LOS ANGELES COUNTY COMMISSION ON HIV
3530 Wilshire Boulevard, Suite 1140, Los Angeles, CA 90010 · TEL. (213) 7382816 · FAX (213) 637-4748
Website: http://hiv.lacounty.gov Email: hivcomm@lachiv.org

COMMISSION ON HIV MEETING

Thursday, August 10, 2017
9:00 AM - 1:00 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) 7382816 · FAX (213) 637-4748
Website: http://hiv.lacounty.gov Email: hivcomm@lachiv.org

2. APPROVAL OF THE AGENDA:

A. Agenda
B. Membership Roster
C. Committee Assignments
D. Commission Member Conflict of Interest
E. Geographic Maps
F. August - November 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
http://hiv.lacounty.gov

Los Angeles County Commission on HIV (COH)
[REVISED] MEETING AGENDA

Thursday, August 10, 2017
9:00am – 1:00pm
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, COH	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 - 9:09am

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 - 9:15am
6. Co-Chairs Report		**B Land/R Rosales,** Co-Chairs, COH	9:15am - 9:20am
A. Commissioner Welcome & Service Recognition **B.** Meeting Management **C.** Co-Chair Open Nominations			
7. Colloquia Series:	**2017 Greater Los Angeles Homeless Count**	**J Decell, Data Integration, Los Angeles Homeless Services Authority**	9:20am - 10:00am
8. County's Health Department Integration Advisory Board (IAB) Report Report		**COH IAB Representatives**	10:00am - 10:03am
9. Break			10:03am - 10:13am
10. Housing Opportunities for People Living Wlith HIV/AIDS (HOPWA) Report		**R Ronquillo** Housing + Community Investment Dept City of Los Angeles	10:13am - 10:18am
11. Department of Public Health, Immunization Program Report		**F Pratt, MD, MPHTM, FACEP** Medical Director, Immunization Program Dept of Public Health	10:18am - 10:23am
12. Division of HIV/STD Programs (DHSP) Report, Department of Public Health		**M Peréz, MPH, Director, DHSP**	10:23am - 10:38am
A. National HIV Behavioral Survey		**E Sey, PhD, DHSP**	10:38am - 11:23am
13. California Office of AIDS (OA) Report		**State Office of AIDS**	11:23am - 11:33am
A OA Work/Information		**M Arnold, MS-HAS, Chief, Care Branch, OA**	
14. Standing Committee Reports			11:33am - 12:28pm

A. Planning, Priorities and Allocations (PP&A) Committee **A Ballesteros, MBA/J Brown,** Co-Chairs

(1) RW PY28 Service Categories Priority Rankings **MOTION # 4**
(2) RW PY26 Final Expenditures Review
(3) CDC HIV Prevention & Surveillance Notice of Funding Announcement

B. Standards and Best Practices (SBP) Committee **J Cadden, MD/G Granados, MSW,** Co-Chairs

(1) Prevention Standards
(2) Housing Standards

C. Operations Committee **T Bivens-Davis/K Stalter,** Co-Chairs

(1) Assessment of the Administrative Mechanism (AAM)
(2) Policies and Procedures
(3) Membership Management
(4) Community Engagement
(a) Tier 3 Listening Session Report PPT **T Bivens-Davis,** Co-Chair
(5) 2017-18 Training and Orientation

D. Public Policy Committee — **A Fox, MPM/ E Leue** Co-Chairs
(1) 2017 COH Legislative Docket Updates — **MOTION #5**
(2) Healthcare Access and Landscape

15.	**Caucus,Task Force and Work Group Reports**	**Caucus, Task Force and Work Group** Co-Chairs	12:28pm	-	12:31pm
16.	**City/Health District Reports**	**City/Health District Representatives**	12:31pm	-	12:34pm
17.	**SPA/District Reports**	**SPA/District Representatives**	12:34pm	-	12:38pm
18.	**Public Comment (*Non-Agendized or Follow-Up*)**	**Public**	12:38pm	-	12:48pm
19.	**Commission Comment (*Non-Agendized or Follow-Up*)**	**Commission Members/Staff**	12:48pm	-	12:58pm
20.	**Announcements**	**Commission/Public**	12:58pm	-	1:00pm
21.	**Adjournment**			-	1:00pm

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 the RW PY28 Service Categories Priority Rankings, as presented**
MOTION #5:	**Approve the 2017 Legislative Docket, 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	**Deborah Owens Collins**, PA, MSPAS, AAHIVS	**Michele Daniels**	**Kevin Donnelly**
Matthew Emons, MD	**Susan Forrest** (Alternate)	**Aaron Fox, MPP**	**Jerry D. Gates, PhD**
Joseph Green	**Terry Goddard, MA**	**Bridget Gordon**	**Grissel Granados, MSW**
Ernest Hammond III (Alternate)	**Lee Kochems, MA** *Eduardo Martinez (Alternate)*	**David P. Lee** (Alternate)	**Eric Paul Leue**
Abad Lopez	**Miguel Martinez, MSW, MPH**	**Anthony Mills, MD**	**José Munoz**
Derek Murray	**Frankie Darling-Palacios**	**John Palomo**	**Raphael Péna**
Mario Peréz, MPH	**Juan Preciado**	**Thomas Puckett, Jr.**	**Ace Robinson, MPH**
Maria Roman	**Rebecca Ronquillo**	**Sabel Samone-Loreca**	**Martin Sattah, MD**
LaShonda Spencer, MD	**Kevin Stalter**	**Yolanda Sumpter**	**Greg Wilson**
Russell Ybarra			

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.

COMMISSION ON HIV

PROPOSED M EMBERSHIP SLATE

*Highlights denote renewing members and new applicants recommended for BOS re/appointment.
COH Approved 7/13/2017

MEMBERSHIP SEAT #	MEMBERSHIP SEAT	Commissioners Seated	Committee Assignement	COMMISSIONER	AFFILIATION *(if any)*	TERM BEGINS	TERM ENDS	Alternates Seated	ALTERNATE
1)	Medi-Cal representative			*Vacant*		July 1, 2017	June 30, 2019		
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, 2017	June 30, 2019		
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, 2017	June 30, 2019		
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, 2017	June 30, 2019		
0)	Part F representative	1	PP	Jerry D. Gates, PhD	Keck School of Medicine of USC	July 1, 2016	June 30, 2018		
1)	Provider representative #1	1	SBP	*Joseph Cadden, MD*	Rand Shrader Clinic (SPA1), LA County Department of Health Services	July 1, 2017	June 30, 2019		
2)	Provider representative #2	1	PP	Maria Roman	APAIT Health Center	July 1, 2016	June 30, 2018		
3)	Provider representative #3	1	PP&A	*Miguel Martinez, MSW, MPH*	Children's Hospital Los Angeles	July 1, 2017	June 30, 2019		
4)	Provider representative #4	1	EXC|OPS	Raquel Cataldo	Tarzana Treatment Center	July 1, 2016	June 30, 2018		
5)	Provider representative #5	1	PP	*Terry Goddard, MA*	Alliance for Housing and Healing	July 1, 2017	June 30, 2019		
6)	Provider representative #6	1	PP&A	Anthony Mills, MD	Southern CA Men's Medical Group	July 1, 2016	June 30, 2018		
7)	Provider representative #7	1		*H. Frankie Darling-Palacios*	Los Angeles Gay and Lesbian Center (LAGLC)	July 1, 2017	June 30, 2019		
8)	Provider representative #8	1	PP	Martin Sattah, MD	Rand Shrader Clinic (SPA1), LA County Department of Health Services	July 1, 2016	June 30, 2018		
9)	Unaffiliated consumer, SPA 1	1	OPS	*Michele Daniels*	*unaffiliated consumer*	July 1, 2017	June 30, 2019		
0)	Unaffiliated consumer, SPA 2	1	PPA	Abad Lopez	*unaffiliated consumer*	July 1, 2016	June 30, 2018		
1)	Unaffiliated consumer, SPA 3	1	PPA	*Jason Brown*	*unaffiliated consumer*	July 1, 2017	June 30, 2019		
2)	Unaffiliated consumer, SPA 4			*Vacant*	*unaffiliated consumer*	July 1, 2016	June 30, 2018	1	Susan Forrest
3)	Unaffiliated consumer, SPA 5	1	PPA	*Yolanda Sumpter*	*unaffiliated consumer*	July 1, 2017	June 30, 2019		
4)	Unaffiliated consumer, SPA 6			*Vacant*	*unaffiliated consumer*	July 1, 2016	June 30, 2018		*David Lee, MPH, LCSW*
5)	Unaffiliated consumer, SPA 7	1	PPA	*Raphael Péna*	*unaffiliated consumer*	July 1, 2017	June 30, 2019		
6)	Unaffiliated consumer, SPA 8	1	PP	Lee Kochems, MA	*unaffiliated consumer*	July 1, 2016	June 30, 2018	1	
7)	Unaffiliated consumer, Supervisorial District 1	1	PP	*Jose Muñoz*	*unaffiliated consumer*	July 1, 2017	June 30, 2019		
8)	Unaffiliated consumer, Supervisorial District 2			*Vacant*	*unaffiliated consumer*	July 1, 2016	June 30, 2018	1	*Ernest Hammond, III*
9)	Unaffiliated consumer, Supervisorial District 3			*Vacant*	unaffiliated consumer	July 1, 2017	June 30, 2019	1	Eduardo Martinez
0)	Unaffiliated consumer, Supervisorial District 4	1	EXC|OPS	Kevin Donnelly	*unaffiliated consumer*	July 1, 2016	June 30, 2018		
1)	Unaffiliated consumer, Supervisorial District 5	1	SBP	*Thomas Puckett, Jr.*	*unaffiliated consumer*	July 1, 2017	June 30, 2019		
2)	Unaffiliated consumer, at-large #1	1		*Russell Ybarra*	*unaffiliated consumer*	July 1, 2016	June 30, 2018		
3)	Unaffiliated consumer, at-large #2	1	EXC|OPS	*Joseph Green*	*unaffiliated consumer*	July 1, 2017	June 30, 2019		
4)	Unaffiliated consumer, at-large #3	1	OPS	Kevin Stalter	The Brotherhood IMPACT Fund	July 1, 2016	June 30, 2018		
5)	Unaffiliated consumer, at-large #4	1	OPS	*Bridget Gordon*	*unaffiliated consumer*	July 1, 2017	June 30, 2019		
6)	Representative, Board Office 1	1	PPA	Al Ballesteros, MBA	JWCH Institute, Inc.	July 1, 2016	June 30, 2018		
7)	Representative, Board Office 2			*Vacant*		July 1, 2017	June 30, 2019		
8)	Representative, Board Office 3			*Vacant*		July 1, 2016	June 30, 2018		
9)	Representative, Board Office 4	1	SBP	*Ace Robinson, MPH*	No Affiliations	July 1, 2017	June 30, 2019		
0)	Representative, Board Office 5	1	EXC	Brad Land	*unaffiliated consumer*	July 1, 2016	June 30, 2018		
1)	Representative, HOPWA	1	PP	*Rebecca Ronquillo*	City of Los Angeles, HOPWA	July 1, 2017	June 30, 2019		
2)	Behavioral/social scientist			*Vacant*		July 1, 2016	June 30, 2018		
3)	Local health/hospital planning agency representative	1	SBP	*Matthew Emons, MD, MBA*	LA Care	July 1, 2017	June 30, 2019		
4)	HIV stakeholder representative #1	1	SBP	Grissell Granados, MSW	Children's Hospital Los Angeles	July 1, 2016	June 30, 2018		
5)	HIV stakeholder representative #2	1		*Greg Wilson*	In the Meantime Men's Group	July 1, 2017	June 30, 2019		
6)	HIV stakeholder representative #3	1	OPS	Juan Preciado	Northeast Valley Health Corporation	July 1, 2016	June 30, 2018		
7)	HIV stakeholder representative #4	1	PP	*Eric Paul Leue*	Free Speech Coaltion	July 1, 2017	June 30, 2019		
8)	HIV stakeholder representative #5	1	OPS	Danielle Campbell, MPH	UCLA/MLKCH	July 1, 2016	June 30, 2018		
9)	HIV stakeholder representative #6	1	OPS	*Traci Bivens-Davis*	N/A	July 1, 2017	June 30, 2019		
0)	HIV stakeholder representative #7	1	OPS	Sabel Samone-Loreca	*unaffiliated consumer*	July 1, 2016	June 30, 2018		
1)	HIV stakeholder representative #8			*Vacant*		July 1, 2015	June 30, 2017		
	TOTAL	42	0	42				4	

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
Website: http://hiv.lacounty.gov Email: hivcomm@lachiv.org

COMMITTEE ASSIGNMENTS
(Updated 08/08/17)

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
Al Ballesteros, MBA	Co-Chair, PP&A	Commissioner
Traci Bivens-Davis	Co-Chair, Operations	Commissioner
Jason Brown	Co-Chair, PP&A	Commissioner
Joseph Cadden, MD	Co-Chair, SBP	Commissioner
Raquel Cataldo	At-Large Member*	Commissioner
Kevin Donnelly	At-Large Member*	Commissioner
Aaron Fox, MPM	Co-Chair, Public Policy	Commissioner
Grissel Granados, MSW	Co-Chair, SBP	Commissioner
Joseph Green	At-Large Member*	Commissioner
Eric Paul Leue	Co-Chair, Public Policy	Commissioner
Mario Pérez, MPH	DHSP Director	Commissioner
Kevin Stalter	Co-Chair, Operations	Commissioner

OPERATIONS COMMITTEE

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

Number of Voting Members: 11 ***Number of Quorum***: 6

Traci Bivens-Davis	**Committee Co-Chair***	Commissioner
Kevin Stalter	**Committee Co-Chair***	Commissioner
Danielle Campbell, MPH	*	Commissioner
Raquel Cataldo	*	Commissioner
Michele Daniels	*	Commissioner
Kevin Donnelly	*	Commisisoner
Bridget Gordon	*	Commissioner
Joseph Green	*	Commissioner
Sabel Samone-Loreca	*	Commissioner
John Palomo	*	Commissioner
Juan Preciado	*	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: **12** ***Number of Quorum***: **7**

Al Ballesteros, MBA	**Committee Co-Chair***	Commissioner
Jason Brown	**Committee Co-Chair***	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
Russell Ybarra	*	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: **11** ***Number of Quorum***: **6**

Aaron Fox, MPM	**Committee Co-Chair***	Commissioner
Eric Paul Leue	**Committee Co-Chair***	Commissioner
Jerry Gates, PhD	*	Commissioner
Terry Goddard, MA	*	Commissioner
Lee Kochems, MA	*	Commissioner
Eric Paul Leue	*	Commissioner
José Munoz	*	Commissioner
Maria Roman	*	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: 9 ***Number of Quorum***: 6

Grissel Granados, MSW	**Committee Co-Chair***	Commissioner
Joseph Cadden, MD	**Committee Co-Chair***	Commissioner
Darling-Palacios, Frankie	*	Commissioner
Matthew Emons, MD, MPH	*	Commissioner
Angelica Palmeros, MSW	*	Committee member
Thomas Puckett, Jr.	*	Commissioner
Wendy Garland, MPH	DHSP staff	DHSP representative
Ace Robinson, MPH	*	Commissioner
Wilson, Greg	*	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
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
Maria Roman	Member	Commissioner
Kevin Stalter	Member	Commissioner
Yolanda Sumpter	Member	Commissioner

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

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

TRANSGENDER TASK FORCE

Time/Date: TBD		
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

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	HIV/AIDS Oral Health Care (Dental) Services
			HIV/AIDS Medical Care Coordination Services
			HIV/AIDS Ambulatory Outpatient Medical Services
			HIV/AIDS Medical Care Coordination Services
			nPEP Services
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
DANIELS	Michele	Unaffiliated consumer	No Ryan White or prevention contracts
DARLING-PALACIOS	Frankie	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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
DONNELLY	Kevin	Unaffiliated consumer	No Ryan White or prevention contracts
EMONS	Matthew	LA CARE	No Ryan White or prevention contracts
FORREST	Susan	Los Angeles Center for Alcohol and Drug Abuse	HIV/AIDS Health Education
			HIV/AIDS Substance Abuse
			Risk Reduction Prevention Services
			Residential Rehabilitation Services
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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
HAMMOND	Ernest	No Affiliation	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
LEE	David	Charles R. Drew University of Medicine and Science	HIV/AIDS Benefits Specialty Services
			HIV Counseling, Testing, and Referral Prevention Services
			HIV/AIDS Mental Health, Psychotherapy Services
LEUE PAUL	Eric	Free Speech Coalition	No Ryan White or prevention contracts
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)

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
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
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	No Affiliation	No Ryan White or prevention contracts
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 Department of Health Services	Ambulatory Outpatient Medical (AOM) Medical Care Coordination (MCC) Mental Health, Psychiatry

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

HIV Calendar

August 2017

Sun	Mon	Tue	Wed	Thu	Fri	Sat
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 (CANCELED)	**2** 9:30 AM - 11:30 AM BOS Agenda Review	**3** 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	**4**	**5**
6 Week 32	**7** 1:00 PM - 3:00 PM Public Policy Committee	**8** 9:30 AM - 1:00 PM Board of Supervisors (BOS)	**9** 9:30 AM - 11:30 AM BOS Agenda Review	**10** 9:00 AM - 1:00 PM Commission Meeting	**11**	**12**
13 Week 33	**14**	**15** 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 3:00 PM Planning, Priorities & Allocations (PP&A)	**16** 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Women's Caucus	**17**	**18**	**19**
20 Week 34	**21**	**22** 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 3:00 PM Training for Commissioners: Planning Council Refresher	**23** 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Housing Taskforce	**24**	**25**	**26**
27 Week 35	**28** 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	**29** 9:30 AM - 1:00 PM Board of Supervisors (BOS)	**30** 9:30 AM - 11:30 AM BOS Agenda Review	**31**	1	2

HIV Calendar

September 2017

Sun	Mon	Tue	Wed	Thu	Fri	Sat
27 Week 35	28 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	29 9:30 AM - 1:00 PM Board of Supervisors (BOS)	30 9:30 AM - 11:30 AM BOS Agenda Review	31	1	2
3 Week 36	4 1:00 PM - 3:00 PM Public Policy Committee	5 9:30 AM - 1:00 PM Board of Supervisors (BOS)	6 9:30 AM - 11:30 AM BOS Agenda Review	7 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	8	9
10 Week 37	11	12 9:30 AM - 1:00 PM Board of Supervisors (BOS)	13 9:30 AM - 11:30 AM BOS Agenda Review	14 9:00 AM - 1:00 PM Commission Meeting	15	16
17 Week 38	18 National HIV/AIDS and Aging Awareness Day	19 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 3:00 PM Planning, Priorities & Allocations (PP&A)	20 9:30 AM - 11:30 AM BOS Agenda Review	21	22	23
24 Week 39	25 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	26 9:30 AM - 1:00 PM Board of Supervisors (BOS)	27 National Gay Men's HIV/AIDS Awareness Day 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Housing Taskforce	28	29	30

HIV Calendar

October 2017

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1 Week 40	**2** 1:00 PM - 3:00 PM Public Policy Committee	**3** 9:30 AM - 1:00 PM Board of Supervisors (BOS)	**4** 9:30 AM - 11:30 AM BOS Agenda Review	**5** 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	**6**	**7**
8 Week 41	**9**	**10** 9:30 AM - 1:00 PM Board of Supervisors (BOS)	**11** 9:30 AM - 11:30 AM BOS Agenda Review	**12** 9:00 AM - 1:00 PM Commission Meeting	**13**	**14**
15 Week 42 National Latinx AIDS Awareness Day	**16**	**17** 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 3:00 PM Planning, Priorities & Allocations (PP&A)	**18** 9:30 AM - 11:30 AM BOS Agenda Review	**19**	**20**	**21**
22 Week 43	**23** 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	**24** 9:30 AM - 1:00 PM Board of Supervisors (BOS)	**25** 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Housing Taskforce	**26**	**27**	**28**
29 Week 44	**30**	**31** 9:30 AM - 1:00 PM Board of Supervisors (BOS)	1 9:30 AM - 11:30 AM BOS Agenda Review	2 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	3	4

HIV Calendar

November 2017

Sun	Mon	Tue	Wed	Thu	Fri	Sat
29 Week 44	30	31 9:30 AM - 1:00 PM Board of Supervisors (BOS)	1 9:30 AM - 11:30 AM BOS Agenda Review	2 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	3	4
5 Week 45	6 1:00 PM - 3:00 PM Public Policy Committee	7 9:30 AM - 1:00 PM Board of Supervisors (BOS)	8 9:30 AM - 11:30 AM BOS Agenda Review	9 9:00 AM - 4:00 PM Annual Commission Meeting at the Dorothy Chandler Pavillion Salons A&B,5th Floor	10	11
12 Week 46	13	14 9:30 AM - 1:00 PM Board of Supervisors (BOS)	15 9:30 AM - 11:30 AM BOS Agenda Review	16	17	18
19 Week 47	20	21 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 3:00 PM Planning, Priorities & Allocations (PP&A)	22 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Housing Taskforce	23	24	25
26 Week 48	27 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	28 9:30 AM - 1:00 PM Board of Supervisors (BOS)	29 9:30 AM - 11:30 AM BOS Agenda Review	30	1 World AIDS Day	2

LOS ANGELES COUNTY COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140, Los Angeles, CA 90010 · TEL. (213) 7382816 · FAX (213) 637-4748
Website: http://hiv.lacounty.gov Email: hivcomm@lachiv.org

3. MEETING MINUTES

A. July 13, 2017 Commission Meeting

LOS ANGELES COUNTY COMMISSION ON HIV
3530 Wilshire Boulevard, Suite 1140, Los Angeles, CA 90010 · TEL. (213) 7382816 · FAX (213) 637-4748
Website: http://hiv.lacounty.gov Email: hivcomm@lachiv.org

6. CO-CHAIR'S REPORT

A. Policy/Procedure #06.1000, The Bylaws of the Los Angeles County Commission on HIV

B. Duty Statement, Commission Co-Chair

LOS ANGELES COUNTY COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA90010 • TEL (213) 738-2816 • FAX (213) 637-4748
www.hivcommission-la.info

ADOPTED, 7/11/2013

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

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

[...]

VIII. LEADERSHIP:

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

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

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

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

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

1. Assign the members of the Commission to committees;
2. Approve committee co-chairs, in consultation with the Executive Committee;
3. Represent the Commission at functions, events and other public activities, as necessary;
4. Call special meetings, as necessary, to ensure that the Commission fulfills its duties;
5. Consult with and advise the Executive Director regularly, and the Ryan White Part A and CDC project officers, as needed;
6. Conduct the performance evaluation of the Executive Director, in consultation with the Executive Committee and the Executive Office of the BOS;
7. Chair or co-chair committee meetings in the absence of both committee co-chairs;
8. Serve as voting members on all committees when attending those meetings;
9. Are empowered to act on behalf of the Commission or Executive Committee on emergency matters; and
10. Attend to such other duties and responsibilities as assigned by the BOS or the Commission.

[...]

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

Originally Adopted: 3/15/1995

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

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

DUTY STATEMENT

COMMISSION CO-CHAIR

(APPROVED 3-28-17)

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

ORGANIZATIONAL LEADERSHIP:

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

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

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

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

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

MEETING MANAGEMENT:

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

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

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

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

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

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

COMMITMENT/ACCOUNTABILITY TO THE OFFICE:

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

LOS ANGELES COUNTY COMMISSION ON HIV
3530 Wilshire Boulevard, Suite 1140, Los Angeles, CA 90010 · TEL. (213) 7382816 · FAX (213) 637-4748
Website: http://hiv.lacounty.gov Email: hivcomm@lachiv.org

13. CALIFORNIA OFFICE OF AIDS (OA) REPORT

A. OA Work/Information

California Department of Public Health CDPH

OFFICE OF AIDS
California Department of Public Health

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

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

- **ADAP Client Eligibility**
  The California Department of Public Health (CDPH), Office of AIDS (OA) extended eligibility to July 31 for clients whose birthday or half-birthday is in July. Enrollment workers have been reminded to reach out to their clients whose birthday or half-birthday is in July to re-enroll and recertify them in a timely manner, so their eligibility is extended to their next recertification or re-enrollment date.

- **Emergency Medication Access**
  - Enrollment workers have been reminded that ADAP clients who do not have access to ADAP medications and are at risk for an interruption in treatment should contact the ADAP Call Center at (844) 421-7050, 8:00 a.m. - 5:00 p.m., Monday through Friday (excluding state holidays). They may also contact the Magellan Call Center at (800) 424-5906, 24 hours a day, seven days a week.

  - Effective July 19, ADAP staff and Magellan Call Center staff are able to change clients' eligibility dates via an Emergency Access Process. Clients whose eligibility has lapsed (in the last 30 days) due to not re-enrolling or re-certifying will be granted a one-time Emergency Access approval.

    Clients whose eligibility has been expired for more than 30 days, who were dis-enrolled from ADAP due to not meeting ADAP eligibility requirements (i.e. exceeded the income criteria, moved out of state, etc.), or who have an expired Temporary Access Period (TAP) will not be granted emergency access.

- **ADAP Enrollment System**
  The ADAP Enrollment System is being developed in stages, with releases of features and improvements every four weeks to support eligibility management, system navigation, data exchange, reporting, quality assurance, and data security. ADAP continues to coordinate each release with training and outreach to ensure enrollment workers and other users are aware of changes and can correctly use any new features.

- **ADAP Enrollment Worker System Onboarding**
  As of August 8, 99 percent of ADAP enrollment workers have completed the required WebEx system training, 96 percent have completed the eLearning course, and 87 percent have logged in to the system.

RW Part B: HIV Care Program

- The OA, HIV Care Branch will conduct the *Building the Care Continuum: Comprehensive Approaches to HIV Care in California* statewide meeting on August 28-30, 2017, in Los Angeles. This meeting is for OA's HIV Care Program (HCP), Minority AIDS Initiative (MAI), and Housing Opportunities for People Living With AIDS (HOPWA) program contractors and subcontractors, by invite only. At this meeting, contractors will learn about (and prepare for) the changing federal landscape with respect to the Affordable Care Act, future of HIV programs, share best practices that can realistically be replicated, determine how to implement California's *Laying a Foundation for Getting to Zero* Plan, and learn HCP basics.

- OA is planning to update the HCP, MAI, and HOPWA allocation formulas, which will be completed by July 2018 and implemented in fiscal year 2019-2020. To assist in this process, OA will convene a Stakeholder Engagement Group (SEG) that will provide valuable input to OA as the formulas are updated. The SEG will consist of approximately 10 members that represent the California Planning Group, the California Sexually Transmitted Disease/HIV Controllers Association, and HCP, MAI, and HOPWA contractors. An email invitation was sent out to these stakeholders on July 31st, with a deadline of August 18th to respond with an expression of interest in participating. Questions about the SEG can be sent to Liz Hall at liz.hall@cdph.ca.gov.

AIDS Medi-Cal Waiver Program (MCWP)

The Budget Act of 2017 (Assembly Bill 120 Section 3, Provision 3) included an allocation increase of up to $4,000,000 General Fund ($8,000,000 Total Fund) for MCWP provider payments. The full text of Assembly Bill 120 can be found on the California Legislative Information website at http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180AB120

The OA and the Department of Health Care Services (DHCS), Long Term Care Division held a conference call on Friday, July 28, 2017, at 10:00 a.m. to discuss MCWP provider payments pursuant to Assembly Bill 120 that appropriates Proposition 56 funds for specified DHCS expenditures for supplemental payments.

DHCS has proposed to increase payments for select HIV/AIDS Waiver services. The increased payments, subject to Federal approval, would work as follows:

Providers who are eligible to provide and bill for the following Current Procedural Terminology (CPT) codes under the HIV/AIDS Waiver will receive an increased payment, in order to bring their payment total to the amount identified.

Procedure Code	Service	Total Payment Amount
G0299	Skilled Nursing (RN)	$19.27
G0300	Skilled Nursing (LVN)	$13.97
90837	Psychotherapy (Hr)	$98.02
G0156	Attendant Care	$9.52
S5130	Homemaker	$7.07
T2003	Non-Emergency Medical Transportation (Month)	$100.00
S9470	Nutritional Counseling (Hr)	$63.61
T2022	Case Management	$363.23
T2025	Admin	$246.91
Payment for codes G0299, G0300, S5130 and G0156 are reflected, as billed, in 15 min. time increments.		

DHCS is seeking federal approval of a Waiver Amendment. DHCS estimates that the total increased payments made for services in Fiscal Year 2017-18 under this proposal will total approximately $8M total funds ($4M proposition 56). These payments will occur once the systems necessary to implement these payments are in place, with proposed effective date of July 1, 2017 (subject to federal approval).

HIV Prevention

In June, the Centers for Disease Control and Prevention (CDC) announced the availability of fiscal year 2018 funds for a cooperative agreement for health departments to implement an integrated HIV surveillance and prevention program. The purpose of this funding opportunity announcement (FOA) is to implement a comprehensive HIV surveillance and prevention program to prevent new HIV infections and achieve viral suppression among persons living with HIV. OA will be applying for PS18-1802 Component A and B funding. The FOA can be found on the CDC website at www.cdc.gov/hiv/funding/announcements/ps18-1802/index.html.

Surveillance, Research, and Evaluation

- Enhanced HIV surveillance data sets are now available to all local health jurisdictions who have a current data use agreement on file. These new data sets have been modified to include ALL of the cases currently living in the local health jurisdiction (LHJ), and will enable the more effective use of surveillance data for accomplishing our Getting to Zero goals. Previously only cases for which the LHJ had "ownership" [as defined by the Enhanced HIV/AIDS Reporting System (eHARS) database] were available. Besides more complete case inclusion, these data sets have been enhanced with more accurate and complete address information gleaned from all available eHARS documentation. These data sets will be uploaded to each LHJ's Secure File Transfer (SFT) quarterly, replacing the previous Data Use Agreement (DUA) data sets. The Q2 data which was uploaded in early July included these enhancements.

- In early August, LHJ-level continuums containing final 2015 information were released to all LHJs via SFT. These continuums are identical to the 2014 continuums released for the first time last year, and contain detailed information about newly diagnosed and living cases by multiple factors, including race/ethnicity, age, risk, and other factors. Because of the multiple crosstabs included, they should be treated as confidential, potentially identifiable data. Continuums containing ***preliminary*** 2016 data were also released to Ryan White Part A primary grantees via SFT. Note that these contain preliminary data and are only intended to be used for Ryan White applications. Finally, OA will soon release a streamlined continuum document containing continuum information for all LHJs using a letter masking scheme. LHJs will be informed of which letter identifies their information, and will be able to compare it to information of other, similarly-sized LHJs.

California Planning Group (CPG)

The CPG will have an in-person meeting on October 17-19, 2017, in Anaheim. The meeting is open to the public and there will be an opportunity for public comment. Information about the meeting and the public comment opportunity will be available on the OA website at www.cdph.ca.gov/Programs/CID/DOA/Pages/OAmain.aspx#.

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

LOS ANGELES COUNTY COMMISSION ON HIV
3530 Wilshire Boulevard, Suite 1140, Los Angeles, CA 90010 · TEL. (213) 7382816 · FAX (213) 637-4748
Website: http://hiv.lacounty.gov Email: hivcomm@lachiv.org

14. STANDING COMMITTEE REPORTS

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

(1) Ryan White Program (RWP) Year 28 Service Categories Priority Rankings

(2) RW PY26 Final Expenditures Review

(3) CDC HIV Prevention & Surveillance Notice of Funding Announcement

C Operations Committee

(4) Community Engagement

(a) Tier 3 Listening Session Report PPT

D. Public Policy Committee

(1) 2017 COH Legislative Docket Updates

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

Planning, Priorities and Allocations Committee
Recommended Service Category Rankings
PY 28 (2018-19)

COH 2018-19 Ranking	Commission on HIV (COH) Service Categories	HRSA Core/ Support Service	Core and Support Services Defined by Health Resources and Services Administration (HRSA)
1	Ambulatory Outpatient Medical Services	C	Outpatient/Ambulatory Health Services
	Medical Subspecialty Services		
	Therapeutic Monitoring Program		
2	Housing	S	Housing
	Permanent Support Housing		
	Transitional Housing		
	Emergency Shelters		
	Transitional Residential Care Facilities (TRCF)		
	Residential Care Facilities for the Chronically Ill (RCFCI)		
3	Mental Health Services	C	Mental Health Services
	MH, Psychiatry		
	MH, Psychotherapy		
4	Medical Care Coordination	C	Medical Case Management (including treatment adherence services)
5	Medical Transportation	S	Medical Transportation
6	Non-Medical Case Management	S	Non-Medical Case Management Services
	Linkage Case Management		
	Benefit Specialty		
	Benefits Navigation		
	Transitional Case Management		
	Housing Case Management		
7	Oral Health Services	C	Oral Health Care
8	Psychosocial Support Services	S	Psychosocial Support Services
9	Outreach Services	S	Outreach Services

COH 2018-19 Ranking	Commission on HIV (COH) Service Categories	HRSA Core/ Support Service	Core and Support Services Defined by Health Resources and Services Administration (HRSA)
10	Nutrition Support	S	Food Bank/Home Delivered Meals
11	Early Intervention Services	C	Early Intervention Services
12	Substance Abuse Residential	S	Substance Abuse Treatment Services (Residential)
13	Home Base Case Management	C	Home and Community Based Health Services
14	Home Health Care	C	Home Health Care
15	Health Education/Risk Reduction	S	Health Education/Risk Reduction
16	Direct Emergency Financial Assistance	S	Emergency Financial Assistance
17	Substance Abuse Outpatient	C	Substance Abuse Outpatient Care
18	Referral	S	Referral for Health Care and Support Services
19	Child Care Services	S	Child Care Services
20	Health Insurance Premium/Cost Sharing	C	Health Insurance Premium and Cost-Sharing Assistance for Low-income Individuals
21	Hospice	C	Hospice
22	Other Professional Services	S	Other Professional Services
	Legal Services		
	Permanency Planning		
23	Language	S	Linguistics Services
24	Medical Nutrition Therapy	C	Medical Nutrition Therapy
25	Rehabilitation Services	S	Rehabilitation Services
26	Respite	S	Respite Care
27	Local Pharmacy Assistance	C	AIDS Pharmaceutical Assistance

RYAN WHITE PART A SUMMARY

DRAFT

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH

DIVISION OF HIV AND STD PROGRAMS

SUMMARY REPORT

RYAN WHITE PART A, PART B AND MAI YEAR 26 EXPENDITURES BY SERVICE CATEGORIES

GRANT YEAR 26 RYAN WHITE PART A FUNDING EXPENDITURES THROUGH FEBRUARY 28, 2017

1	2	3	4	5	6	7
PRIORITY RANKING	SERVICE CATEGORY	FY 16 APPROVED PERCENTAGES	TOTAL ALLOCATIONS BASED ON REVISED PERCENTAGES PARTS A	PART A TOTAL YTD EXPENDITURES	PART A FULL YEAR EXPENDITURES	VARIANCE TOTAL ALLOCATIONS VS. FULL YR. EXPENDITURES (Columns 4 vs. 6)
1	OUTPATIENT/AMBULATORY MEDICAL CARE	30.0%	$ 10,033,619	**8,700,822**	**8,700,822**	$ 1,332,797
6	CASE MANAGEMENT SERVICES (Non Medical) - Benefits Specialty	3.6%	1,204,034	**1,408,716**	**1,408,716**	(204,682)
2	ORAL HEALTH CARE	2.3%	769,244	**5,858,769**	**5,858,769**	(5,089,525)
5	MENTAL HEALTH SERVICES - Psychiatry	1.3%	434,790	**444,726**	**444,726**	(9,936)
5	MENTAL HEALTH SERVICES - Psychotherapy	4.7%	1,571,934	**1,563,642**	**1,563,642**	8,292
4	MEDICAL CASE MANAGEMENT SERVICES - Medical Care Coordination	30.0%	10,033,619	**8,389,120**	**8,389,120**	1,644,499
6	CASE MANAGEMENT SERVICES (Non Medical) Linkage Case Management	2.0%	668,908	**649,917**	**649,917**	18,991
7	OUTREACH SERVICES	0.0%	-	0	0	-
10	SUBSTANCE ABUSE TREATMENT SERVICES - RESIDENTIAL	6.0%	2,006,724	**2,649,333**	**2,649,333**	(642,609)
9	HOUSING SERVICES (RCFCI, TRCF) (a)	13.5%	4,515,129	**1,085,596**	**1,085,596**	3,429,533
17	MEDICAL TRANSPORTATION SERVICES	2.1%	702,353	**723,697**	**723,697**	(21,344)
12	FOOD BANK/HOME DELIVERED MEALS - Nutrition Support	2.9%	969,917	**1,123,106**	**1,123,106**	(153,189)
6	CASE MANAGEMENT SERVICES (Non Medical) Transitional Case Management	0.0%	-	0	0	-
15	HOME AND COMMUNITY BASED HEALTH SERVICES	0.0%	-	**667,777**	**667,777**	(667,777)
21	REFERRAL FOR HEALTH CARE / SUPPORT SERVICES	0.9%	301,009	**0**	**0**	301,009
18	MEDICAL NUTRITION THERAPY (SPA 1 only)	0.1%	33,445	**19,506**	**19,506**	13,939
19	LEGAL SERVICES	0.6%	200,672	**160,671**	**160,671**	40,001
11	LINGUISTICS SERVICES	0.0%	-	0	0	-
	SUB-TOTAL DIRECT SERVICES	100.0%	33,445,398	**33,445,398**	**33,445,398**	0
	QUALITY MANAGEMENT (4.78% of Part A award)		1,872,973	1,872,973	1,872,973	-
	ADMINISTRATION (Includes COH Budget) (10% of Part A award)		3,924,264	3,924,264	3,924,264	-
	GRAND TOTAL	100.0%	**$ 39,242,635**	**$ 39,242,635**	**$ 39,242,635**	**$ 0**

Year 26 Grant funding for Part A is $39,242,635 $ 39,242,635

$ -

Notes: (a) Allocation amounts for this service category is also funded with Year 2016 Part B funding.

Column 3 - Year 26 Allocation % (These percentages represents the current COH approved percentages for Ryan White Year 26 allocations).

Column 4 - Total Allocations: The Ryan White Part A Year 26 award is $39,242,635

Column 5 - The Total Year To Date (YTD) Part A Expenditures represents actual reimbursements/payments made to subcontracted agencies/vendors as of the date identified on this report.

Column 6 - Total Full Year expenditures represents costs through the end of the grant funding term.

Column 7 - Represents the variances between the allocation amounts for each service category (Column 4) and the full year expenditures for each service category (Column 6).

DRAFT

Ryan White Part B Summary

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH

DIVISION OF HIV AND STD PROGRAMS

SUMMARY REPORT

RYAN WHITE PART A, PART B AND MAI YEAR 26 EXPENDITURES BY SERVICE CATEGORIES

GRANT YEAR 26 RYAN WHITE PART B FUNDING EXPENDITURES THROUGH MARCH 31, 2017

1	2	3	4	5	6	7
PRIORITY RANKING	SERVICE CATEGORY	FY 26 APPROVED PERCENTAGES	TOTAL ALLOCATIONS BASED ON REVISED PERCENTAGES PART B	PART B TOTAL YTD EXPENDITURES	PART B FULL YEAR EXPENDITURES	VARIANCE TOTAL ALLOCATIONS VS. FULL YR. EXPENDITURES (Columns 4 vs. 6)
1	OUTPATIENT/AMBULATORY MEDICAL CARE	30.0%				$ -
6	CASE MANAGEMENT SERVICES (Non Medical) - Benefits Specialty	3.6%				-
2	ORAL HEALTH CARE	2.3%				-
5	MENTAL HEALTH SERVICES - Psychiatry	1.3%				-
5	MENTAL HEALTH SERVICES - Psychotherapy	4.7%				-
4	MEDICAL CASE MANAGEMENT SERVICES - Medical Care Coordination	30.0%				-
6	CASE MANAGEMENT SERVICES (Non Medical) Linkage Case Management	2.0%				-
7	OUTREACH SERVICES	0.0%				-
10	SUBSTANCE ABUSE TREATMENT SERVICES - RESIDENTIAL	6.0%				-
9	HOUSING SERVICES (RCFCI, TRCF) (a)	13.5%	2,430,000	**2,430,000**	**2,430,000**	-
17	MEDICAL TRANSPORTATION SERVICES	2.1%				-
12	FOOD BANK/HOME DELIVERED MEALS - Nutrition Support	2.9%				-
6	CASE MANAGEMENT SERVICES (Non Medical) Transitional Case Management	0.0%				-
15	HOME AND COMMUNITY BASED HEALTH SERVICES	0.0%				-
21	REFERRAL FOR HEALTH CARE / SUPPORT SERVICES	0.9%				-
18	MEDICAL NUTRITION THERAPY (SPA 1 only)	0.1%				-
19	LEGAL SERVICES	0.6%				-
11	LINGUISTICS SERVICES	0.0%				-
	SUB-TOTAL DIRECT SERVICES	100.0%	$ 2,430,000	**$ 2,430,000**	**$ 2,430,000**	-
	QUALITY MANAGEMENT		0	0	0	-
	ADMINISTRATION (10% of Part B award)		270,000	270,000	270,000	-
	GRAND TOTAL	100.0%	**$ 2,700,000**	**$ 2,700,000**	**$ 2,700,000**	$ -

Year 26 revised State allocation for Part B is $2,700,000. $ 2,700,000

$ -

Notes:

Columns 3 - Year 26 Allocation % (These percentages represents the current COH approved percentages for Ryan White Program Year 26 allocations).

Column 4 - Total Allocations: The Ryan White Part B Year 26 award is $2,700,000.

Column 5 - The Total Year To Date (YTD) Part B Expenditures represents actual reimbursements/payments made to subcontracted agencies/vendors as of the date identified on this report.

Column 6 - Total Full Year expenditure represents costs through the end of the grant funding term.

Column 7 - Represents the variances between the allocation amounts for each service category (Column 4) and the full year expenditures for each service category (Column 6).

RYAN WHITE MAI SUMMARY

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH

DIVISION OF HIV AND STD PROGRAMS

SUMMARY REPORT

RYAN WHITE PART A, PART B AND MAI YEAR 16 EXPENDITURES BY SERVICE CATEGORIES

GRANT YEAR 16 RYAN WHITE MAI FUNDING EXPENDITURES THROUGH FEBRUARY 28, 2017

1	2	3	4	5	6	7
PRIORITY RANKING	SERVICE CATEGORY	FISCALYEAR 16 MAI ALLOC. %	TOTAL ALLOCATION MAI FISCAL YEAR 16	MAI FISCAL YEAR 16 TOTAL YTD EXPENDITURES	MAI FISCAL YEAR 16 FULL YEAR EXPENDITURES	VARIANCE TOTAL ALLOCATIONS S. FULL YR. EXPENDITURE (Columns 4 vs. 6)
1	OUTPATIENT/AMBULATORY MEDICAL CARE		$ -	$ -		$ -
6	CASE MANAGEMENT SERVICES (Non Medical) - Benefits Specialty	-	-			0
2	ORAL HEALTH CARE	-				0
5	MENTAL HEALTH SERVICES - Psychiatry					0
5	MENTAL HEALTH SERVICES - Psychotherapy					0
4	MEDICAL CASE MANAGEMENT SERVICES - Medical Care Coordination	-				0
6	CASE MANAGEMENT SERVICES (Non Medical) Linkage Case Management					0
7	OUTREACH SERVICES	10.5%	632,378	**1,219,536**	**1,219,536**	(587,158)
10	SUBSTANCE ABUSE TREATMENT SERVICES - RESIDENTIAL					0
9	HOUSING SERVICES (RCFCI, TRCF) (a)	63.3%	3,812,333	**1,677,088**	**1,677,088**	2,135,245
17	MEDICAL TRANSPORTATION SERVICES					0
12	FOOD BANK/HOME DELIVERED MEALS - Nutrition Support					0
6	CASE MANAGEMENT SERVICES (Non Medical) Transitional Case Management	21.1%	1,270,778	**617,540**	**617,540**	653,238
15	HOME AND COMMUNITY BASED HEALTH SERVICES					0
21	REFERRAL FOR HEALTH CARE / SUPPORT SERVICES					0
18	MEDICAL NUTRITION THERAPY (SPA 1 only)					0
19	LEGAL SERVICES					0
11	LINGUISTIC SERVICES	5.1%	307,155	**218,269**	**218,269**	88,886
	SUB-TOTAL DIRECT SERVICES	100.0%	6,022,643	**3,732,433**	3,732,433	2,290,210
	ADMINISTRATION (10% of MAI Year 16 award)		337,179	337,179	337,179	0
	GRAND TOTAL	100.0%	$ **6,359,822**	$ **4,069,612**	$ **4,069,612**	$ **2,290,210**

The total MAI funding for Year 26 includes $3,371,793 for Year 26 and $2,988,029 in rolled over Year 25 underspending.

$	6,359,822
$	2,290,210

Notes: (a) Allocation amounts for this service category are also funded with Year 2016 Part A and Part B funding.

Column 3 - Year 26 Allocation % approved by the COH.

Column 4 - Total grant allocations for the Ryan White Year 16 MAI award is $3,371,793 plus $2,988,029 in Ryan White Year 15 roll over funding ($3,371,793 + $2,988,029 = $6,359,822).

Column 5 - The Total Year To Date (YTD) Expenditures represents actual reimbursements/payments made to subcontracted agencies/vendors as of the date identified on this report.

Column 6 - Total Full Year expenditures represents costs through the end of the grant funding term.

Column 7 - Represents the variances between the allocation amounts for each service category (Column 4) and the full year expenditures for each service category (Column 6).

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH

DIVISION OF HIV AND STD PROGRAMS

SUMMARY REPORT

RYAN WHITE PART A, PART B AND MAI YEAR 26 EXPENDITURES BY SERVICE CATEGORIES

GRANT YEAR 26 RYAN WHITE AND OTHER FISCAL YEAR 16/17 FUNDING EXPENDITURES

2	3	4	5 (*)	6 (*)	7 (*)	8	9	10
SERVICE CATEGORY	FY 26 REVISED PARTS A&B PERCENTAGES	TOTAL ALLOC. PARTS A, B and MAI (Column 5 pgs. 1, 2, & Column 4, page 3)	OTHER CONTRACTED FUNDING NCC FY 2016/17	OTHER CONTRACTED FUNDING STATE FY 2016/17	OTHER CONTRACTED FUNDING CDC 2016	TOTAL OTHER FUNDING (Cols 5 thru 7)	TOTAL ALL FUNDING COMMITTED (Columns 4 + 8)	VARIANCE TOTAL ALLOC. (Col 4) VS. TOTAL ALL FNDG/COMMIT (Col 9) (Columns 4 vs. 9)
OUTPATIENT/ AMBULATORY MEDICAL CARE	30.0%	$ 10,033,619	$ 400,000	$ 80,000		$ 480,000	$ 10,513,619	$ (480,000)
CASE MANAGEMENT SERVICES (Non Medical) - Benefits Specialty	3.6%	1,204,034				0	1,204,034	0
ORAL HEALTH CARE	2.3%	769,244				0	769,244	0
MENTAL HEALTH SERVICES, PSYCHIATRY	1.3%	434,790				0	434,790	0
MENTAL HEALTH SERVICES, PSYCHOTHERAPY	4.7%	1,571,934				0	1,571,934	0
MEDICAL CASE MGMT SVCS - MEDICAL CARE COORDINATI	30.0%	10,033,619	234,044			234,044	10,267,663	(234,044)
CASE MANAGEMENT SERVICES - LINKAGE CASE MANAGEN	2.0%	668,908		-		0	668,908	0
OUTREACH SERVICES	0.0%	632,378				0	632,378	0
SUBSTANCE ABUSE TREATMENT SERVICES - RESIDENTIAL	6.0%	2,006,724		2,200,000		2,200,000	4,206,724	(2,200,000)
HOUSING SERVICES	13.5%	10,757,462				0	10,757,462	0
MEDICAL TRANSPORTATION SERVICES	2.1%	702,353	51,000			51,000	753,353	(51,000)
FOODBANK HOME DELIVERED MEALS - NUTRITION SUPPOI	2.9%	969,917				0	969,917	0
CASE MANAGEMENT (NON MEDICAL) TRANSITIONAL CASE	0.0%	1,270,778	150,000			150,000	1,420,778	(150,000)
HOME AND COMMUNITY BASED HEALTH SERVICES	0.0%	-	1,320,000			1,320,000	1,320,000	(1,320,000)
REFERRAL FOR HEALTH CARE / SUPPORT SERVICES	0.9%	301,009				0	301,009	0
MEDICAL NUTRITION THERAPY	0.1%	33,445	6,800			6,800	40,245	(6,800)
LEGAL SERVICES	0.6%	200,672	50,000			50,000	250,672	(50,000)
LINGUISTICS SERVICES	0.0%	307,155	71,000			71,000	378,155	(71,000)
SUB-TOTAL DIRECT SERVICES	100.0%	$ 41,898,041	$ 2,282,844	$ 2,280,000	$ -	$ 4,562,844	$ 46,460,885	$ (4,562,844)
QUALITY MANAGEMENT		1,872,973	0	0	0	0	1,872,973	0
ADMINISTRATIVE SERVICES		4,531,443	4,500,000	163,000		4,663,000	9,194,443	(4,663,000)
GRAND TOTAL	**100.0%**	**$ 48,302,457**	**$ 6,782,844**	**$ 2,443,000**	**$ -**	**$ 9,225,844**	**$ 57,528,301**	**$ (9,225,844)**

Note: Cols 5 & 6 - The Ambulatory Outpatient Medical allocation for subcontracted agency's in Column 5 represents the enhanced AOM rates for some providers for meeting program objectives, Column 6 represents an estimate of DHSP's administrative costs for ADAP coordination.

(*) Columns 5, 6 and 7 reflects the estimated contract expenditure amounts and can be adjusted for contract increases, reductions or contract terminations.

Note: column 10 Variance of Total Allocation Part A, Part B and MAI Year 26 vs. Total All Contracts/Commitments - if the variance amount is a negative number, this means that the contracts/commitments exceeds the Part A, Part B or MAI Year 26 available funding. Expenditures that exceeds grant funding will be offset with Net County Cost, State or CDC funding.

Overview of CDC-RFA-PS18-1802 – Integrated HIV Surveillance and Prevention Programs for Health Departments

Los Angeles County Department of Public Health
Division of HIV and STD Programs

Commission on HIV, Committee on Priorities, Planning and Allocation
July 18, 2017

Presented by Dr. Michael Green

Summary

- This new funding opportunity will integrate HIV surveillance and prevention programs in an effort to take advantage of recent advances in both surveillance and prevention.
- With this integration CDC looks to accelerate progress toward a goal of no new infections through two central priorities:
  - *Ensure that all people living with HIV are aware of their infection and successfully linked to medical care and treatment to achieve viral suppression.*
  - *Expand access to pre-exposure prophylaxis (PrEP), condoms, and other proven strategies for people at high risk of becoming infected.*

County of Los Angeles Public Health

Differences between current grant (PS12-1201) and new FOA (PS18-1802)

Grant Focus Areas	Current PS12-1201	New PS18-1802
Funding Categories	Cat A: (core) Cat B: Expanded Testing for Disproportionately Affected Populations (optional) Cat C: Demonstration Project (optional/competitive)	Component A: (core) Comp B: Demonstration Project (optional/competitive)
Number of Demonstration Project Awards	Up to 36 awards	Up to 20 awards
COH Letter of Concurrence	Required	Not Required
Program Narrative Page Limits	Cat A: 50 pages Cat B: 40 pages Cat C: 10 pages	Cat A & Cat B combined: 19 pages

3

County of Los Angeles Public Health

Differences between current grant (PS12-1201) and new FOA (PS18-1802) cont.

Grant Focus Areas	Current PS12-1201	New PS18-1802
Distribution of Funds	Minimum of 75% of the award must be spent on 4 required activities	• Minimum of 75% of the award must be spent on 7 required activities. • Minimum of 14% of the award must be spent on surveillance activities.
Required Activities/Strategies (75% or more of the award amount)	1. HIV Testing 2. Comprehensive Prevention for Positives 3. Condom Distribution 4. Policy Initiatives	1. Systematically collect, analyze, interpret, and disseminate HIV data to characterize trends in HIV infection, detect active HIV transmission, implement public health interventions, and evaluate public health response 2. Identify persons with HIV infection and uninfected persons at risk for HIV infection 3. Develop, maintain, and implement a plan to respond to HIV transmission clusters and outbreaks

4

County of Los Angeles Public Health

Differences between current grant (PS12-1201) and new FOA (PS18-1802) cont.

Grant Focus Areas	Current PS12-1201	New PS18-1802
Required Activities/Strategies (75% or more of the award amount)	1. HIV Testing 2. Comprehensive Prevention for Positives 3. Condom Distribution 4. Policy Initiatives	4. Provide comprehensive HIV-related prevention services for people living with diagnosed HIV infection 5. Provide comprehensive HIV-related prevention services for HIV-negative persons at risk for HIV infection 6. Conduct perinatal HIV prevention and surveillance activities 7. Conduct community-level HIV prevention activities

5

County of Los Angeles Public Health

Differences between current grant (PS12-1201) and new FOA (PS18-1802) cont.

Grant Focus Areas	Current PS12-1201	New PS18-1802
Other Required Activities/Strategies (25% or less of the award amount)	5. Jurisdictional Planning 6. Capacity Building and Technical Assistance 7. Program Planning, Monitoring, and Evaluation	8. Develop partnerships to conduct integrated HIV prevention and care planning 9. Implement structural strategies to support and facilitate HIV surveillance and prevention 10. Conduct data-driven planning, monitoring, and evaluation to continuously improve HIV surveillance, prevention, and care activities 11. Build capacity for conducting effective HIV program activities, epidemiologic science, and geocoding

County of Los Angeles Public Health

Required Strategy 1

Systematically collect, analyze, interpret, and disseminate HIV data to characterize trends in HIV infection, detect active HIV transmission, implement public health interventions, and evaluate public health response

- Activities include:
  - HIV Surveillance
  - HIV Prevention Program Monitoring and Evaluation

7

County of Los Angeles Public Health

Required Strategy 2

Identify persons with HIV infection and uninfected persons at risk for HIV infection

- Activities include:
  - Implement HIV testing
  - Provide partner services
  - Conduct Data-to-Care (D2C) activities

8

County of Los Angeles Public Health

Required Strategy 3

Develop, maintain, and implement plan to respond to HIV transmission clusters and outbreaks

- Activities include:
  - Develop and maintain a jurisdiction-wide cluster and outbreak detection and response plan
  - Develop program capacity for cluster detection and response
  - Identify and investigate HIV transmission clusters and outbreaks
  - Rapidly respond to and intervene in HIV transmission clusters and outbreaks

9

County of Los Angeles Public Health

Required Strategy 4

Provide comprehensive HIV-related prevention services for persons living with diagnosed HIV infection

- Activities include:
  - Provide linkage to medical care, treatment, and prevention services for PLWH
  - Promote early ART and provide medication adherence strategies
  - Promote and monitor viral suppression
  - Monitor HIV drug resistance
  - Conduct risk reduction interventions for PLWH
  - Refer PLWH to other essential support services (e.g., screening and active referrals for healthcare benefits, behavioral health, and other medical and social services)

10

County of Los Angeles Public Health

Required Strategy 5

Provide comprehensive HIV-related prevention services for HIV-negative persons at risk for HIV infection

- Activities include:
  - Provide periodic HIV testing and risk screening
  - Increase awareness of and expand access to PrEP and medication adherence to PrEP
  - Identify communities/individuals for implementation of PrEP services using HIV surveillance, testing, and other data
  - Refer populations at greatest risk to PEP
  - Conduct risk reduction interventions for HIV-negative persons at risk for HIV infection
  - Refer HIV-negative persons at risk for HIV infection to other essential support services

11

County of Los Angeles Public Health

Required Strategy 6

Conduct Perinatal HIV Prevention and Surveillance Activities

- Activities include:
  - Promote routine, perinatal HIV testing of all pregnant women
  - Conduct case surveillance activities for women with diagnosed HIV infection and their infants
  - Conduct annual matching of HIV-infected women reported to surveillance from the state birth registry and tribal birth registry
  - Analyze and disseminate data on HIV-infected women of childbearing age, perinatal HIV exposures, and HIV-infected infants

12

County of Los Angeles Public Health

Required Strategy 7

Conduct Community-level HIV Prevention Activities

- Activities include:
  - Social marketing campaigns
  - Social media strategies
  - Community mobilization
  - Condom Distribution Programs

13

County of Los Angeles Public Health

Required Strategy 8

Develop partnerships to conduct integrated HIV prevention and care planning

- Activities include:
  - Establish and maintain an HIV planning group and a process that entails engaging partners and stakeholders in prevention and care planning
  - Develop, monitor, and update the jurisdiction's 2017 – 2021 CDC and HRSA Integrated HIV prevention and Care Plan
  - Develop HIV prevention and care networks for increased coordination of, availability of, and access to comprehensive HIV prevention, treatment, and support services

14

County of Los Angeles Public Health

Required Strategy 9

Implement structural strategies to support and facilitate HIV surveillance and prevention

- Activities include:
  - Strengthen policies and protocols to support HIV surveillance and prevention at the state and local level
  - Strengthen health information systems infrastructure
  - Promote expansion of technological advances to enhance HIV surveillance, testing, data analysis, and sharing
  - Ensure data security, confidentiality, and sharing

15

County of Los Angeles Public Health

Required Strategy 10

Conduct data-driven planning, monitoring, and evaluation to continuously improve HIV surveillance, prevention, and care activities

- Activities include:
  - Develop a work plan
  - Develop a local evaluation and performance measurement plan
  - Monitor the Integrated HIV Prevention and Care Plan
  - Monitor the Jurisdictional Epidemiologic Profile
  - Monitor HIV within the jurisdiction for program planning, resource allocation, and monitoring and evaluation purposes

16

County of Los Angeles Public Health

Required Strategy 11

Build capacity for conducting effective HIV program activities, epidemiological science, and geocoding

- Activities include:
  - Assess, identify, provide, and/or support capacity building and technical assistance within the jurisdiction
  - Develop and implement a capacity building assistance plan, including technical assistance
  - Build capacity of CBOs and community partners to effectively deliver HIV program strategies and interventions
  - Enhance analytic capacity to support epidemiological science and geocoding (e.g., D2C, cluster detection and investigation, and other prevention activities)

17

County of Los Angeles Public Health

Funding Range for Component A (Core)

	Floor	Ceiling
Prevention	$14,618,947	$16,157,784
Surveillance	$2,432,389	$2,688,429
Total for Year 1 January 1 –December 31, 2018	**$17,051,336**	**$18,846,213**

Compared to other jurisdictions, funding for Los Angeles County is 

18

County of Los Angeles Public Health

Component A Funding Requirements

- 75% of Component A funding will be directed toward Core Activities (Strategies 1-7) – approximately $12,788,502
- At least 14% of total Component A funding will be directed toward HIV Surveillance – approximately $2,432,389

19

County of Los Angeles Public Health

Funding Range for Component B (Demonstration Project)

- $1,000,000 to $2,000,000 (approx. two (2) awards)
- $500,000 to $1,000,000 (approx. six (6) awards)
- Up to $500,000 (approx. twelve (12) awards)

20

2017
LISTENING SESSIONS HIGHLIGHTS
TIER 3

LOS ANGELES COUNTY COMMISSION ON HIV

1

PROCESS HIGHLIGHTS

- Multiple Community Engagement Workgroup meetings to review data opportunities and gaps.
- Identified priority populations and recognized importance of creating opportunities to hear from the broader community.
- Purpose is to engage the community, inform the Commission's work, and understand community needs.

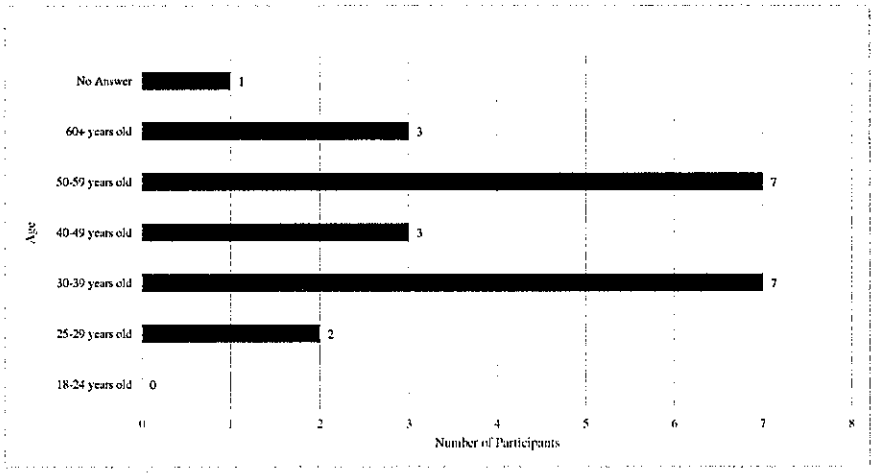
2

TARGET GROUPS

Group 1	Group 2	Group 3
Undocumented (Spanish)	Spanish-Speaking Women of Color	Asians/Pacific Islanders (16)
Women of Color	Teen Youth (13-17yrs)	Trans-Masculine Individuals (2)
Older Adults (50+)	Native Americans	Recently Post-Incarcerated (1)
Service Planning Area 1		25-29 Years Old (4)
		HIV Workforce (24)

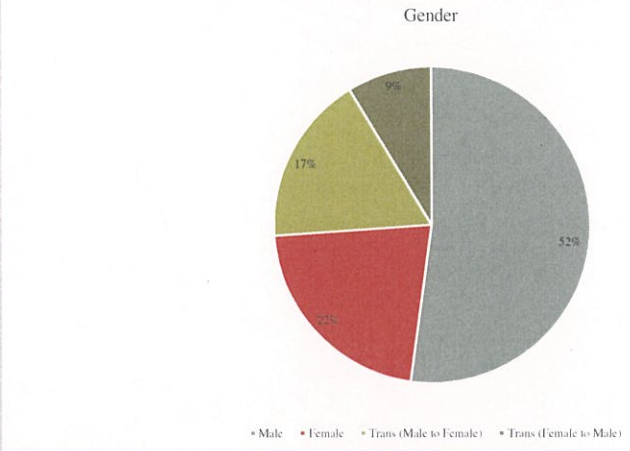
3

AGE (N=23)



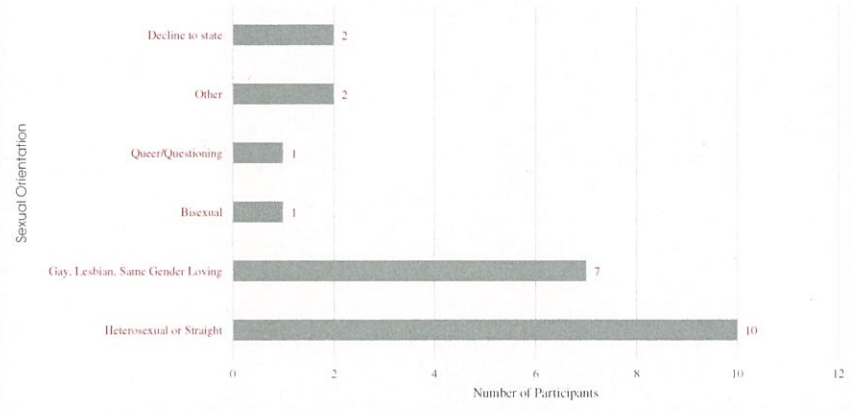
4

GENDER(N=23)



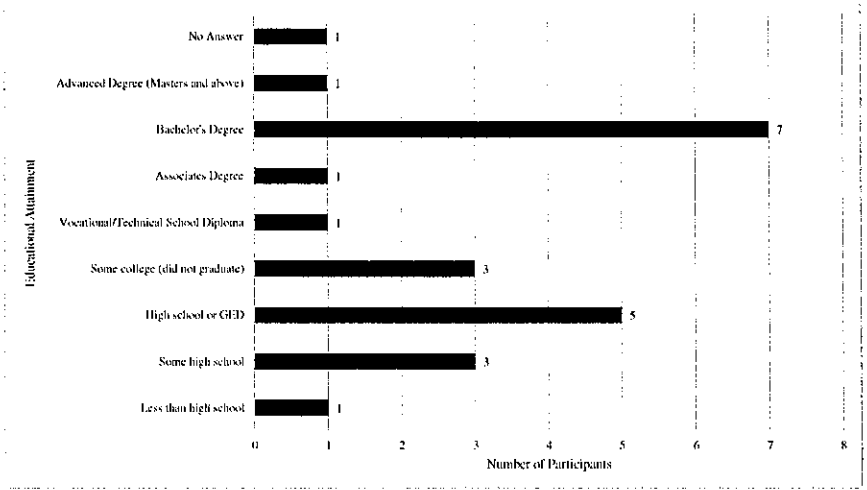
5

SEXUAL ORIENTATION (N=23)



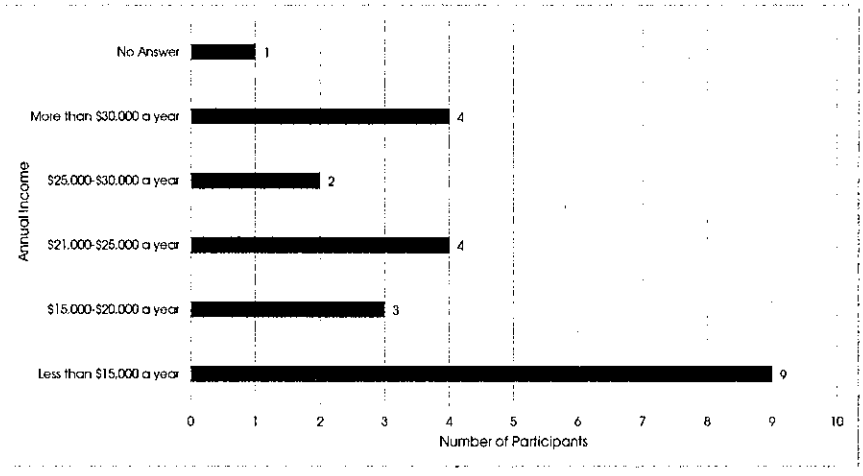
6

EDUCATIONAL LEVEL (N=23)



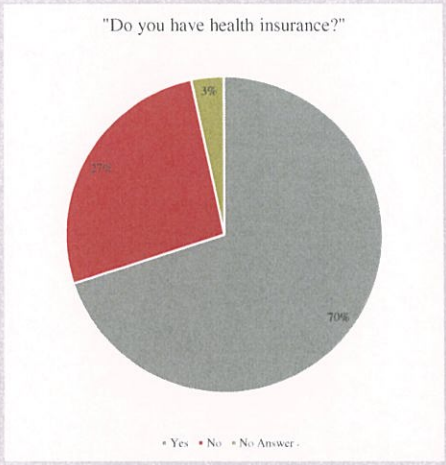
7

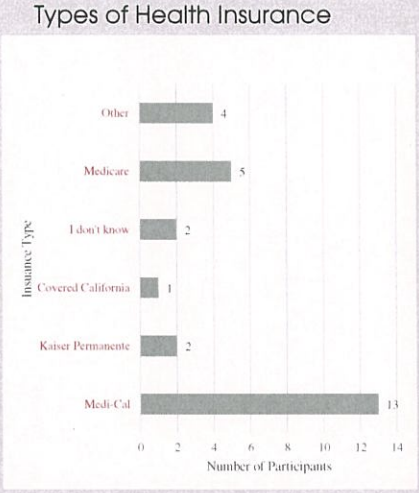
ANNUAL INCOME (N=23)



8

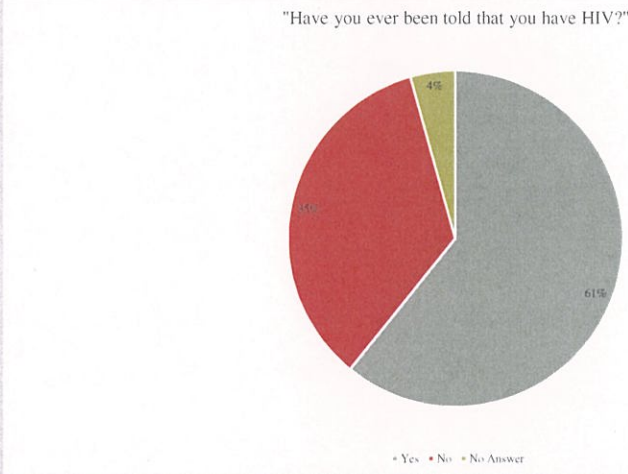
HEALTH INSURANCE





9

PARTICIPANTS DIAGNOSED WITH HIV (N=23)



10

Use of Services

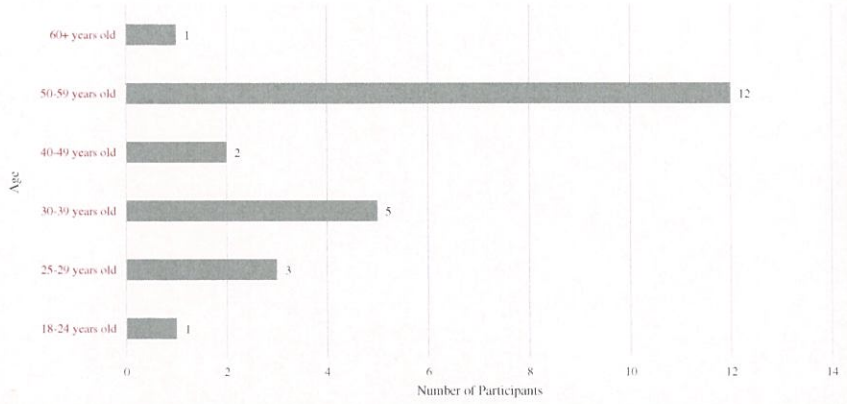
"What kind of services are you currently receiving?"	I am using now		I need but am having trouble accessing it		I will need in the next year		I don't need it right now	
	n	Percent	n	Percent	n	Percent	n	Percent
Condoms (free)	11	48%	0	0%	0	0%	10	44%
Psychiatry mental health services	11	48%	3	13%	0	0%	8	35%
HIV medical care	9	41%	1	5%	0	0%	8	36%
STD prevention education	8	35%	0	0%	0	0%	11	48%
Psychotherapy mental health services	8	36%	3	14%	1	5%	7	32%
Referrals for services	8	42%	0	0%	1	5%	9	47%
Help getting enrolled in health insurance	7	32%	2	9%	0	0%	10	46%
HIV prevention education	7	30%	1	4%	1	4%	10	48%
HIV testing	7	30%	0	0%	0	0%	13	57%
Medical case management services	7	37%	1	5%	0	0%	9	47%
Non-medical case management	7	39%	3	17%	0	0%	6	33%
STD testing	6	26%	0	0%	1	4%	13	57%
Specialty oral health services	5	22%	4	17%	0	0%	10	44%
Food bank/home-delivered meals	5	28%	0	0%	2	11%	10	56%
HOPWA program services (housing assistance for PLWHA)	5	26%	1	5%	1	5%	10	53%
STD treatment	4	18%	0	0%	0	0%	14	64%
Home and community based services	4	21%	3	16%	1	5%	9	47%
Medical nutrition therapy	4	22%	4	22%	0	0%	8	45%
Housing services	4	22%	3	17%	1	6%	8	44%
Legal services	4	21%	2	11%	1	5%	10	53%
PrEP (Pre-Exposure Prophylaxis)	3	13%	0	0%	2	9%	14	61%
General oral health services	3	13%	7	30%	2	9%	7	30%
Medical transportation services	2	11%	2	11%	2	11%	12	63%
Outreach	2	11%	3	16%	1	5%	11	58%
Language services (interpretation, translation)	1	6%	1	6%	0	0%	14	78%
Other	7	37%	0	0%	0	0%	0	0%
Residential substance abuse treatment	0	0%	0	0%	1	6%	16	84%
Outpatient substance abuse treatment	0	0%	0	0%	3	16%	14	74%
Total (N)	23							

11

HIV WORKFORCE (N=24)

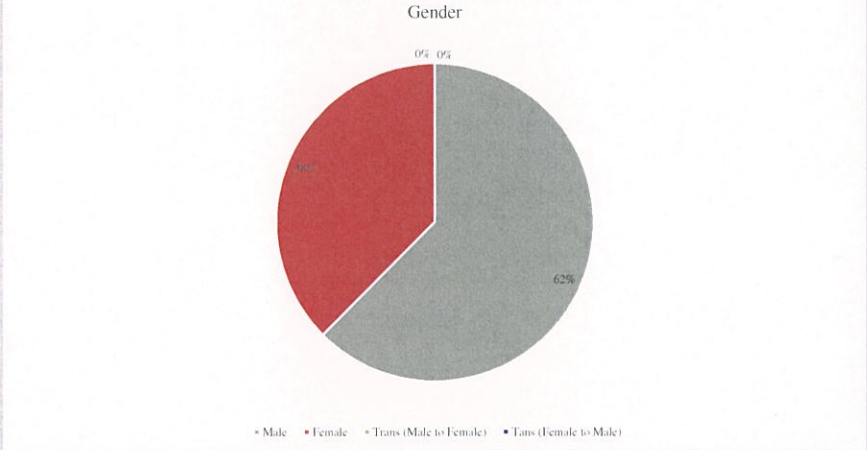
12

AGE (N=24)



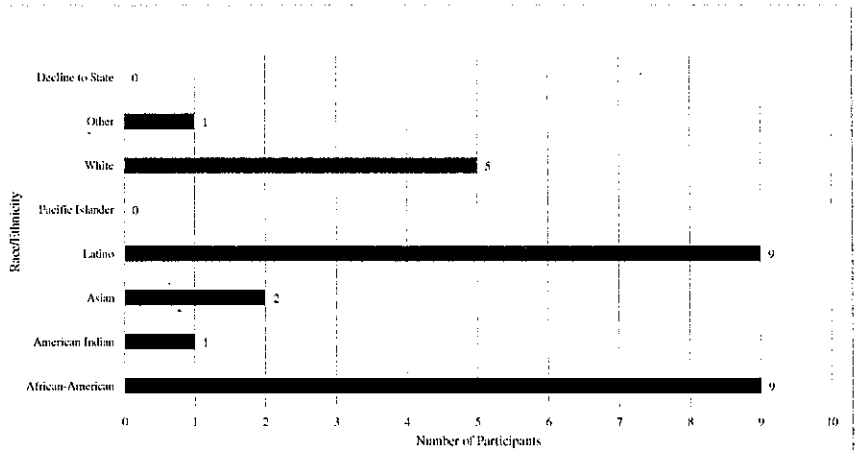
13

GENDER (N=24)



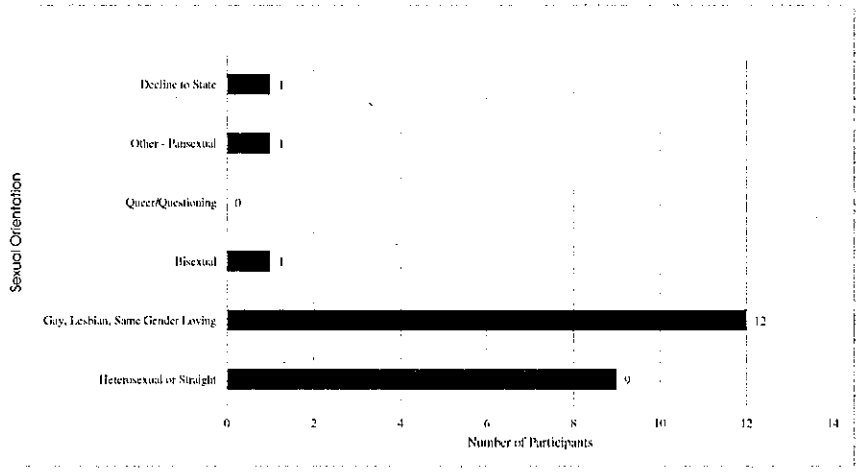
14

RACE/ETHNICITY(N=23)



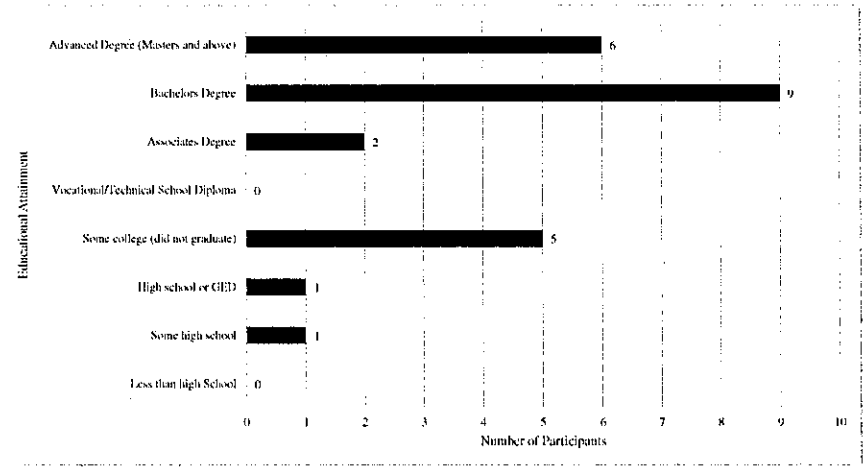
15

SEXUAL ORIENTATION(N=24)



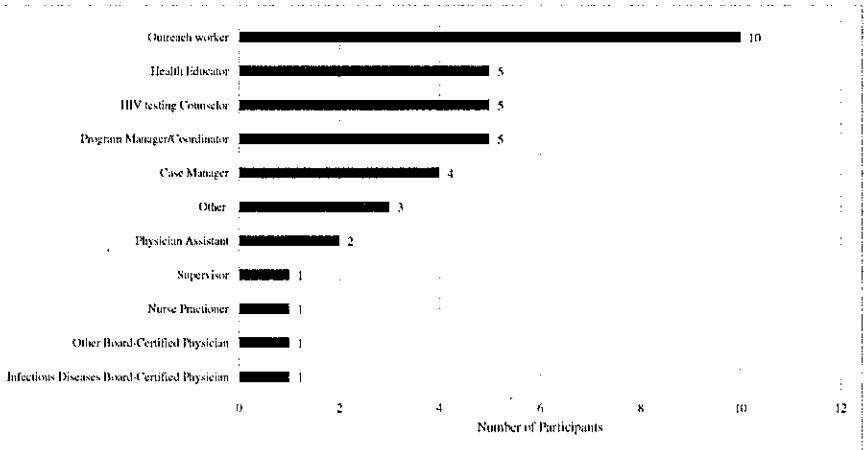
16

EDUCATIONAL ATTAINMENT (N=24)



17

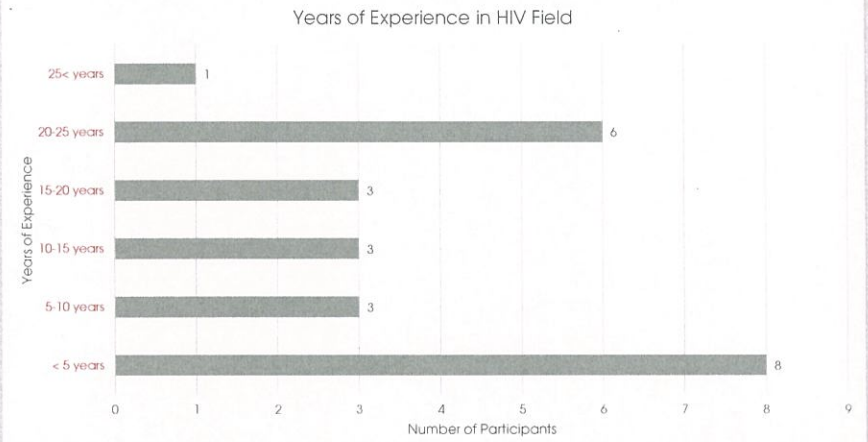
TYPE OF HIV PROFESSION (N=24)



Other types of professions: harm reduction counselor, peer educator, PrEP navigator

18

WORKING EXPERIENCE IN HIV FIELD (N=24)

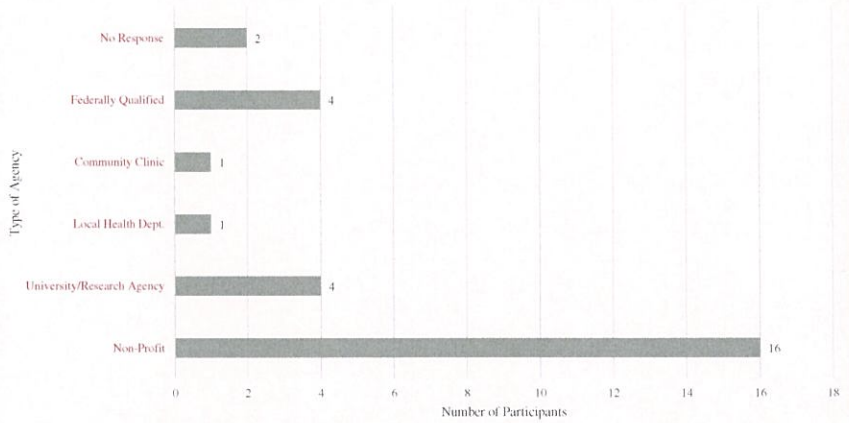


19

SATISFACTION IN THE WORKPLACE (N=24)

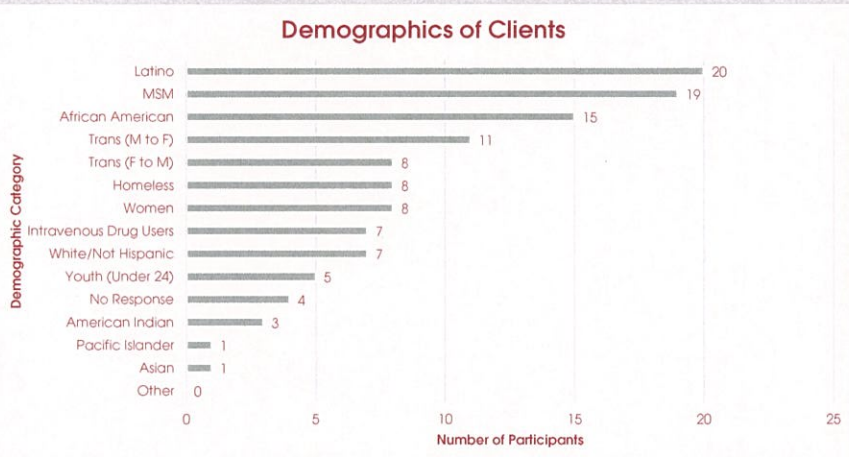
20

TYPE OF AGENCY (N=22)



21

DEMOGRAPHIC CHARACTERISTICS OF CLIENTS SERVED (N=22)



22

EXPERIENCES OBTAINING HIV PREVENTION SERVICES

- Difficulty accessing various services and concerns over losing access to services they were currently receiving.
- Do not know where to receive testing for sexually transmitted infections (STI) even though they were insured.
- Many felt that primary care providers should take more responsibility in promoting and making STI testing accessible to their patients.

23

EXPERIENCES OBTAINING HIV PREVENTION SERVICES

- Outreach and education was also mentioned to increase knowledge about where resources exist, specifically testing resources as prevention, as well as the need for comprehensive prevention efforts
- Participants across subpopulations also mentioned the importance of prevention through creating a safe dialogue about sex and sexual health in various aspects of the public.
- Safe dialogue could be used to inform, empower, and educate both HIV positive and others about how to protect their health and the health of their partners and loved ones.

24

BARRIERS TO ACCESSING MEDICATION INCLUDING PREP AND PEP

- Some of the barriers to "on demand" access to HIV medication and PrEP discussed were cost, awareness/knowledge (among both users and physicians) and insurance bureaucracy.
- HIV workforce participants indicated the need to educate non-physician health care staff in hospitals and large clinics, as well are "front line" physicians and staff at small, community clinics.
- Not enough PrEP/PEP providers in different locations throughout LAC.

25

CONDOM USE

- Participants mentioned that oftentimes there is a lack of use or resistance to the use of condoms for a variety of reasons.
- Some participants felt that individuals on PrEP felt that condoms were less important for them.
- Others either disliked condoms or felt that they were either ineffectual for their lifestyle or type of sexual activity.

26

UNAWARE/UNINFORMED/ UNDERINFORMED

- A prominent theme regarding the prevention of HIV infection was that many people are still widely under-informed about sex education, HIV/AIDS
- Great need for general education and outreach.
- Among both the Trans-Masculine and Asian-Pacific Islander groups, participants mentioned that they do not see messages or illustrations targeting these aspects of their identities; they do not receive the information.
- Recurrent theme from previous listening sessions

27

EXPERIENCES OBTAINING HIV-SPECIFIC CARE

- Participants reported having to utilize more than one clinic to receive the breadth of services they needed.
- Transportation and time cited as barriers
- Often patients' schedules made it difficult to attend appointments.
- Issues with their care providers, such as their doctor changing or unpleasant interactions with their providers.

28

HOW CULTURE INFLUENCES HIV PREVENTION AND CARE

- Among Asian Pacific Islanders one of the key factors influencing the decision to disclose is a desire to protect the family from shame. The fear of bringing dishonor to the family has made the discussion of sexual orientation and HIV or other sexually transmitted disease (STD) status taboo subjects.
- Among lesbians and transgender men preventative services and education were not easily accessible or they felt excluded, even if they are engaged in high-risk activities.

29

HOW CULTURE INFLUENCES HIV PREVENTION AND CARE

- Stigma is present across all cultures. However, participants perceived it to be more prevalent in certain cultures or communities.
- Notably they would name their own culture as being more stigmatizing.

30

HOW CULTURE INFLUENCES HIV PREVENTION AND CARE

- Participants from the workforce acknowledge that gay men and adolescents are increasingly at risk for HIV and STI/STDs due to lack of culturally relevant education for them as well as high risk behavior.
- High risk behavior is fueled by the "app culture". However, they believe that preventive care and education should be available to all cultural groups.

31

ACCESSING HEALTH SERVICES: INSURANCE RELATED ISSUES

- Participants critiqued the Medi-Cal system for lacking consistency and transparency.
- Providers of health services describe similar obstacles when dealing with Medi-Cal. In particular they described difficulty communicating with Medi-Cal representatives and that they often feel they are sending clients into a "lion's den" of bureaucracy when they are forced to interact with Medi-cal representatives.

32

ISSUES RELATING TO HIV STATUS

- Stigma and discrimination remains one of the biggest barriers people living with HIV face.
- Largely due to stigma, people who are positive sometimes live in fear of disclosing their status, while those who are negative are discouraged from accessing preventive care in fear of being associated with HIV.
- In spite of the barriers people living with HIV face, participants also expressed hope and thankfulness for treatments that now exist.

33

HOUSING AS A SOCIAL DETERMINANT OF HEALTH AND HIV

- Homelessness creates barriers to accessing HIV care services as well as heightening the risk for contracting HIV.
- Several healthcare workers articulated that their patients cannot prioritize their HIV treatment if they do not know where they are going to sleep or what they are going to eat.
- One speaks of their female clients who use meth to stay awake and vigilant at night because they feel unsafe sleeping outdoors, another noted that patients sell their HIV medications to survive.

34

SUGGESTIONS TO IMPROVE HEALTHCARE RELATED TO HIV/STDs

- Consistency, or lack thereof, of their doctors. They requested being informed if there doctor was leaving the practice.
- A wider range of availability to access mental health services.
- Participants from various sessions requested services more supportive of the transgender population including sexual health education, practitioner awareness, and funding for non-traditional sexual relationships.

35

SUGGESTIONS TO IMPROVE HEALTHCARE RELATED TO HIV/STDs

- Comprehensive Clinical Services
- There were several comments centered on the inconvenience of needing to visit several different clinics to meet all of one's health care needs and the potential insurance problems this could initiate.

36

SUGGESTIONS TO IMPROVE SERVICES TO PREVENT HIV

- Due to the low levels of awareness, focus group participants mentioned the high need for outreach and education as prevention to occur in many locations, utilizing multiple and wide reaching communication methods.
- Prevention within schools was specifically mentioned as an ideal place to spread awareness and information on the topic of HIV.
- Increased testing-more informed doctors, more sites and mobile units, more access points
- Continued relevance of print sources

37

NEXT STEPS

- Thank you
- Operations Committee will spearhead community engagement efforts
- Thank you and recruitment letters have sent to the participants
- Incorporate relevant information into CHP progress report
- Work with the Consumer Caucus on additional community engagement strategies and activities

38

Los Angeles County Commission on HIV
2017-2018 Legislative Docket

(Updated 8/7/2017)

POSITIONS: SUPPORT | OPPOSE | SUPPORT w/ AMENDMENTS | OPPOSE unless AMENDED | NO POSITION

BILL	TITLE	DESCRIPTION	POSITION	STATUS	COMMENTS
STATE ASSEMBLY & SENATE BILLS					
AB 9 (Garcia)	Sales and Uses Taxes; Feminine Hygiene Products	Would exempt the sale, use, storage, and other consumption, of tampons, sanitary napkins, menstrual sponges, and menstrual cups, from State sales and use taxes; would take effect January 1, 2018.	**SUPPORT**	Author changed to two-year bill. Set aside to next year, second of California's two-year legislative session	
AB 39 (Bocanegra)	Hate Crimes Registry	This bill would declare the intent of the Legislature to enact legislation to establish a "Hate Crime Registry" for purposes of creating a repository of information on hate crimes committed in California.	**OPPOSE unless AMENDED**	Died in Appropriation Committee	A repository of data is a good starting point but not clear as to what happens to data once collected. What "summary" will be reported to law enforcement? Can a person potentially be "outed" if suspected, although not proven to have committed a crime? **Supportive of intent.*
AB 74 (Chiu et al)	Housing Grant Funds	This bill would require the Department of Housing and Community Development (HCD) to establish the Housing for a Healthy California Program on or before April 1, 2019, to award grants to eligible grant applicants based on specified guidelines, including that the applicant identify a source of funding; agree to contribute funding for interim and long-term rental assistance; agree to collect and report data; and use the funds for long-term rental assistance and interim housing. The bill would apply to homeless Medi-Cal beneficiaries eligible for Supplemental Security Income and who are likely to improve their health with supportive services; would require HCD to analyze and report program data to specified legislative committees; would declare that it is to take effect immediately as a bill providing for appropriations related to the Budget Bill.	**SUPPORT**	**ASM APPROPRIATIONS**	

BILL	TITLE	DESCRIPTION	POSITION	STATUS	COMMENTS
STATE ASSEMBLY & SENATE BILLS					
AB 182 (Waldren et al)	Heroin and Opioid Abuse	This bill would require the State Department of Health Care Services (DHCS) to implement a comprehensive and, the "Heroin and Opioid Public Education (HOPE) Initiative," a multicultural public awareness education and awareness campaign on the effects and warning signs of heroin and opioid medication abuse. The bill would require DHCS to conduct a survey of households and one focus group, each annually, to gauge the initiative's effectiveness, the results of which would be reported to the Governor and Legislature.	**SUPPORT (Changed from SUPPORT w/ AMENDMENTS)**	**ASM APPROPRIATIONS**	Amend to include harm reduction language and potentially include a broad list drugs, specifically meth; relates to those living with and at risk for HIV/AIDS. Also, states should not be in business of stigmatizing and condemning drug use; references to such should be stricken. **Friendly amendments made. Stigmatizing language removed. Further f/u requested re: broader list of drugs.*
AB 186 (Eggman et al)	Controlled Substance: safer drug consumption program	Until January 1, 2022, this bill would authorize specified counties or cities within those counties to authorize the operation of supervised injection services programs for adults that satisfies specified requirements, including, among other things, a space supervised by healthcare professionals or other trained staff where people who use drugs can consume preobtained drugs, sterile consumption supplies, and access to referrals to addiction treatment. The bill would require any entity operating a program under its provisions to provide an annual report to the city, county, or city and county, as specified. The bill would exempt a person from existing criminal sanctions while he or she is using or operating a supervised injection services program for adults authorized by a city, county, or city and county.	**SUPPORT**	**ASSEMBLY**	Upon recommendation to BOS, emphasize this bill as priority for Commission.
AB 210 (Santiago)	Housing Services; Multidisciplinary Personnel Team	This bill would authorize counties to also establish a homeless adult, child, and family multidisciplinary personnel team with the goal of expediting linkage of homeless individuals to housing and supportive services and to ensure continuity of care to allow service providers to share confidential information; would authorize the homeless adult, child, and family multidisciplinary personnel team, to designate qualified persons to be a member of the team and bound each member to the same privacy and confidentiality obligations. The bill would also require confidential records to be managed under maximum protection of privacy.	**SUPPORT w/ AMENDMENT**	**ASM PRIVACY AND CONSUMER PROTECTION;** Re-referred to Com. on APPR (7/12/17)	BOS supports bill. Amend to strike out language limiting legal representation to just criminal matters; language should reflect broad representation in all legal matters. Public Counsel recommended same amendments.
AB 265 (Wood/Chiu)	Prescription Drug Discounts	This bill would prohibit a prescription drug manufacturer, operating in California, from offering discounts or other cost savings on any prescription drug if a lower cost (brand name or non-brand name), therapeutically equivalent, as designated United States Food and Drug Administration, as the manufacturer's product.	**SUPPORT w/ AMENDMENT (Changed from OPPOSE unless AMENDED**	**ASM APPROPRIATIONS**	Bill amended to carve-out language for STRs and PrEP as requested. However, Hep C still not included.

BILL	TITLE	DESCRIPTION	POSITION	STATUS	COMMENTS
STATE ASSEMBLY & SENATE BILLS					
AB 291 (Chiu et al)	Housing; Immigration; Extortion	Would stiffen existing laws imposing penalties, up to and including disbarment, of any member of the State Bar for threatening to disclose the suspected immigration status of a party to a civil or administrative action, because said party has exercised a right related to his or her employment. The bill would also prohibit a lessor from using, or threatening to use, the immigration status against a tenant or someone associated with that tenant, for any reason related to the property at hand; would prohibit a lessor from disclosing immigration status, to immigration or law enforcement authorities unless directed or requested by federal authorities. The bill would also declare the immigration or citizenship status of any person as irrelevant to any issue of liability or remedy pertaining to tenant rights unless two exceptions apply.	**SUPPORT**	Senate Judiciary Committee. Read second time. Ordered to third reading.	
AB 677 (Chiu)	LGBT Disparities Reduction Act	Would take existing reporting requirements identified in the LGBT Disparities Reduction Act, which requires specific State departments who collect voluntary data as to the demographic ancestry and ethnic origin, gender identity, and sexual orientation of Californians, and extend those requirements to additional State agencies and require them to comply as early as possible, but no later than July 1, 2019.	**SUPPORT**	Read second time and amended. Re-referred to Com. on APPR.	
AB 800 (Chiu)	Hate Crimes Hotline	This bill would require the State Attorney General to establish a toll-free public hotline telephone number for the reporting of hate crimes, and for the dissemination of information about the characteristics of hate crimes, protected classes, civil remedies, and reporting options; would require the Attorney General to post, maintain, and publicize a reporting form for hate crimes and hate incidents online.	**SUPPORT**	Held in Assembly	Will not move this year likely due to unanswered questions regarding implementation
AB 888 (Low)	Cal Grants: Private Postsecondary Educational Institutions	Would require, beginning in 2018, every private postsecondary educational institution that receives Cal Grant funding to annually report to the Legislature its student disciplinary actions, including, but not limited to, its rate of expulsion, for the previous academic year in connection with whether the disciplined students were Cal Grant recipients, and whether the disciplinary action was taken in connection with students who fit one or more of a list of specified categories; would specify that each report shall not include personally identifiable information about the disciplined students.	**SUPPORT**	Set aside to next year	Author changed to two-year bill due to complexity of Cal Grants and Title IX issues.

BILL	TITLE	DESCRIPTION	POSITION	STATUS	COMMENTS
STATE ASSEMBLY & SENATE BILLS					
AB 1033 (Garcia)	Sexual Battery: Condoms	This bill would make it felony sexual battery to without consent removes a condom during sexual intercourse, intentionally uses a condom that has been tampered with, tampers with a condom that is used in the act of sexual intercourse or knowingly misrepresents to the other person that some form of contraception other than a condom is being used.	**OPPOSE**	**ASM APPROPRIATIONS**	Concerns: could potentially further stigmatize and criminalize HIV; evidence of conduct hard to prove; intent to harm requirement is hard to prove.
AB 1161 (Ting)	Hate Crimes	This bill would require any hate crime policy adopted or revised by a State or local law enforcement agency to include, among other things, the model policy framework developed by the Commission on Peace Officer Standards and Training (POST) and information regarding bias motivation; would require any state or local law enforcement agency that adopts or revises a hate crime policy to consult specified groups.	**SUPPORT**	Held in Assembly	
AB 1534 (Nazarian)	Healthcare Coverage; HIV Specialists; Primary Care Physicians	The bill would require a health care service plan contract or health insurance policy to include an HIV specialist, as defined, as an eligible primary care provider; would require access to HIV specialists to be subject to the regulations, standards, and reporting requirements as mandated by the Department of Managed Health Care and the Insurance Commissioner.	**OPPOSE (Changed from WATCH)**	**ASSEMBLY APPROPRIATIONS**	If intent is to expand access to care, the bill does not go far enough to address network adequacy requirement and parity in quality of care across all health systems. Language is unclear on potential impacts to Ryan White-funded services.

BILL	TITLE	DESCRIPTION	POSITION	STATUS	COMMENTS
STATE ASSEMBLY & SENATE BILLS					
SB 17 (Hernandez/Chiu)	Health care: prescription drug costs	This bill would require health care service plans or health insurers that file the above-described rate information to report to DMHC or DOI, on a date no later than the reporting of the rate information, specified cost information regarding covered prescription drugs, including generic drugs, brand name drugs, and specialty drugs, dispensed as provided. DMHC and DOI would be required to compile the reported information into a report for the public and legislators that demonstrates the overall impact of drug costs on health care premiums and publish the reports on their Internet Web sites by January 1 of each year. The bill would require a manufacturer of a prescription drug that is purchased or reimbursed by specified purchasers, including state agencies, health care service plans, health insurers, and pharmacy benefit managers, to notify the purchaser if the wholesale acquisition cost of a prescription drug exceeds a specified threshold. The bill would require the manufacturer to notify the Office of Statewide Health Planning and Development (OSHPD) of specified information relating to that increase in wholesale acquisition cost at the time that the increase takes effect. The bill would require the manufacturer to notify OSHPD of specified information relating to the wholesale acquisition cost of a new prescription drug if the cost exceeds a specified threshold. The bill would require OSHPD to enforce these provisions and would subject a manufacturer to liability for a civil penalty if the information described above is not reported. The bill would authorize OSHPD to adopt regulations or issue guidance for the implementation of these provisions.	**SUPPORT**	**SENATE APPROPRATIONS**	

BILL	TITLE	DESCRIPTION	POSITION	STATUS	COMMENTS
STATE ASSEMBLY & SENATE BILLS					
SB 31 (Lara et al)	California Religious Freedom Act: state agencies: disclosure of religious affiliation information	This bill would prohibit a state or local agency or a public employee acting under color of law from providing or disclosing to the federal government personal information regarding a person's religious beliefs, practices, or affiliation, as specified, when the information is sought for compiling a database of individuals based on religious belief, practice, or affiliation, national origin, or ethnicity for law enforcement or immigration purposes. The bill would also prohibit a state agency from using agency resources to assist with any government program compiling such a database, or from making state databases available in connection with an investigation or enforcement under such a program. The bill would prohibit state and local law enforcement agencies and their employees from collecting personal information on the religious beliefs, practices, or affiliation of any individual, except as part of a targeted investigation, as provided, or where necessary to provide religious accommodations. The bill would also prohibit law enforcement agencies from using agency or department moneys, facilities, property, equipment, or personnel to investigate, enforce, or assist in the investigation or enforcement of any criminal, civil, or administrative violation, or warrant for a violation, of any requirement that individuals register with the federal government or any federal agency based on religion, national origin, or ethnicity. The bill would also terminate, to the extent of any conflict, any existing agreements that make any agency or department information or database available in conflict with these provisions. This bill would declare that it is to take effect immediately as an urgency statute.	**SUPPORT**	**SENATE APPROPRATIONS**	
SB 54 (De Leon)	Law enforcement: sharing data	This bill would, among other things, and subject to exceptions, prohibit state and local law enforcement agencies, including school police and security departments, from using resources to investigate, interrogate, detain, detect, or arrest persons for immigration enforcement purposes, as specified	**SUPPORT (Changed from WATCH to Support)**	**SENATE APPROPRATIONS**	
SB 179 (De Leon et al)	Gender Recognition Act of 2017	This bill would authorize a person (including minors) to amend their birth certificate, driver's license, gender change court order, and/or other state issued forms of identification, to read female, male, or non-binary; would require driver's license applicants to choose a gender category of female, male, or non-binary as part of the applicant's description.	**SUPPORT**	**SENATE APPROPRIATIONS**	

BILL	TITLE	DESCRIPTION	POSITION	STATUS	COMMENTS
STATE ASSEMBLY & SENATE BILLS					
SB 219 (Wiener et al)	Seniors Long Term Care Bill of Rights	Would prohibit, except as specified, long-term care facilities from basing treatment and/or care on an individual's actual or perceived sexual orientation, gender identity, gender expression, or HIV status. Would also prohibit, among other things, a facility from refusing to communicate with an individual per their preferred name/pronoun, denying that individual admission, transferring or refusing to transfer a resident within a facility or to another facility, or discharging a resident from based on the same factors; would impose a state-mandated local program.	**SUPPORT**	**SENATE APPROPRIATIONS**	
SB 239 (Wiener et al)	Modernizing Discriminatory HIV Criminalization Laws	Would reduce conviction of intentional transmission of an infectious or communicable disease, including HIV, from a felony to a misdemeanor charge; would also apply to third party defendants as well; would mandate the identities of the parties involved be concealed, vacate/dismiss any conviction, charge, and/or related arrest, and mandate any legal records of such a legal event be destroyed by June 30, 2018; would authorize persons convicted of such an offense to petition for a recall or dismissal of their sentence before the trial court that entered the judgment and require courts to then vacate these convictions and grant credit for time already served for any remaining counts; would repeal provisions of existing law requiring persons convicted of prostitution for the first time to complete education on the acquisition of AIDS and to submit to testing for AID; would also repeal provisions requires such a defendant, as a condition of either probation or participating in a drug diversion program, to participate in an AIDS education program.	**SUPPORT**	**SENATE APPROPRIATIONS**	Disclosure: APLA co-authored bill and is supported by a host of local stakeholders, i.e. LGBT, Free Speech Coalition, etc.
SB 310 (Atkins)	Name and Gender Change: State Prisons and County Jails	Would remove limitations on a petition for a change of name filed by a person incarcerated in a State prison; would instead establish the right of an inmate in a State or County facility to petition the court for a change of name or gender; would require the facility to address an individual, who has legally obtained a name change, by their new name and to list the prior name only as an alias; would create a state-mandated local program.	**SUPPORT**	**SENATE APPROPRIATIONS**	

BILL	TITLE	DESCRIPTION	POSITION	STATUS	COMMENTS
STATE ASSEMBLY & SENATE BILLS					
SB 562 (Lara et al)	Single-Payer Health Insurance Program	This bill would enact the Healthy California Act and create a comprehensive universal single-payer health care program, Healthy California; would provide that the program cover, among other things, the Children's Health Insurance Program (CHIP), Medi-Cal, ancillary care and social services for persons with developmental disabilities, Knox-Keene, and Medicare; would create the Healthy California Trust Fund in the State Treasury, as a continuously appropriated fund, consisting of any federal and state moneys received; would create a nine member Healthy California governing board and establish a public advisory committee to advise the board on policy matters; would prohibit health insurers from offering benefits or coverage offered under the program, except as provided; would authorize providers to collectively negotiate rates of payment for services, prescription and nonprescription drugs, and payment methodologies using a third-party representative, as provided.	**SUPPORT**	**HELD AT DESK**	
SB 695 (Lara/Mitchell)	Sex Offender Registration	Would establish 3 tiers of the State's sex offender registration based on specified criteria, for periods of at least 10 years, at least 20 years, and life, respectively, as specified; would establish specified procedures for removal the sex offender registry for a first or second tier offender who completes their mandated minimum registration period; would require the offender to file a petition at the expiration of his or her minimum registration period; would authorize a hearing on the petition if the petitioner has not fulfilled the requirement of successful tier completion; would also establish eligibility criteria for a tier three offender to petition the court for placement in tier two, under specified conditions.	**SUPPORT**	**SENATE COM. EDU**	

AMENDED IN SENATE JULY 18, 2017

AMENDED IN SENATE JUNE 29, 2017

AMENDED IN SENATE MAY 18, 2017

AMENDED IN ASSEMBLY MARCH 22, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 1033

Introduced by Assembly Member Cristina Garcia
(Coauthors: Senators Galgiani and Jackson)

February 16, 2017

An act to amend ~~Section~~ *Sections* 243.4 *and 290* of the Penal Code, relating to sexual battery.

LEGISLATIVE COUNSEL'S DIGEST

AB 1033, as amended, Cristina Garcia. Sexual battery: condoms.

Existing law ~~establishes~~ *prohibits* several ~~species~~ *forms* of sexual battery, including among others, ~~a felony in the circumstance of a person who touches~~ *the touching of* an intimate part of another person while that person is unlawfully restrained by the accused or an accomplice, ~~and~~ if the touching is against the will of the person touched and is for the purpose of sexual arousal, sexual gratification, or sexual abuse.

This bill would establish an additional sexual battery offense when an act of sexual intercourse is accomplished under certain circumstances, including, among others, when ~~the~~ *a* person using a condom intentionally and without consent removes the condom prior to or during the act, when ~~the~~ *a* person using the condom intentionally and without consent tampers with the condom and that condom is used during the act, or when the person intentionally and without consent uses a condom during

the act that the person knows has been tampered with. The bill would provide that the offense is punishable by imprisonment *in a county jail not exceeding one year and a fine not exceeding $2,000, or by imprisonment* in the state prison for 2, 3, or 4 years, and by a fine not exceeding $10,000. *The bill would make additional conforming changes.*

By creating a new crime, this bill would impose a state-mandated program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 243.4 of the Penal Code is amended to read:

243.4. (a) Any person who touches an intimate part of another person while that person is unlawfully restrained by the accused or an accomplice, and if the touching is against the will of the person touched and is for the purpose of sexual arousal, sexual gratification, or sexual abuse, is guilty of sexual battery. A violation of this subdivision is punishable by imprisonment in a county jail for not more than one year, and by a fine not exceeding two thousand dollars ~~($2,000)~~ *($2,000),* or by imprisonment in the state prison for two, three, or four years, and by a fine not exceeding ten thousand dollars ($10,000).

(b) Any person who touches an intimate part of another person who is institutionalized for medical treatment and who is seriously disabled or medically incapacitated, if the touching is against the will of the person touched, and if the touching is for the purpose of sexual arousal, sexual gratification, or sexual abuse, is guilty of sexual battery. A violation of this subdivision is punishable by imprisonment in a county jail for not more than one year, and by a fine not exceeding two thousand dollars ~~($2,000)~~ *($2,000),* or by imprisonment in the state prison for two, three, or four years, and by a fine not exceeding ten thousand dollars ($10,000).

(c) Any person who touches an intimate part of another person for the purpose of sexual arousal, sexual gratification, or sexual abuse, and the victim is at the time unconscious of the nature of the act because the perpetrator fraudulently represented that the touching served a professional purpose, is guilty of sexual battery. A violation of this subdivision is punishable by imprisonment in a county jail for not more than one year, and by a fine not exceeding two thousand dollars ~~($2,000);~~ *($2,000),* or by imprisonment in the state prison for two, three, or four years, and by a fine not exceeding ten thousand dollars ($10,000).

(d) Any person who, for the purpose of sexual arousal, sexual gratification, or sexual abuse, causes another, against that person's will while that person is unlawfully restrained either by the accused or an accomplice, or is institutionalized for medical treatment and is seriously disabled or medically incapacitated, to masturbate or touch an intimate part of either of those persons or a third person, is guilty of sexual battery. A violation of this subdivision is punishable by imprisonment in a county jail for not more than one year, and by a fine not exceeding two thousand dollars ~~($2,000);~~ *($2,000),* or by imprisonment in the state prison for two, three, or four years, and by a fine not exceeding ten thousand dollars ($10,000).

(e) (1) Any person who touches an intimate part of another person, if the touching is against the will of the person touched, and is for the specific purpose of sexual arousal, sexual gratification, or sexual abuse, is guilty of misdemeanor sexual battery, punishable by a fine not exceeding two thousand dollars ($2,000), or by imprisonment in a county jail not exceeding six months, or by both that fine and imprisonment. However, if the defendant was an employer and the victim was an employee of the defendant, the misdemeanor sexual battery shall be punishable by a fine not exceeding three thousand dollars ($3,000), by imprisonment in a county jail not exceeding six months, or by both that fine and imprisonment. Notwithstanding any other ~~provision of~~ law, any amount of a fine above two thousand dollars ($2,000) which is collected from a defendant for a violation of this subdivision shall be transmitted to the State Treasury and, upon appropriation by the Legislature, distributed to the Department of Fair Employment and Housing for the purpose of enforcement of the California Fair Employment and Housing Act (Part 2.8

(commencing with Section 12900) of Division 3 of Title 2 of the Government Code), including, but not limited to, laws that proscribe sexual harassment in places of employment. However, in no event shall an amount over two thousand dollars ($2,000) be transmitted to the State Treasury until all fines, including any restitution fines that may have been imposed upon the defendant, have been paid in full.

(2) As used in this subdivision, "touches" means physical contact with another person, whether accomplished directly, through the clothing of the person committing the offense, or through the clothing of the victim.

(f) An act of sexual intercourse accomplished under any of the following circumstances is ~~a felony~~ punishable by *imprisonment in a county jail for not more than one year and by a fine not exceeding two thousand dollars ($2,000), or by* imprisonment in the state prison for two, three, or four ~~years,~~ *years* and a fine not exceeding ten thousand dollars ($10,000):

(1) ~~The~~ *There was an agreement that a condom would be used during the act and the* person using a condom intentionally and without consent removes the condom prior to or during the act.

(2) ~~The~~ *There was an agreement that a condom would be used during the act and the* person using a condom intentionally and without consent tampers with the condom and that condom is used during the act.

(3) ~~The~~ *There was an agreement that a condom would be used during the act and the* person intentionally and without consent uses a condom during the act that the person knows has been tampered with.

(4) A person intentionally and without consent tampers with a condom or knows the condom has been tampered with, provides the condom to the other person for use by the other person during the act, and the condom is used by the other person during the act.

(5) A person knowingly misrepresents to the other person that the first person is using a form of contraception other than a condom.

(g) A person who commits a violation of subdivision (a), (b), (c), or (d) against a minor when the person has a prior felony conviction for a violation of this section shall be guilty of a felony, punishable by imprisonment in the state prison for two, three, or four years and a fine not exceeding ten thousand dollars ($10,000).

(h) As used in subdivisions (a), (b), (c), and (d), "touches" means physical contact with the skin of another person whether accomplished directly or through the clothing of the person committing the offense.

(i) As used in this section, the following terms have the following meanings:

(1) "Intimate part" means the sexual organ, anus, groin, or buttocks of any person, and the breast of a female.

(2) "Sexual battery" does not include the crimes defined in Section 261 or 289.

(3) "Seriously disabled" means a person with severe physical or sensory disabilities.

(4) "Medically incapacitated" means a person who is incapacitated as a result of prescribed sedatives, anesthesia, or other medication.

(5) "Institutionalized" means a person who is located voluntarily or involuntarily in a hospital, medical treatment facility, nursing home, acute care facility, or mental hospital.

(6) "Minor" means a person under 18 years of age.

(j) This section ~~shall not be construed to~~ *does not* limit or prevent prosecution under any other law which also proscribes a course of conduct that also is proscribed by this section.

(k) In the case of a felony conviction for a violation of this section, the fact that the defendant was an employer and the victim was an employee of the defendant ~~shall be~~ *is* a factor in aggravation in sentencing.

SEC. 2. Section 290 of the Penal Code is amended to read:

290. (a) Sections 290 to 290.024, inclusive, shall be known and may be cited as the Sex Offender Registration Act. All references to "the Act" in those sections are to the Sex Offender Registration Act.

(b) Every person described in subdivision (c), for the rest of his or her life while residing in California, or while attending school or working in California, as described in Sections 290.002 and 290.01, shall be required to register with the chief of police of the city in which he or she is residing, or the sheriff of the county if he or she is residing in an unincorporated area or city that has no police department, and, additionally, with the chief of police of a campus of the University of California, the California State University, or community college if he or she is residing upon the

campus or in any of its facilities, within five working days of coming into, or changing his or her residence within, any city, county, or city and county, or campus in which he or she temporarily resides, and shall be required to register thereafter in accordance with the Act.

(c) The following persons shall be required to register:

Any person who, since July 1, 1944, has been or is hereafter convicted in any court in this state or in any federal or military court of a violation of Section 187 committed in the perpetration, or an attempt to perpetrate, rape or any act punishable under Section 286, 288, 288a, or 289, Section 207 or 209 committed with intent to violate Section 261, 286, 288, 288a, or 289, Section 220, except assault to commit mayhem, subdivision (b) and (c) of Section 236.1, *subdivision (a), (b), (c), (d), or (e) of* Section 243.4, paragraph (1), (2), (3), (4), or (6) of subdivision (a) of Section 261, paragraph (1) of subdivision (a) of Section 262 involving the use of force or violence for which the person is sentenced to the state prison, Section 264.1, 266, or 266c, subdivision (b) of Section 266h, subdivision (b) of Section 266i, Section 266j, 267, 269, 285, 286, 288, 288a, 288.3, 288.4, 288.5, 288.7, 289, or 311.1, subdivision (b), (c), or (d) of Section 311.2, Section 311.3, 311.4, 311.10, 311.11, or 647.6, former Section 647a, subdivision (c) of Section 653f, subdivision 1 or 2 of Section 314, any offense involving lewd or lascivious conduct under Section 272, or any felony violation of Section 288.2; any statutory predecessor that includes all elements of one of the above-mentioned offenses; or any person who since that date has been or is hereafter convicted of the attempt or conspiracy to commit any of the above-mentioned offenses.

~~SEC. 2.~~

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIIIB of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within

the meaning of Section 6 of Article XIII B of the California Constitution.

O

SENATE COMMITTEE ON PUBLIC SAFETY

Senator Nancy Skinner, Chair
2017 - 2018 Regular

Bill No:	AB 1033	**Hearing Date:**	July 11, 2017
Author:	Cristina Garcia		
Version:	June 29, 2017		
Urgency:	No	**Fiscal:**	Yes
Consultant:	MK		

Subject: ***Sexual Battery: Condoms***

HISTORY

Source: Author

Prior Legislation: None

Support: California Women's Law Center; City of West Hollywood; Planned Parenthood

Opposition: American Civil Liberties Union; California for Attorneys for Criminal Justice; California Right to Life Committee

Assembly Floor Vote: Not applicable

PURPOSE

The purpose of this bill is to make it felony sexual battery to without consent removes a condom during sexual intercourse, intentionally uses a condom that has been tampered with, tampers with a condom that is used in the act of sexual intercourse or knowingly misrepresents to the other person that some form of contraception other than a condom is being used.

Existing law provides that nay person who touches an intimate part of another person if the touching is against the will of the person touched and is for the specific purpose of sexual arousal, sexual gratification, or sexual abuse is guilty of a misdemeanor sexual battery punishable by a fine not exceeding$2,000 or by imprisonment not exceeding six months or by both fine and imprisonment. (Penal Code § 243.4 (e)(1))

Existing law provides that any person who commits an assault upon the person of another by any means of force likely to produce great bodily injury shall be punished by imprisonment in the state prison for 2, 3 or 4 years or in a county jail for not exceeding one year, or by a fine not exceeding $10,000 or by both the fine and imprisonment. (Penal Code § 245(a)(4))

Existing law provides that rape is an act of sexual intercourse accomplished with a person not the spouse of the perpetrator, under specified circumstances including: where the person is at the time of the act unconscious of the act. Unconscious of the nature of the act includes "was not aware, knowing, perceiving, or cognizant of the essential characteristics of the act due to the perpetrator's fraud in fact." (Penal Code § 261 (a)(4)(C))

Existing law provides that rape of a person who is the spouse of the perpetrator is an act of sexual intercourse under specified circumstances including: where the person is at the time of the act unconscious of the act. Unconscious of the nature of the act includes "was not aware, knowing, perceiving, or cognizant of the essential characteristics of the act due to the perpetrator's fraud in fact." (Penal Code § 262(a)(3)(C))

This bill provides that an act of sexual intercourse accomplished under any of the following circumstances is a felony punishable by imprisonment in the state prison for two, three, or four years, and a fine not exceeding ten thousand dollars ($10,000):

(1) The person using a condom intentionally and without consent removes the condom prior to or during the act.

(2) The person using a condom intentionally and without consent tampers with the condom and that condom is used during the act.

(3) The person intentionally and without consent uses a condom during the act that the person knows has been tampered with.

(4) A person intentionally and without consent tampers with a condom or knows the condom has been tampered with, provides the condom to the other person for use by the other person during the act, and the condom is used by the other person during the act.

(5) A person knowingly misrepresents to the other person that the first person is using a form of contraception other than a condom.

COMMENTS

1. Need for This Bill

According to the author:

> "Stealthing", a new name for an ancient, sneaky practice, is the nonconsensual intentional removal or tampering with the condom during sexual intercourse and its occurrence is on the rise. If a condom is used there is an expectation that the condom will stay on unless there is explicit consent to take it off. Some realize their partner had removed the condom at the moment of re-penetration; others may not realize until the partner ejaculated, and some may never find out. Regardless of when, or if, the victim learns of this breach of trust, this practice exposes them to physical risks of pregnancy and disease, and is a grave violation of one's dignity and autonomy.
>
> There are online communities who defend stealthing as a male "right," particularly a right of every man to "spread his seed". Online blogs and forums "train" other men about stealthing best practices, and offer support and advice in their pursuit of nonconsensual condom removal during sex. Deeply rooted in centuries of rape culture based on dominance and control, particularly of women by men, stealthing is gaining attention in the media by both straight and gay men.
>
> What is rape? Penetration, by a body part or a foreign object, without consent. When you remove a condom without permission, there is no consent and there is penetration. It's clear, "stealthing" is rape. However, current California law does

not acknowledge the act of "stealthing" which is why AB 1033 is necessary. AB 1033 makes the nonconsensual intentional removal or tampering with a condom during sexual intercourse a form of rape.

2. Felony Sexual Battery

Most sexual batteries are either a wobbler or a misdemeanor. Sexual battery of a person while he or she is restrained is a wobbler (Penal Code § 243.4 (a)). Sexual battery of a person who is institutionalized or seriously disabled or medically incapacitated is a wobbler. (Penal Code § 243 (b)). Sexual battery when a person misleads the victim that the touching is for a professional purpose is a wobbler. (Penal Code § 234.4 (c)) Misdemeanor battery includes touching a person against their will for the purpose of sexual arousal. (Penal Code § 234.4 (e))

This bill would create a felony sexual battery punishable by 2, 3 or 4 years in state prison and a fine not exceeding $10,000 (approximately $41,000 with penalty assessments) for the following offenses:

(1) The person using a condom intentionally and without consent removes the condom prior to or during the act.
(2) The person using a condom intentionally and without consent tampers with the condom and that condom is used during the act.
(3) The person intentionally and without consent uses a condom during the act that the person knows has been tampered with.
(4) A person intentionally and without consent tampers with a condom or knows the condom has been tampered with, provides the condom to the other person for use by the other person during the act, and the condom is used by the other person during the act.
(5) A person knowingly misrepresents to the other person that the first person is using a form of contraception other than a condom.

Should these offenses have a higher penalty than the existing sexual battery offenses? Are these offenses deserving a higher penalty than the sexual battery of a person who is being restrained or medically incapacitated or inappropriately touched by a doctor or other professional?

3. Issue of Proof not Available Laws

While the author is correct in that "stealthing" is not specifically covered by existing law, if evidence exists then the behavior could be prosecuted under existing sections relating to misdemeanor sexual battery (Penal Code § 243.4 (e)(1)); felony rape where a person is unconscious of the nature of the act (Penal Code 261 (a)(4)(c)); felony spousal rape where a person is unconscious of the nature of the act (Penal Code § 262(3)(c)); and assault with force likely to create great bodily injury, as pregnancy has been found to be great bodily injury, and an actual pregnancy would not be necessary (Penal Code § 245 (a) (4)).

The issue is not available crimes, it is that evidence of the conduct will be hard to find. Was the condom taken off or did it fall off? Was the condom tampered with or did it fail? Was the woman not on birth control or did that fail? Was the sex even contingent on the use of a condom or other birth control?

As the California Attorneys for Criminal Justice notes:

> The "intent, "tampered with" and "knows has been tampered with" requirements are extremely vague. There is not actual requirement of "bad intent" in AB 1033, only intent to "tamper with." It is easy to imagine a case where the person may adjust a condom during sex, with a neutral intent, with an undesired result of accidental insemination. Pursuant to the language of the bill, this adjustment would constitute a sexual battery. Furthermore, the language does not clarify who can be convicted of the act- the person wearing the condom? The person having sex with the person wearing the condom? Both parties would be technically suing the condom during a consensual act. Nor does the bill language require that consent is contingent on an understanding that a condom be used.

Should the bill clarify who can be prosecuted? Should the bill clarify that consent had to be contingent on the use of a condom or the use of birth control?

- END –

AMENDED IN SENATE JUNE 26, 2017

AMENDED IN ASSEMBLY APRIL 6, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 1534

Introduced by Assembly Member Nazarian

February 17, 2017

An act to add Section 1367.693 to the Health and Safety Code, *and to add Section 10123.833 to the Insurance Code,* relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1534, as amended, Nazarian. Health care coverage: HIV specialists.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. A willful violation of the act is a crime. *Existing law provides for the regulation of health insurers by the Department of Insurance.* Existing law requires the Department of Managed Health Care to adopt regulations to ensure that enrollees have access to needed health care services in a timely manner. Existing law requires the Department of Managed Health Care to develop indicators of timeliness of access to care, including waiting times for appointments with physicians, including primary care and ~~specialty~~ *specialty* physicians. Existing law requires health care service plans to report annually to the Department of Managed Health Care on compliance with the standards developed pursuant to these provisions. *Existing law requires the Insurance Commissioner to promulgate regulations applicable to health insurers that contract with providers*

to patients, for maintaining the continuity of patient care, and for initiating referral for specialist care. This means providing care for the majority of health care problems, including, but not limited to, preventive services, acute and chronic conditions, and psychosocial issues.

(c) For purposes of this section, "HIV specialist" means a physician, physician assistant, or a nurse practitioner who meets the criteria for an HIV specialist as published by the American Academy of HIV Medicine or the HIV Medicine Association, or who is contracted to provide outpatient medical care under the federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 (Public Law 101-381).

(d) This section shall not be construed to include an HIV specialist as a primary care physician for the purposes of network adequacy requirements under this chapter.

SEC. 2. Section 10123.833 is added to the Insurance Code, to read:

10123.833. (a) Every health insurance policy that is issued, amended, or renewed on or after January 1, 2018, that provides hospital, medical, or surgical coverage, excluding specialized health insurance policies, shall permit an HIV specialist to be an eligible primary care provider, if the provider requests primary care provider status and meets the health insurer's eligibility criteria for all specialists seeking primary care provider status.

(b) For purposes of this section, "primary care provider" means a physician or a nonphysician medical practitioner, as each term is defined in Section 14254 of the Welfare and Institutions Code, who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referral for specialist care. This means providing care for the majority of health care problems, including, but not limited to, preventive services, acute and chronic conditions, and psychosocial issues.

(c) For purposes of this section, "HIV specialist" means a physician, physician assistant, or a nurse practitioner who meets the criteria for an HIV specialist as published by the American Academy of HIV Medicine or the HIV Medicine Association, or who is contracted to provide outpatient medical care under the federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 (Public Law 101-381).

SENATE COMMITTEE ON HEALTH

Senator Ed Hernandez, O.D., Chair

BILL NO:	AB 1534
AUTHOR:	Nazarian
VERSION:	April 6, 2017
HEARING DATE:	June 21, 2017
CONSULTANT:	Teri Boughton

SUBJECT: Health care coverage: HIV specialists

SUMMARY: Requires every health care service plan contract that is issued, amended, or renewed on or after January 1, 2018 to permit an HIV specialist to be an eligible primary care provider, if the provider requests primary care provider status and meets the health care service plan's eligibility criteria for all specialists seeking primary care provider status.

Existing law:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health care service plans in the Health and Safety Code and the California Department of Insurance (CDI) to regulate health insurers in the Insurance Code.

2) Requires every health care service plan, except a specialized health care service plan, to establish and implement a procedure by which an enrollee with a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling may receive a referral to a specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the specialist coordinate the enrollee's health care. Requires after the referral is made, the specialist to be authorized to provide health care services that are within the specialist's area of expertise and training to the enrollee in the same manner as the enrollee's primary care physician, subject to the terms of the treatment plan.

3) Requires every health care service plan contract that provides hospital, medical, or surgical coverage, and every policy of disability insurance that covers hospital, medical, or surgical expenses, that is issued, amended, delivered, or renewed in this state, to include obstetrician-gynecologists as eligible primary care physicians, provided they meet the plan's or insurer's eligibility criteria for all specialists seeking primary care physician status.

4) Defines "primary care physician" as defined in 5) below, as a physician who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referral for specialist care. This means providing care for the majority of health care problems, including, but not limited to, preventive services, acute and chronic conditions, and psychosocial issues.

5) Defines "primary care physician" as a physician who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referral for specialist care. Requires a primary care physician to be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner. States that a non-physician medical practitioner, (defined as a physician assistant, nurse midwife, or nurse practitioner, as specified) who is supervised by a primary care physician, has the responsibility for providing initial and primary care to patients, for

maintaining the continuity of patient care, and for initiating referral for specialist care.

6) Requires every health care service plan contract issued, amended, renewed, or delivered in this state, except a specialized health care service plan, and every policy of disability insurance that covers hospital, medical, or surgical expenses, to allow an enrollee or insured the option to seek obstetrical and gynecological physician services directly from a participating obstetrician and gynecologist or directly from a participating family practice physician and surgeon designated by the plan as providing obstetrical and gynecological services.

7) Permits a health care service plan to establish reasonable provisions governing utilization protocols and the use of obstetricians and gynecologists, or family practice physicians and surgeons, as provided for in 6) above, participating in the plan network, medical group, or independent practice association, consistent with the intent and those customarily applied to other physicians and surgeons, such as primary care physicians and surgeons, to whom the enrollee has direct access, and not be more restrictive for the provision of obstetrical and gynecological physician services.

8) Prohibits an enrollee from being required to obtain prior approval from another physician, another provider, or the health care service plan prior to obtaining direct access to obstetrical and gynecological physician services, but permits the plan to establish reasonable requirements for the participating obstetrician and gynecologist or family practice physician and surgeon, as specified in 7) above, to communicate with the enrollee's primary care physician and surgeon regarding the enrollee's condition, treatment, and any need for follow-up care.

9) Requires a health care service plan to ensure that there is at least one full-time equivalent primary care physician for every 2,000 enrollees of the plan. The number of enrollees per primary care physician may be increased by up to 1,000 additional enrollees for each full-time equivalent non-physician medical practitioner supervised by that primary care physician.

This bill:

1) Requires every health care service plan contract that is issued, amended, or renewed on or after January 1, 2018, that provides hospital, medical, or surgical coverage, excluding specialized health care service plan contracts, to permit an HIV specialist to be an eligible primary care provider, if the provider requests primary care provider status and meets the health care service plan's eligibility criteria for all specialists seeking primary care provider status.

2) Defines, "primary care provider" to mean a physician or a non-physician medical practitioner, as defined, who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referral for specialist care. This means providing care for the majority of health care problems, including, but not limited to, preventive services, acute and chronic conditions, and psychosocial issues.

3) Defines "HIV specialist" to mean a physician, physician assistant, or a nurse practitioner who meets the criteria for an HIV specialist as published by the American Academy of HIV Medicine or the HIV Medicine Association, or who is contracted to provide outpatient

medical care under the federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 (Public Law 101-381).

FISCAL EFFECT: According to the Assembly Appropriations Committee, costs to DMHC of approximately $160,000 in 2017-18, approximately $100,000 in 2018-19, and approximately $180,000 for 2019-20 and annually thereafter (Managed Care Fund). One-time costs are to amend existing regulations and review plan documents. Ongoing costs are to review filings to ensure compliance and to investigate and enforce the law in instances of non-compliance.

PRIOR VOTES:

Assembly Floor:	76 - 0
Assembly Appropriations Committee:	17 - 0
Assembly Health Committee:	15 - 0

COMMENTS:

1) *Author's statement.* According to the author, Californians living with HIV should have access to care from physicians and other providers with the training and experience required to meet their complex needs. Given the intricate nature of the virus, something as simple as a routine flu shot could cause serious complications for an HIV patient if administered by a provider without the understanding of the patient's status. By allowing HIV specialists to serve as primary care providers for their patients, this bill eliminates administrative impediments, such as ordering tests or making additional referrals, and maintains continuity of care for a disease that has become manageable today.

2) *California Health Benefits Review Program (CHBRP) analysis.* AB 1996 (Thomson, Chapter 795, Statutes of 2002) requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. CHBRP was created in response to AB 1996, and reviewed this bill. CHBRP's analysis is based on an earlier version of this bill and does not incorporate the April 17, 2017 amendments. Key findings related to parental involvement, setting and location, or time of treatment, frequency of review of treatment plan include:

    a) *Coverage impacts and enrollees covered.* According to the responses to the CHBRP carrier survey, most health plans and policies, including Medi-Cal managed care plans and plans accessed through the California Public Employees Retirement System, allow HIV specialists to act as primary care providers if the HIV specialist meets the health plan's requirements. CHBRP estimates that in 2018, 23.4 million Californians enrolled in state-regulated health insurance will have insurance subject to this bill;
    b) *Essential health benefits.* CHBRP believes the provisions of this bill do not appear to exceed essential health benefits, and would not trigger the Affordable Care Act requirement that the state defray the cost of additional benefit coverage for enrollees in qualified health plans in Covered California;
    c) *Medical effectiveness.* There is limited evidence from two studies with moderate research design that providers with more experience/expertise in HIV provide equivalent or better primary care screening services to persons living with HIV/AIDS compared to providers with less HIV experience/expertise or generalists.

d) *Utilization.* CHBRP is unable to estimate enrollee utilization of designating an HIV specialist as a primary care provider due to limitations in health claims data;
e) *Impact on expenditures.* Unknown; and,
f) *Public health.* There appear to be more than 900 HIV specialists (some of whom are credentialed by the American Academy of HIV Medicine and many more who likely meet the AB 1534 definition who treat some of the persons living with HIV/AIDS in California. However, the use of primary care services provided by HIV specialists and the resulting health outcomes is unknown.

3) *HIV/AIDS background.* According to the Centers for Disease Control and Prevention, in 2015, an estimated 39,393 people in the United States were diagnosed with HIV, the virus that causes AIDS. In 2015, an estimated 4,720 adults and adolescents were diagnosed with HIV in California. California ranked 2nd among the 50 states in the number of HIV diagnoses in 2015. The California Office of AIDS maintains an HIV/AIDS surveillance system that records the prevalence and incidence of HIV diagnoses and the prevalence of AIDS cases (CDPH, 2016). The most recent data available from 2014 indicate that 126,241 people in California are living with HIV/AIDS. According to CHBRP, HIV providers may be physicians, physician assistants, or nurse practitioners and may be credentialed as an HIV Specialist™ by the American Academy of HIV Medicine (AAHIVM). Persons living with HIV may see an HIV specialist who is in private practice, or practices at an HIV clinic, general healthcare clinic, or a community health center.

4) *Prior legislation.* AB 2372 would have allowed HIV specialists, as defined, to be included as an eligible primary care provider, if the provider requests primary care provider status and meets the health care service plan's eligibility criteria for all specialists seeking primary care provider status, that access to HIV specialists is subject to regulations that govern network adequacy, consistent with the specialty designation. *AB 2372 was held in the Assembly Appropriations Committee.*

AB 1954 (Burke, Chapter 495, Statutes of 2016) establishes the Direct Access to Reproductive Health Care Act, which prohibits health care service plans (health plans) and health insurers from requiring an enrollee to receive a referral prior to receiving coverage or services for reproductive and sexual health care.

AB 1181 (Escutia, Chapter 31, Statutes of 1998) establishes a system for health plans and providers to follow to provide enrollees with "standing referrals" to specialists treating various diseases and conditions.

AB 2493 (Speier, Chapter 759, Statutes of 1994) requires health care service plans, non-profit hospital service plans, and disability insurance policies that provide hospital, medical care or surgical coverage to include obstetrician-gynecologists as primary care providers, provided they meet the insurer's written eligibility criteria for all specialists seeking primary care physician status.

AB 12 (Davis, Chapter 22, Statutes of 1998) requires health care service plans and disability insurers to allow enrollees to seek obstetrical and gynecological physician services directly from either an obstetrician and gynecologist or a family practice physician.

5) *Support.* The AIDS Healthcare Foundation (AHF) writes that because plans do not always recognize HIV specialist's as primary care physicians, there are too many times when the HIV specialist cannot order tests, make referrals to other specialists or any of the other services a primary care physician can provide. In addition, a patient with a non-HIV specialist primary care physician runs the risk that the primary care physician does not have the expertise necessary to know that some routine care decisions become complicated when they impact a person with HIV. This situation makes delivery of care more uncertain, interrupts the provision of care, puts additional demands on the patient and ultimately costs more in an unnecessary duplication of services. According to AHF, unlike a previous version of this bill, AB 1534 does not impact health plans' network adequacy obligations and it does not insert HIV specialists into network adequacy considerations. The focus of this bill is discretely on the ability of a patient to select an HIV specialist to act as the patient's primary care physician. Beyond AIDS writes a clinic that provides both HIV specialty care and primary care can currently only bill for the services of such an all-purpose provider as a primary care provider, because the combination of that with being an HIV specialist has not been recognized. Alternatively, the HIV care can be billed, but not the time-consuming and essential primary care. This is a disincentive to integrated care, and AB 1534 will resolve the problem. The California Chapters of the American College of Physicians views this bill as a critical measure to help ensure HIV-infected patients have providers that meet their unique health care needs. The California Academy of PAs writes that research shows that patients with HIV have better health outcomes, as well as an increase in cost-effective and coordinated care when a clinician with experience and expertise in HIV manages their condition. HIV specialists receive additional medical education and experience in order to provide comprehensive primary health care services to patients with HIV.

6) *Opposition.* The DMHC has strong concerns that designating a particular disease specialist as a primary care provider in statute set a precedent for other specialty types to follow suit, potentially harming the managed care model that relies on primary care physicians. In addition, DMHC writes that there is already a mechanism (termed "standing referrals") to permit specialists to act as primary care physicians for health plan enrollees, and specifically references HIV specialists. Furthermore, regulations already require that standing referrals for HIV patients be made to qualified HIV specialist physicians and health plans must demonstrate network adequacy standards. Designating HIV specialist physicians and non-physicians as primary care providers could potentially reduce the number of primary care physicians in the network. Finally, DMHC is unaware of any demonstrated problem related to access to qualified HIV specialists.

7) *Policy comments/questions.*

   a) *The problem this bill is trying to resolve is not entirely clear.* The author and sponsor indicate that the intent is to ensure HIV specialists can be designated as primary care providers. According to the CHBRP survey, most carriers already allow HIV specialists to act as primary care providers. This is likely because health care service plans are already required to allow standing referrals to specialists, including HIV specialists. The law specifically authorizes the specialist to provide health care services in the same manner as the enrollee's primary care physician; subject to the terms of a treatment plan (if a treatment plan is deemed necessary). Health insurance policies allow direct access to all providers without first receiving a referral from a primary care physician. Proponents seem to want to ensure that the HIV specialist has ability to control referrals, which may be limited under existing law as an HIV

specialist with a standing referral still may have to coordinate with another primary care physician and function under a treatment plan. One of the proponents suggests that this bill will resolve payment issues. It is not clear how or if this policy change will affect reimbursement.

b) *Should this bill include parallel provisions in the Insurance Code?* While primary care physicians are not "gatekeepers" in PPOs as they are in HMOs, there are requirements for both HMOs and PPOs to have adequate ratios of primary care "physicians" not "providers" in their networks compared to enrollees/insureds. If HIV specialists are to be considered primary care providers under the Health and Safety Code, the committee may also wish to incorporate similar provisions in the Insurance Code, which has been the Legislature's preference and practice in recent history (i.e., the OBGYN provisions also appear in the Insurance Code as well as direct access to reproductive health services). However, it is not clear what impact this bill could have on these ratios.

Relatedly, Covered California (California's health benefit exchange) requires qualified health plan issuers (which includes PPOs) to ensure that all Covered California enrollees either select or be provisionally assigned to a primary care "clinician" by January 1, 2017 or within 60 days of effectuation into the plan, whichever is sooner. If an enrollee does not select a primary care clinician, the issuer must provisionally assign the enrollee to a primary care clinician, inform the enrollee of the assignment and provide the enrollee with an opportunity to select a different primary care clinician.

c) *Will other specialists want to have this same option?* If existing law related to standing referrals, which applies broadly to many types of specialists, is insufficient for HIV specialists, will other specialists also seek this option to be considered primary care providers? What impact would this have on the HMO model?

SUPPORT AND OPPOSITION:

Support: AIDS Healthcare Foundation
Beyond AIDS
California Academy of PAs
California Chapters of American College of Physicians
CaliforniaHealth + Advocates
National Association of Social Workers

Oppose: Department of Managed Health Care

-- END --

AB 1534 HIV Specialists

Assemblymember Adrin Nazarian

Background:
Due to the unique care provided by HIV specialists, many of them have become the de facto primary care provider (PCP) for the HIV patient. The HIV specialist will be by the patient's side for the rest of his or her life, providing care for all aspects of the patient's medical needs.

Additionally, a patient with a non-HIV specialist PCP runs the risk that the PCP does not have the expertise necessary to know that some routine care decisions become complicated when they impact a person with HIV. This situation makes delivery of care more uncertain, interrupts the provision of care, puts additional demands on the patient, and ultimately costs more in unnecessary duplication of services.

This bill:
Requires a health plan to permit an HIV specialist to be an eligible PCP, if the provider requests PCP status and meets the health care service plan's eligibility criteria for all specialists seeking PCP status.

Defines an "HIV specialist" to mean a physician, physician assistant, or a nurse practitioner who meets the criteria for an HIV specialist as published by the American Academy of HIV Medicine or the HIV Medicine Association, or who is contracted to provide outpatient medical care under the federal Ryan White CARE Act of 1990.

Purpose:
Under a grant from the California HIV/AIDS Research Program at the UC, researchers issued a report earlier this year about the potential to increase preventive care and screening for people with HIV if AB 1534 were enacted.

The report found that patients treated by providers, deemed to HIV specialists, are more likely to receive guideline-consistent HIV care as compared to patients treated by non-specialists.

There are an estimated 5,000 new infections every year, adding to the estimated 140,000 persons living with HIV. Only 43% of those are retained in HIV care, meaning that they have had at least 2 care visits in a year. Access to the right medical care will help strengthen the state's efforts to secure appropriate treatment for all persons with HIV and achieve viral suppression for thousands of Californians who are currently not in treatment and/or are not virally suppressed.

Support:
AIDS Healthcare Foundation (sponsor)
Beyond AIDS
California Academy of Physician Assistants
California Chapters of the American College of Physicians
CaliforniaHealth+ Advocates
National Assoc. of Social Workers - CA

Staff Contact:
Christopher Clemons
916-319-2046
Chris.Clemons@asm.ca.gov