 2017

Sun	Mon	Tue	Wed	Thu	Fri	Sat
26 Week 13	27 César Chávez Holiday - COH Office Closed	28 9:30 AM - 1:00 PM Board of Supervisors (BOS) 10:00 AM - 12:00 PM Operations Committee Meeting	29 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Executive Committee Meeting	30	31	1
2 Week 14	3 12:00 PM - 4:00 PM Public Policy Committee	4 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 4:00 PM Comprehensive HIV Plan Task Force/Goals and Objectives Workgroup	5 9:30 AM - 11:30 AM BOS Agenda Review 1:00 PM - 3:00 PM Training for Commissioners: Running and Facilitating Meetings	6 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	7	8
9 Week 15	10 Naitonal Youth HIV/AIDS Awareness Day	11 9:30 AM - 1:00 PM Board of Supervisors (BOS)	12 9:30 AM - 11:30 AM BOS Agenda Review	13 9:00 AM - 1:00 PM Commission Meeting	14	15
16 Week 16	17 10:00 AM - 12:00 PM Transgender Caucus	18 National Transgender HIV Testing Day 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 4:00 PM Planning, Priorities & Allocations (PP&A)	19 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Women's Caucus	20	21	22
23 Week 17	24 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	25 9:30 AM - 1:00 PM Board of Supervisors (BOS)	26 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Housing Taskforce	27	28	29
30 Week 18	1 1:00 PM - 3:00 PM Public Policy Committee	2 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 4:00 PM Comprehensive HIV Plan Task Force/Goals and Objectives Workgroup	3 9:30 AM - 11:30 AM BOS Agenda Review	4 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	5	6

HIV Calendar

May 2017

Sun	Mon	Tue	Wed	Thu	Fri	Sat
30 Week 18	**1** 1:00 PM - 3:00 PM Public Policy Committee	**2** 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 4:00 PM Comprehensive HIV Plan Task Force/Goals and Objectives Workgroup	**3** 9:30 AM - 11:30 AM BOS Agenda Review	**4** 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	**5**	**6**
7 Week 19	**8**	**9** 9:30 AM - 1:00 PM Board of Supervisors (BOS)	**10** 9:30 AM - 11:30 AM BOS Agenda Review	**11** 9:00 AM - 1:00 PM Commission Meeting	**12**	**13**
14 Week 20	**15** 10:00 AM - 12:00 PM Transgender Caucus	**16** 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 4:00 PM Planning, Priorities & Allocations (PP&A)	**17** 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Women's Caucus	**18** HIV Vaccine Awareness Day	**19** Hepatitis Testing Day National Asian and Pacific Islander HIV/AIDS Awareness Day	**20**
21 Week 21	**22** 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	**23** 9:30 AM - 1:00 PM Board of Supervisors (BOS)	**24** 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Housing Taskforce	**25**	**26**	**27**
28 Week 22	**29**	**30** 9:30 AM - 1:00 PM Board of Supervisors (BOS)	**31** 9:30 AM - 11:30 AM BOS Agenda Review	1 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	2	3

HIV Calendar

June 2017

Sun	Mon	Tue	Wed	Thu	Fri	Sat
28 Week 22	29	30 9:30 AM - 1:00 PM Board of Supervisors (BOS)	31 9:30 AM - 11:30 AM BOS Agenda Review	1 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	2	3
4 Week 23	5 HIV Long-Term Survivors' Day 1:00 PM - 3:00 PM Public Policy Committee	6 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 4:00 PM Comprehensive HIV Plan Task Force/Goals and Objectives Workgroup	7 9:30 AM - 11:30 AM BOS Agenda Review	8 9:00 AM - 1:00 PM Commission Meeting	9	10
11 Week 24	12	13 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 3:00 PM Training for Commissioners: Running and Facilitating Meetings	14 9:30 AM - 11:30 AM BOS Agenda Review	15 1:00 PM - 3:00 PM Training for Commissioners: Effective Communication and Active Listening	16	17
18 Week 25	19 10:00 AM - 12:00 PM Transgender Caucus	20 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 4:00 PM Planning, Priorities & Allocations (PP&A)	21 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Women's Caucus	22	23	24
25 Week 26	26 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	27 National HIV Testing Day 9:30 AM - 1:00 PM Board of Supervisors (BOS)	28 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Housing Taskforce	29	30	1

HIV Calendar

July 2017

Sun	Mon	Tue	Wed	Thu	Fri	Sat
25 Week 26	26 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	27 National HIV Testing Day 9:30 AM - 1:00 PM Board of Supervisors (BOS)	28 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Housing Taskforce	29	30	1
2 Week 27	3 1:00 PM - 3:00 PM Public Policy Committee	4 9:30 AM - 1:00 PM Board of Supervisors (BOS)	5 9:30 AM - 11:30 AM BOS Agenda Review 1:00 PM - 4:00 PM Comprehensive HIV Plan Task Force/Goals and Objectives Workgroup	6 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	7	8
9 Week 28	10	11 9:30 AM - 1:00 PM Board of Supervisors (BOS)	12 9:30 AM - 11:30 AM BOS Agenda Review	13 9:00 AM - 1:00 PM Commission Meeting	14	15
16 Week 29	17 10:00 AM - 12:00 PM Transgender Caucus	18 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 4:00 PM Planning, Priorities & Allocations (PP&A)	19 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Women's Caucus	20 1:00 PM - 3:00 PM Training for Commissioners: Data and Epidemiology Overview	21	22
23 Week 30	24 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	25 9:30 AM - 1:00 PM Board of Supervisors (BOS)	26 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Housing Taskforce	27	28	29
30 Week 31	31	1 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 4:00 PM Comprehensive HIV Plan Task Force/Goals and Objectives Workgroup	2 9:30 AM - 11:30 AM BOS Agenda Review	3 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	4	5

LOS ANGELES COUNTY COMMISSION ON HIV
3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
http://hiv.lacounty.gov

3. MEETING MINUTES

A. March 9, 2017 Commission Meeting

LOS ANGELES COUNTY COMMISSION ON HIV
3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
http://hiv.lacounty.gov

5. EXECUTIVE DIRECTOR'S REPORT:

A. Barbara Ferrer, PhD, MPH, MEd, Director of the LA County Department of Public Health

NEWS RELEASE

County of Los Angeles Public Health

313 N. Figueroa Street, Room 806 • Los Angeles, CA 90012 • (213) 240-8144 • media@ph.lacounty.gov
Facebook.com/LAPublicHealth • Twitter.com/LAPublicHealth

For Immediate Release:
January 10, 2017

For more information contact:
Public Health Communications
(213) 240-8144
media@ph.lacounty.gov

Board of Supervisors Appoints Dr. Barbara Ferrer as New Director For Public Health

LOS ANGELES – The Los Angeles County Board of Supervisors appointed Barbara Ferrer, PhD, MPH, MEd, a nationally known public health leader, to the position of Director of the Los Angeles County Department of Public Health (Public Health) effective February 6, 2017. As Director of Public Health, Dr. Ferrer will work under the Los Angeles County Health Agency (Health Agency) to further its mission to integrate services and activities that enable the Health Agency to build health equity across the county. Work will continue in advancing the eight strategic priorities in the Departments of Health Services, Mental Health, and Public Health.

"Dr. Ferrer is uniquely qualified to lead and serve Los Angeles County's diverse populations, and has a gift for engaging youth and families," said Board Chair Mark Ridley-Thomas. "I look forward to the energy and creativity that she will bring to protecting the health of our communities during this time of uncertainty in federal healthcare policy."

Most recently, Dr. Ferrer worked as the Chief Strategy Officer of the W.K. Kellogg Foundation. Previously, she was the Executive Director of the Boston Public Health Commission where she led a range of public health programs and built innovative partnerships to promote health and education, improve family economic security and address racial health disparities.

"I would like to thank the Board of Supervisors for the opportunity to join the leadership of the Health Agency as Director of Public Health," said Dr. Ferrer. "I am excited to lead the talented, dedicated staff of over 4000 employees who work tirelessly to make health possible for all in Los Angeles County, particularly the most vulnerable populations."

Dr. Ferrer earned a doctorate from Brandeis University's Heller School for Advanced Studies in Social Welfare, where she was a Pew Doctoral Fellow. She also holds a master's degree in public health from Boston University and a master's degree in education from the University of Massachusetts, Boston.

The Department of Public Health is committed to protecting and improving the health of the nearly 10 million residents of Los Angeles County. Through a variety of programs, community partnerships and services, Public Health oversees environmental health, disease control, and community and family health. Public Health comprises nearly 4,000 employees and has an annual budget exceeding $900 million. To learn more about the LA County Department of Public Health and the work they do, visit PublicHealth.LACounty.gov, and follow Public Health on social media at twitter.com/LAPublicHealth, facebook.com/LAPublicHealth, and youtube.com/LAPublicHealth.

LOS ANGELES COUNTY COMMISSION ON HIV
3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
http://hiv.lacounty.gov

7. COLLOQUIA SERIES:

Ask Me About PrEP:
A 3-Part Digital Campaign to Increase PrEP Uptake

HIV Research & Community Colloquia Series 2017

The Los Angeles County Commission on HIV and the UCLA Center for HIV Identification, Prevention, and Treatment Services (CHIPTS) invite you to attend

Ask Me About PrEP: A Three-Part Digital Campaign to Increase PrEP Uptake

Presented by AltaMed

Natalie Sanchez, MPH, Clinic Administrator
Hilda Sandoval, PhD, MFT, Psychosocial Services Manager
Gabriela Leon, Prevention Manager
Ramon Garcia, Marketing Manager

Thursday, April 13, 2017
9:30am to 10:45am*

St. Anne's Maternity Home
155 N. Occidental Blvd
Los Angeles, CA 90026

*As part of the Commission on HIV meeting agenda. No registration required.

LOS ANGELES COUNTY COMMISSION ON HIV

CHIPTS
Center for HIV Identification, Prevention and Treatment Services

Natalie Sanchez, MPH

Natalie has dedicated her career to HIV prevention with 15 years of HIV work experience implementing CDC evidence based prevention interventions, developing Social Marketing campaigns, and successfully incorporating CDC recommended guidelines for HIV and Hepatitis C screening and PrEP implementation into AltaMed's 24 clinic network. Natalie is a two time BRUIN with a Master in Public Health degree from UCLA's Executive MPH Program and holds a Bachelor degree in Sociology. Natalie is Studer trained in Evidence-Based Leadership which has improved clinical quality, patient satisfaction, and more importantly employee engagement. She has a background in program development, project management, and community planning. She is well-known for her work as creator and writer of the award-winning telenovela webseries "Sin Vergüenza" which addresses HIV in Latino communities. Her educational training in socio-cultural and gender related topics has influenced her approach to addressing public health issues. As the HIV Prevention Manager at AltaMed, she has created and led some of the largest and most successful HIV campaigns as well as implemented a combination of public health strategies to reduce HIV infections in Southern California. Natalie is currently the Administrator of AltaMed's Specialty Department where she manages a team of 50 employees overseeing medical and prevention services for HIV and Hepatitis C. AltaMed serves over 1700 HIV positive clients and is one of the largest Latino HIV medical providers in Southern California with clinics in Los Angeles and Orange County.

Hilda Sandoval, PHD

Hilda co-wrote and produced the Sin Vergüenza and Ask Me About webseries. As a Mexican-American and trained mental health professional, she served as an instrumental subject matter expert on the impact of HIV in the Latino community. She is currently the Mental Health Manager at AltaMed and has worked on many initiatives designed to promote wellness, education, and increase HIV awareness in a culturally appropriate manner to HIV and LGBT communities. Hilda received her PHD from The Chicago School of Professional Psychology.

Gabriela Leon

Gabriela serves as the Interim HIV Prevention Manager at AltaMed. Gabriela has over 17years experience working in the HIV field. She was a writer of the FIERCE Campaign and a co-producer for the AskMeAbout PrEP campaigns. Her background includes program and project development. She serves in various planning bodies, such as the LAC HIV Commission, PPC, Women's task force, among many. In her role she is responsible for community targeted testing, strategy development for new initiatives, grant writing. Gabriela has presented in several local and national conferences including USCA. She served as the principal writer for the transgender PrEP awareness vignettes.

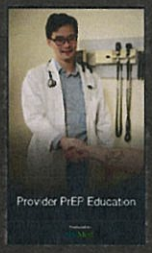
Ramon Garcia

Ramon is the Marketing Manager at AltaMed leading digital online marketing strategies for the AskMeAboutPrEP campaigns. He has developed and executed several AltaMed, first of its kind, digital campaigns. Ramon received his BA from UC Santa Barbara and is currently an MBA candidate from the Marshall School of Business at USC. He is part of the award winning team who has been recognized by the Imagen Foundation and MarCom Awards.

AltaMed
QUALITY CARE WITHOUT EXCEPTION™

Ask Me About PrEP:

A 3-part Digital Campaign to Increase PrEP uptake



Natalie Sanchez, MPH, Clinic Administrator, Specialty Services
Hilda Sandoval, PhD, MFT, Psychosocial Services Manager
Gabriela Leon, Prevention Manager
Ramon Garcia, Marketing Manager

AltaMed Specialty Services

Specialty Services

- HIV Medical Care
- Hepatitis C Consultation and Treatment
- Pre-Exposure Prophylaxis
- Post-Exposure Prophylaxis

5 Specialty Sites

- Los Angeles- Commerce, Pico Rivera, El Monte and Hollywood Presbyterian
- Orange County- Santa Ana Central
- 1,700 HIV positive clients
- Over 70 NEW HIV+ persons

Presented by AltaMed

Video Production

AltaMed
QUALITY CARE WITHOUT EXCEPTION™

Social Marketing Campaigns

Sin Verguenza Series
*7 Episodes

¡LISTO!
*4 Vignettes

2017 PrEP Campaign
* Provider Education
* Kiki n' Brunch
* Fierce/ Ella

Coming 2018
* Sexual Health Campaign

Staff Educational

HIV 101

LGBT Cultural Sensitivity

Routine HIV Testing

Delivering a Positive Result

Linguistic Services

Service Promotion

HIV Services

Hepatitis C

Behavioral Health

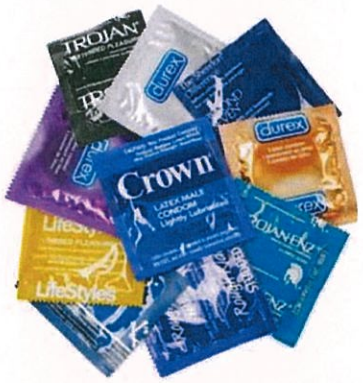
The Pharmacy @AltaMed

HIV Campaigns

AltaMed
QUALITY CARE WITHOUT EXCEPTION™

HIV Prevention and New Era

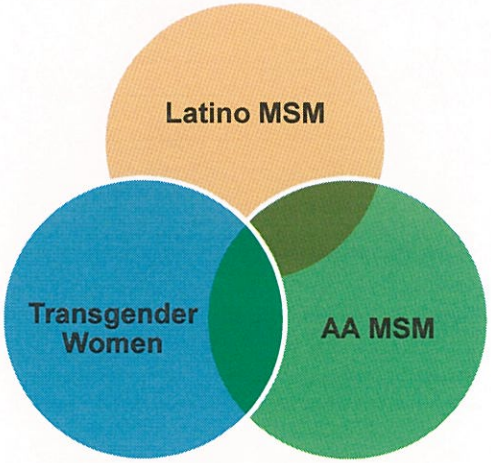
AltaMed
QUALITY CARE WITHOUT EXCEPTION™



PrEP is a new prevention method in which **people who do not have HIV** infection **take a pill daily to reduce their risk** of becoming infected.

Sexual Health

Inspiring PrEP Demand



5,002 newly diagnosed with HIV in California

	New Infections	
Black	38.5 per 100,000	17.1%
Latino	14.8 per 100,000	44.1%
White	9.8 per 100,000	26.9%

	PrEP Users
African American	10%
Latino	12%
White	74%

Leveraging Community Partnerships

AltaMed
QUALITY CARE WITHOUT EXCEPTION™

OFFICE OF AIDS

KAVICH REYNOLDS

center of excellence for TRANSGENDER health

please PrEPme

BAWN MEDIA GROUP

FIERCE Campaign Contributors:
Joanne Keatly
Jenna Rapues
Luis Gutierrez Mock
Maria Roman
Sabel Samone-Loreca
Chandi Moore

Kiki and Brunch Contributors:
Joaquin Gutierrez
Percival Pandy
Andre Molette
Milton Smith
Greg Wilson

Newly Launched PrEP Campaign

AltaMed
QUALITY CARE WITHOUT EXCEPTION™

Ask Me About PrEP .org

1. **Provider PrEP Training Videos**
Launch: Dec, 2016

2. **Kiki n' Brunch**
Launch: Feb, 2017

3. **Fierce/Ella**
Launch: April 14th

The Role of Primary Care Providers

AltaMed
QUALITY CARE WITHOUT EXCEPTION™

Ask Me About PrEP

PrEP IS A NEW HIV PREVENTION METHOD IN WHICH PEOPLE WHO DO NOT HAVE HIV INFECTION TAKE A PILL DAILY TO REDUCE THEIR RISK OF BECOMING INFECTED.

Identify → **Inform/ Educate** → **Refer to AltaMed Specialty Services**

Primary Care Providers & PrEP Rx

AltaMed
QUALITY CARE WITHOUT EXCEPTION™

According to the CDC, 1 in 3 primary care doctors and nurses haven't heard about Pre-Exposure Prophylaxis (PrEP).

- Treatment requires continuing collaboration between patients and providers
- Missed opportunities to prevent new HIV infections

CDC recommendations for health care providers (2015)

- Test patients for HIV as a regular part of medical care.
- Follow the 2014 PrEP Clinical Practice Guidelines to perform recommended tests and prescribe PrEP to patients without HIV who could benefit.
- Counsel patients who can benefit from PrEP on how to take it every day and help them apply for insurance or other programs to pay for PrEP.
- Schedule appointments for patients using PrEP every 3 months for follow-up, including HIV testing and prescription refills.

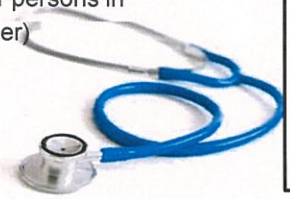
Provider Focused Education Videos

AltaMed
QUALITY CARE WITHOUT EXCEPTION™

Video #1: PrEP Overview

Provider Education Training Video

- Overview of PrEP specific for health care providers
- Designed to raise awareness of the drug as an effective prevention method among doctors and high-risk patients (gay men, transgender women, and/or persons in relationship with an HIV positive partner)



1. What is PrEP?
2. What are the community needs as they consider PrEP?
3. Key elements in practice settings to follow:
   - Sexual Health History
   - Provider Biases
   - PrEP Stigma
4. Provider Concerns
   - Drug resistance
   - Risk compensation (higher risk behavior)
   - Treatment Adherence
   - Access & Drug Cost

Provider Focused Training Videos

AltaMed
QUALITY CARE WITHOUT EXCEPTION™

Video #2: Prescribing PrEP

Provider Education Training Video

Model the patient/doctor exchange

1. Features scenarios:
   * Conducting a brief sexual health history
   * Addressing PrEP usage with patients who are at high-risk for contracting HIV

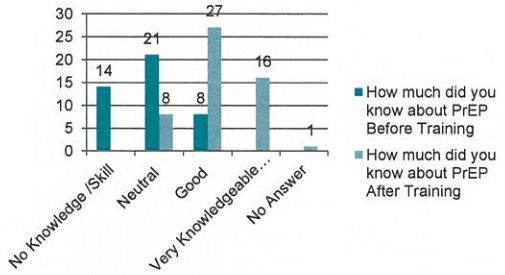
2. Screen, counsel and prescribe PrEP

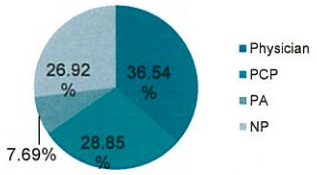
Provider Focused Training Videos

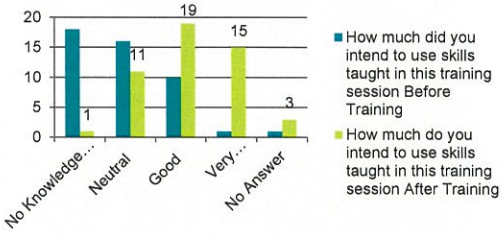
AltaMed
QUALITY CARE WITHOUT EXCEPTION™

Surveyed Providers (Physicians, PCP, PA, NP) = 52

- Used a 5 point Likert scale.
- Evaluate knowledge in topic areas ***Before*** and ***After*** training.







PrEP Campaign

AltaMed
QUALITY CARE WITHOUT EXCEPTION™

Kiki n'Brunch

AltaMed
QUALITY CARE WITHOUT EXCEPTION™

Goals:

1. Aims to reach young Black gay & bisexual men
2. Increase awareness and uptake of PrEP in this highly impacted community

About Kiki n' Brunch

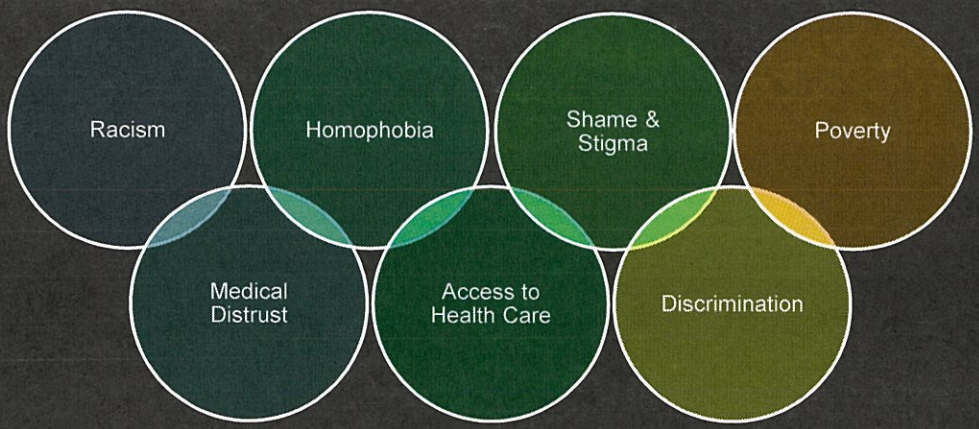
- Scripted segment follows a group of friends as they laugh and chat about life, love, dating and PrEP because there's always time to talk about PrEP.
- Brunch is an occasion that is common amongst the community to encourage, empower, and have in-depth conversations.
- Model conversations around PrEP
- Answers key concerns around PrEP & sexual risk taking in the African American MSM community.

Presented by AltaMed

Barriers to PrEP

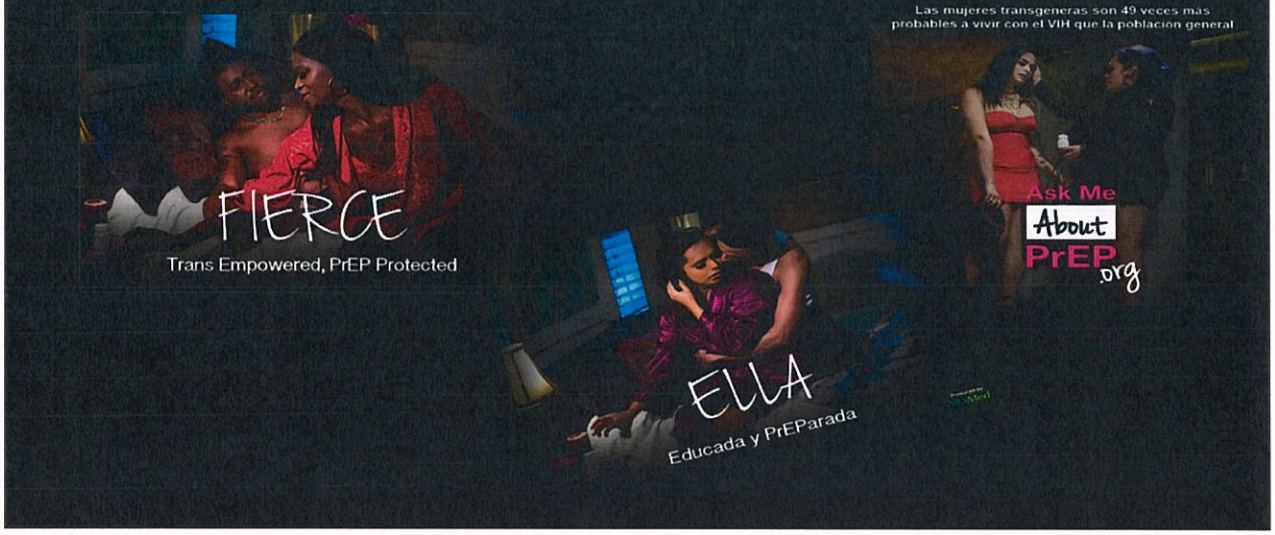
AltaMed
QUALITY CARE WITHOUT EXCEPTION™

African American Community



Fierce /Ella Campaign

AltaMed
QUALITY CARE WITHOUT EXCEPTION™



Transgender Women

AltaMed
QUALITY CARE WITHOUT EXCEPTION™

41% attempted suicide

19% report being refused medical care because of their gender non-conforming status

50% of the sample reported having to teach their medical providers about transgender care.

Many fear for their safety because of anti TG violence

Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force, 2011

49x more likely to have HIV than other adults

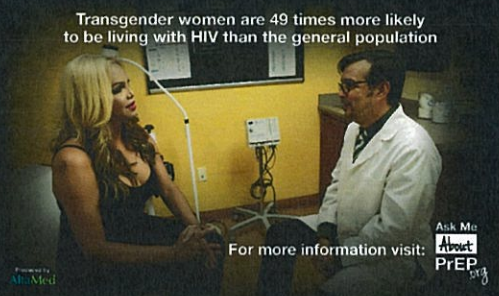
- Social and economic marginalization
- High unemployment/sex work
- Limited health care access
- Lack of family support

Addressing PrEP Access Barriers

AltaMed
QUALITY CARE WITHOUT EXCEPTION™

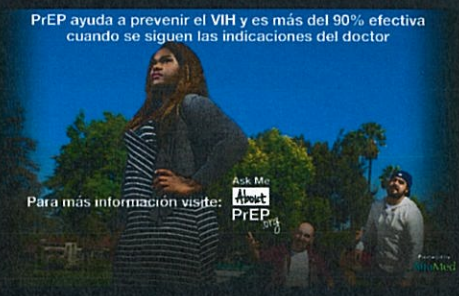
Goals:

- Increase PrEP knowledge
- Increase awareness of PrEP as an effective prevention tool for trans women
- Empower Trans Women to request PrEP
- Model PrEP conversations with medical provider on trans specific concerns (i.e. hormone interactions)



Addressing PrEP Access Barriers

AltaMed
QUALITY CARE WITHOUT EXCEPTION™



Video **focus** on specific issues that may impact access, such as:

- Transphobia
- Distrust in Intimate Relationships
- Lack of Support: Mentorship
- Equality in Health Care Access (provider competency)
- Isolation: Comradery and Unity Among Trans Women

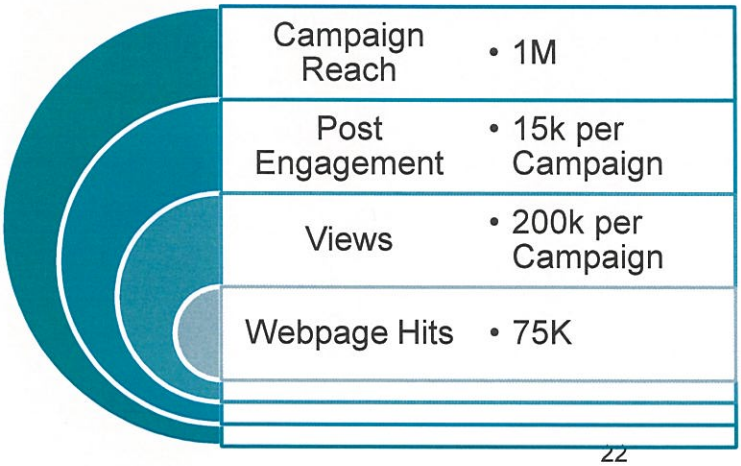
Fierce/Ella Launch Event

AltaMed
QUALITY CARE WITHOUT EXCEPTION™

Marketing Strategy

AltaMed
QUALITY CARE WITHOUT EXCEPTION™

Goal Metrics



22

Marketing Strategy

AltaMed
QUALITY CARE WITHOUT EXCEPTION™

PCPs, MSM & Transwomen → Landing Page → PrEP Resources

- Partnerships
- AltaPride

AskMeAbout PrEP.org

California Providers

23

Marketing Strategy

AltaMed
QUALITY CARE WITHOUT EXCEPTION™

AskMeAboutPrEP.org

New webpage gallery of AltaMed's PrEP campaigns

Features:

- Embedded YouTube videos
- Carousel of campaign images
- Links to additional resources
- PrEP directory link

24

Marketing Strategy

AltaMed
QUALITY CARE WITHOUT EXCEPTION™

Partnerships

- 20+ agencies
- California Statewide
- Presentations on PrEP
- Media Box Kit Provided
  - Palm Cards
  - Postcards
  - Counter Cards

Marketing Strategy

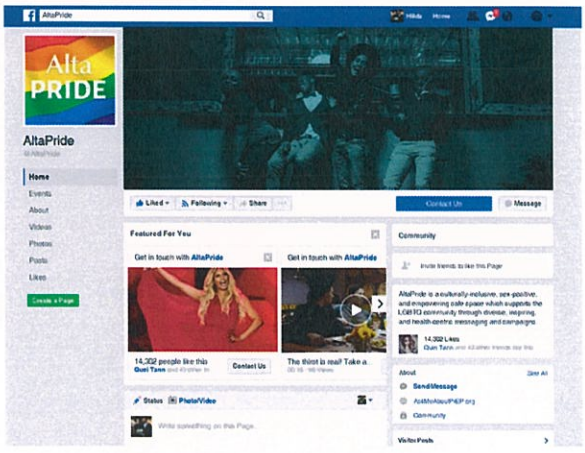
AltaMed
QUALITY CARE WITHOUT EXCEPTION™

AltaPride

Launched October 2016

Mission:

AltaPride is a culturally-inclusive, sex-positive, and empowering safe space which supports the LGBTQ community through diverse, inspiring, and health-centric messaging and campaigns.

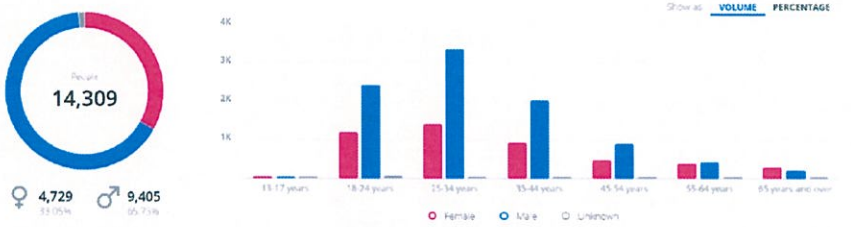


26

Marketing Strategy

AltaMed
QUALITY CARE WITHOUT EXCEPTION™

AltaPride - Demographics



41% are men 18-34 years of age with LGBTQ related interests

27

Marketing Strategy

AltaMed
QUALITY CARE WITHOUT EXCEPTION™

AltaPride – Ad tests

Results By Creative Unit

Ad Name	Spend	Impressions	Reach	Engagement	CPV :10	:10 Views	100% Views	CPV 100%	View Rate 100%
KnB_Both_Alonzo	$18.48	7,202	6,985	2,721	$0.013	1,376	405	$0.046	5.62%
KnB_Both_Brandon	$162.36	75,208	63,953	26,161	$0.012	13,343	124	$1.309	0.16%
KnB_Both_Jamal	$28.33	5,554	4,839	2,836	$0.014	2,074	1,349	$0.021	24.29%
KnB_Both_Top_Bottom	$52.94	17,823	16,723	7,292	$0.013	4,139	1,426	$0.037	8.00%
KnB_Health_ Foolish_15	$22.56	2,280	1,769	1,761	$0.016	1,444	1,394	$0.016	61.14%
KnB_Health_Lets_Kiki	$32.13	9,324	8,933	3,334	$0.024	1,357	15	$2.142	0.16%
KnB_Health_Lets_Kiki_30	$23.67	2,280	1,666	1,629	$0.017	1,402	1,368	$0.017	60.00%
KnB_Health_No_Shame	$130.78	37,038	32,501	14,921	$0.018	7,073	67	$1.952	0.18%
KnB_Health_ReadytoKiki	$19.88	5,880	5,673	2,045	$0.022	889	15	$1.325	0.26%
KnB_Health_Talk_Sex	$29.64	9,256	8,440	3,177	$0.022	1,349	15	$1.976	0.16%
KnB_Lifestyle_GotReal	$26.80	9,878	9,568	4,176	$0.012	2,158	14	$1.914	0.14%
KnB_Lifestyle_GotReal_30	$63.77	5,663	3,654	4,946	$0.014	4,682	4,585	$0.014	80.96%
KnB_Lifestyle_Join_Fun	$58.19	23,569	21,418	9,019	$0.012	4,750	43	$1.353	0.18%
KnB_Lifestyle_Spilling	$20.74	7,561	7,207	3,079	$0.013	1,595	10	$2.074	0.13%
KnB_Lifestyle_Thirst	$39.86	14,663	13,811	5,934	$0.013	3,075	26	$1.533	0.18%
KnB_Lifestyle_Thirst_15	$50.39	6,651	5,991	5,286	$0.012	4,245	4,038	$0.012	60.71%
Total	$780.52	239,830	213,131	98,317	$0.014	54,951	14,894	$0.05	6.21%

28

Marketing Strategy

AltaMed
QUALITY CARE WITHOUT EXCEPTION™

Outcomes of Ad Test 2/21-2/28

Reach- 31,701
Facebook 5,554
YouTube- 26,147

Video Views- 15,177
Facebook- 2,074
YouTube- 13,103

Engagement- 2,836
Likes, Shares, & Comments- 2,836

Webpage Hits- 1,724
Unique Hits- 1,724

29

Contact

AltaMed
QUALITY CARE WITHOUT EXCEPTION™

Natalie Sanchez, MPH
Clinic Administrator, Specialty Services
nsanchez@altamed.org
(323)869-5468

Gabriela Leon
HIV Prevention Manager
galeon@altamed.org
(323)307-0133

Hilda Sandoval, PhD, MFT
Psychosocial Services Manager
Hsandoval@altamed.org
(323) 869-5459

Ramon Garcia
Marketing Manager
ramgarcia@altamed.org
(323) 278-4239

30

LOS ANGELES COUNTY COMMISSION ON HIV
3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
http://hiv.lacounty.gov

12. DIVISION OF HIV/STD PROGRAMS (DHSP) REPORT

COUNTY OF LOS ANGELES
Public Health

BARBARA FERRER, Ph.D., M.P.H., M.Ed.
Director

JEFFREY D. GUNZENHAUSER, M.D., M.P.H.
Interim Health Officer

CYNTHIA A. HARDING, M.P.H.
Chief Deputy Director

MARIO J. PÉREZ, M.P.H.
Director, Division of HIV and STD Programs

600 South Commonwealth Avenue, 10th Floor
Los Angeles, CA 90005
TEL (213) 351-8001 • FAX (213) 387-0912

www.publichealth.lacounty.gov

March 30, 2017

Dear DHSP-funded HIV Prevention Partner:

SUBJECT: UPDATE ON THE EVOLUTION AND FUNDING OF LOCAL HIV PREVENTION SERVICES

This is to provide you with an update related to the current state of HIV prevention services funded by the Los Angeles County (LAC) Department of Public Health's (DPH) Division of HIV and STD Programs (DHSP) and to outline several factors that may impact the evolution and funding level of these programs.

In partnership with our public- and private-sector service delivery partners, local community HIV planners (the Commission on HIV (COH)) and federal funding partners, DHSP remains committed to supporting a robust HIV prevention strategy that has the greatest impact on the reduction of new HIV infections, including strategies that promote HIV knowledge awareness, reduce the transmission of HIV by increasing viral suppression rates (Treatment as Prevention) and by preventing HIV infection through biomedical interventions.

The current DHSP-supported HIV prevention portfolio includes a broad cross-section of behavioral interventions implemented at the individual and group levels and targeting sub-groups most at risk for HIV infection. DHSP intends to continue relying on grant revenue from the federal Centers for Disease Control and Prevention (CDC) and the County general fund (Net County Cost) to support our HIV prevention programming while assessing the scale and effectiveness of these services.

At this time, several factors are being considered simultaneously that will reshape our local HIV prevention strategy, and our current HE/RR portfolio. First, in early 2016, the CDC announced the extension of CDC 12-1201 Comprehensive HIV Prevention Planning for Health Departments (CHPP) grants, extending them for an additional year to December 31, 2017. The extension was intended to give Health Department's additional time to craft a new five-year comprehensive HIV plan and to allow the CDC time to finalize their next Funding Opportunity Announcement (FOA).

DHSP anticipates that the release of the new CDC FOA for Health Departments will occur sometime in summer 2017 with new program funding expected effective January 1, 2018. While our CDC partners have not yet signaled specific programmatic changes as part of the new FOA, given past experience (e.g. CDC 2011 FOA 12-1201), we expect to see new programmatic requirements and recommendations to which DHSP must respond. Because CHPP funding remains the cornerstone of our HIV prevention efforts, new and ongoing local HIV prevention activities will be influenced and contingent upon any new program requirements and recommendations from the CDC.

Second, in late 2016, CDC released FOA CDC 17-1704 designed to support HIV prevention services through direct funding to community-based organizations in highly impacted jurisdictions, including LAC, beginning July 1, 2017. To ensure that our local HIV prevention efforts have maximum reach and minimum redundancy, DHSP will consider the results of CDC 17-1704 and the full complement of directly-funded HIV prevention programs locally as we finalize local HIV prevention funding decisions.

Third, DHSP is now completing several HIV prevention solicitations that will influence the local HIV prevention landscape for the next five years. The following is a snapshot of the status of these solicitations:

- DHSP is in the review phase of RFP #2015-03: Promoting Health Care Engagement among Vulnerable Populations at Risk for or Living with HIV and STDs.
- DHSP is in the review phase of RFP #2016-05: Comprehensive HIV and STD Prevention Services to be delivered in the City of Long Beach.

Fourth, DHSP will review the last three years of programmatic performance for all currently funded HIV prevention partners (with a specific focus on Health Education/Risk Reduction (HE/RR) contracts), and share a performance assessment with each agency by April 30, 2017. Based on this assessment, DHSP will execute a plan for continuation or discontinuation of each existing HE/RR contract, and a timeline for such.

In summary, over the next several months, DHSP will consider 1) the new CDC HIV Prevention FOA for Health Departments; 2) the results of new CDC direct funding to local community-based partners; 3) the final outcome of DHSP-related HIV prevention solicitations; and 4) programmatic performance of currently funded prevention partners as we finalize countywide HIV prevention programming for the next five years. Based on these multiple factors, DHSP may or may not recommend continued funding for each currently funded prevention program beyond June 30, 2017. These decisions will be communicated by May 15, 2017, so that agencies have time to plan accordingly.

DHSP looks forward to meeting the complex prevention needs of diverse populations at risk for HIV infection in Los Angeles County.

If you have any questions or require additional information, please contact Paulina Zamudio, Co-Manager, Contracted Community Services, at (213) 351-8059.

Very truly yours,

Mario J. Pérez, Director

MJP:MG

c: Commission on HIV
DHSP Senior Management Team

LOS ANGELES COUNTY COMMISSION ON HIV
3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
http://hiv.lacounty.gov

13. CALIFORNIA OFFICE OF AIDS (OA) REPORT:

A. April 2017 Report

California Department of Public Health CDPH

OFFICE OF AIDS
California Department of Public Health

California Department of Public Health, Office of AIDS
Monthly Report
April 2017

Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention and Care Plan

Work is continuing within the California Department of Public Health (CDPH), Office of AIDS (OA) coordinating the tasks associated with the 12 objectives within the *Laying the Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention, and Care Plan* (Plan). At the April California Planning Group meeting, members were:

- Updated on the Plan and provided input regarding objectives and strategies.
- Provided a description of the Needs Assessment effort to-date. Preliminary results from two, forthcoming briefs—Partner Services and Housing—along with the findings of the briefs already submitted to federal agencies were discussed.

Office of AIDS Division/Cross Branch Issues

HIV Affinity Group: OA is collaborating with the Department of Health Care Services (DHCS) to improve data sharing and analysis of data on Medi-Cal beneficiaries living with HIV in order to improve viral suppression. An initial analysis identified that in calendar year 2014, there were 45,033 Medi-Cal beneficiaries identified by DHCS as being HIV infected and confirmed through a match with California HIV surveillance data as being HIV infected. Analysis of viral suppression in this population is on-going.

Ryan White (RW) Part B: AIDS Drug Assistance Program (ADAP)

Staffing Update

- OA is pleased to announce the hire of a permanent ADAP Branch Chief, Sandra Robinson, who will be starting on Monday, April 17th. Sandra has extensive experience in public health and in the health care delivery system, both of which will be helpful in her work with ADAP. Most recently, Sandra served as the Chief of Healthy Aging Programs with the Chronic Disease Control Branch at CDPH, overseeing the Colon Cancer Control Program, the California Arthritis Partnership Program, the Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) program, and the Alzheimer's Disease Program; previously she was the Program Director of the Colon Cancer Control Program within CDPH. Prior to her service with the state, she served as Vice President of Programs with the California Medical Association Foundation and as Statewide Director of Health Systems with the American Cancer Society. Sandra's previous managed care healthcare delivery system work included managing a network of physicians while working for the largest Independent Practice Association in Northern California, Hill Physicians Medical Group; she

has also spent time in pharmaceutical sales and business development with a large Healthcare Hospital system. Sandra holds a Master of Business Administration degree and a Bachelor of Science degree in Business Administration, with a Concentration in Strategic Management.

- OA would like to thank Majel Arnold, OA's Care Branch Chief and Project Director for OA's Ryan White Part B funding, for temporarily serve as Acting ADAP Branch Chief during the last 3 and a half months. Majel will return to her usual job as Care Branch Chief on April 17th.

Breach of ADAP Client Information

- CDPH has currently identified 93 ADAP clients whose information in the A.J. Boggs portal was likely inappropriately accessed by an unknown individual (or individuals) who were not authorized to access the information between July and November 2016.
- CDPH became aware of this on February 7, 2017, mailed breach notification letters to these clients on April 6, 2017, and is providing one year of credit monitoring for these individuals.
- Affected clients can contact the ADAP Call Center (844-421-7050) for more information and how to activate and use the free credit monitoring services.
- ADAP enrollment workers or other staff who are contacted by an affected client regarding this matter should refer the client to the ADAP Call Center.
- ADAP has identified the date(s) that information was accessed and the computer (internet protocol or IP) addresses used to access the information, but there is no way for CDPH to link the computer IP address to an individual (or individuals) who may have viewed the information.
- This breach is disappointing for CDPH and OA, as the protection of confidential public health information is one of CDPH's and OA's top priorities and strongest values.

ADAP Transition

- ADAP Enrollment System Training
  ADAP enrollment workers have been informed that by May 5, 2017, all ADAP enrollment workers must complete the 1.5 hour WebEx training and self-paced eLearning course, receive their username and password, and log into the ADAP Enrollment System. Any enrollment worker with an extenuating circumstance that may prevent meeting this requirement should contact their ADAP Advisor by April 28th.
- Communications
  Clients were sent a letter in English and Spanish from Magellan Rx Management informing them of this transition and letting them know that there is no required action for clients at this time. The letter was dated March 22, 2017, and mailed

on March 31, 2017. A sample client letter was shared with Enrollment Workers for their reference and is also included with this communication. Clients will also receive a new Magellan Rx Management card with the CDPH phone number for eligibility questions. Clients enrolled in the OA-Health Insurance Premium Payment (OA-HIPP) program were mailed a letter from Pool Administrators Inc. (PAI) on April 3, 2017, informing them of the medical out-of-pocket claims submission process, and is also included with this communication. PAI will also issue new client ID cards.

In addition, on March 3rd and March 6th, Magellan notified all pharmacies via fax of the change in ADAP contractors. Pharmacies should not be impacted by this transition.

Contractor Update

Magellan will continue to provide real-time, 24/7 access to medications, including a 30-day supply for existing ADAP clients who experience access issues at the pharmacy.

The PAI contract has been modified to include a full-time employee to oversee and manage Medical Out-of-Pocket Claim forms and supporting documentation for eligible OA-HIPP clients. Effective March 6, 2017, Medical Out-of-Pocket Claim forms and supporting documentation must be submitted directly to PAI.

Updated ADAP Forms

Updated ADAP forms that contain the ADAP call center phone number and new fax number have been posted to the ADAP webpage. The ADAP application has been shortened and modified so it aligns with the new ADAP enrollment system. The ADAP application is available in English and Spanish. OA has also developed a "Job Aid" document to guide enrollment workers in completing the newly modified ADAP application. ADAP forms can be found on the OA website at www.cdph.ca.gov/programs/aids/Pages/ADAPForms.aspx

RW Part B: HIV Care Program (HCP)

- OA is applying for RW Part B Supplemental X08 funding. The application is due to Health Resources and Services Administration (HRSA) on May 15, 2017. Last year OA received an award of $18.7 million, Care received $5.965 million which was distributed amongst 24 HCP contractors, ADAP received $10 million, and $2.735 million was used for program support.

- The Care Operations Unit has completed monitoring site visits to all 42 HCP contractors. Contractors were monitored for the contract period of April 1, 2015, through March 31, 2016.

- Sean Abucay has joined the Care Operations Unit as the new Fiscal Analyst.

AIDS Medi-Cal Waiver Program (MCWP)

On March 27, 2017, the Centers for Medicare & Medicaid Services approved the §1915(c) Home and Community-Based Services Waiver Application (AIDS Waiver). The AIDS Waiver is effective January 1, 2017, through December 31, 2021. On April 12, 2017, MCWP staff will provide an overview of the AIDS Waiver changes to the Project Directors on their monthly teleconference.

HIV Prevention

HIV Prevention Branch subject matter experts contributed to the development of a new non-competitive Request for Applications (RFA) released by the CDPH, Safe and Active Communities Branch on March 27, 2017. The RFA offers grants of naloxone product (Narcan nasal spray) and funding to all 61 local health departments (LHDs) to conduct Naloxone Distribution Projects. LHDs will provide Narcan to local programs, agencies and community-based organizations within their jurisdictions that have naloxone distribution systems and are in the best position to save lives from opioid overdose. Opiate overdose is one of the most common causes of non-AIDS death among people with HIV and is the leading cause of death for people who inject drugs (PWID). "Encouraging naloxone programs throughout the state" is one of the key activities put forth in California's *Laying the Foundation for Getting to Zero* OA's Plan to increase and improve HIV prevention and support services for PWID.

Information about the RFA is available on the CDPH, Safe and active Communities website at www.cdph.ca.gov/programs/SACB/Pages/NaloxoneGrantProgram.aspx.

Surveillance, Research, and Evaluation

The Surveillance, Research, and Evaluation Branch, Electronic Laboratory Records (ELR) team has been awarded a 2017 CDPH Public Health Acknowledging My Efforts (PHAME) award in the Quality Improvement category. The ELR team successfully implemented a complex system that has yielded substantial efficiencies in the reporting of laboratory data and improvements to the continuum of HIV care. The team was honored in a CDPH-wide ceremony on April 4th.

California Planning Group (CPG)

An in-person CPG meeting was held on April 4-6, 2017, in Sacramento, which was the first meeting of the new CPG membership. All members attended, as well as seven subject matter experts. The meeting allowed for CPG members to become more familiar with each other, their CPG roles and responsibilities, how OA is addressing the epidemic, and resources and technical assistance available throughout the state. Two

CPG members were elected to be the Community Co-Chairs: Robyn Learned, who works for the Sacramento Gender Health Clinic, and Tony Viramontes, who works for the Lesbian, Gay, Bisexual, and Transgender Center, Orange County. Presentation slides and meeting notes from the meeting will be posted on the OA website at www.cdph.ca.gov/programs/aids/Pages/OACPG.aspx.

For questions regarding this report, please contact: michael.foster@cdph.ca.gov.

State of California—Health and Human Services Agency
California Department of Public Health

KAREN L. SMITH, MD, MPH
Director and State Public Health Officer

EDMUND G. BROWN JR
Governor

This letter was mailed to all ADAP clients

March 22, 2017

Dear Client:

You are getting this letter because you are a client of the California Department of Public Health (CDPH) Medication Assistance Program. This program pays the full or partial cost of some of your monthly medications. This letter is to inform you of a change in program contractors. **Effective March 6, 2017, A.J. Boggs & Company will no longer be conducting eligibility and enrollment services for this program.** Beginning on March 6, 2017, eligibility and enrollment services will be handled directly by CDPH.

Consistent with usual business practices, the call center will be closed on weekends (including March 4-5). Existing clients can call Magellan 24 hours a day, 7 days a week at (800) 424-5906 with questions or issues related to medication access at the pharmacy.

What you should know:

1. THERE IS NO ACTION REQUIRED FROM YOU.
2. The benefits you are currently receiving from this program are NOT impacted by this change.
3. The pharmacy you are using is NOT impacted by this change.
4. The program enrollment worker with whom you meet to submit program eligibility documents has NOT changed.
5. **Effective March 6, 2017, the toll-free phone number to call regarding any eligibility questions is (844) 421-7050. The new fax number is (844) 421-8008.**
6. If you sent information by fax to A.J. Boggs and have not heard back, please fax the information to CDPH directly at (844) 421-8008.

Questions?
Please contact your enrollment worker or call CDPH at (844) 421-7050.

Thank You
California Department of Public Health Notice

State of California—Health and Human Services Agency
California Department of Public Health

KAREN L. SMITH, MD, MPH
Director and State Public Health Officer

EDMUND G. BROWN JR
Governor

Marzo 22, 2017

Estimado cliente:

Usted ha recibido esta carta porque es cliente del Programa de Asistencia de Medicamentos del Departamento de Salud Pública de California (CDPH). Este programa paga el costo total o parcial de algunos de sus medicamentos mensuales. Esta carta es para informarle de un cambio en los contratistas del programa. **A partir del 6 de marzo de 2017, A.J. Boggs & Company ya no llevará a cabo los servicios de elegibilidad y matriculación para este programa.** A partir del 6 de marzo de 2017, los servicios de elegibilidad y inscripción serán manejados directamente por CDPH.

De acuerdo con las prácticas comerciales habituales, el centro de llamadas permanecerá cerrado los fines de semana (incluidos los días 4 y 5 de marzo). Los clientes existentes pueden llamar a Magellan las 24 horas del día, los 7 días de la semana al (800) 424-5906 con preguntas o problemas relacionados con el acceso a los medicamentos en la farmacia.

Lo que debe de Saber:

1. NO HAY ACCIONES REQUERIDAS DE USTED.
2. Los beneficios que recibe actualmente de este programa NO seran afectados por este cambio.
3. La farmacia que está usando NO es afectada por este cambio.
4. El trabajador de inscripción del programa con el cual usted se reúne para presentar los documentos de elegibilidad del programa NO ha cambiado.
5. A partir del 6 de marzo de 2017, el número de teléfono gratuito para llamar con respecto a cualquier pregunta de elegibilidad es (844) 421-7050. El nuevo número de fax es (844) 421-8008.
6. Si envió información por fax a A.J. Boggs y no ha tenido alguna respuesta, por favor envíe la información por fax a CDPH directamente al (844) 421-8008.

¿Preguntas?
Por favor comuníquese con su trabajador de inscripción o llame al CDPH al (844) 421-7050.

Gracias - Departamento de Salud Pública de California (CDPH)

This letter was mailed to all OA-HIPP clients

April 3, 2017

Dear Client,

You are receiving this letter because you may be enrolled in the California Department of Public Health (CDPH), Medication Assistance Program and receiving insurance premium payment assistance. If you are enrolled, this program pays for some of your medical co-pays and all or part of your health insurance premiums.

On July 1, 2016, our contractor, Pool Administrators Incorporated (PAI), began issuing payments for eligible medical out-of-pocket costs for outpatient services for clients enrolled in our insurance assistance premium payment program. If you are not eligible for this benefit or do not receive premium payment assistance, please disregard this letter. If you are unsure if you qualify, please contact CDPH at (844) 421-7050. If you are already receiving the medical out-of-pocket benefit and have questions, please call (877) 495-0990.

If you are eligible for this benefit, please note the changes outlined below.

Submission of Medical out-of-pocket claims
Effective immediately, clients who are eligible for insurance assistance must send all medical out-of-pocket cost claims to PAI using one of the following methods:

1. Fax: (860) 560-8225
2. Email: CDPH_MBM_Fax@pooladmin.com
3. Mail: PAI-CDPH, 628 Hebron Avenue, Suite 100, Glastonbury, CT 06033

To submit a complete and valid claim you must provide:

1. Medical out-of-pocket claim form (attached)
2. Supporting documentation such as an invoice, claim, and/or receipt
3. Explanation of Benefits (EOB), if available

This supporting documentation must include: your name, the date of service, the type of outpatient medical service received, the provider's name and/or clinic, and the out-of-pocket cost amount.

If you are eligible to receive the medical out-of-pocket cost benefit, you will receive an updated ID card and detailed instructions on how to submit claims within the next four to six weeks.

If you have any questions regarding this new process, please call PAI Customer Service at (877) 495-0990, Monday-Friday 8 a.m. to 5 p.m. PST.

Thank You,
Pool Administrators Inc.
Client Services Unit

Insurance Premium Payment Assistance Medical Out-of-Pocket Claim Form

Submitter must complete Sections A and B. This claim form AND supporting documentation must be sent to Pool Administrators, Inc. (PAI)

- Fax: (860) 560-8225
- Email: CDPH_MBM_Fax@pooladmin.com
- Mail: PAI-CDPH, 628 Hebron Ave., Suite 100, Glastonbury, CT 06033

If you have any questions about submitting this form, please contact PAI Customer Service at (877) 495-0990.

A. Client Information

First Name _____ Last Name _____ Date of Birth _____ Client ID Number _____

Client Mailing Address: _____
Street/PO Box City State Zip Code

□ Spousal Claim

Language Preference: □ English □ Spanish □ Other: _____

B. Service and Provider Information

Type of Service (select one):

□ Lab
□ Provider Visit
□ Other (please specify): _____
□ Radiology/X-ray/Imaging
□ Emergency/Urgent Care

_____ $ _____
Date of Service Client's Out of Pocket Cost Amount

_____ _____ _____
Provider Name (Print) Provider Phone Number Provider Fax Number

C. Enrollment Worker Information

_____ _____ _____
Enrollment Worker Name Enrollment Worker Phone Number Enrollment Worker Email Address

D. Pool Administrators Use Only

_____ _____ _____
Received By Date Received Date Updated

Comments by Pool Administrators (Check all that apply):

□ **Approved:**
PAI Payment Date: _____ Payment Amount: _____
PAI Check Number: _____ Check Memo Line: _____

□ **Denial Reason:** _____

□ **Pending Reason:** _____

□ **Appeal Reason:** _____
Date received: _____ Date responded: _____

LOS ANGELES COUNTY COMMISSION ON HIV
3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
http://hiv.lacounty.gov

14. STANDING COMMITTEE REPORTS

B. Standards and Best Practices (SBP) Committee:

(1) Standards of Care

(a) Universal Service Standards for HIV Care Services

(b) Standards of Care Updates for HIV Substance Use Residential and Treatment Services

(c) Incarcerated/Post-Release Transitional Case Management Services

(d) Youth Transitional Case Management Services

C. Operations Committee:

(2) Membership Management

(b) Application: Juan Preciado | HIV Stakeholder #3

2017

Los Angeles County
Commission on HIV

FOR COMMISSION ON HIV
APPROVAL
FINAL DRAFT (4/10/17)

[PROPOSED UNIVERSAL SERVICE STANDARDS FOR HIV CARE SERVICES]

The development of service standards is one of the core functions of the Commission on HIV. The public is invited to review the proposed Universal Service Standards for HIV care services in Los Angeles County.

Los Angeles County Commission on HIV
UNIVERSAL STANDARDS OF CARE

INTRODUCTION

These Standards of Care updates reflect current guidelines from federal and national agencies on a broad array of HIV/AIDS care and treatment services. These revised standards build upon the Los Angeles County Commission on HIV 2005 *Standards of Care for HIV/AIDS Services.*

Furthermore, the Commission on HIV supports activities and initiatives that facilitate viral suppression in among people living with HIV/AIDS (PLWHA), and more importantly, recognizes the important role that community partnerships play in achieving the goals of the National HIV/AIDS Strategy (NHAS). The Universal Standards of Care seek to establish a set of minimum standards aimed achieving optimal health among PLWHA.

The development of these revised and expanded standards of care included the input and feedback of service providers, consumers and members of the Standards and Best Practices Committee (SBP). All comments were thoroughly reviewed by the SBP Committee resulting in some recommended revisions.

UNIVERSAL SERVICE STANDARDS

Standards of Care (SoC) are the minimum requirements that programs are expected to meet when providing HIV/AIDS care and support services funded by Ryan White Part A through the Los Angeles County, Department of Public Health, Division of HIV and STD Programs (DHSP). The SoC establish the minimum standards intended to help agencies meet the needs of their clients. Providers may exceed these standards.

The objectives of the universal service standards are to help achieve the goals of each service type by ensuring that programs:

- have policies and procedures in place to protect clients' rights and ensure quality of care;
- provide clients with access to the highest quality services through experienced, trained and, when appropriate, licensed staff;
- provide services that are culturally and linguistically appropriate;
- meet federal, state, and county requirements regarding safety, sanitation, access, public health, and infection control;
- guarantee client confidentiality, protect client autonomy, and ensure a fair process of grievance review and advocacy;
- comprehensively inform clients of services, establish client eligibility, and collect client information through an intake process;
- effectively assess client needs and encourage informed and active client participation;

- address client needs effectively through coordination of care with appropriate providers and referrals to needed services; and
- are accessible to all people living with HIV in Los Angeles County

1. AGENCY POLICIES AND PROCEDURES

The objectives of the standards for agency policies and procedures are to:

- guarantee client confidentiality, ensure quality care, and provide a fair process to address clients' grievances;
- ensure client and staff safety and well-being;
- facilitate communication and service delivery; and
- ensure that agencies comply with appropriate county, state and federal regulations.

All provider agencies offering services must have written policies that address client confidentiality, release of information, client grievance procedures, and eligibility.

Confidentiality assures protection of release of information regarding HIV status, behavioral risk factors, or use of services. Each agency will have a client confidentiality policy that is in accordance with state and federal laws. As part of the confidentiality policy, all agencies will provide a *Release of Information Form* describing under what circumstances client information can be released (name of agency/individual with whom information will be shared, information to be shared, duration of the release consent, and client signature). Clients shall be informed that permission for release of information can be rescinded at any time either verbally or in writing. Releases must be dated and are considered no longer binding after one year. For agencies and information covered by the Health Insurance Portability and Accountability Act (HIPAA), the release of information form must be a HIPAA-compliant disclosure authorization.

A service provider must have a current grievance procedures that conform to the requirements set forth by DHSP. A provider agency grievance procedure ensures that clients have recourse if they feel they are being treated in an unfair manner or do not feel they are receiving quality services. Each agency will have a policy identifying the steps a client should follow to file a grievance and how the grievance will be handled. All agencies must inform clients of the DHSP Grievance Line and procedures (http://publichealth.lacounty.gov/dhsp/QuestionServices.htm).

1.0 AGENCY POLICIES AND PROCEDURES	
Standard	**Measure**
1.1 Client confidentiality policy exists.	1.1 Written policy on file at provider agency.
1.2 Grievance procedure exists.	1.2 Written procedure on file at provider agency.
1.3 Agency has eligibility requirements for services, in written form, available upon request. Eligibility requirements must	1.3 Written policy on file at provider agency.

follow guidance from HRSA under PCN #16-02.	
1.4 A complete file for each client exists. All client files are stored in a secure and confidential location, and electronic client files are protected from unauthorized use.	1.4 Files stored in a locked file or cabinet with access limited to appropriate personnel. Electronic files are password protected with access limited to appropriate personnel. Paper copies of all required forms that must be signed by the client and/or provider are in every client's file.
1.5 Client's consent for release of information is determined.	1.5 An up-to-date *Release of Information Form* exists for each specific request for information and each request is signed and dated by the client. Each release form indicates the destination of the client's information or from whom information is being requested before the client signs the release.
1.6 Client's consent for on-site file review by funders is determined.	1.6 Signed and dated *File Review Consent Form* in client's record. Consent forms have an expiration date of one year. In event of refusal of consent, file is coded to remove identifying information in accordance with federal, state, and local laws.
1.7 Agency maintains progress notes of all communication between provider and client. Progress notes indicate service provided and referrals that link clients to needed services. Notes are dated, legible, and in chronological order.	1.7 Progress notes maintained in individual client files.
1.8 Crisis management policy exists that addresses, at a minimum, infection control (e.g., needle sticks), mental health crises, and dangerous behaviors by clients or staff.	1.8 Written policy on file at provider agency.
1.9 Policy on universal precautions exists; staff members are trained in universal precautions.	1.9 Written policy on file at provider agency. Documentation of staff training in personnel file.
1.10 Policy and procedures exist for handling medical emergencies.	1.10 Policy and procedures on file and posted in visible location at site.

1.11 Agency complies with ADA criteria for programmatic accessibility. In the case of programs with multiple sites offering identical services, all sites must be compliant with relevant ADA criteria.	1.11 Site visit conducted by funder.
1.12 Agency complies with all applicable state and federal workplace and safety laws and regulations, including fire safety.	1.12 Signed confirmation of compliance with applicable regulations on file.

2. CLIENT RIGHTS AND RESPONSIBILITIES

The objectives of establishing minimum standards for client rights and responsibilities are to:

- ensure that services are available to all eligible clients;
- ensure that services are accessible for clients;
- involve consumers of HIV/AIDS services in the design and evaluation of services; and
- inform clients of their rights and responsibilities as consumers of HIV/AIDS services.

HIV/AIDS services funded by DHSP must be available to all clients who meet eligibility requirements and must be easily accessible.

A key component of HIV/AIDS service delivery is the historic and continued involvement of consumers in the design and evaluation of services. Substantive client input and feedback must be incorporated into the design and evaluation of HIV/AIDS services funded by DHSP; this can be accomplished through a range of mechanisms including consumer advisory boards, participation of consumers in HIV program committees or other planning bodies, and/or other methods that collect information from consumers to help guide and evaluate service delivery (e.g., needs assessments, focus groups, or satisfaction surveys).

The quality of care and quality of life for people living with HIV/AIDS is maximized when consumers are active participants in their own health care and share in health care decisions with their providers. This can be facilitated by ensuring that clients are aware of and understand their rights and responsibilities as consumers of HIV/AIDS services. Providers of HIV/AIDS services funded by DHSP must provide all clients with a *Client Rights and Responsibilities* document that includes, at a minimum, the agency's confidentiality policy, the agency's expectations of the client, the client's right to file a grievance, the client's right to receive no-cost interpreter services, and the reasons for which a client may be discharged from services, including a due process for involuntary discharge. "Due process" refers to an established, step-by-step process for notifying and warning a client about unacceptable or inappropriate behaviors or actions and allowing the client to respond before discharging them

from services. Some behaviors may result in immediate discharge.

Clients are entitled to access their files with some exceptions: agencies are not required to release psychotherapy notes, and if there is information in the file that could adversely affect the client (as determined by a clinician) the agency may withhold that information but should make a summary available to the client. Agencies must provide clients with their policy for file access. The policy must at a minimum address how the client should request a copy of the file (in writing or in person), the timeframe for providing a copy of the file (cannot be longer than 30 days), and what information if any can be withheld.

2.0 CLIENT RIGHTS AND RESPONSIBILITIES	
Standard	**Measure**
2.1 Services are available to any individual who meets program eligibility requirements.	2.1 Written eligibility requirements on file; client utilization data made available to funder.
2.2 Programs include input from consumers (and as appropriate, caregivers) in the design and evaluation of service delivery.	2.2 Documentation of meetings of consumer advisory board, or other mechanisms for involving consumers in service planning and evaluation (e.g., satisfaction surveys, needs assessments) in regular reports to funder(s).
2.3 Services are accessible to clients.	2.3 Site visit conducted by funder that includes, but is not limited to, review of hours of operation, location, proximity to transportation, availability of bilingual staff or language interpretation service, and other accessibility factors.
2.4 Program provides each client a copy of a *Client Rights and Responsibilities* document that informs him/her of the following: • the agency's client confidentiality policy; • the agency's expectations of the client as a consumer of services; • the client's right to file a grievance; • the client's right to receive no-cost interpreter services; • the reasons for which a client may be discharged from services, including a due process for involuntary discharge.	2.4 Copy of *Clients Rights and Responsibilities* document is given to client; a copy of the form (or a signature/acknowledgement page) is signed by client and kept in client file.

2.5 Clients have the right to access their file.	2.5 Copy of agency's Client File Access policy is signed by client and kept in client file.

3. PERSONNEL

The objectives of the standards of care for personnel are to:

- provide clients with access to the highest quality of care through qualified staff;
- inform staff of their job responsibilities; and
- support staff with training and supervision to enable them to perform their jobs well.

All staff and supervisors will be given and will sign a written job description with specific minimum requirements for their position. Agencies are responsible for providing staff with supervision and training to develop capacities needed for effective job performance. At a minimum, all staff should be able to provide appropriate care to clients infected/affected by HIV/AIDS, be able to complete all documentation required by their position, and have previous experience (or a plan for acquiring experience) in the appropriate service/treatment modality (for clinical staff). Clinical staff must be licensed or registered as required for the services they provide.

3.0 PERSONNEL	
Standard	**Measure**
3.1 Staff members have the minimum qualifications expected for their job position, as well as other experience related to the position and the communities served.	3.1 Résumé in personnel file meeting the minimum requirements of the job description.
3.2 Staff members are licensed as necessary to provide services.	3.2 Copy of license or other documentation in personnel file.
3.3 Staff and supervisors know the requirements of their job description and the service elements of the program.	3.3 Documentation in personnel file that each staff members received job description.
3.4 Newly hired staff are oriented within 6 weeks, and begin initial training within 3 months of being hired. Ongoing training continues throughout staff's tenure.	3.4 Documentation in personnel file of completed orientation within 6 weeks of date of hire; (b) commencement of initial training within 3 months of date of hire; and (c) ongoing trainings.

4. CULTURAL AND LINGUISTIC COMPETENCE

The objective for establishing standards of care for cultural and linguistic competence is to

provide services that are culturally and linguistically appropriate.

Culture is the integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, and values of individuals and groups, all which may be influenced by race, ethnicity, religion, class, age, gender, gender identity, disability, sexual orientation, and other aspects of life upon which people construct their identities. In our work with people living with HIV, culture may also include past or current substance use, homelessness, mental health, and/or incarceration, among others.

Cultural competence is a set of behaviors, attitudes, and policies that come together in a system, agency, or among individuals that 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 providers must aspire, but one that may never be completely achieved given the diversity of languages and cultures throughout our communities. However, all providers should be involved in a continual process of learning, personal growth, experience, education, and training that increases cultural and linguistic competence and enhances the ability to provide culturally and linguistically appropriate services to all individuals living with HIV/AIDS. Culturally and linguistically appropriate services are services that:

- respect, relate, and respond to a client's culture, in a non-judgmental, respectful, and supportive manner;
- are affirming and humane, and rely on staffing patterns that match the needs and reflect the culture and language of the communities being served;
- recognize the power differential that exists between the provider and the client and seek to create a more equal field of interaction; and
- are based on individualized assessment and stated client preferences rather than assumptions based on perceived or actual membership in any group or class.

As part of the on-going process of building cultural and linguistic competence, providers should strive to develop:

- a comfort with and appreciation of cultural and linguistic difference;
- interpersonal behaviors that demonstrate and convey concern and respect for all cultures;
- the comfort and ability to acknowledge the limits of personal cultural and linguistic competence and the skills to elicit, learn from, and respond constructively to relevant personal and cultural issues during service interactions; and
- a commitment to increasing personal knowledge about the impact of culture on health and specific knowledge about the communities being served.

Ongoing trainings that help build cultural and linguistic competence may include traditional

cultural and linguistic competency trainings, as well as a range of trainings that help build specific skills and knowledge to work and communicate more effectively with the communities we serve.

NOTE: Interpretation refers to verbal communication that translates speech 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	**Measure**
4.1 Programs recruit, retain, and promote a diverse staff that reflects the cultural and linguistic diversity of the community.	4.1 Programs have a strategy on file to recruit, retain and promote qualified, diverse, and linguistically and culturally competent administrative, clinical, and support staff who are trained and qualified to address the needs of people living with HIV/AIDS.
4.2 All staff receive ongoing training and education to build cultural and linguistic competence and/or deliver culturally and linguistically appropriate services.	4.2 All staff members receive appropriate training within the first year of employment and periodically thereafter as needed. Copies of training verification in personnel file.
4.3 Programs assess the cultural and linguistic needs, resources, and assets of its service area and target population(s).	4.3 Programs collect and use demographic, epidemiological, and service utilization data in service planning for target population(s).
4.4 Programs' physical environment and facilities are welcoming and comfortable for the populations served.	4.4 Funder site visit. Physical facilities are clean and safe.
4.5 All programs ensure access to services for clients with limited English skills in one of the following ways (listed in order of preference): • Bilingual staff who can communicate directly with clients in preferred language; • Face-to face interpretation provided by • Qualified staff, contract interpreters, or volunteer interpreters; • Telephone interpreter services (for emergency needs or for infrequently encountered languages); or	4.5 Programs document access to services for clients with limited English skills through the following: • For bilingual staff, résumés on file demonstrating bilingual proficiency and documentation on file of training on the skills and ethics of interpreting; • Copy of certifications on file for contract or volunteer interpreters; • Listings/directories on file for telephone interpreter services; or • Listings/directories on file for referring clients to programs with

• Referral to programs with bilingual/bicultural clinical, administrative and support staff and/or interpretation services by a qualified bilingual/bicultural interpreter.	bilingual/bicultural clinical, administrative and support staff, and/or interpretation services by a qualified bilingual/bicultural interpreter.
4.6 Clients are informed of their right to obtain no-cost interpreter services in their preferred language, including American Sign Language (ASL).	4.6 *Client Rights and Responsibilities* document includes notice of right to obtain no-cost interpreter services.
4.7 Family and friends are not considered adequate substitutes for interpreters because of privacy, confidentiality, and medical terminology issues. If a client chooses to have a family member or friend as their interpreter, the provider obtains a written and signed consent in the client's language. Family member or friend must be over the age of 18.	4.7 Family/friend interpretation consent form signed by client and maintained in client file.
4.8 Clients have access to linguistically appropriate signage and educational materials.	4.8 Programs provide commonly used educational materials and other required documents (e.g., grievance procedures, release of information, rights and responsibilities, consent forms, etc.) in the threshold language of all threshold populations. Programs that do not have threshold populations have a documented plan for explaining appropriate documents and conveying information to those with limited English proficiency.
4.9 Programs conduct ongoing assessments of the program and staff's cultural and linguistic competence.	4.9 Programs integrate cultural competence measures into program and staff assessments (e.g., internal audits, performance improvement programs, patient satisfaction surveys, personnel evaluations, and/or outcome evaluations).

5. INTAKE AND ELIGIBILITY

The objectives of the standards for the intake process are to:

- assess client's immediate needs;
- inform the client of the services available and what the client can expect if s/he were to enroll;
- establish the client's eligibility for services, including HIV status and other criteria;
- establish whether the client wishes to enroll in a range of services or is interested only in a discrete service offered by the provider agency;
- explain the agency policies and procedures;
- collect required county, state, federal client data for reporting purposes;
- collect basic client information to facilitate client identification and client follow-up; and
- begin to establish a trusting client relationship.

Intake Process: All clients who request or are referred to HIV services will participate in the intake process. Intake is conducted by an appropriately trained program staff or intake worker. The intake worker will review client rights and responsibilities, explain the program and services to the client, explain the agency's confidentiality and grievance policies to the client, assess the client's immediate service needs, and secure permission from the client to release information (if there is an immediate need to release information).

Intake is considered complete if the following have been accomplished: (1) the client's HIV positive status has been verified and documented; (2) all required forms have been completed, and (3) the information below (at a minimum) has been obtained from the client:

- name, address, phone, and email (if available);
- preferred method of communication (e.g., phone, email, or mail);
- emergency contact information;
- preferred language of communication;
- enrollment in other HIV/AIDS services;
- primary reasons and need for seeking services at agency.

A client who chooses to enroll in services and who is eligible will be assigned a staff member who is responsible for making contact with the client to set up a time for a more thorough assessment, if necessary, to determine appropriate services. Referrals for other appropriate services will be made if ineligible. The intake process will **begin within five days** of the first client contact with the agency. Ideally, the client intake process should be completed as quickly as possible; however, recognizing that clients may not have on hand the required documentation (e.g., documentation of HIV status), the intake process should be completed within 30 days of beginning intake.

5.0 INTAKE AND ELIGIBILITY

Standard	Measure
5.1 Intake process is completed within 30 days of initial contact with client and documents client's contact information (including his/her emergency contact's name and phone number) and assesses his/her immediate service needs and connection to primary care and other services.	5.1 Completed intake, dated no more than 30 days after initial contact, in client's file.
5.2 To determine minimum eligibility for services, client's HIV-positive status is verified if client chooses to enroll.	5.2 Physician's note or laboratory test in client's file documenting that client is HIV-positive.

6. Assessment and Service Plan

The objectives of the standards for assessment and service plan are to:

- gather information to determine the client's needs;
- identify the client's goals and develop action steps to meet them;
- identify a timeline and responsible parties for meeting the client's goals; and
- ensure coordination of care with appropriate providers and referral to needed services.

Assessment

All providers must assess the client's needs to develop an appropriate service plan. Service assessments include an assessment of all issues that may affect the need for the provider service. The assessment is a cooperative and interactive endeavor between the staff and the client. The client will be the primary source of information. However, with client consent, assessments may include additional information from case manager(s), medical or psychosocial providers, caregivers, family members, and other sources of information, if the client grants permission to access these sources. The assessment should be conducted face-to-face within 30 days of intake, with accommodations for clients who are too sick to attend the appointment at the provider agency.

It is the responsibility of the staff to reassess the client's needs with the client as his/her needs change. The reassessment should be done as needed, but no less than once every six (6) months. If a client's income, housing status, or insurance status/resource has changed since assessment or the most recent reassessment, agencies must ensure that the data on the Client Information Form is updated accordingly. The staff member is encouraged to contact other service providers/care givers involved with the client or family system in support of the client's well-being. Staff members must comply with established agency confidentiality policies (see Standard 1.1) when engaging in information and coordination activities.

Individual Service Plan (ISP)

The purpose of the individual service plan (ISP) is to guide the provider and client in their collaborative effort to deliver high quality care corresponding to the client's level of need. It should include short-term and long-term goals, based upon the needs identified in the assessment, and action steps needed to address each goal. The ISP should include specific services needed and referrals to be made, including clear time frames and an agreed upon plan for follow up.

As with the assessment process, service planning is an on-going process. It is the responsibility of the staff to review and revise a client's ISP as needed, but not less than once every six (6) months.

As part of the ISP, programs must ensure the coordination of services. Coordination of services requires identification of other staff or service providers with whom the client may be working. As appropriate and with client consent, program staff will act as a liaison among clients, caregivers, and other service providers to obtain and share information that supports optimal care and service provision. If a program is unable to provide a specific service, it must be able to make immediate and effective referrals. In case of referrals, staff must facilitate the scheduling of appointments, transportation, and the transfer of related information.

6.0 ASSESSMENT AND SERVICE PLAN	
Standard	**Measure**
6.1 Within 30 days of client contact, assessment is conducted of client's need for particular service.	6.1 Completed assessment form in the client file.
6.2 Within 30 days of client contact, ISP is developed collaboratively with the client that identifies goals and objectives, resources to address client's needs, and a timeline.	6.2 Completed ISP in client file signed by the client and staff person.
6.3 Reassessment of the client's needs is conducted as needed, but not less than once every six months.	6.3 Documentation of reassessment in the client files (e.g., progress notes, update notes on the initial assessment, or new assessment form).
6.4 Service plan is reviewed and revised as needed, but not less than once every six months.	6.4 Documentation of ISP review/revision in client's file (e.g., progress notes, update notes on initial ISP, or new ISP). Updated ISP shall be signed by client, staff person, and supervisor.
6.5 Program staff identify and communicate as	6.5 Documentation in client file of other staff

appropriate (with documented consent of client) with other service providers to support coordination and delivery of high quality care and to prevent duplication of services.	within the agency or at another agency with whom the client may be working.

7. TRANSITION AND DISCHARGE

The objectives of the standards for transition and discharge are to:

- ensure a smooth transition for clients who no longer want or need services at the provider agency;
- maintain contact with active clients and identify inactive clients;
- assist provider agencies in more easily monitoring caseload; and
- plan after-care and re-entry into service.

A client may be discharged from any service through a systematic process that includes a discharge summary in the client's record. The discharge summary will include a reason for the discharge 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 discharge, (s)he should be referred to the provider agency's and DHSP's grievance procedure.

A client may be discharged from any service for any of the following reasons:

- client dies;
- client requests a discharge;
- client's needs change and (s)he would be better served through services at another provider agency;
- client's actions put the agency, service provider, or other clients at risk;
- client sells or exchanges emergency assistance, child care, or transportation vouchers for cash or other resource for which the assistance is not intended;
- client moves/relocates out of the service area; or
- the agency is unable to reach a client, after repeated attempts, for a period of 12 months.

7.0 TRANSITION AND DISCHARGE	
Standard	**Measure**
7.1 Agency has a transition and discharge procedure in place that is implemented for clients leaving or discharged from services for any of the reasons listed in the narrative above.	7.1 Completed transition/discharge summary form on file, signed by client and supervisor (if possible). Summary form 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.
7.2 Agency has a due process policy in place for involuntary discharge of clients from services; policy includes a series of verbal and written warnings before final notice and discharge.	7.2 Due process policy on file as part of transition and discharge procedure; due process policy described in the *Client Rights and Responsibilities* document.
7.3 Agency has a process for maintaining communication with clients who are active and identifying those who are inactive.	7.3 Documentation of agency process for maintaining communication with active clients and identifying inactive clients.
7.4 Agency provides clients with referral information to other services, as appropriate.	7.4 HIV/ STD prevention and treatment, and other health and social service referrals are documented in client's chart. Resource directories are available for clients.

ACKNOWLEDGEMENTS

This document was under the guidance of the Los Angeles County Commission on HIV, Standards and Best Practices (SBP) Committee and critique from subject matter experts. We thank them for their leadership and dedication to ensuring that high quality HIV services are accessible to PLWHA.

Grissel Granados, MSW*
Joseph Cadden, MD*
Angelica Palmeros, MSW*
Thomas Puckett, Jr.*
Terry Smith, MPA*
Octavio Vallejo, MD, MPH*
Wendy Garland, MPH*
Susan Forrest
Martha Tadesse, MSN MPH MPA CCHP-RN
Natalie Valdez, MSSW
Martin Sattah, MD
John Thompson, MSW
Terina Keresoma
**SBP Committee Members*

2017

Los Angeles County
Commission on HIV

FOR COMMISSION ON HIV
APPROVAL
FINAL DRAFT (4/10/17)

[PROPOSED STANDARDS OF CARE UPDATES FOR HIV SUBSTANCE USE RESIDENTIDAL AND TREATMENT SERVICES]

The development of service standards is one of core functions of the Commission on HIV. The public is invited to review the proposed Standards of Care for Substance Use Residential and Treatment services in Los Angeles County.

Los Angeles County Commission on HIV
SUBSTANCE USE SERVICES STANDARDS OF CARE

Substance Use Services Definition
Per HRSA Policy Guidance, Substance Use Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Services include:

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

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

- Pretreatment/recovery readiness programs
- Harm reduction
- Behavioral health counseling associated with substance use disorder
- Medication assisted therapy
- Neuro-psychiatric pharmaceuticals
- Relapse prevention

Detoxification, if offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital)

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

Substance Use Services Standards of Care
The overall objectives of the Substance Use Services standards of care are to:

- comply with state regulations, including licensing requirements, for substance Use services; and
- provide services with skilled, licensed professionals with experience and/or

education in relevant disciplines.

The service specific standards of care for Substance Use Services provide additional requirements around the following components of service provision:

A. Agency Licensing and Policies
B. Competencies

Substance Use Services providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

A. Agency Licensing and Policies

The objective of the standards for agency licensing and policies for Substance Use Services is to ensure that programs comply with state regulations and licensing requirements.

If residential substance Use treatment services are provided in a facility that primarily provides inpatient medical or psychiatric care, the component providing the substance Use treatment must be separately licensed for that purpose.

A. Agency Licensing and Policies (Substance Use)	
Standard	**Measure**
Agency is licensed and accredited by appropriate state and local agency to provide substance Use services.	Current license(s) on file.

B. Competencies

The objective of the competencies standards for Substance Use Services is to ensure that clients have access to the highest quality services through experienced and trained staff.

B. Competencies (Substance Use)	
Standard	**Measure**
Staff members are licensed or certified, as necessary, to provide substance Use services and have experience and skills appropriate to the specified substance Use treatment modality.	Current license and résumé on file.

Key systems level changes affecting substance use disorder (SUD) treatment in Los Angeles County:

The Drug Medi-Cal Organized Delivery System (DMC-ODS) is a new health care services paradigm for Medi-Cal eligible individuals with substance use disorders (SUD). The Los Angeles

County Department of Public Health, Substance Use Prevention and Control (SAPC) will implement an initial benefit package for SUD services within the initial 12 months of approval from the California Department of Health Care Services (DHCS). California's Medi-Cal 2020 1115(a) Waiver Demonstration Project paves the way for Los Angeles County (LAC) to increase access to substance use disorder (SUD) treatment services for adolescents and adults who are eligible for Medi-Cal.

It expands Drug Medi-Cal (DMC) reimbursable services beyond outpatient (OP), intensive outpatient (IOP), and opioid (narcotic) treatment program (OTP) to create a fuller continuum of care that includes withdrawal management (WM), medication-assisted treatment (MAT), short-term residential (RS), case management and care coordination with physical and mental health, and recovery support services. With the new benefits, also comes the responsibility to make placement decisions based on the American Society of Addiction Medicine (ASAM) Criteria and medical necessity; provide care at the lowest and most appropriate level of care (LOC), including improved transitions between LOCs; and use MAT in conjunction with other treatment services.

UPDATES TO SUBSTANCE USE SERVICES STANDARDS OF CARE:

As Ryan White serves as the payor of last resort for critical HIV/AIDS care and treatment services, its service level standards must align with SAPC's standards. In recognition of these systems-level changes to the treatment of SUD in publicly funded settings, the following changes are noted in the Substance Use Treatment and Residential Standards of Care:

- All Ryan White funded substance Use services must provide integrated services of behavioral health treatment and HIV medical care. An integrated behavioral health and HIV medical care program addresses alcohol, marijuana, cocaine, heroin, injection drug use (IDU), and prescription drug misuse; mental disorder treatment and HIV/viral hepatitis services, including HIV and hepatitis B and C testing; and use evidence-based interventions defined by the Substance Use and Mental Health Services Administration (SAMHSA).

- Use a trauma-informed approach following SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach (http://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-aTrauma-Informed-Approach/SMA14-4884).

- Link clients and partners to appropriate community-based behavioral health services/systems including primary HIV care and antiretroviral treatment (ART), HIV pre-exposure prophylaxis (PrEP), primary health care, and other recovery support services.

- Offer and use appropriate behavioral health services include engagement services (e.g., outreach, assessment, service planning); outpatient treatment services; intensive outpatient treatment services; substance use or mental disorders residential treatment

services; medication-assisted treatment (MAT); community support services such as case management (e.g., assessment, planning, linking, monitoring, and advocacy), and peer and other recovery support services http://www.samhsa.gov/recovery.

- Use the Medical Care Coordination Assessment tool to determine acuity level and eligibility for MCC services.

- Screen and assess clients for the presence of co-occurring mental disorders and use the information obtained from the screening and assessment to develop appropriate treatment approaches for the persons identified as having co-occurring disorders.

- Ensure that patients who need trauma-related services have access to these services through case management and referral to certified trauma providers.

- All clients who are considered to be at risk for vital hepatitis (B and C), as specified by the United States Preventive Services Task Force (USPSTF) recommendations for hepatitis B and hepatitis C screening, must be tested for viral hepatitis (B and C) in accordance with state and local requirements, either onsite or through referral.

- Provide a plan for providing referrals and linkages to follow-up care and treatment for all individuals infected with viral hepatitis (B or C).

- Develop a plan for case management of all clients who have a preliminary positive HIV and confirmatory HIV test result. The process of case management includes: comprehensive assessment of the client's needs and development of an individualized service plan.

- Medication Assisted Treatment (MAT) is an evidence-based substance Use treatment therapy. SAMHSA supports the right of individuals with an opioid or alcohol use disorder to be given access to MAT as appropriate under the care of a physician.

- Screen and assess clients for the presence of co-occurring mental and substance use disorders and use the information obtained from the screening and assessment to develop appropriate treatment approaches for the persons identified as having such co-occurring disorders.

Substance Use Treatment	
Standard	**Measure**
Providers must provide the following service components: • Intake • Individual counseling • Group counseling • Patient education • Family therapy • Medication services • Collateral services • Crisis intervention services • Treatment planning • Discharge services	A comprehensive written program service delivery protocol outlining how staff will deliver all service components based on SAPC, SAMHSA and ASAM guidelines.
Providers are responsible to provide culturally competent services. Services must be embedded in the organizational structure and upheld in day-to-day operations.	Agencies must have in place policies, procedures and practices that are consistent with the principles outlined in the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS).
Agencies provide services that accounts for a client's age and developmental level to ensure his/her engagement into the treatment process.	Use of assessment and screening tools that establishes age and developmental levels and appropriate individualized treatment plan. Case notes clearly articulate action steps and treatment modifications for the client's age and developmental level.
Agencies must have procedures for linkage/integration of Medication-Assisted Treatment (MAT) for patients to ensure adequate access to core components of substance use disorder (SUD) treatment.	Established protocols for MAT following prescribing standards from the American Society of Addiction Medicine (ASAM) and SAMHSA.
Agencies must use Evidence-Based Practices such as Motivational Interviewing and Cognitive Behavioral Therapy, relapse prevention, trauma-informed treatment, and psychoeducation.	Written evidence-based program protocol.
Agencies must provide Field-Based Services (FBS) based on comprehensive assessment.	Proper certifications are in place for staff to provide FBS. Written FBS protocol.
Providers must deliver a variety of case management and care coordination services	Written case management and care coordination protocol.

including transitioning clients from one level of care to another and navigating the mental health, physical health, and social service delivery systems.	MOUs with agencies for ensuring coordination of services for patients. List of service providers and partners.
Providers must delivery recovery support services to clients upon discharge from treatment services, including outpatient /intensive outpatient programs.	Written recovery support services protocol. MOUs with agencies for ensuring coordination of care.
Agencies must maintain complete and thorough documentation of services provided to client.	Agencies maintain documentation based on the ASAM Criteria. Progress notes are thorough, dated, and verified by a licensed supervisor.

Substance Use – Residential	
Standard	**Measure**
Providers must provide the following service components: • Intake • Individual counseling • Group counseling • Patient education • Family therapy • Safeguard medications • Medication services • Collateral services • Crisis intervention services • Treatment planning • Transportation services • Discharge services	A comprehensive written program service delivery protocol outlining how staff will deliver all service components based on SAPC, SAMHSA and ASAM guidelines.
Appropriate medical evaluation must be performed prior to initiating residential treatment services, including physical examinations when deemed necessary.	Medical record of physical examinations and medical evaluation by a licensed medical provider.
Providers are responsible to provide culturally competent services. Services must be embedded in the organizational structure and upheld in day-to-day operations.	Agencies must have in place policies, procedures and practices that are consistent with the principles outlined in the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS).
Agencies must have procedures for linkage/integration of Medication-Assisted Treatment (MAT) for patients to ensure adequate access to core components of	Established protocols for MAT following prescribing standards from the American Society of Addiction Medicine (ASAM) and SAMHSA.

substance use disorder (SUD) treatment.	
Agencies must use Evidence-Based Practices such as Motivational Interviewing and Cognitive Behavioral Therapy, relapse prevention, trauma-informed treatment, and psychoeducation.	Written evidence-based program protocol.
Case management will assist patients in navigating and accessing mental health, physical health, and social service delivery systems.	Case notes must show that the initiating provider provided case management services and communicated with the next provider along the continuum of care to ensure smooth transitions between levels of care. If the client is referred to a different agency, case notes must show that the client has been successfully admitted for services with the new treating provider.
Providers must delivery recovery support services to clients to sustain engagement and long-term retention in recovery, and re-engagement in SUB treatment and other services and supports as needed.	Written recovery support services protocol. MOUs with agencies for ensuring coordination of care.
Agencies must maintain complete and thorough documentation of services provided to client.	Agencies maintain documentation based on the ASAM Criteria.

ACKNOWLEDGMENTS

This document was under the guidance of the Los Angeles County Commission on HIV, Standards and Best Practices (SBP) Committee and critique from subject matter experts. We thank them for their leadership and dedication to ensuring that high quality HIV services are accessible to PLWHA.

Grissel Granados, MSW*
Joseph Cadden, MD*
Angelica Palmeros, MSW*
Thomas Puckett, Jr.*
Terry Smith, MPA*
Octavio Vallejo, MD, MPH*
Wendy Garland, MPH*
Susan Forrest
Martha Tadesse, MSN MPH MPA CCHP-RN
Natalie Valdez, MSSW
Martin Sattah, MD
John Thompson, MSW
Terina Keresoma

**SBP Committee Members*

2017

Los Angeles County
Commission on HIV

FOR COMMISSION ON HIV APPROVAL

FINAL DRAFT (4/10/17)

[PROPOSED STANDARDS OF CARE FOR INCARCERATED/POST-RELEASE TRANSITIONAL CASE MANAGEMENT SERVICES]

The development of service standards is one of the core functions of the Commission on HIV. The public is invited to review the proposed Incarcerated and Post-Release Transitional Case Management Standards of Care in Los Angeles County.

Transitional Case Management (TCM) Definition
HIV transitional case management is a client-centered activity that coordinates care for special transitional populations and those living with HIV. TCM includes:

- Intake and assessment of available resources and needs
- Development and implementation of individual release plans or transitional independent living plans
- Coordination of services
- Interventions on behalf of the client or family
- Linked referral
- Active, ongoing monitoring and follow-up
- Periodic reassessment of status and needs
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Access to HIV and STI information, education, partner services, and behavioral and biomedical interventions (such as pre-exposure prophylaxis (PrEP)) to prevent acquisition and transmission of HIV/STIs

Incarcerated and Post-Release Transitional Case Management (IPRTCM) provides services to incarcerated individuals who are living with HIV and are transitioning back to the community. These services include: complete psychosocial assessment; individual care plan development; appropriate referrals to housing, community case management, medical, mental health and drug treatment.

Unique Needs of the Incarcerated/Post-Release Individuals

Assuring and maintaining access to medical care and social support services for incarcerated/post-release individuals facilitate retention in care, viral suppression and overall health. However, the needs of the incarcerated and post-incarcerated individuals are unique and complex.

The following are resources to assist agencies the health and social needs of this community:
https://careacttarget.org/sites/default/files/JailsLinkageIHIPPocketCard.pdf
https://www.cdc.gov/correctionalhealth/rec-guide.html
http://www.enhancelink.org/

IPRTCM service providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

A. OUTREACH

Programs providing Incarcerated and Post-Release Transitional Case Management services will conduct outreach to educate potential clients, HIV and STI services providers and other supportive service organizations about the availability and benefits of transitional management services for incarcerated and post-released persons with HIV within the Los Angeles County Jail system. Promotion and outreach will include the provision of information sessions to HIV-positive inmates that facilitate enrollment into incarcerated TCM programs. Programs will collaborate with HIV primary health care and support services providers, as well as HIV and STI testing sites.

A. Outreach	
Standard	**Measure**
Transitional case management programs will outreach to potential clients and providers.	Outreach plan on file at provider agency.
Transitional case management programs will provide information sessions to HIV-positive inmates.	Record of information sessions at the provider agency. Copies of flyers and materials used. Record of referrals provided to clients.
Transitional case management programs establish appointments (whenever possible) prior to release date.	Record of appointment made with the client prior to release date.

B. COMPREHENSIVE ASSESSMENT AND REASSESSMENT

Comprehensive assessment/reassessment is completed in a cooperative, interactive, face-to-face interview process. Assessment/reassessment identifies and evaluates a client's medical, physical, psychosocial, environmental and financial strengths, needs and resources. Comprehensive assessment is conducted to determine the:

- Client's needs for treatment and support services
- Client's current capacity to meet those needs
- Ability of the client's social support network to help meet client need
- Extent to which other agencies are involved in client's care
- Areas in which the client requires assistance in securing services
- Readiness for transition to adult/mainstream case management services (Youth will remain in transitional case management services at least until age 29. Appropriateness of continued transitional case management services will be assessed annually through age 29. Planning will be made for eventual transition to adult/mainstream case management at least by the client's 29th birthday.)

B. Comprehensive Assessment	
Standard	**Measure**
Complete and enter comprehensive assessments into DHSP's data management system within 30 days of the initiation of services. Perform reassessments at least once per year or when a client's needs change or he or she has re-entered a case management program.	Comprehensive assessment or reassessment on file in client chart to include: o Date o Signature and title of staff person o Client strengths, needs and available resources in: o Medical/health care o Medications o Adherence issues o Physical health o Mental health o Substance use, history and treatment o Nutrition/food o Housing and living situation o Family and dependent care issues o Access to hormone replacement therapy, gender reassignment procedures, name change/gender change clinics and other transition-related services. o Transportation o Language/literacy skills o Cultural factors o Religious/spiritual support o Social support system o Relationship history o Domestic violence/Intimate Partner Violence (IPV) o Financial resources o Employment o Education o Legal issues/incarceration history o Risk behaviors o HIV and STI prevention issues o Environmental factors o Resources and referrals

C. Individual Release Plan (IRP)

In conjunction with the client, an IRP is developed that determines the case management goals

to be reached. IRPs will be completed for each client within two weeks of the conclusion of the comprehensive assessment or reassessment. IRPs will be updated on an ongoing basis. At a minimum, IRPs should be updated when clients are re-assessed for their needs.

Programs will ensure that IRP goals include transportation, housing/shelter, food, primary health care, substance use treatment and community-based case management.

C. **Individual Release Plan (IRP)**	
Standard	**Measure**
IRPs will be developed in conjunction with the client within two weeks of completing the assessment or reassessment	IRP on file in client chart to includes: • Name of client and case manager • Date and signature of case manager and client • Date and description of client goals and desired outcomes • Action steps to be taken by client, case manager and others • Customized services offered to client to facilitate success in meeting goals, such as referrals to peer navigators and other social or health services. • Goal timeframes • Disposition of each goal as it is met, changed or determined to be unattainable

D. Implementation of IRP, Monitoring and Follow-up

Implementation, monitoring and follow-up involve ongoing contact and interventions with (or on behalf of) the client to ensure that IRP goals are addressed and that the client is linked to and appropriately accesses and maintains primary health care and community-based supportive services identified on the IRP. These activities ensure that referrals are completed and services are obtained in a timely, coordinated fashion.

D. Implementation of IRP, Monitoring and Follow-up	
Standard	**Measure**
Case managers will: • Provide referrals, advocacy and interventions based on the intake, assessment and IRP • Monitor changes in the client's condition • Update/revise the IRP	Signed, dated progress notes on file that detail (at minimum): • Description of client contacts and actions taken • Date and type of contact • Description of what occurred

• Provide interventions and linked referrals • Ensure coordination of care • Help clients obtain health benefits and care • Conduct monitoring and follow-up to confirm completion of referrals and service utilization • Advocate on behalf of clients with other service providers • Empower clients to use independent living strategies • Help clients resolve barriers • Follow up on IRP goals • Maintain/attempt contact at a minimum of once every two weeks and at least one face-to-face contact monthly • Follow up missed appointments by the end of the next business day • Collaborate with the client's community-based case manager for coordination and follow-up when appropriate • Transition clients out of incarcerated transitional case management at six month's post-release.	• Changes in the client's condition or circumstances • Progress made toward IRP goals • Barriers to IRPs and actions taken to resolve them • Linked referrals and interventions and current status/results of same • Barriers to referrals and interventions/actions taken • Time spent with, or on behalf of, client • Case manager's signature and title

E. Case Conferences

Programs will ensure that each case manager participates in group and/or multidisciplinary team case conferences. Case conferences can be conducted in accordance with client care-related supervision or independently from client care-related supervision. Those case conferences conducted independently from client care-related supervision will be discussions of selected clients to assist in problem-solving related to clients' IRP goal progress.

E. Case Conferences	
Standard	**Measure**
All case managers will participate in case conferences either in client care-related supervision or independently.	Documentation on file in client chart to include: • Date of case conference

Independent case conferences will be documented.	• Notation that conference is independent of supervision • Names and titles of participants • Issues and concerns identified • Guidance and/or follow-up plan • Results of implementing guidance/follow-up

F. Staffing Requirements and Qualifications

At minimum, all transitional case management staff will be able to provide linguistically and culturally appropriate care to people living with HIV and complete documentation as required by their positions. Case management staff will complete an agency-based orientation before providing services. Staff will also be trained and oriented regarding client confidentiality and HIPAA regulations. See Personnel and Cultural Linguistic Competence Universal Standards.

F. **Staffing Requirements and Qualifications**	
Standard	**Measure**
Case managers will have: • Knowledge of HIV/AIDS/STIs and related issues • Knowledge of and sensitivity to incarceration and correctional settings and populations • Knowledge of and sensitivity to lesbian, gay, bisexual and transgender persons • Effective motivational interviewing and assessment skills • Ability to appropriately interact and collaborate with others • Effective written/verbal communication skills • Ability to work independently • Effective problem-solving skills • Ability to respond appropriately in crisis situations • Effective organizational skills	Resume, training certificates, interview assessment notes, reference checks, and annual performance reviews on file.
Case managers will hold a Bachelor's degree in an area of human services; high school diploma (or GED equivalent) and at least one year's experience working as an HIV case manager or	Resumes on file at provider agency documenting experience.

at least two years' experience working within a related health services field. Prior experience providing services to incarcerated individuals is preferred. Personal life experience with relevant issues is highly valued and should be considered when making hiring decisions.	Copies of diplomas on file.
All staff will be given orientation prior to providing services.	Record of orientation in employee file at provider agency.
Case management staff will complete DHSP's required case management certifications/training within three months of being hired. Case management supervisors will complete DHSP's required supervisor's certification/training within six months of being hired.	Documentation of certification completion maintained in employee file.
Case managers will participate in recertification as required by DHSP and in at least 20 hours of continuing education annually. Management, clerical and support staff must attend a minimum of eight hours of HIV/ AIDS/STIs training each year.	Documentation of training maintained in employee files to include: • Date, time and location of function • Function type • Staff members attending • Sponsor or provider of function • Training outline, handouts or materials • Meeting agenda and/or minutes
Case management staff will receive a minimum of four hours of client care-related supervision per month from a Master's degree-level mental health professional.	All client care-related supervision will be documented as follows (at minimum): • Date of client care-related supervision • Supervision format • Name and title of participants • Issues and concerns identified • Guidance provided and follow-up plan • Verification that guidance and plan have been implemented • Client care supervisor's name, title and signature.
Client care-related supervision will provide general clinical guidance and follow-up plans for case management staff.	Documentation of client care-related supervision for individual clients will be maintained in the client's individual file.

Recommended training topics for IPRTCM staff:

- Integrated HIV/STI prevention and care services

- Substance use harm reduction models and strategies
- The role of substances in HIV and STI prevention and progression
- Sexual identification, gender issues, and provision of trans-friendly services
- Cultural competence
- Correctional issues
- Risk reduction and partner notification
- Current medical treatment and updates
- Mental health issues for people living with HIV
- Confidentiality and disclosure
- Behavior change strategies
- Stigma and discrimination
- Community resources including public/private benefits
- Grief and loss

ACKNOWLEDGEMENTS

This document was under the guidance of the Los Angeles County Commission on HIV, Standards and Best Practices (SBP) Committee and critique from subject matter experts. We thank them for their leadership and dedication to ensuring that high quality HIV services are accessible to PLWHA.

- Grissel Granados, MSW*
- Joseph Cadden, MD*
- Angelica Palmeros, MSW*
- Thomas Puckett, Jr.*
- Terry Smith, MPA*
- Octavio Vallejo, MD, MPH*
- Wendy Garland, MPH*
- Susan Forrest
- Martha Tadesse, MSN MPH MPA CCHP-RN
- Natalie Valdez, MSSW
  Martin Sattah, MD
- John Thompson, MSW
- Terina Keresoma

**SBP Committee Members*

2017

Los Angeles County
Commission on HIV

FOR COMMISSION ON HIV
APPROVAL
FINAL DRAFT (4/10/17)

[PROPOSED STANDARDS OF CARE FOR YOUTH TRANSITIONAL CASE MANAGEMENT SERVICES]

The development of service standards is one of the core functions of the Commission on HIV. The public is invited to review the proposed Youth Transitional Case Management Standards of Care in Los Angeles County.

Transitional Case Management (TCM) Definition

HIV transitional case management is a client-centered activity that coordinates care for special transitional populations living with HIV. TCM includes:

- Intake and assessment of available resources and needs
- Development and implementation of individual service plans
- Coordination of services
- Interventions on behalf of the client or family
  - Engagement in HIV Care
  - Risk Reduction
  - HIV Education
  - Disclosure and Partner Notification Activities
- Linked referrals
- Enhancing self-care practices and health promotion, including safer sex behaviors and harm reduction strategies through the provision of Brief Interventions.
- Active, ongoing monitoring and follow-up
- Periodic reassessment of status and needs
- Ongoing assessment of the client's and other key family members' needs and personal support systems

Youth Transitional Case Management (YTCM)

For the purposes of these standards, "youth" is defined as adolescents and young adults aged 13-29 years living with HIV, including homeless, runaways, and emancipating/emancipated youth at risk for HIV/STIs. HIV/AIDS case management - youth transitional case management services (YTCM) are client centered, comprehensive services designed to promote access to and utilization of HIV care by identifying and linking youth living with HIV/AIDS to HIV medical and supportive services. The goals of youth transitional case management include:

- Locating youth not engaged in HIV care;
- Identifying and addressing client barriers to care (e.g., homelessness, substance use, and emotional distress);
- Improving the health status of youth
- Easing a youth's transition from youth-focused supportive and health care services to adult-focused supportive and health care services
- Increasing access to education, job training, employment and other services that foster self-sufficiency
- Helping youth increase their self-efficacy and self-sufficiency
- Facilitating access and adherence to primary HIV health care
- Ensuring access to developmentally appropriate services and to the continuum of HIV

prevention and care services
- Increasing access to HIV and STI information, education, and behavioral and biomedical interventions to keep their partners HIV-negative
- Reducing homelessness
- Reducing substance use
- Developing resources and increasing coordination between providers, regardless of funding source

Youth-Friendly Services

Many of the barriers that adolescents and young adults face in accessing health and social services are unique to young people due to their developmental stage in life and associated special needs, perceptions, and abilities. Youth-friendly services are services that all youth are able to obtain, and these services should meet developmental needs and improve their health well-being. Youth-friendly services are able to effectively attract young people, meet their needs comfortably and responsively, and succeed in retaining young clients for continuing preventive care and treatment.

Advocates for Youth, a national organization that advocate for policies and champion programs that recognize young people's rights to honest sexual health information, has developed a publication titled, *"Best Practices for Youth-Friendly Clinical Services".* YTCM service providers are expected to use these guidelines as a tool for creating and creating safe, youth-friendly organizational culture. The key attributes to youth-friendly services are:

Confidentiality – Confidentiality means that the provider keeps an adolescent's sensitive health care issues in strict confidence between the adolescent and the provider. The imperative need to guard the adolescent's confidentiality extends, as well, to every member of the agency's staff, including receptionists and technicians.

Respectful Treatment - Adolescents are particularly sensitive to rude, judgmental, or overbearing attitudes and behaviors on the part of adults. In fact, such attitudes and behaviors can cause adolescents to:
- Leave the clinic before they get the care or service they need;
- Fail to comply with treatment requirements (such as taking medicine on time, getting physical therapy, etc.); and/or
- Refuse or forget follow-up care.

Integrated Services - Integrated care allows youth to obtain different services in a single location. Often known as 'one-stop shopping', integrated care is important to young men and women. Integrated care operates from a comprehensive health lens which includes addressing HIV, STIs, and overall health and well-being of adolescents and young adults. Agencies must strive to have strong referral networks to ensure integrated services for youth.

Cultural Competence (Diverse, Well Trained Staff) - Cultural competence in health care acknowledges and incorporates the importance of culture(s); assesses cross-cultural relations; is vigilant regarding dynamics that result from cross-cultural differences; expands cultural knowledge; and adapts services to meet the culturally unique needs of clients. For youth services, cultural competency extends to developmentally-appropriate services. Programs should consider adolescent development stages and models when creating services and delivering services.

Easy Access to Care - Easy access to health services is important to youth. Access issues may include lack of transportation; difficulties making appointments; not knowing where to go; hours and days when services are available; and requirements to return for follow-up.

Free or Low Cost Services - Fear about costs is a major barrier to healthcare for youth. Whether youth have insurance or not, cost can be a major factor in whether they even attempt to get medical care. Clinics should offer free services and/or use sliding fee scales to ensure that young people get the services they need.

Reproductive & Sexual Health Services - Reproductive and sexual health services can include education and counseling, contraceptive services, STI/HIV testing and treatment, in addition to prenatal and obstetrical care, and fertility counseling and treatment. Most of these services are important to adolescents and young adults.

Services for Youth Communities Most impacted by HIV – providers must recognize the unique needs of young gay and bisexual men, and transgender youth to facilitate a safe and welcoming environment for young men.

Promoting Parent/Caregiver/Guardian-Child Communication - Today, many clinicians work to promote parent/caregiver/guardian-child communication about sexuality, drug use, and other critical health issues. Studies have shown that parents' improved communication skills resulted in better communication with their teens and improved behavioral health outcomes for youth.

Youth-Adult Partnerships – Services should be developed in collaboration with youth or with input from youth through the use of Youth Community Advisory Boards. Young people are the experts on their own lives and have valuable insight on how to develop and maintain effective, relevant, and culturally responsive services.

Trauma-Informed Services – Adolescent behaviors should be understood through the lens of trauma-informed care. Providers should have a basic of understanding of trauma triggers and trauma responses in adolescents and young adults.

Additional resources to assist agencies develop a youth-friendly culture and atmosphere:

- http://www.advocatesforyouth.org/publications/publications-a-z/1347--best-practices-for-youth-friendly-clinical-services
- http://www.healthyteennetwork.org/blog/characteristics-youth-friendly-health-care-services/
- https://www.engenderhealth.org/pubs/gender/youth-friendly-services.php
- https://www.iywg.org/topics/youth-friendly-services
- http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/training/Assests/2014%20Conference/youthfriendlyclinic.pdf
- http://www.umhs-adolescenthealth.org/

YTCM service providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

A. OUTREACH

Outreach activities are defined as targeted activities designed to bring youth who are HIV-positive into HIV medical treatment services. This includes effective and culturally relevant methods to locate, engage, and motivate HIV+ youth to engage in HIV medical services.

A. Outreach	
Standard	**Measure**
Transitional case management programs will outreach to potential clients and providers.	Outreach plan on file at provider agency.

B. COMPREHENSIVE ASSESSMENT AND REASSESSMENT

Comprehensive assessment/reassessment is completed in a cooperative, interactive, face-to-face interview process. Youth friendly assessment should consider the length of the questionnaire. Providers are highly encouraged to use or adapt youth-friendly assessment tools such as the HEADSS assessment for adolescents (Home and Environment; Education and Employment; Activities; Drugs; Sexuality; Suicide/Depression).

Assessment/reassessment identifies and evaluates a client's medical, physical, psychosocial, environmental and financial strengths, needs and resources.

Comprehensive assessment is conducted to determine the:

- Client's needs for engaging in HIV medical care and treatment, and supportive services
- Client's current capacity to meet those needs
- Ability of the client's social support network to help client gain access to, engage in, and maintain adherence to HIV care and treatment.

- Extent to which other agencies are involved in client's care
- Areas in which the client requires assistance in securing services
- Readiness for transition to adult/mainstream case management services (Youth may remain in youth transitional case management services until age 29. Appropriateness of continued transitional case management services will be assessed annually and clients shall be transitioned into non-youth specific HIV care as appropriate but not later than aged 30. Planning will be made for eventual transition to adult/non-youth specific case management at least by the client's 30th birthday.)
- Eligibility for the Los Angeles County Department of Mental Health (DMH) Transition Age Youth Services, Adult Services Full Service Partnership Program, and other DMH and Los Angeles County-funded programs to ensure continuing support while the client is in the YTCM program or once the client has completed or aged out of the HIV/STI YTCM services.

B. Comprehensive Assessment	
Standard	**Measure**
Complete and enter comprehensive assessments into DHSP's data management system within 30 days of the initiation of services. Perform reassessments at least once per year or when a client's needs change or he or she has re-entered a case management program.	Comprehensive assessment or reassessment on file in client chart to include: • Date • Signature and title of staff person • Client strengths, needs and available resources in: • Medical/health care • Medications • Adherence issues • Nutrition/food • Housing and living situation • Family and dependent care issues • DCFS and other agency involvement • Transportation • Language/literacy skills • Cultural factors • Religious/spiritual support • Social support system • Relationship history • Domestic violence/Intimate Partner Violence (IPV) • Gang impact • Violence and/or trauma • Financial resources

	• Public benefits • Employment • Education • Legal issues/incarceration history • Risk behaviors • HIV and STI prevention issues • Harm reduction services and support • Environmental factors • Resources and referrals • Assessment of readiness for transition to adult services. Readiness for adult services should link clients to programs that foster self-sufficiency, such as job training and employment programs, permanent supportive housing, and facilitate access to full range of services under the Department of Mental Health, Substance Abuse Prevention Control, and other health, medical, and social services provided in Los Angeles County.

C. Service Plan (SP)

In conjunction with the client, a SP is developed to determine the case management goals to be reached. A service plan is a tool that enables the youth transitional case manager to assist the client in systematically addressing barriers to HIV medical care by developing a concrete strategy to improve access and engagement to needed medical and other support services. A SP shall be developed within two (2) weeks of the Comprehensive Assessment/Reassessment's completion. All goals shall be determined by utilizing information gathered during assessment and subsequent reassessments.

C. **Transitional Independent Living Plan (TILP)**	
Standard	**Measure**
SPs will be developed in conjunction with the client within two weeks of completing the assessment or reassessment.	SP on file in client chart to include: • Name of client and case manager • Date and signature of case manager and client • Date and description of client goals and desired outcomes • Action steps to be taken by client, case

	manager and others • Goal timeframes • Disposition of each goal as it is met, changed or determined to be unattainable

D. Brief Interventions

Brief intervention sessions actively facilitate a client's entry into HIV medical care through the resolution of barriers to primary HIV-specific health care. The interventions focus on specific barriers identified through a client assessment, and assists the client in successfully addressing those barriers to HIV care. Youth transitional case managers must prepare clients for the transition into non-youth specific HIV medical services and a lifetime of managing HIV disease. This means empowering youth with information and skills necessary to increase youths' readiness to engage in non-youth specific HIV medical care.

D. Brief Interventions	
Standard	**Measure**
Case managers will: • Provide brief interventions and linked referrals • Risk Reduction Counseling: Provide risk reduction/harm reduction sessions for clients that are actively engaging in behaviors that put them at risk for transmitting HIV and acquiring other sexually transmitted infections (STIs). • Linkage to HIV Medical Care: to assist the client with access to and engagement in primary HIV-specific health care by linking them to an HIV medical clinic. • Disclosure and Partner Notification: Addressing disclosure and partner notification for clients who have not disclosed their HIV status to partner(s) or family member(s). • Help clients resolve barriers	Signed, dated progress notes on file that detail (at minimum): • Description of client contacts and actions taken • Date and type of contact • Description of what occurred • Changes in the client's condition or circumstances • Progress made toward goals • Barriers to SPs and actions taken to resolve them • Linked referrals and interventions and current status/results of same • Barriers to referrals and interventions/actions taken • Time spent with, or on behalf of, client • Case manager's signature and title • Detailed transition plan to adult services with specific linkage to health, medical, and social services.

E. Implementation of SP, Monitoring and Follow-up

Implementation, monitoring and follow-up involve ongoing contact and interventions with (or on behalf of) the client to ensure that SP goals are addressed and that the client is linked to and appropriately accesses and maintains primary health care and community- based supportive services identified on the SP. These activities ensure that referrals are completed and services are obtained in a timely, coordinated fashion.

E. Implementation of SP, Monitoring and Follow-up	
Standard	**Measure**
Case managers will: • Provide referrals, advocacy and interventions based on the intake, assessment and SP • Monitor changes in the client's condition • Update/revise the SP • Provide brief interventions and linked referrals • Ensure coordination of care • Help clients obtain health benefits and care • Conduct monitoring and follow-up to confirm completion of referrals and service utilization • Advocate on behalf of clients with other service providers • Help clients resolve barriers • Follow up on SP goals • Maintain/attempt contact at a minimum of once every two weeks and at least one face-to-face contact monthly • Follow up missed appointments by the end of the next business day • Collaborate with the client's adult case manager when appropriate • Transition clients out of transitional case management when appropriate • Develop a transition plan to adult services such as Medical Care Coordination (MCC), job placement, permanent supportive housing, or other	Signed, dated progress notes on file that detail (at minimum): • Description of client contacts and actions taken • Date and type of contact • Description of what occurred • Changes in the client's condition or circumstances • Progress made toward goals • Barriers to SPs and actions taken to resolve them • Linked referrals and interventions and current status/results of same • Barriers to referrals and interventions/actions taken • Time spent with, or on behalf of, client • Case manager's signature and title • Detailed transition plan to adult services with specific linkage to health, medical, and social services. • Documentation of expedited linkage to MCC for eligible clients.

appropriate services at least 6 months prior to the formal date of release from the YTCM program. • Upon transition case, communicate to client the availability of case manager for occasional support and role as a resource to maintain stability for client.	

F. Case Conferences

Programs will ensure that each case manager participates in group and/or multi-disciplinary team case conferences. Case conferences can be conducted in accordance with client care-related supervision or independently from client care-related supervision. Those case conferences conducted independently from client care-related supervision will be discussions of selected clients to assist in problem-solving related to clients' SP goal progress.

F. Case Conferences	
Standard	**Measure**
All case managers will participate in case conferences either in client care-related supervision or independently. Independent case conferences will be documented.	Documentation on file in client chart to include: • Date of case conference • Notation that conference is independent of supervision • Names and titles of participants • Issues and concerns identified • Guidance and/or follow-up plan • Results of implementing guidance/follow-up

G. Staffing Requirements and Qualifications

At minimum, all transitional case management staff will be able to provide linguistically and culturally appropriate care to clients and complete documentation as required by their positions. Case management staff will complete an agency-based orientation before providing services. Staff will also be trained and oriented regarding client confidentiality and HIPAA regulations. See Personnel and Cultural Linguistic Competence Universal Standards.

G. Staffing Requirements and Qualifications	
Standard	**Measure**
Case managers will have: • Knowledge of HIV/AIDS/STIs and related issues • Knowledge of and sensitivity to runaway, homeless or emancipated/emancipating youth • Effective interviewing and assessment skills • Knowledge of adolescent development • Knowledge of, and sensitivity to, lesbian, gay, bisexual and transgender persons • Ability to appropriately interact and collaborate with others • Effective written/verbal communication skills • Ability to work independently • Effective problem-solving skills • Ability to respond appropriately in crisis situations • Effective organizational skills	Resume, training certificates, interview assessment notes, reference checks, and annual performance reviews on file.
Case managers will hold a Bachelor's degree in an area of human services, social services, sociology, and other related humanities field; high school diploma (or GED equivalent) and at least one year's experience working as an HIV case manager or at least two years' experience working within a related health services field. Prior experience providing services to runaway, homeless or emancipated/emancipating youth is preferred. Personal life experience with relevant issues is highly valued and should be considered when making hiring decisions.	Resumes on file at provider agency documenting experience. Copies of diplomas on file.
All staff will be given orientation prior to providing services.	Record of orientation in employee file at provider agency.
Case management staff will complete DHSP's required case management certifications/training within three months of being hired. Case management supervisors will complete DHSP's required supervisor's certification/training within six months	Documentation of certification completion maintained in employee file.

of being hired.	
Case managers will participate in in at least 20 hours of continuing education annually. Management, clerical and support staff must attend a minimum of eight hours of HIV/AIDS/STI training each year.	Documentation of training maintained in employee files to include: • Date, time and location of function • Function type • Staff members attending • Sponsor or provider of function • Training outline, handouts or materials • Meeting agenda and/or minutes
Case management staff will receive a minimum of four hours of client care-related supervision per month from a Master's degree-level mental health professional.	All client care-related supervision will be documented as follows (at minimum): • Date of client care-related supervision • Supervision format • Name and title of participants • Issues and concerns identified • Guidance provided and follow-up plan • Verification that guidance and plan have been implemented • Client care supervisor's name, title and signature.
Client care-related supervision will provide general clinical guidance and follow-up plans for case management staff.	Documentation of client care-related supervision for individual clients will be maintained in the client's individual file.

Recommended training topics for YTCM staff:

- Integrated HIV/STI prevention and care services
- The role of substances in HIV and STI prevention and progression
- Substance use harm reduction models and strategies
- Sexual identification, gender issues, and provision of trans-friendly services
- Cultural competence
- Correctional issues
- Youth development issues
- Risk reduction and partner notification
- Current medical treatment and updates
- Mental health issues for people living with HIV
- Confidentiality and disclosure
- Behavior change strategies
- Stigma and discrimination
- Community resources including public/private benefits
- Grief and loss

Resources for Providers: Providers must use existing services in Los Angeles County to ensure the delivery of a comprehensive, client-centered YTCM program.

Department of Mental Health (DMH)
http://dmh.lacounty.gov/wps/portal/dmh/aboutdmh
Access Hotline 1-800-854-7771 (for screening, assessment, referral, and crisis counseling)

Department of Health Services (DHS)
http://dhs.lacounty.gov/wps/portal/dhs

Department of Public Social Services (DPSS)
http://dpss.lacounty.gov/wps/portal/dpss
Customer Service Center (866) 613-3777 (single point of contact for Cal-WORKS, CalFresh, Medi-Cal, and General Relief.

ACKNOWLEDGEMENTS

This document was under the guidance of the Los Angeles County Commission on HIV, Standards and Best Practices (SBP) Committee and critique from subject matter experts. We thank them for their leadership and dedication to ensuring that high quality HIV services are accessible to PLWHA.

Grissel Granados, MSW*
Joseph Cadden, MD*
Angelica Palmeros, MSW*
Thomas Puckett, Jr.*
Terry Smith, MPA*
Octavio Vallejo, MD, MPH*
Wendy Garland, MPH*
Susan Forrest
Martha Tadesse, MSN MPH MPA CCHP-RN
Natalie Valdez, MSSW
Martin Sattah, MD
John Thompson, MSW
Terina Keresoma
**SBP Committee Members*

LOS ANGELES COUNTY COMMISSION ON HIV
3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
www.hivcommission-la.info

Section 2: Participation Information

1. **Can you commit to the Commission's minimum expectations of active participation, regular attendance and sustained involvement?** YES ☒ NO ☐

If you are unsure of the Supervisorial District in which your home or office is located, go to the LA County Registrar's website at http://rrcc.lacounty.gov/VOTER_ELECTIONS and click on "Locate District by Name or Address." For more information about the Service Planning Areas (SPAs), visit the DPH web page at http://publichealth.lacounty.gov/chs/SPAMain/ServicePlanningAreas.htm. You can also contact staff at the Commission office for further assistance.

2. In which Supervisorial District and SPA do you work? Check all that apply.					
District 1	☐		SPA 1	☐	SPA 5 ☐
District 2	☐		SPA 2	☒	SPA 6 ☐
District 3	☒		SPA 3	☐	SPA 7 ☐
District 4	☐		SPA 4	☐	SPA 8 ☐
District 5	☐				
3. In which Supervisorial District and SPA do you live?					
District 1	☐		SPA 1	☐	SPA 5 ☐
District 2	☒		SPA 2	☐	SPA 6 ☐
District 3	☐		SPA 3	☐	SPA 7 ☐
District 4	☐		SPA 4	☒	SPA 8 ☐
District 5	☐				
4. In which Supervisorial District and SPA do you receive HIV (care or prevention) services? Check all that apply.					
District 1	☐		SPA 1	☐	SPA 5 ☒
District 2	☒		SPA 2	☐	SPA 6 ☒
District 3	☒		SPA 3	☐	SPA 7 ☐
District 4	☐		SPA 4	☐	SPA 8 ☐
District 5	☐				

5. Demographic Reflectiveness and Representation:
Federal funders require that the Commission report the following demographic information annually to ensure its conformity with reflection/representation rules.

5a. Gender:	☒ Male	☐ Female	☐ Trans (Male to Female)	☐ Trans (Female to Male)
5b. Race/Ethnicity: Check all that apply.	☐ African-American	☐American Indian/Alaskan Native	☐ Asian	☐ Pacific Islander/Native Hawaiian
	☒Latino/Hispanic	☐ White/Not Hispanic	☐ Other: _____	☐ Decline to State/Not Specified

5c. Are you a parent/guardian/direct caregiver to a child with HIV under 19? ☐ Yes ☒ No

6. FOR APPLICANTS LIVING WITH HIV: N/A

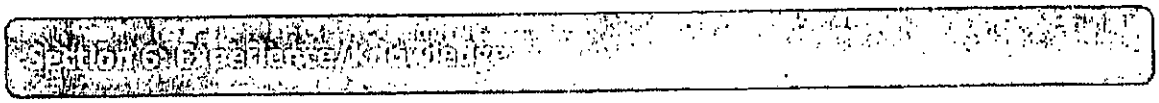
6a. Are you willing to publicly disclose your HIV status? ☐ Yes* ☐ No

*DO NOT CHECK YES HERE if you do not want your HIV status known publicly. There is NO requirement that someone with HIV must disclose his/her status to the Commission or publicly.

6b. Age at diagnosis: ☐ < 13 years old ☐ 13 – 19 years old ☐ 20 – 44 years old ☐ > 45 years old

6c. Are you a "consumer" (patient/client) of Ryan White Part A services? ☐ Yes ☐ No

6d. Are you "affiliated" with a Ryan White Part A-funded agency? ☐ Yes ☐ No
By indicating "affiliated," you are a: ☐ board member, ☐ employee, or ☐ consultant at the agency. A volunteer at an agency is considered an unaffiliated consumer.



7. Recommending Entities/Constituency(ies): "Recommending Entities" are the Individuals/ organizations who may have suggested or asked you to represent them on the Commission.

7a. What organization/Who, if any/anyone, recommended you to the Commission?
NORTHEAST VALLEY HEALTH CORP., VAN NUYS ADULT CONSUMER ADVISORY BOARD

7b. If recommended, what seat, if any, did he/she/they recommend you fill?
COMMISSIONER

8. Please check all of the boxes that apply to you:

1 ☑ I am willing to publicly disclose that I have Hepatitis B or C.

2 ☑ I am an HIV-negative user of HIV prevention services and who is a member of an identified high-risk, special or highly impacted population.

3 ☐ I am a member of a federally-recognized American Indian tribe or Native Alaskan village.

4 ☐ I am a behavioral or social scientist who is active in research from my respective field.

5 ☐ I am involved in HIV-related research in the following capacity(ies) (Check all that apply):
☐ scientist, lead researcher or PI, ☐ staff member, ☐ study participant, or ☐ IRB member.

6 ☑ A health or hospital planning agency has recommended that I fill that seat on the Commission.

7 ☐ I am an HIV specialty physician or an Infectious Disease (ID) doctor with HIV-positive patients.

8 ☑ The agency where I am employed provides mental health services.

9 ☐ The agency where I am employed provides substance abuse services.

10 ☑ The agency where I am employed is a provider of HIV care/treatment services.

11 ☑ The agency where I am employed is a provider of HIV prevention services.

12 ☐ The agency where I am employed is provider of ☐ housing and/or ☐ homeless services.

13 ☑ The agency where I am employed has HIV programs funded by Federal sources (other than Ryan White).

14 ☑ I work for or am otherwise affiliated with a health care provider that is a Federally Qualified Health Center (FQHC) or a Community Health Clinic (CHC).

15 ☑ As someone who is employed as an advocate for incarcerated PWLH and/or as a PWLH who has been incarcerated in the past three years, I can represent the interests of incarcerated PWLH.

16 ☑ I am able to represent the interests of Ryan White Part C grantees.

17 ☑ I am able to represent the interests of Ryan White Part D grantees.

18 ☑ I am able to represent the interests of Ryan White Part F grantees given my affiliation with:
☐ one of LA County's AETC grantees/sub-grantees ☑ a HRSA SPNS grantee
☐ Part F dental reimbursement provider ☐ HRSA-contracted TA vendor

19 ☑ As an HIV community stakeholder, I have experience and knowledge given my affiliation with: (Check all that apply)
- ☑ union or labor interests
- ☑ provider of employment or training services
- ☑ faith-based entity providing HIV services
- ☑ organization providing harm reduction services
- ☑ an organization engaged in HIV-related research
- ☑ the business community
- ☑ local elementary-/secondary-level education agency
- ☑ youth-serving agency, or as a youth.

LOS ANGELES COUNTY COMMISSION ON HIV
3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
www.hivcommission-la.info

9. Training Requirements: The Commission requires all members to complete the following trainings, which can be fulfilled if the trainings were provided by other institutions. Applicants will not be penalized for no prior training, but must take it once appointed.

9a. Have you completed an "Introduction to HIV/STI,""HIV/STI 101," or a related basic informational HIV/STI training before? (If so, include Certificate of Completion; if not, the Commission provides the training) ☑ Yes ☐ No

9b. Have you completed a Health Insurance Portability and Accountability Act (HIPAA) training before? (If so, please include Certificate of Completion; if not, the Commission will provide the training) ☑ Yes ☐ No

9c. Have you completed a "Protection of Human Research Subjects" training before? (If so, please include Certificate of Completion; if not, the Commission will provide the training) ☑ Yes ☐ No

10. Personal Statement: The "personal statement" is a snapshot of your goals of your Commission participation, against which you can measure your effectiveness as a Commission member. This statement may be included on the Commission's website in the member section. Provide a short (50-word maximum) statement expressing why you want to be a Commission member:

Voice underrepresented visions/concepts re HIV care specific to elderly Spanish speaking women, the undocumented from Uganda, Nigeria, Mexico, Central & South American including refugees alive to HIV status. In addition to age growing

11. Biography/Resume: If you would like, you can indicate below that you are updating this section from your original or renewal application, or simply write a new paragraph. You may—but it is not required —attach a new/updated resume. You may continue on an additional page, if necessary. As you feel appropriate, please provide a short biography detailing your background, and how it has prepared you for service on the Commission:

undocumented, homeless (M→F) trans* population. Provide first hand realities obtained through direct services and North East Valley Health corp's, Consumer Advisory Board.

Continue building on NEVHC & VNA's 91% suppression rate - disseminating successes on a micro and mid scale ultimately ACHIEVING AN AIDS FREE GENERATION.

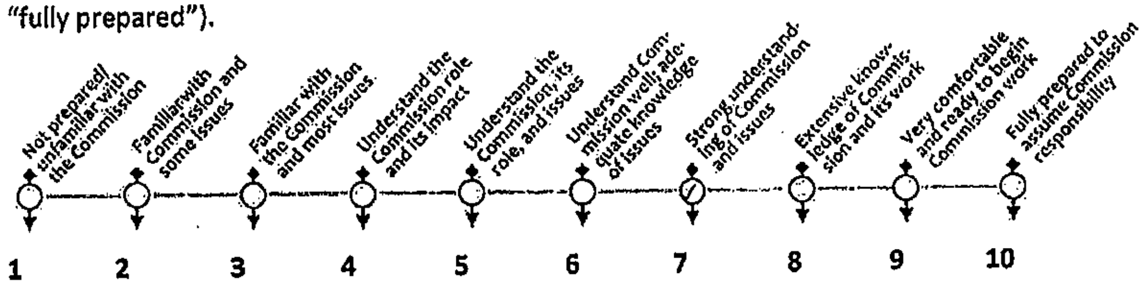
3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
www.hivcommission-la.info

12. Additional Information: In this section, please provide any additional information about yourself—or update information from your original or renewal application—that you feel will enhance the application review. If you choose not to include any additional information, indicate it here with "N/A". Your additional information may continue on an additional page, if necessary:

SERVED AS ALT. FOR MARIA ROMAN FOR 1 YEAR.

Section 4: New Member Applicant (only to be completed by new member applicants)

13. How prepared do you feel you are to serve as a member of the Commission, if appointed? A candidate's "preparedness" for Commission service is assessed—for this response—according to the 10-point scale located on the next page, which indicates that those who are the "least" prepared ("1" on the scale) are "not familiar" with the Commission and the issues that it reviews. The more prepared a candidate is—as indicated on the scale (moving towards "10" from "1")—s/he should demonstrate increased familiarity with the Commission and its content, evolving into "understanding" and "comfort" with the role of the Commission and its practices, and "limited" to "extensive" knowledge about the topics it addresses. Mark the circle that represents where you feel you fall on this scale of "preparedness" ("1" is "not prepared"→"10," "fully prepared").



14. Describe any personal/professional experience that you believe has prepared you to perform effectively as a member of the Commission. Continue on an additional page if necessary.

15. What do you anticipate your greatest hurdles will be acclimating to your new role on the Commission? How do you think you will overcome them? Continue on an additional page if necessary.

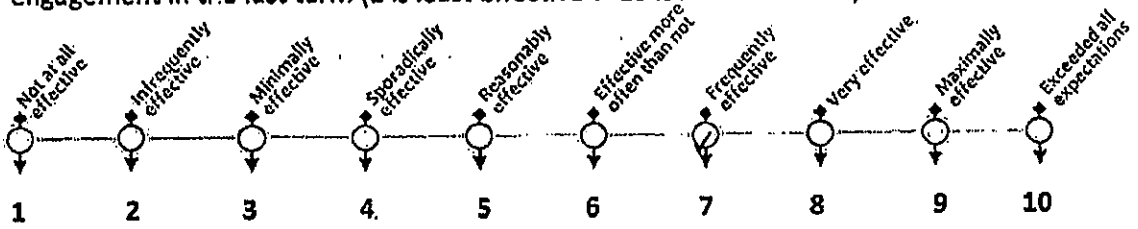
16. How will your Commission membership benefit the lives of LA County residents with HIV/STDs and/or who are at high-risk of HIV-/STD-infection? Continue on an additional page if necessary.

17. Which of your strengths do you feel will enhance your Commission performance? What skills will you need to develop further for optimal Commission performance? Continue on an additional page if necessary.

18. Candidates are also nominated to fill Alternate seats as well: if you were nominated for an Alternate seat, would you be willing to serve in that capacity? ☑ Yes ☐ No

Section 2: Renewal Applicants Only (Skip if you are a new applicant)

19. How effective do you feel you were during your most recent term on the Commission? Mark the circle that you feel is the best assessment of your Commission participation and engagement in the last term (1 is least effective→ 10 is most effective).



20. **Explain why you rated yourself the way you did in Question #16. Continue on an additional page, if necessary.**

21. **In your last term, what would you have done differently and what would you have improved, if anything (e.g., quality, communication skills, participation)?** Continue on an additional page, if necessary.

22. **In your last term, what, if any, barriers and/or obstacles prevented you from fully carrying out your Commission responsibilities as you would have liked?** Continue on an additional page, if necessary.

23. **What can the Commission do to help improve your effectiveness and/or level of contribution/accomplishment in your next term?** Continue on an additional page, if necessary.

24. **Candidates are also nominated to fill Alternate seats as well: If you were nominated for an Alternate seat, would you be willing to serve in that capacity?** ☐ Yes ☐ No

LOS ANGELES COUNTY COMMISSION ON HIV
3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
http://hiv.lacounty.gov

18. AIDS Education/Training Centers (AETCs):

A. Cocaine, Methamphetamine, and HIV & Heroin, Prescription Opioids and HIV: What Clinicians Need to Know – April 24, 2017 @ 9am-4:30pm

Los Angeles
Pacific AIDS Education and Training Center

AETC AIDS Education & Training Center Program

A Two for One Special Last Tuesday Training On A Monday

April 24, 2017
9:00am-4:30pm

9:00am - 9:30am Registration
9:30am - 12:00pm C.M.H.
12:00pm - 1:00pm Lunch Provided
1:00pm - 4:00pm H.P.O.
4:00pm - 4:30pm Closing

Please arrive 10-15 minutes early

LOCATION

Cocaine, Methamphetamine, and HIV:
&
Heroin, Prescription Opioids, and HIV:

What Clinicians Need to Know

Facilitated by:

Beth A. Rutkowski, MPH
UCLA Integrated Substance Abuse Programs
Pacific Southwest Addiction Technology

Albert Hasson, MSW
UCLA Integrated Substance Abuse Programs
Pacific Southwest Addiction Technology

Pacific Southwest ATTC

REGISTER ONLINE:

https://tinyurl.com/cmhpo2017

By the end of this training participants will be able to:

1) Review the neurobiology, medical consequences, and epidemiology of cocaine and methamphetamine use and discuss at least two (2) ways that cocaine or methamphetamine use can lead to increased HIV risk.

2) Explain the key concepts of at least three (3) effective behavioral interventions and risk reduction strategies for cocaine and methamphetamine use disorders.

3) Discuss the nature of the opioid epidemic, specifically where the drugs are coming from, who is using them, and the impact on the healthcare system.

4) Describe the history of opioid treatment and the FDA-approved medications for the treatment of opioid use disorder, including naltrexone, buprenorphine and methadone.

The LA PAETC Last Tuesday HIV Training Series is a free event for providers who serve patients living with HIV.

LOS ANGELES COUNTY COMMISSION ON HIV
3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
http://hiv.lacounty.gov

21. ANNOUNCEMENTS

Do You Identify as Native American?

Are You a Transgender Woman, Gay Male, Bisexual Male, or Two Spirit?

We are enrolling HIV+ and HIV- individuals to share their opinions and experiences about health care

Check your eligibility here:

https://www.surveymonkey.com/r/MaroonHealth

For more information email:
health@maroonsociety.com
Call:
213-222-8504

MAROON SOCIETY

PARTICIANTS WILL RECEIVE $150 CASH!