LOS ANGELES COUNTY
COMMISSION ON HIV

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WOMEN'S CAUCUS

Virtual Meeting

Monday, November 21, 2022
2:00pm-4:00pm (PST)

Agenda and meeting materials will be posted on https://hiv.lacounty.gov/meetings *Other Meetings

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TO JOIN BY PHONE:

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COMMISSION ON HIV

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WOMEN'S CAUCUS

(Revised) Virtual Meeting Agenda

Monday, November 21, 2022 @ 2:00-4:00PM

To Join by Computer:
https://lacountyboardofsupervisors.webex.com/lacountyboardofsupervisors/j.php?MTID=mf59e5b829ccd1b15d7746a833a43a181
Password: WOMEN
To Join by Phone
Dial +1-213-306-3065 Access Code: 2590 088 0407

1. Welcome + Introductions + Check-In — 2:00 PM – 2:10 PM
2. Executive Director/Staff Report — 2:10 PM – 2:15 PM
   - Operational and Programmatic Updates
3. Co-Chair's Report — 2:15 PM – 2:20 PM
   - 2023 Co-Chair Nominations
   - 2022 Holiday Meeting Schedule
4. DISCUSSION: — 2:20 PM – 3:30 PM
   - Virtual Lunch & Learn: Women Living with HIV & Sexuality | FEEDBACK
   - 2023 Workplan Brainstorming
5. Meeting Recap + Next Meeting Agenda — 3:30 PM – 3:45 PM
   - Psychosocial Support Services Programmatic Development
6. Public Comment + Announcements — 3:45 PM – 4:00 PM
7. Adjournment — 4:00 PM

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COMMISSION ON HIV

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CODE OF CONDUCT

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

All participants and stakeholders should adhere to the following:

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

Approved (11/12/1998); Revised (2/10/2005; 9/6/2005); **Revised (4/11/19; 3/3/22)**

LOS ANGELES COUNTY
COMMISSION ON HIV

Women's Caucus Workplan 2022

Updated for 11/21/22 Meeting

PURPOSE OF THIS DOCUMENT: To identify activities and priorities the Women's Caucus will lead and advance throughout 2022.
CRITERIA: Select activities that 1) represent the core functions of the COH and Caucus, 2) advance the goals of the 2022 Comprehensive HIV Plan (CHP), and 3) align with COH staff and member capacities and time commitment.
CAUCUS RESPONSIBILITIES: 1) Facilitate dialogue among caucus members, 2) develop caucus voice at the Commission and in the community, 3) provide the caucus perspective on various Commission issues, and 4) cultivate leadership within the caucus membership and consumer community.

#	GOAL/ACTIVITY	ACTION STEPS/TASKS	TIMELINE/ DUE DATE	STATUS/COMMENTS
1	**Comprehensive HIV Plan (CHP):** *Participate in the development of the CHP to ensure women are represented in all aspects of the CHP.*	Provide input to consultant, AJ King to ensure women living with HIV are prioritized in the CHP.	Ongoing/CHP Deadline: Dec 5	Consultant, AJ King, presented to the Caucus to secure feedback for inclusion in the CHP. CHP will open for Public Comment Nov 1-17, final will be submitted by December 5.
2	**Women-Centered HIV-Related Programming:** *Identify programs and services centered around women, assess their effectiveness in meeting the needs of women, provide specific strategies to address gaps.*	1. Plan 2022 Lunch & Learn Series: • Perinatal Syphilis & HIV Prevention* • Biomedical Prevention Awareness for Women, i.e. injectables • Sexual Health for Aging Women	Ongoing	January 24: Black Women & HIV | Danielle Campbell February 28: Women Together Program | Jeff Bailey & Brian Risley, APLA Health March 21: Perinatal Syphilis and HIV Transmission | Dr. Mikhaela Cielo Sept 27 & Oct 17: Women Living w/ HIV & Sexuality | Dr. Erica Holmes.
3	**Women's Caucus 2019 Recommendations:** *Review for updates and status.*	Review DHSP's Response to PP&A Directives which include the Caucus' recommendations.	Ongoing	Pending DHSP response to PP&A Directives.

4	**Biomedical HIV Prevention for Women**	1.Request update from DHSP re: women-centric programming under the new biomedical prevention RFP 2. Plan awareness strategies		Updates provided by Paulina Zamudio.

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POLICY/PROCEDURE #08.1102	Subordinate Commission Working Units	Page 1 of 12

F I N A L Revised
Approved 8/11/16

SUBJECT: **The role(s), structures and governing rules of the Commission's various types of subordinate committees and working groups.**

PURPOSE: **To describe the purpose, status, structure, rules, work and timeframes of various subordinate working groups that facilitate advancement, review and completion/fulfillment of Commission responsibilities, tasks, work and projects.**

BACKGROUND:

- Federal Ryan White legislation is the largest source of non-entitlement funding for HIV care and treatment in the country. Part A funding is directed to the most impacted urban jurisdictions across the country. The Ryan White Treatment and Modernization Act of 2009 requires all Part A jurisdictions established before 2008 to create local HIV planning councils. The Health Resources and Services Administration (HRSA) in the US Department of Health and Human Services (DHHS) administers the Ryan White Program nationally.

- The Los Angeles County Commission on HIV serves as LA County's Ryan White and Centers for Disease Control (CDC) prevention HIV planning council. The County has chartered the Commission in County Code, Ordinance 3.29. Both roles as the Ryan White HIV planning council and a County-chartered commission carry specific responsibilities and expectations. The Commission's annual work plan is driven and governed by all of these sources (Ryan White legislation, HRSA and CDC guidance, and County directive/need), yielding an annual schedule of review, discussion, decision-making and work product.

- In order to fulfill its responsibilities and accomplish the work assigned to it, the Commission adopted a strategy in 2003 that relies almost entirely on its committees to perform initial analysis of, generate recommendations to and implement actions for the full Commission. Since then, the Commission's committees have had an indispensable impact on the Commission's capacity to fulfill its varied responsibilities and advance significant initiatives benefiting people with HIV/AIDS/STDs in LA County.

- While the Commission generates, modifies and/or finalizes work and/or decisions, it rarely prepares the work directly as a full body. Rather, it relies on the standing committees and other working groups to forward recommended decisions or work for consideration by the full body. As a result, the Commission counts on the committees and related work units to complete more focused analysis. The committees, in turn, may rely on different types of working units to which they assign/delegate the work. This policy details the various working units the Commission and its committees can access to advance and expedite its decisions and work as needed.

POLICY:

1) **Policy/Procedure Description**: These policies and descriptions define and detail the organization, structure and governing rules/procedures of various working units the Los Angeles County Commission on HIV can engage to generate, develop and complete tasks and work necessary to fulfill its mission and purpose.

2) **Committee-Driven Process**: The Commission is an HIV community planning body that regularly generates planning and implementation decisions and work product consistent with federal Ryan White legislative and Los Angeles County Charter requirements and guidance. Generally, the Commission's work flow and process is "committee-driven," meaning that recommended decisions, actions and work are typically proposed by the Commission's standing committees or other working units to the full Commission for review, consideration, and final decision-making. While the Com-mission generates, modifies and/or finalizes work and/or decisions, it rarely performs the work directly as a full body.

3) **Standing Committees**: The Commission's primary working units are the five standing committees—the Executive, Public Policy (PP), Operations, Planning, Priorities and Allocations, (PP&A) and Standards and Best Practices (SBP). Each of the standing committees has specific responsibilities detailed in the Commission's By-Laws, which they, in turn, implement through ongoing analysis, study, discussion, debate, decision-making, work product, action and/or implementation.

4) **Annual Work Planning**: The Executive Director in consultation with the Co-Chairs and Committee Co-Chairs will develop an Annual Work Plan at the beginning of the program year (March – February). The annual work plan will be aligned with the Comprehensive HIV Plan's Goals and Objectives Section.

5) **Role of the Working Units**: The Commission, its Co-Chairs, the Executive Committee and the Commission's standing committees are entitled to establish caucuses, subcommittees, ad-hoc committees, task forces and various types of working groups to more thoroughly address responsibilities, decisions, work, tasks and projects in accordance with their and the Commission's work plan.

6) **Openness and Transparency Requirements**: Like the Commission, the standing committees are covered by the Ralph M. Brown Act, comply with HRSA guidance and other "sunshine" law requirements regarding meeting transparency and related agendas, notices and preparations; meeting conduct, voting procedures and decision-making; public participation; and meeting record-keeping.

7) **Caucus(es)**: The Commission establishes caucuses, as needed, to provide a forum for Commission members of designated "special populations" to discuss their Commission-related experiences and to strengthen that population's voice in Commission deliberations. Caucuses are not, by definition, Brown Act-covered bodies, and are not required to comply with open meeting, public participation and other, related "sunshine" requirements. With Commission consent, caucuses determine their membership, meeting conduct and timelines, work plans, and activities.

8) **Ad-Hoc Committee(s)**: The Commission, its Co-Chairs and/or the Executive Committee can create ad-hoc committees to address longer-term Commission special projects or initiatives that require more than one standing committee's input, involvement and/or representation. Once the project has been completed, the ad-hoc committee automatically sunsets. The Commission Co-Chairs are responsible for assigning Commission members to the ad-hoc committees, and during their tenure, ad-hoc committees maintain the same stature and reporting expectations as other standing committees. Ad-hoc committees are required to comply with all of the same Brown Act and other transparency requirements as the Commission and its standing committees.

9) **Subcommittee(s)**: Standing Committees and/or their co-chairs may establish subcommittees to address and carry out work, tasks and activities to address one of the committee's primary responsibilities. Consequently, subcommittees are not necessarily time-limited, but the committee can extend, suspend, amend and or conclude the subcommittee's work at any time. The committee may delegate certain authorities to the subcommittee, and the subcommittee's work plan is incorporated into the committee work plan. The committee's co-chairs assign committee, and possibly other Commission, members to the subcommittee. Sub-committees are required to comply with all of the same Brown Act and other transparency requirements as their respective committees.

10) **Task Forces(s)**: Task Forces can be created by the Commission, its Co-Chairs and/or the Executive Committee, and are intended to address a significant Commission priority that may entail multiple levels of work or activity and are envisioned as longer-term in nature. Task forces are similar to ad-hoc committees, except that their membership is expected to include at least as many non-Commission members as Commission members. Task force decisions, work, activities and plans must be reported to and approved by the Executive Committee. While, technically, task forces do not have to comply with Brown Act and other

transparency requirements, it is encouraged that they do so in the spirit of the law. Various community task forces are **not** formal Commission working units, unless recognized as such by the Commission; however, they are invited to report and recommend actions to the Commission.

11) **Work Group(s)**: Work groups are primarily created by the committees for work on a single, short-term project that the committee cannot as thoroughly address during its regular meetings. By definition, work groups—which can come in many different forms—are only operational for short, time-limited periods. Commission and non-Commission members may participate in a work group, but no more Commission members than the originating committee's quorum. Work groups are not covered by the Brown Act and other transparency laws, and the final decisions/recommendations/work serve as a record of the work group's deliberations and must be forwarded to the originating committee for review, consideration and modification/approval.

12) **Organizational Purpose, Structure and Responsibilities**: The following procedures comprehensively describe the various types of subordinate Commission working units; their role(s) and purpose(s); the conditions under which they can be established; and what rules, governance, processes and expectations guide their activities. Each working unit description approximates the following organization:
    - Establishing authority
    - Definition, standing and reporting responsibilities
    - Role and purpose
    - Necessary conditions/provisions
    - Legal requirements
    - Organization, membership and leadership
    - Scope of responsibility and timeframe
    - Staff support, and
    - Other distinctions.

PROCEDURE(S):

1. **Work Plan Implementation**: The Commission develops an annual work plan for the federal Ryan White program year (March – February) detailing the tasks and work projects it expects to complete in the year and that serves as the Commission's primary work outline Each of the Commission's standing committees and caucuses prepares an individual work plan, and the compilation of those work plans is modified/ approved by the Commission.
    a. Commission decisions and work products are guided by federal Ryan White legislation, Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC) and County Ordinance requirements and guidance.
    b. The work plan is a "living document" that may change as unanticipated pressing, urgent and/or time-sensitive issues need to be addressed during the course of the year.

c. Various types of subordinate working units are created at the Commission to carry out and fulfill work and decision-making responsibilities in accordance with that workplan. The organization, structures, rules, work activities and timelines for each type of working group are defined in the following procedures.

d. The group's work objectives and timeframe for completing them will dictate which type of working unit is necessary to carry out those responsibilities.

2. Standing Committee(s): The Commission's standing committees and their respective responsibilities are authorized by and defined in the Commission's By-Laws (*see Pol/Proc #06.1000: Commission By-Laws*). The standing committees:

- are continuing work units;
- meet monthly or more frequently;
- concurrently juggle multiple tasks and activities within their respective purviews; and
- are the Commission's primary means of discharging its duties and responsibilities.

a. All of the Commission's major function(s) and responsibilities are assigned to at least one of the standing committees. While the standing committees primarily generate recommendations and propose work products for the Commission's modification/ approval, they are authorized to make some limited final decisions—such as document revisions in the Operations and Standards and Best Practices (SBP) Committees, policy position modifications in the Public Policy (PP) Committee, and final appeals at the Planning, Priorities and Allocations (PP&A) Committee.

b. Standing committees forward reports, completed work and Committee-approved decisions/recommendations to the Executive Committee and the Commission, as appropriate, understanding agenda items at those meetings.

c. As the Commission's fundamental working units and in the spirit of transparent and open decision-making, the standing committees are subject to Ralph M. Brown Act, HRSA and other applicable sunshine law requirements .As such, the standing committees must adhere to the relevant rules governing:

- meetings open to the public;
- public participation and comment periods;
- development, notification and posting of agendas;
- quorums and voting procedures; and
- meeting record-keeping, audio-recording, and minutes.

1) The Commission's standing committees perform their work, conduct their business, and discuss and deliberate in open, public settings and meetings (except for rare closed Committee sessions that are consistent with Brown Act provisions).
2) Members of the public are encouraged to attend and participate in standing committee meetings.

3) Agendas detailing topics to be addressed are developed for all meetings, and meeting agendas are posted 72 hours in advance.
4) A quorum must be present at any meeting in which votes are taken and only Board of Supervisor (BOS)-appointed Commission members are entitled to cast votes.
5) All meetings are electronically recorded and minutes summarizing meeting discussions and actions are subsequently produced and approved.

d. Standing committee voting privileges are only conferred on Board of Supervisors (BOS)-appointed Commission members who have been assigned to the Committee by the Commission's Co-Chairs, or designated OAPP representatives consistent with the By-Laws.
   1) There is no limit to the number of Commission members who can be assigned to a standing committee.
   2) The standing committee quorum equals one member more than 50% of the assigned membership.
   3) A quorum is required before votes can be taken at a meeting. While all of the Commission's working groups aim for consensus, votes may be necessary to arrive at a decision or for record-keeping purposes.
   4) A motion is successful when more than half of the voting members at the meeting support it.

e. Standing committees elect their committee co-chairs from among their designated membership.
   1) Although a standing committee meeting can proceed without a quorum (however no voting allowed), it cannot proceed without at least one of the Committee or Commission Co-Chairs to lead the meeting.
   2) The Commission's Ordinance and By-Laws dictate that all standing committee co-chairs also serve on the Commission's Executive Committee.

f. Standing committees determine their scope of responsibilities in accordance the standing committee's charge in the Commission By-Laws. The committee outlines how it intends to fulfill those responsibilities by detailing the projecting work tasks/activities and when they will be performed in its annual work plan.
   1) Work priorities are determined by the committee and its co-chairs, shifted accordingly throughout the year due to unforeseen circumstances.
   2) The Commission, its Co-Chairs and/or Executive Committee may also shift standing committee work priorities in consideration of overall Commission priorities and/or existing resources to support the entirety and scheduling of the anticipated Commission workload.

g. The Executive Director assigns each standing committee one lead and at least one support staff person from among the Commission Office staff.

3. Caucus(es): Only the Commission is authorized to create Commission caucuses. When establishing a caucus, the Commission must balance the number of existing caucuses, their

workloads and schedules, and determine that staff resources exist to provide adequate support to the roster of caucuses and committees.

a. Only caucuses created by the Commission with BOS-appointed membership are formally recognized as formal working units of the Commission.
   1) Commission caucuses maintain the same stature as the Commission's standing committees, including monthly reporting responsibilities to the Commission.
   2) Consistent with the Commission's By-laws, caucuses do not maintain representative seats on the Executive Committee.

b. The caucus was developed as a vehicle to provide a safe and judgement-free setting where the Commission's caucus members can easily and freely discuss their reactions and experiences, share their insights, and exchange perceptions of issues addressed by the Commission among other Commission members who are more likely to share/ understand those perspectives. Second, the caucus was intended to develop a more organized voice to ensure that the caucus population's perspective is effectively heard when relevant issues are raised and discussed at the Commission. Thus, each caucus has four primary responsibilities:
   1) Facilitating a forum for a dialogue among the caucus members;
   2) Developing the caucus voice at the Commission and in the community;
   3) Providing the caucus perspective on various Commission issues; and
   4) Cultivating leadership in the caucus membership and population.

c. When forming a caucus, the Commission must adhere to the following criteria:
   1) the population proposed to be represented by the caucus must be one of the Commission's designated "special populations" ;
   2) the Commission must conclude that the population's voice can be strengthened by caucus representation; and
   3) caucus membership must include more than five Commission members and fewer members than the Commission quorum.

d. Since the caucus structurally does not comprise a quorum of the Commission or any of its standing committees, the Commission's caucuses are not governed by the Brown Act, HRSA, CDC or other rules and requirements that apply to the Commission's other committees. Consequently:
   1) the caucus is not required to adhere to quorum requirements;
   2) posted agendas are not required for the Caucuses; and
   3) caucus meetings are not open to Commission membership or the public, unless the caucus chooses to do so;
   4) caucus meetings are not audio recorded and meeting minutes are not produced, however the caucus may use meeting summaries to ensure operational efficiency.

e. Decisions about the caucus organization, structure, membership, process and schedule are left to the caucus membership:

1) all Commission members of the designated population are considered members of the established caucus, whether or not they choose to participate;
2) the caucus determines its leadership and leadership responsibilities;
3) the caucus determines how and when to involve the broader Commission and community in its meetings and activities;
4) the caucus determines its internal organization and meeting/activity schedule.

f. The caucus determines what and how many issues it will address throughout the year by establishing its own scope of responsibility and identifying the work and type of activities in which it will engage. Among the activities it may use to advance its work are education and dialogue, mobilization and advocacy, written communications, presentations, member recruitment, improved representation, events, community involvement, and other options.
   1) Like the standing committees, caucuses are expected to develop annual workplans, which, in turn, are included in the Commission's annual workplan.
   2) The Executive Committee's and Commission's modifications to caucus workplans and final approval of the annual Commission workplan constitute acceptance of the caucus' self-defined scope and timeframe of responsibility.

g. The Executive Director is responsible for determining who among the Commission staff is the most suited to provide staff support to the caucus.

4. Subcommittee(s): Standing committees create subcommittees, as needed, to carry out one or more of the standing committee's major areas of responsibility. The standing committee can "sunset" a subcommittee or continue, amend, suspend, extend and/or reclaim the work or responsibility or parts of it at will.

a. The subcommittee's work priorities are established by its respective standing committee as the standing committee deems appropriate as it endeavors to fulfill its responsibilities and determines that it does not have the time to address the topic as specifically as needed in the context of its regular meetings.

b. Subcommittees must forward their decisions, recommendations and work products to their respective standing committees for consideration, review, modification and/or approval, unless the standing committee has instructed otherwise.
   1) Subcommittee reports are regularly agendized for their respective standing committee meetings.
   2) The standing committee may delegate a portion of the committee's decision-making authority to the subcommittee or instruct the subcommittee to report its decisions/ actions directly to the full Commission.

c. During its tenure, the subcommittee is considered a formal working unit of the Commission, and, as such, must comply with the same Brown Act, HRSA and other, related legal operational rules and requirements as standing committees (*see Procedure #2.c*).

d. The standing committee co-chairs are entitled to assign members of their committee to any subcommittees the committee establishes, and to determine if they will accept other Commission members who volunteer for the designated subcommittee(s).
   1) Standing committee rules governing membership, voting privileges and meeting conduct also apply to subcommittees (*see Procedure #2.d*)
   2) Only Commission or standing committee members with voting privileges are entitled to membership on subcommittees—although the public are invited to attend and participate in subcommittee meetings.
   3) Like the standing committees, subcommittees elect their own co-chairs. At least one of the standing committee co-chairs should attend and lead the first subcommittee meeting in order for the subcommittee to choose its own leadership.

e. While the standing committee determines the subcommittee's scope and limits of responsibility, the subcommittee may elaborate on that topic, extend, revise or modify it, and design the appropriate work strategies to address it, with the standing committee's or its co-chairs' consent.
   1) The subcommittee's annual work plan is incorporated into the standing committee's annual work plan.
   2) That responsibility may be time-limited or assumed to be a long-term or permanent delegation of the standing committee's authority.

f. The respective standing committee staff support also staffs its subcommittees.
   1) With the Executive Director, the standing committee must balance the number of its subcommittees, its work-load and schedule to determine if staff resources are adequate to provide the necessary support to a subcommittee.

5. Ad-Hoc Committee(s): The Commission, its Co-Chairs or the Executive Committee are entitled to create ad-hoc committees, as needed and appropriate.

a. For the duration of an ad-hoc committee's work, the ad-hoc committee maintains the stature of Standing Committees, including regular inclusion on the agenda and reports to the Executive Committee and the Commission.
   1) Consistent with the Commission By-Laws, ad-hoc committees do not maintain representative seats on the Executive Committee.

b. Ad-hoc committees are "special project"-focused in nature, meaning they are assigned one significant project, versus limited-activity or short-term projects that can be addressed by other working units or as part of a standing committee's or subcommittee's more expansive agenda.

c. Ad-hoc committees are created for special projects that extend beyond a single standing committee's authority or purview and require membership from multiple committees.
   1) The Commission Co-Chairs determine who will serve on an ad-hoc committee by assigning members and/or accepting volunteers.

d. The ad-hoc committee determines rules, activities and schedules regarding its organization, membership and leadership.
   1) Ad-hoc committees must comply with all of the same legal requirements and guidance governing meeting preparations and their conduct as standing committees and subcommittees.

e. Given its defined purpose to address a single, significant Commission special project, an ad-hoc committee is established for a distinct time period and automatically sunsets at the conclusion or completion of the project.

f. Executive Committee staff support provides staff support to ad-hoc committees, unless the Executive Director designates other staff support.

6. Task Force(s): Task Forces can be created by the Commission, its Co-Chairs or the Executive Committee. Task forces are intended to address a topic that is broader and more expansive in nature, encompassing multiple activities and a continuing, longer-term time frame.

a. Unlike ad-hoc committees or subcommittees with similar purposes, task forces are created to include Commission members and non-Commission members alike, generally at equal proportions, or with Commission members forming a minority of the task force membership.

b. Task forces report to the Executive Committee, to which they forward their recommendations and work. Since membership is not confined to solely Commission members, any recommendation or action from a Task Force must be approved by the Executive Committee before advancing it to the full Commission.

   1) The Commission's task forces are expected to provide periodic reports to the full body.

c. Technically—only unless the Task Force membership comprises a majority of Commission members from one of its working units—it does not have to comply with public noticing and other Brown Act rules; practicality, though, suggests compliance with those rules, even if not specifically mandated.

d. The task force membership is empowered to determine its own leadership, structure, and schedule.

e. The task force assumes its scope of responsibility and develops its work plan(s) in consultation with the Executive Committee and the Executive Director.
   1) The task force work plan, scheduling and timeline is incorporated into the Executive Committee's annual work plan.

f. Executive Committee staff support provides staff support to ad-hoc committees, unless the Executive Director designates other staff support.

g. It is important to note that the HIV community has created a number of population- and service-centered task forces that are **not** Commission working units, unless formally recognized by the Commission.
   1) Community task forces are welcome, though, to report their recommendations or work to the Commission under the standing "Task Force" agenda item, as needed and appropriate.

7. Work Groups: The committees are primarily responsible for establishing work groups, the most informal of the Commission's subordinate working units. Work groups are created to complete a specific short-term, single-focused task, resulting in a final work product that concludes the work group's activities.

a. Most frequently, work groups are established to work in more specific detail on a task that the committee does not have time to address in its regular meetings, or to finish a task that requires direct involvement and input from the work group members (e.g., such as developing plans, reviewing and generating documents and/or conducting studies, among other possible activities).
   1) All work group actions must be approved by the committee of origin, as work groups are only performing work on the committee's behalf and request.

b. Due to their short-term timeframe, specific work assignment and limited membership, work groups are not governed by the Brown Act or other sunshine law requirements.

c. Work groups cannot include more members than the originating standing committee's quorum, otherwise additional meeting preparation, membership, timeline and management requirements will be invoked.
   1) Work group meetings are not intended to be open to the public, or subject to transparency and public participation requirements.
   2) Work group meetings are, instead, intended to be working meetings that produce decisions, documents and/or other products that will be presented for open, public discussion, debate and/or consideration at the originating standing or other committee.
   3) Agendas and meeting minutes are not needed for work groups. Summaries may be provided, if needed, to capture information discussed at prior meetings or to ensure continuity and progress of meeting discussions.
   4) Generally, the final documentation and/or work product from the work group serves as a record of the work group meeting proceedings.

d. Work groups can come in many forms: as a committee work group, an expert review panel, a focus group or in other formats.

e. Non-Commission members can be included in the work group with the consent of the standing committee or the Executive Director, as needed.
   1) Due to the mix of Commission and non-Commission members on work groups, votes and voting procedures are not used at work group meetings.

2) Due to its short-term nature, work groups do not require formal leadership.

f. The work group's scope of responsibility is defined by the originating committee, are short-term limited, and range from one to a dozen meetings in total.
   1) More frequently work groups meet only once or twice and finish their assigned projects within a month (for example, by the committee's next meeting).

g. Work groups are staffed by one of the committee's support staff and the work is not intended to exceed six months, at the maximum.

NOTED AND APPROVED: Cheryl A Barnett

EFFECTIVE DATE: December 9, 2010; 8/11/16

Original Approval: 12/9/10 *Revision(s):7/25/16*

LOS ANGELES COUNTY COMMISSION ON HIV

APPROVED
COH Meeting 6-7-22

Approval Dates: Planning, Priorities, and Allocations Committee 5/17/22/; Executive Committee 5/26/22/; COH 6/9/22; DHSP Response 11/14/22

Program Directives for Maximizing Health Resources Services Administration (HRSA) Ryan White Part A and MAI Funds for Program Years (PY) 32, 33, 34 and Centers for Disease Control and Prevention (CDC) Funding

Purpose: These program directives approved by the Los Angeles County Commission on HIV (COH) on June 9, 2022 articulate instructions to the Division of HIV and STD Programs (DHSP) on how to meet the priorities established by the COH. The Ryan White PY Years 32, 33, and 34 service rankings and allocations table are found in Attachment A.

1. Across all prevention programs and services, use a status-neutral approach in service delivery models and create a connected network of services that promote access to PrEP, ongoing preventive care, mental health, substance use, and housing services. A status-neutral approach considers the steps that can lead to an undetectable viral load and steps for effective HIV prevention (such as using condoms and PrEP). The status-neutral approach uses high-quality, culturally affirming care and empowers PLWH to get treatment and stay engaged in care. Similarly, high-quality preventive services for people who are at risk of HIV exposure help keep them HIV-negative.[1] A status-neutral approach to HIV care means that all people, regardless of HIV status, are treated the same way, with dignity and respect, and with the same access to high-quality care and services.

   DHSP Response:
   - DHSP's EHE Outreach and Education team developed HIV Testing palm cards that are status-neutral. One side of the palm card has resources for persons diagnosed with HIV, and the other side of the card contains resources for persons who are HIV negative.
   - DHSP recently released a new RFP (through Heluna Health) to fund mini-projects that will improve linkage to care, diagnoses, or engagement in care. The RFP recommends the use of a status-neutral approach and is available at https://www.helunahealth.org/news/rfp-la-county-department-of-public-health-ending-the-hiv-epidemic-mini-grant-program-short-version-
   - All DHSP prevention contracts are status-neutral
   - Under vulnerable population contracts, at least four provide housing vouchers and three provide mental health services
   - Persons at risk for HIV should have access to substance use prevention and treatment if they have any private health insurance or through MediCal
   - Identification of a funding source for housing services for persons at risk of HIV has been a challenge. DHSP will advocate with CDC and HRSA to allow more flexibility with funding in order to support the status neutral approach

2. Across all funding sources for prevention and care, prioritize investments in populations most disproportionately affected and in health districts with the highest disease burden and prevalence, where service gaps and needs are most severe. To determine populations and geographic areas most affected by HIV, request DHSP to provide data on the following:
    a. HIV and STD surveillance
    b. Continuum of care
    c. PrEP continuum
    d. Data on low service utilization in areas with high rates of HIV
    e. Viral suppression and retention rates by service sites
    f. and other relevant prevention and care data

Priority populations are those groups defined in the Los Angeles County Ending the HIV Epidemic plan. "Based on the epidemiologic profile, situational analysis, and needs assessment in Los Angeles County, the key populations of focus selected for local Ending the HIV Epidemic activities to reduce HIV-related disparities include Black/African American

[1] hiv-status-neutral-prevention-and-treatment-cycle (nyc.gov)

MSM, Latinx MSM, women of color, people who inject drugs, transgender persons, and youth under 30 years of age. Although priority populations have been selected for EHE, the LAC HIV portfolio will continue to support all populations affected by HIV and will not diminish efforts to prevent, diagnose, and treat HIV for populations who remain a critical concern, including people over age 50 who account for over 51% of PLWH in LAC and people experiencing unstable housing or homelessness, among others" (pg. 21).

The Health Districts with the highest disease burden represent five cluster areas that account for more than 80% of the disease burden (LACHAS, pg. 7)

1. Hollywood Wilshire (SPA 4)
2. Central (SPA 4)
3. Long Beach (SPA 8)
4. Southwest (SPA 6)
5. Northeast (SPA 4)

See health district (HD) maps for ranking by HIV disease burden (Attachment B).

DHSP Response:

- DHSP has developed HIV and STD dashboards which present current data and trends. Health district and SPA results are available. The dashboards can be accessed at http://publichealth.lacounty.gov/dhsp/Dashboard.htm
- DHSP Data Visualization team has developed Health District-level Epi Profiles and a Power BI tool to help track clusters and inform cluster detection and response initiatives more efficiently
- DHSP has and will continue to provide responses to COH data requests. HIV and STD surveillance, RWP Utilization, NHBS, HIV testing, and MMP data were presented during 2021 and 2022. Data were also provided and included in the Comprehensive Prevention Plan.

3. Integrate telehealth across all prevention and care services, as appropriate.

DHSP Response:

- DHSP augmented some biomedical contracts to purchase telehealth software
- RWP AOM, MCC, MH, Transitional Case Management (TCM) and Home-Based Case Management (HBCM) services have had the capacity to deliver services via telehealth since March 2020, and will continue using telehealth (phone)
- Prevention programs used Zoom, Facebook and phone and will continue to use these telehealth modalities and a hybrid approach.
- DHSP will continue to monitor and evaluate telehealth usage in the RWP
- New services such as the Spanish language mental health services will require both on-site and telehealth options

4. Continue the implementation of the recommendations developed by the Black/African Community (BAAC) Task Force (TF) which set a progressive and

inclusive agenda to eliminate the disproportionate impact of HIV/AIDS/STDs in all subsets of the African American/Black diaspora. PP&A is calling special attention to the following recommendations from the BAAC TF as key priorities for RFP development, funding, and service implementation starting in 2020:

a. Require contracted agencies to complete training for staff on cultural competency and sensitivity, implicit bias, medical mistrust, and cultural humility. DHSP should work with the Black/African American community as subject matter experts in developing training materials and curriculum, monitoring, and evaluation.

   DHSP Response:

   - DHSP developed a training that addresses issues of cultural humility and implicit bias last year. Three hundred people have been trained so far and this work is ongoing.

b. In collaboration with the Black/African American community, conduct a comprehensive needs assessment specific to all subsets of the Black/African American population with a larger sample size. Subgroups include MSM, transgender masculine and feminine communities, and women. Integrate needs assessment objectives and timelines in the 2022-2026 Comprehensive HIV Plan.

   DHSP Response:

   - DHSP has collaborated with Raniyah Copeland to obtain perspectives and feedback from the Black/African American community to develop a social marketing strategy
   - Black/African American Taskforce will conduct key informant interviews with service providers including workforce development needs
   - Conducting LACHNA is extremely labor intensive and time-consuming activity. The NHBS data can be used for prevention planning and the Medical Monitoring Project (MMP) can be used to understand HIV care needs.
   - A more targeted needs assessments can be completed by COH and AJ as part of the CHP development

c. Assess available resources by health districts by order of high prevalence areas.

   DHSP Response:

   - DHSP will update analyses to better understand geographic diversity of the HIV epidemic and will share the results with the COH.
   - See response to item #2

- DHSP will help improve the response of local HIV efforts to address epidemic among Blacks and African Americans by enlisting new providers and working with other county departments to help make the county contracting process easier to navigate and more inclusive.

d. Conduct a study to identify out-of-care individuals, and populations who do not access local services and why they do not.

DHSP Response:

- DHSP staff are currently analyzing data from the Linkage and Re-Engagement Program (LRP) as well as other Data-to-Care activities to identify out of care individuals and better understand their service needs.
- DHSP has developed a dedicated in-house Data to Action team

e. Fund mental health services for Black/African American women that are responsive to their needs and strengths. Maximize access to mental services by offering services remotely and in person. Develop a network of Black mental health providers to promote equity and reduce stigma and medical mistrust.

DHSP Response:

- Under the HRSA EHE grant, DHSP has secured a contractor who has conducted a Mental Health Needs Assessment. This assessment includes three levels of inquiry: systems, providers, and clients/consumers. Fifteen keyholder interviews were conducted, and surveys were collected from 35 providers and 29 consumers.
- The consultant presented preliminary findings at the October COH meeting and the final report will be available before the end of 2022.
- Based on the results of the Needs Assessment, DHSP will determine next steps to increase availability of mental health services for Black/African American women.
- Three RFPs for Black/African American or Latino MSM, Black/African American cisgender women, and Black/African American transgender were recently released (October 2022)
- To fully accomplish this goal, reform in the educational and reimbursement systems are needed which is outside DHSP's scope.

5. Earmark funds for peer support and psychosocial services for Black gay and bisexual men. The Commission allocated 1% funding for Psychosocial Support Services in PY 34. The updated psychosocial service standards approved by the COH on 9/10/2020 include peer support as a service component. The COH requests a solicitations schedule and updates from DHSP on annual basis. It is recommended that DHSP collaborate with SBP to convene subject matter experts from the African American

community to ensure that mental health and psychosocial support services are culturally tailored to the needs of the community. For 2022, SBP is developing Best Practices for Special Populations with a specific document for Black/African community across multiple service categories.

DHSP Response:

- It would be helpful to obtain more specific information on the programmatic design of these psychosocial services from the COH
- One of the recently released priority population intervention RFPs (through Heluna Health) is for Black/African American MSM. This RFP requires both MH and psychosocial support services in the program model.
- DHSP currently supports one agency that has a robust peer support program and will obtain more information from them on their program model to inform the development of a RFP. A solicitation is scheduled for release in 2023.

6. Provide Non-Medical Case Management (NMCM) services in non-traditional and traditional locations to support improved service referrals and access points to Ryan White services for identified priority populations, such as young men who have sex with men (YMSM), African American men and women, Latinx communities, transgender individuals, and older adults (over 50 years). The COH's approved allocations for NMCM for PYs 32, 33, and 34 are as follows: 2.44% Part A and 12.61% MAI. The COH requests a solicitations schedule and updates from DHSP on an annual basis.

   DHSP Response:

   - DHSP recently released a new RFP (through Heluna Health) to fund mini-projects that will improve linkage to care, diagnoses, or engagement in care. Traditional and non-traditional service sites can be proposed. The RFP also encourages non-traditional HIV providers to apply, and the RFP is available at https://www.helunahealth.org/news/rfp-la-county-department-of-public-health-ending-the-hiv-epidemic-mini-grant-program-short-version-
   - Two additional RFPs (through Heluna Health) were released. There is one RFP for ciswomen and another for TG persons. A peer-to-peer model to assist with referrals, access to care, and support services is a component of these new RFPs
   - One possible way to improve referral and care coordination is electronically through a new data system. DHSP plans to use EHE funds to procure a new data system in 2023.
   - DHSP is also exploring the possibility of developing a program that combines psychosocial and NMCM services
   - It would be helpful to obtain more specific information on the programmatic design of the requested NMCM services from the COH

7. Continue to enhance Foodbank and Home Delivered Meals services to include dietary guidance, better quality foods (specifically more high-quality nutrient-rich fruits, vegetables, and lean proteins), and increase the amount of food available for clients based on their individual needs or by gaps observed or reported by agencies and clients; cover essential non-food items such as personal hygiene products (to include feminine hygiene items), household cleaning supplies, and personal protective equipment (PPE). Permit contracted agencies to

provide grocery, gas, and transportation support (e.g., Metro Tap cards, rideshare services) to clients to facilitate expanded access to food.

DHSP Response:

- The majority of HRSA CARES funds were allocated to nutritional support services for new equipment, food, and PPE
- DHSP has augmented and is currently in the processes of augmenting nutritional support contracts
- Essential non-food items are currently available at DHSP contracted nutritional support providers
- Further enhancement of contracts has been a part of DHSP's investment strategy for RWP funds in 2022

8. Food insecurity affects all people regardless of their HIV status. Support agencies that provide prevention services to have access to and the ability to provide or link clients to foodbanks, food delivery services, and nutritious meals to maintain overall health and wellness. The PrEP navigation system offers a model for linking clients regardless of their status to benefits counseling and leveraging prevention funds to link individuals to wrap- around services and social supports such as housing, transportation, job referrals, legal services, and foodbanks.

   DHSP Response:

   - DHSP highly recommends that all prevention contractors provide referrals to foodbanks and food delivery services
   - DHSP will advocate with CDC and other prevention funders to be more flexible in allowable services/costs

9. Support intensive case management services for people living with HIV served in Ryan White HIV housing programs and increase the target number of clients served during the reallocation process. Funds should also be used to support additional training for housing specialists to serve the housing needs of families.

   DHSP Response:

   - Intensive Case Management services are available to clients participating in the Housing for Health (MAI Housing) program. Initially, Housing for Health notified DHSP that they had other funding to cover the Intensive Case Management services so it was not part of their DHSP contract.
   - DHSP is working with Housing for Health to now cover the costs of Intensive Case Management Services and to expand the number of clients served under this contract. DHSP is waiting for a budget proposal from Housing for Health.

10. Continue to support the expansion of medical transportation services for all individuals regardless of their HIV status.

    DHSP Response:

    - Some HTS providers have transportation under their incentive line items. It is up to each provider to request a transportation line item.
    - Transportation services are available and an integral part of Linkage and

Reengagement and Rapid and Ready program.
- DHSP RWP transportation contracts allow family members to utilize ride share
- DHSP will ask CDC if transportation is an allowable cost

11. Continue efforts to develop Ryan White client eligibility cards and welcome packets, with information on Ryan White-funded services in Los Angeles County; train providers on the use of eligibility cards to reduce the paperwork burden on clients. Develop and implement eligibility cards without the need to issue a Request for Proposals (RFP) to expedite the distribution of eligibility cards as stated by DHSP representatives. The COH requests a solicitations schedule and updates from DHSP on annual basis.

    DHSP Response:
    - RWP Fact Sheets for each service category are currently available on online in both English and Spanish language. These documents will be included in the welcome packet.
    - Under the HRSA EHE grant, DHSP has contracted with Heluna Health and the client eligibility cards are one of the scope of work items. The Heluna Health contract was approved within the past 45 days.
    - Additionally, the proposed data system will also contain eligibility information to further reduce the paperwork burden on clients

12. Augment contracts to permit agencies to have an operational line-item budget for childcare and transportation to facilitate consistent engagement in care and support services. This strategy would avoid releasing a stand-alone RFP for childcare and transportation and give service providers the flexibility to provide these services to all clients with children. Explore funding informal childcare for Medical Care Coordination (MCC) programs for maximum flexibility. The County's Department of Public and Social Services administers a program under CalWORKs that provides childcare allowances to foster care parents. This model may provide insights on a possible contractual or administrative mechanism to expand childcare options using Ryan White or Net County Cost funding.

    DHSP Response:
    - RWP transportation contracts currently exist
    - The Childcare RFP is in development with new services starting in 2023

13. Continue to expand flexibility to provide emergency financial support for PLWH. Augment Medical Case Management/Medical Care Coordination services to include Emergency Financial Assistance (EFA) and Childcare services. Priority populations such as women and their families, YMSM, and transgender women, may have unique needs for emergency financial assistance due to domestic and intimate partner, or community violence.

    DHSP Response:
    - All eligible PLWDH can obtain EFA regardless of which RWP service they utilize. Thus, all MCC clients can apply for EFA and a line item is not necessary
    - All MCC providers (subrecipients) will be eligible to apply for a Childcare Services contract

- Note: Although not considered EFA, a contingency management program (iCARE) was launched in August 2022. This program provides financial incentives in the form of store gift cards for successfully reaching milestones in HIV care including appointment attendance, lab draws, linkage to supportive services, achieving and sustaining viral suppression for youth (age 30 or younger) and women of child bearing age that are enrolled in the Linkage and Reengagement Program (LRP).

14. Fund mobile care teams or clinics that provide holistic care for women living with HIV. Mobile teams should be available for all agencies and link women to services where they reside, congregate, or prefer to be engaged. Mobile clinics should aim to be all-inclusive and include bilingual services, STI services, linkages to clinics for ongoing care, STI/HIV testing, PrEP, mammograms, health education, and made availability to women of all ages. Mobile clinics should have the capacity to provide community referrals to food, childcare, housing, recreation and wellness resources, and other support services. Explore partnering with existing street medicine programs to enhance mobile care teams specifically designed for women.

DHSP Response:

- DHSP is assessing the current mobile unit inventory and discussing the type and quantity of mobile units needed
- Beginning in 2019 DHSP staff developed and implemented the POWER project. The goal of the POWER Project is the identification and treatment of women with undiagnosed and/or untreated HIV or syphilis infection who may not otherwise be tested in routine healthcare settings through partnership with County agencies and community-based organizations across Los Angeles County serving women with substance use disorder (SUD), experiencing mental health challenges or experiencing homelessness to provided HIV and STI testing and treatment to these women and their partners. DPH identified three Partner Models for expanding testing and treatment in this population: CBO with DPH staff, street based medicine provider model, and hybrid model (still in development). This project is still ongoing.
- DHSP is collaborating with the USC Street Medicine Group to provide street medicine based services to PLWDH. The program will be called the HIV Transition of Care Project and the contract is currently under review.

15. Fund psychosocial services and support groups for women. Psychosocial support services must include peer support to build a stronger sense of community, empowerment, and resilience among women living with HIV. Maximize access to psychosocial and support group services by offering services remotely and in person. The Commission allocated 1% funding for Psychosocial Support Services for PY 34. The updated psychosocial service standards approved by the COH on 9/10/2020 include peer support as a service component. The COH requests a solicitations schedule and updates from DHSP on annual basis.

DHSP Response:

- Two recently released RFPs recommend peer models for cisgender and transgender women

- A DHSP consultant is training DHSP staff and providing psychosocial and mental health services for women enrolled in the LRP program
- It would be helpful to obtain more specific information on the programmatic design of these psychosocial services from the COH

16. Leverage and build upon Medical Care Coordination Teams & Ambulatory Outpatient Medical Program and integrate the HIV and Aging care framework developed by the Aging Task Force. This framework seeks to facilitate medical wellness examinations and offers a flexible and adaptable guide to customizing care for older adults with HIV. The suggested list of assessments may be used for younger PLWH, as deemed appropriate by the medical care team, especially in communities of color, who experience aging-related issues earlier in life (before age 50). See Attachment C for the HIV and Aging Framework.

DHSP Response:

- A DHSP workgroup will be developed to review this directive. A progress update will be provided to the Aging Caucus in January 2023.

17. Integrate a geriatrician in medical home teams and establish a coordination process for specialty care services for older adults living with HIV.

DHSP Response:

- DHSP is currently reviewing Homebased Case Management Services with the intent of developing a new RFP.

by COH 01-13-2022; PY 32 Approved by COH Sept 2021)

ons (PY 32) (1)				FY 2023 RW Allocations (PY 33)(2)			FY 2024 RW Allocation (PY 34)(2)		
	Part A %	MAI %	Total Part A/ MAI %	Part A %	MAI %	Total Part A/ MAI % (3)	Part A %	MAI %	Total Part A/ MAI % (3)
ies	0.96%	87.39%	8.33%	0.96%	87.39%		0.96%	87.39%	
	2.44%	12.61%	3.30%	2.44%	12.61%		2.44%	12.61%	
	25.51%	0.00%	23.33%	25.51%	0.00%		25.51%	0.00%	
	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
	0.00%	0.00%	0.00%	0.00%	0.00%		1.00%	0.00%	
	28.88%	0.00%	26.41%	28.88%	0.00%		28.00%	0.00%	
	4.07%	0.00%	3.72%	4.07%	0.00%		4.07%	0.00%	
	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
	2.17%	0.00%	1.99%	2.17%	0.00%		2.17%	0.00%	
ed	8.95%	0.00%	8.19%	8.95%	0.00%		8.95%	0.00%	
	17.60%	0.00%	16.13%	17.60%	0.00%		17.48%	0.00%	
	0.95%	0.00%	0.87%	0.95%	0.00%		0.95%	0.00%	
	1.00%	0.00%	0.92%	1.00%	0.00%		1.00%	0.00%	
	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
	6.78%	0.00%	6.21%	6.78%	0.00%		6.78%	0.00%	
	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
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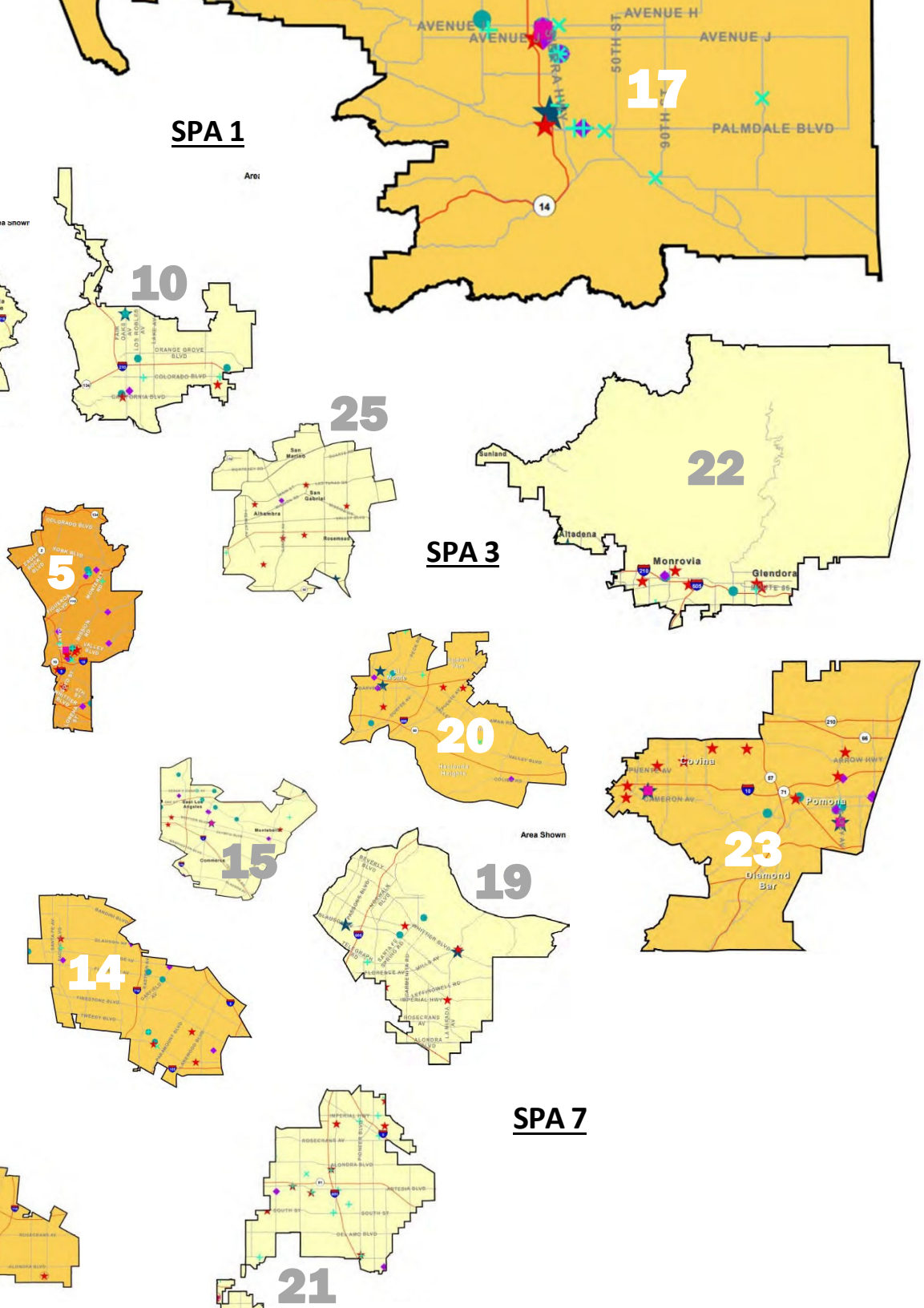
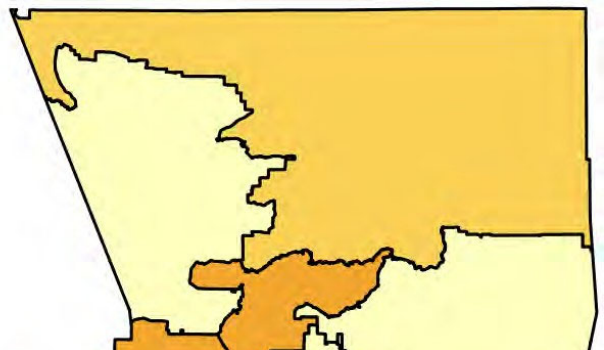


Los Angeles County HIV/AIDS Strategy Goals

By 2022:

1. Reduce annual HIV infections by 500
2. Increase diagnoses to at least 90%
3. Increase viral suppression to 90%



Aging Task Force | Framework for HIV Care for PLHWA 50+ (10.18.21; COH approved on 11/18/21)

STRATEGIES:

1. This framework seeks to facilitate medical wellness examinations and offers a flexible and adaptable guide to customizing care for ALL older adults with HIV. The suggested list of assessments may be used for younger PLWH, as deemed appropriate by the medical care team, especially in communities of color, experience aging-related issues earlier in life (before age 50) .

2. Leverage and build upon Medical Care Coordination Teams & Ambulatory Outpatient Medical Program.

3. Integrate a geriatrician in medical home teams.

4. Establish coordination process for specialty care.

Aging Task Force | Framework for HIV Care for PLHWA 50+ (10.18.21)

Assessments and Screenings			
Mental Health	Hearing	HIV-specific Routine Tests	Immunizations
Neurocognitive Disorders/Cognitive Function	Osteoporosis/Bone Density	Cardiovascular Disease	Advance Care Planning
Functional Status	Cancers	Smoking-related Complications	
Frailty/Falls and Gait	Muscle Loss & Atrophy	Renal Disease	
Social Support & Levels of Interactions	Nutritional	Coinfections	
Vision	Housing Status	Hormone Deficiency	
Dental	Polypharmacy/Drug Interactions	Peripheral Neuropathologies	

From Golden Compass Program

From Aging Task Force/Commission on HIV

Screenings & Assessment Definitions

- HIV-specific Routine Tests
  - HIV RNA (Viral Load)
  - CD4 T-cell count
- Screening for Frailty
  - Unintentional weight loss, self-reported exhaustion, low energy expenditure, slow gait speed, weak grip strength
- Screening for Cardiovascular Disease
  - Lipid Panel (Dyslipidemia)
  - Hemoglobin A1c (Diabetes Mellitus)
  - Blood Pressure (Hypertension)
  - Weight (Obesity)
- Screening for Smoking-related Complications
  - Lung Cancer - Low-Dose CT Chest
  - Pulmonary Function Testing, Spirometry (COPD)

Screening for Renal Disease

  - Complete Metabolic Panel
  - Urinalysis
  - Urine Microalbumin-Creatinine Ratio (Microalbuminuria)
  - Urine Protein-Creatinine Ratio (HIVAN)
- Screening for Coinfections
  - Injection Drug Use
  - Hepatitis Panel (Hepatitis A, B, C)
  - STI - Gonorrhea, Chlamydia, Syphilis

Screenings & Assessment Definitions (continued)

- Screening for Osteoporosis
  - Vitamin D Level
  - DXA Scan (dual-energy X-ray absorptiometry)
  - FRAX score (fracture risk assessment tool)
- Screening for Male and Female Hormone Deficiency
  - Menopause, decreased libido, erectile dysfunction, reduced bone mass (or low-trauma fractures), hot flashes, or sweats; testing should also be considered in persons with less specific symptoms, such as fatigue and depression.
- Screening for Mental Health Comorbidities
  - Depression – Patient Health Questionnaire (PHQ)
  - Anxiety – Generalized anxiety disorder (GAD), Panic Disorder, PTSD
  - Substance Use Disorder - Opioids, Alcohol, Stimulants (cocaine & methamphetamine), benzodiazepines
  - Referral to LCSW or MFT
  - Referral to Psychiatry
- Screening for Peripheral Neuropathologies
  - Vitamin B12
  - Referral to Neurology
  - Electrodiagnostic testing
- Screening for Sexual Health

Other Suggestions from ATF/COH Discussions

- Screen patients for comprehensive benefits analysis and financial security
- Assess patients if they need and have access to caregiving support and related services
- Assess service needs for occupational and physical therapy (OT/PT) and palliative care
- Review home-based case management service standards for alignment with OT and PT assessments
- Establish a coordinated referral process among DHSP-contracted and partner agencies
- Collaborate with the AIDS Education Training Centers to develop training for HIV specialist and geriatricians.