LOS ANGELES COUNTY
COMMISSION ON HIV

Visit us online: http://hiv.lacounty.gov
Get in touch: hivcomm@lachiv.org
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COMMISSION ON HIV
Meeting

Thursday, April 13, 2023
9:00am-1:00pm (PST)
510 S. Vermont Ave,
Terrace Conference Room A (TK11)
Los Angeles, CA 90020
**Validated Parking Available at 523 Shatto Place, LA 90020*
Meeting will be live streamed on Facebook @hivcommissionla

Agenda and meeting materials will be posted on our website at http://hiv.lacounty.gov/Meetings

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

Bartz-Altadonna Community Health Center
43322 Gingham Ave, Lancaster, CA 93535

Members of the Public May Join in Person or Virtually.
For Members of the Public Who Wish to Join Virtually, Register Here:
https://lacountyboardofsupervisors.webex.com/weblink/register/r4c0e346503d6cf2841003121151b861f

To Join by Telephone: 1-213-306-3065
Password: COMMISSION Access Code: 2598 716 7856

Scan QR code to download an electronic copy of the meeting agenda and packet on your smart device. Please note that hard copies of materials will not be made available during meetings unless otherwise determined by staff in alignment with the County's green initiative to recycle and reduce waste. **If meeting packet is not yet available, check back 2-3 days prior to meeting; meeting packet subject to change. Agendas will be posted 72 hours prior to meeting per Brown Act.*

LIKE WHAT WE DO?

Apply to become a Commission Member at:
https://www.surveymonkey.com/r/2023CommissiononHIVMemberApplication
For application assistance call (213) 738-2816 or email hivcomm@lachiv.org

LOS ANGELES COUNTY COMMISSION ON HIV

510 S. Vermont Ave., 14th Floor, Los Angeles CA 90020
MAIN: 213.738.2816 EML: hivcomm@lachiv.org WEBSITE: https://hiv.lacounty.gov

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

Thursday, April 13, 2023 | 9:00 AM – 1:00 PM

510 S. Vermont Ave
Terrace Level Conference Room A (TK11)
Los Angeles, CA 90020
Validated parking available at 523 Shatto Place, LA 90020

Notice of Teleconferencing Sites:
California Department of Public Health, Office of AIDS
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MEMBERS OF THE PUBLIC: TO JOIN VIRTUALLY, REGISTER HERE:
https://lacountyboardofsupervisors.webex.com/weblink/register/r4c0e346503d6cf2841003121151b861f
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AGENDA POSTED: April 7, 2023

SUPPORTING DOCUMENTATION: Supporting documentation can be obtained via the Commission on HIV Website at: http://hiv.lacounty.gov or in person. **The Commission Offices are located at 510 S. Vermont Ave., 14th Floor Los Angeles, 90020. Validated parking is available at 523 Shatto Place, Los Angeles 90020**. ***Hard copies of materials will not be made available during meetings unless otherwise determined by staff in alignment with the County's green initiative to recycle and reduce waste.***

PUBLIC COMMENT: Public Comment is an opportunity for members of the public to comment on an agenda item, or any item of interest to the public, before or during the Commission's consideration of the item, that is within the subject matter jurisdiction of the Commission. To submit Public Comment, you may join the virtual meeting via your smart device and post your Public Comment in the Chat box -or- email your Public Comment to hivcomm@lachiv.org -or- submit your Public Comment electronically here. All Public Comments will be made part of the official record.

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

Los 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 Oficina de la Comisión al (213) 738-2816 (teléfono), o por correo electrónico á HIVComm@lachiv.org, por lo menos setenta y dos horas antes de la junta.

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

LOS ANGELES COUNTY
COMMISSION ON HIV

1. ADMINISTRATIVE MATTERS

A.	Call to Order & Meeting Guidelines/Reminders		9:00 AM – 9:05 AM
B.	County Land Acknowledgment		9:05 AM – 9:07 AM
C.	Introductions, Roll Call, & Conflict of Interest Statements		9:07 AM – 9:10 AM
D.	Assembly Bill 2449 Attendance Notification for "Emergency Circumstances"	**MOTION #1**	9:10 AM – 9:13 AM
E.	Approval of Agenda	**MOTION #2**	9:13 AM – 9:15 AM
F.	Approval of Meeting Minutes	**MOTION #3**	9:15 AM – 9:17 AM
G.	Consent Calendar	**MOTION #4**	9:17 AM – 9:20 AM

2. REPORTS - I

A. Executive Director/Staff Report — 9:20 AM – 9:30 AM

(1) County/Commission Operations | UPDATES

a. Conflict of Interest Form

(2) Reimagining COH Meetings/Schedule

B. Co-Chairs' Report — 9:30 AM – 9:45 AM

(1) Welcome New Members

(2) Bylaws Review Taskforce | RECRUITMENT

(3) Recognition of National Youth HIV/AIDS Awareness Day (NYHAAD)

(4) Recognition of National Transgender HIV Testing Day

(5) March 8, 2023 COH Meeting | FOLLOW-UP & FEEDBACK

a. Address HIV in the Native American communities

(6) Conferences, Meetings & Trainings | OPEN FEEDBACK (Opportunity for members to share **Commission-related** information from events attended)

a. NMAC Biomedical HIV Prevention Summit | April 11-12, 2023

(7) Member Vacancies & Recruitment

a. Third Executive At-Large Seat Open Nomination & Elections **MOTION #5**

C. California Office of AIDS (OA) Report (Part B Representative) — 9:45 AM – 9:55 AM

(1) OAVoice Newsletter Highlights

D. LA County Department of Public Health Report (Part A Representative) — 9:55 AM – 10:45 AM

(1) Division of HIV/STD Programs (DHSP) Updates

a. Programmatic and Fiscal Updates

- Unmet Needs Presentation
- HRSA Ryan White Part A & EHE Site Visit
- DHSP Workforce Summit

b. Mpox Briefing Update

E. Housing Opportunities for People Living with AIDS (HOPWA) Report — 10:45 AM – 11:00 AM

F. Ryan White Program Parts C, D, and F Report — 11:00 AM – 11:05 AM

G. Cities, Health Districts, Service Planning Area (SPA) Reports — 11:05 AM – 11:10 AM

LOS ANGELES COUNTY COMMISSION ON HIV

BREAK 11:10 AM – 11:25 AM

3. REPORTS - II 11:25 AM – 12:25 PM

A. Operations Committee

(1) Membership Management

a. New Member Applications

b. José Magaña | Seat Change from Alternate to Provider Representative #1 **MOTION #6**

(2) Policies & Procedures

a. Policy #08.1104: Co-Chair Terms & Elections **MOTION #7**

b. Proposed Revisions to Code of Conduct | Public Comment Period: March 23-April 21, 2023

(3) Assessment of the Administrative Mechanism (AAM) | UPDATES

(4) 2023 Training Series

(5) Recruitment, Outreach & Engagement

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

(1) Status Neutral Training & Technical Assistance Planning

C. Standards and Best Practices (SBP) Committee

(1) Oral Healthcare Service Standards | **MOTION #8**

(2) Universal Service Standards and Patient Bill of Rights | UPDATES

(3) Medical Care Coordination (MCC) | REVIEW

D. Public Policy Committee (PPC)

(1) County, State and Federal Policy, Legislation, and Budget

a. 2023-2024 Legislative Docket Development

b. 2023-2024 Policy Priorities

c. Presidential Advisory Council on HIV/AIDS (PACHA) Resolution on MSM Blood Donation Deferral Policy

d. Braidwood v. Becerra Ruling

e. County Coordinated STD Response

E. Caucus, Task Force and Work Group Report 12:25 PM – 12:40 PM

(1) Aging Caucus | June 13, 2023 @ 1-3PM **Virtual Meeting*

(2) Black/African American Caucus | April 20, 2023 @ 4-5PM **Virtual meeting*

(3) Consumer Caucus | April 13, 2023 @ 2-4PM **Hybrid meeting (in-person & virtual)*

(4) Transgender Caucus | April 25, 2023 @ 10AM-12PM **In-person meeting @ Vermont Corridor*

(5) Women's Caucus | April 17, 2023 @ 2-4PM **Virtual meeting*

(6) Vision & Mission Statement Review Workgroup | **No meetings scheduled*

(7) Prevention Planning Workgroup | May 24,2023 @ 4-5:30PM **Virtual meeting*

(8) Bylaws Review Taskforce | TBD **Virtual meeting*

LOS ANGELES COUNTY
COMMISSION ON HIV

5. MISCELLANEOUS

A. Public Comment 12:40 PM – 12:50 PM

(Opportunity for members of the public to address the Commission of items of interest that are within the jurisdiction of the Commission. For those who wish to provide public comment may do so in person, electronically here, or by emailing hivcomm@lachiv.org.)

B. Commission New Business Items 12:50 PM – 12:55 PM

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

C. Announcements 12:55 PM – 1:00 PM

(Opportunity for members of the public to announce community events, workshops, trainings, and other related activities. Announcements will follow the same protocols as Public Comment.)

D. Adjournment and Roll Call 1:00 PM

Adjournment for the meeting of April 13, 2023.

PROPOSED MOTION(S)/ACTION(S)	
MOTION #1	Approve Remote Attendance by Member(s) Pursuant to Assembly Bill 2449 Attendance Notification for "Emergency Circumstances", as presented.
MOTION #2	Approve meeting agenda, as presented or revised.
MOTION #3	Approve meeting minutes, as presented or revised.
MOTION #4	Approve Consent Calendar, as presented or revised.

CONSENT CALENDAR	
MOTION #5	Approve third candidate(s) for Executive At-Large seat(s), as elected.
MOTION #6	Approve Seat Change for José Magaña from Alternate to Provider Representative #1, as presented or revised.
MOTION #7	Approve updates to Policy # 08.1104: Co-Chairs Terms & Elections, as presented or revised.
MOTION #8	Approve Oral Healthcare Service Standards, as presented or revised.

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION ON HIV MEMBERS			
Luckie Fuller, Co-Chair	*Bridget Gordon, Co-Chair*	Miguel Alvarez	Everardo Alvizo, LCSW
Jayda Arrington	Al Ballesteros, MBA	Alasdair Burton	Danielle Campbell, MPH
Mikhaela Cielo, MD	Mary Cummings	Erika Davies	Pearl Doan
Kevin Donnelly	Felipe Findley, PA-C, MPAS, AAHIVS	Arlene Frames	Joseph Green
Felipe Gonzalez	Karl Halfman, MA	William King, MD, JD, AAHIVS	Lee Kochems, MA
Jose Magaña (*Alternate)	Eduardo Martinez (*Alternate)	Leon Maultsby, MHA	Anthony Mills, MD
Andre Moléttе	Derek Murray	Dr. Paul Nash, CPsychol, AFBPsS FHEA	Katja Nelson, MPP
Jesus “Chuy” Orozco	Mario J. Pérez, MPH	Mallery Robinson (*Alternate)	Reverend Redeem Robinson
Ricky Rosales	Harold Glenn San Agustin, MD	Martin Sattah, MD	LaShonda Spencer, MD
Kevin Stalter	Justin Valero, MPA	Jonathan Weedman	
MEMBERS:	**39**		
QUORUM:	**20**		

LEGEND:

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

HYBRID MEETING GUIDELINES, ETTIQUETTE & REMINDERS

(Updated 3.22.23)

☐ This meeting is a **Brown-Act meeting** and is being recorded.

- The conference room speakers are *extremely* sensitive and will pick up even the slightest of sounds, i.e., whispers. If you prefer that your private or side conversations, not be included in the meeting recording which, is accessible to the public, we respectfully request that you step outside of the room to engage in these conversations.
- Turn off your ringers/notifications on your smart devices so as not to disrupt the meeting.
- Your voice is important, and we want to ensure that it is captured accurately on the record. Please be respectful of one another and minimize crosstalk.

☐ The **meeting packet** can be found on the Commission's website at https://hiv.lacounty.gov/meetings/ or accessed via the QR code provided. Hard copies of materials will not be provided in compliance with the County's green initiative to recycle and reduce waste.

☐ Please comply with the **Commission's Code of Conduct** located in the meeting packet

☐ **Public Comment** for members of the public can be submitted in person, electronically @ https://www.surveymonkey.com/r/public_comments or via email at hivcomm@lachiv.org. *For members of the public attending virtually, you may also submit your public comment via the Chat box. Should you wish to speak on the record, please use the "Raised Hand" feature or indicate your request in the Chat Box and staff will call upon and unmute you at the appropriate time. Please note that all attendees are muted unless otherwise unmuted by staff.*

☐ For individuals joining in person, to mitigate any potential streaming interference for those joining virtually, we respectfully ask that you **not simultaneously log into the virtual option of this meeting via WebEx.**

☐ Committee members invoking **AB 2449 for "Just Cause" or "Emergency Circumstances**" must communicate their intentions to staff and/or co-chairs no later than the start of the meeting. Members requesting to join pursuant to AB 2449 must have their audio and video on, at all times, and disclose whether there is a person over the age of 18 in the room in order to be counted toward quorum and have voting privileges. For members joining virtually due to "Emergency Circumstances", a vote will be conducted by the Committee/COH for approval.

☐ Members will be required to explicitly state their agency's **Ryan White Program Part A and/or CDC prevention conflicts of interest** on the record (versus referring to list in the packet). A list of conflicts can be found in the meeting packet and are recorded on the back of members' name plates, courtesy of staff.

County of Los Angeles
Land Acknowledgment
(Adopted December 1, 2022)

The County of Los Angeles recognizes that we occupy land originally and still inhabited and cared for by the Tongva, Tataviam, Serrano, Kizh, and Chumash Peoples. We honor and pay respect to their elders and descendants -- past, present, and emerging -- as they continue their stewardship of these lands and waters. We acknowledge that settler colonization resulted in land seizure, disease, subjugation, slavery, relocation, broken promises, genocide, and multigenerational trauma. This acknowledgment demonstrates our responsibility and commitment to truth, healing, and reconciliation and to elevating the stories, culture, and community of the original inhabitants of Los Angeles County. We are grateful to have the opportunity to live and work on these ancestral lands.

We are dedicated to growing and sustaining relationships with Native peoples and local tribal governments, including (in no particular order) the: Fernandeño Tataviam Band of Mission Indians, Gabrielino Tongva Indians of California Tribal Council, Gabrieleno/Tongva San Gabriel Band of Mission Indians, Gabrieleño Band of Mission Indians - Kizh Nation, Board of Supervisors Statement Of Proceedings November 1, 2022 San Manuel Band of Mission Indians, San Fernando Band of Mission Indians.

To learn more about the First Peoples of Los Angeles County, please visit the Los Angeles City/County Native American Indian Commission website at www.lanaic.lacounty.gov .

LOS ANGELES COUNTY
COMMISSION ON HIV

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510 S. Vermont Ave, 14th Floor • Los Angeles, CA 90020 • TEL (213) 738-2816 • FAX (213) 637-4748
HIVCOMM@LACHIV.ORG • https://hiv.lacounty.gov

VISION

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

MISSION

The Los Angeles County Commission on HIV focuses on the local HIV/AIDS epidemic and responds to the changing needs of People Living With HIV/AIDS (PLWHA) within the communities of Los Angeles County. The Commission on HIV provides an effective continuum of care that addresses consumer needs in a sensitive prevention and care/treatment model that is culturally and linguistically competent and is inclusive of all Service Planning Areas (SPAs) and Health Districts (HDs).

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CODE OF CONDUCT

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

All participants and stakeholders should adhere to the following:

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

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

LOS ANGELES COUNTY COMMISSION ON HIV

2023 MEMBERSHIP ROSTER| UPDATED 3.21.23

SEAT NO.	MEMBERSHIP SEAT	Commissioners Seated	Committee Assignment	COMMISSIONER	AFFILIATION (IF ANY)	TERM BEGIN	TERM ENDS	ALTERNATE
1	Medi-Cal representative			***Vacant***		July 1, 2021	June 30, 2023	
2	City of Pasadena representative	1	EXC|SBP	Erika Davies	City of Pasadena Department of Public Health	July 1, 2022	June 30, 2024	
3	City of Long Beach representative	1	EXC|OPS	Everardo Alvizo, LCSW	Long Beach Health & Human Services	July 1, 2021	June 30, 2023	
4	City of Los Angeles representative	1	PP	Ricky Rosales	AIDS Coordinator's Office, City of Los Angeles	July 1, 2022	June 30, 2024	
5	City of West Hollywood representative	1	PP&A	Derek Murray	City of West Hollywood	July 1, 2021	June 30, 2023	
6	Director, DHSP	1	EXC	Mario Pérez, MPH	DHSP, LA County Department of Public Health	July 1, 2022	June 30, 2024	
7	Part B representative	1	PP&A	Karl Halfman, MA	California Department of Public Health, Office of AIDS	July 1, 2022	June 30, 2024	
8	Part C representative	1	PP	Leon Maultsby	Charles R. Drew University	July 1, 2022	June 30, 2024	
9	Part D representative	1	SBP	Mikhaela Cielo, MD	LAC + USC MCA Clinic, LA County Department of Health Services	July 1, 2021	June 30, 2023	
10	Part F representative			***Vacant***		July 1, 2022	June 30, 2024	
11	Provider representative #1			***Vacant***		July 1, 2021	June 30, 2023	
12	Provider representative #2	1	SBP	Andre Molette	Men's Health Foundation	July 1, 2022	June 30, 2024	
13	Provider representative #3	1	SBP	Harold Glenn San Agustin, MD	JWCH Institute, Inc.	July 1, 2021	June 30, 2023	
14	Provider representative #4	1	PP&A	LaShonda Spencer, MD	Charles Drew University	July 1, 2022	June 30, 2024	
15	Provider representative #5			***Vacant***		July 1, 2021	June 30, 2023	
16	Provider representative #6	1	PP&A	Anthony Mills, MD	Men's Health Foundation	July 1, 2022	June 30, 2024	
17	Provider representative #7	1	EXC	Alexander Luckie Fuller	APLA	July 1, 2021	June 30, 2023	
18	Provider representative #8	1	SBP	Martin Sattah, MD	Rand Shrader Clinic, LA County Department of Health Services	July 1, 2022	June 30, 2024	
19	Unaffiliated consumer, SPA 1			***Vacant***		July 1, 2021	June 30, 2023	
20	Unaffiliated consumer, SPA 2			***Vacant***		July 1, 2022	June 30, 2024	
21	Unaffiliated consumer, SPA 3	1	EXC|OPS |PP&A	Joseph Green	*Unaffiliated Consumer*	July 1, 2021	June 30, 2023	
22	Unaffiliated consumer, SPA 4			***Vacant***		July 1, 2022	June 30, 2024	
23	Unaffiliated consumer, SPA 5	1	EXC|SBP	Kevin Stalter	*Unaffiliated Consumer*	July 1, 2021	June 30, 2023	
24	Unaffiliated consumer, SPA 6	1	OPS	Jayda Arrington	*Unaffiliated Consumer*	July 1, 2022	June 30, 2024	
25	Unaffiliated consumer, SPA 7			***Vacant***		July 1, 2021	June 30, 2023	Mallery Robinson (SBP)
26	Unaffiliated consumer, SPA 8	1	EXC|PP&A	Kevin Donnelly	*Unaffiliated Consumer*	July 1, 2022	June 30, 2024	
27	Unaffiliated consumer, Supervisorial District 1			***Vacant***		July 1, 2021	June 30, 2023	
28	Unaffiliated consumer, Supervisorial District 2	1	EXC	Bridget Gordon	*Unaffiliated Consumer*	July 1, 2022	June 30, 2024	
29	Unaffiliated consumer, Supervisorial District 3	1	SBP	Arlene Frames	*Unaffiliated Consumer*	July 1, 2021	June 30, 2023	Eduardo Martinez (SBP/PP)
30	Unaffiliated consumer, Supervisorial District 4			***Vacant***		July 1, 2022	June 30, 2024	
31	Unaffiliated consumer, Supervisorial District 5	1	PP&A	Felipe Gonzalez	Unaffiliated Consumer	July 1, 2021	June 30, 2023	Jose Magana (OPS)
32	Unaffiliated consumer, at-large #1			***Vacant***		July 1, 2022	June 30, 2024	
33	Unaffiliated consumer, at-large #2			***Vacant***		July 1, 2021	June 30, 2023	
34	Unaffiliated consumer, at-large #3			***Vacant***		July 1, 2022	June 30, 2024	
35	Unaffiliated consumer, at-large #4			***Vacant***		July 1, 2021	June 30, 2023	
36	Representative, Board Office 1	1	EXC|PP&A	Al Ballesteros, MBA	JWCH Institute, Inc.	July 1, 2022	June 30, 2024	
37	Representative, Board Office 2	1	EXC|OPS	Danielle Campbell, MPH	UCLA/MLKCH	July 1, 2021	June 30, 2023	
38	Representative, Board Office 3	1	EXC|PP	Katja Nelson, MPP	APLA	July 1, 2022	June 30, 2024	
39	Representative, Board Office 4	1	EXC|OPS	Justin Valero, MA	No affiliation	July 1, 2021	June 30, 2023	
40	Representative, Board Office 5	1	PP&A	Jonathan Weedman	ViaCare Community Health	July 1, 2022	June 30, 2024	
41	Representative, HOPWA	1	PP&A	Jesus Orozco	City of Los Angeles, HOPWA	July 1, 2021	June 30, 2023	
42	Behavioral/social scientist	1	EXC|PP	Lee Kochems	*Unaffiliated Consumer*	July 1, 2022	June 30, 2024	
43	Local health/hospital planning agency representative			***Vacant***		July 1, 2021	June 30, 2023	
44	HIV stakeholder representative #1	1	PP	Alasdair Burton	No affiliation	July 1, 2022	June 30, 2024	
45	HIV stakeholder representative #2	1	PP	Paul Nash, CPsychol AFBPsS FHEA	University of Southern California	July 1, 2021	June 30, 2023	
46	HIV stakeholder representative #3	1	PP	Pearl Doan	No affiliation	July 1, 2022	June 30, 2024	
47	HIV stakeholder representative #4	1	PP&A	Redeem Robinson	No affiliation	July 1, 2021	June 30, 2023	
48	HIV stakeholder representative #5	1	PP	Mary Cummings	Bartz-Altadonna Community Health Center	July 1, 2022	June 30, 2024	
49	HIV stakeholder representative #6	1	PP	Felipe Findley, PA-C, MPAS, AAHIVS	Watts Healthcare Corp	July 1, 2021	June 30, 2023	
50	HIV stakeholder representative #7	1	PP&A	William D. King, MD, JD, AAHIVS	W. King Health Care Group	July 1, 2022	June 30, 2024	
51	HIV stakeholder representative #8	1	OPS	Miguel Alvarez	No affiliation	July 1, 2022	June 30, 2024	
	TOTAL:	36						

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

LOA: Leave of Absence

Overall total: 39

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 3/21/23

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
ALVAREZ	**Miguel**	No Affiliation	No Ryan White or prevention contracts
ALVIZO	**Everardo**	Long Beach Health & Human Services	Benefits Specialty
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention
			HIV Testing Social & Sexual Networks
			HIV Testing Storefront
ARRINGTON	**Jayda**	Unaffiliated consumer	No Ryan White or prevention contracts
BALLESTEROS	**Al**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis, and Treatment
			Health Education/Risk Reduction (HERR)
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
BURTON	**Alasdair**	No Affiliation	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
CAMPBELL	**Danielle**	UCLA/MLKCH	Oral Health Care Services
			Medical Care Coordination (MCC)
			Ambulatory Outpatient Medical (AOM)
			Transportation Services
CIELO	**Mikhaela**	LAC & USC MCA Clinic	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
CUMMINGS	**Mary**	Bartz-Altadonna Community Health Center	No Ryan White or prevention contracts
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DOAN	**Pearl**	No Affiliation	No Ryan White or prevention contracts
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
FINDLEY	**Felipe**	Watts Healthcare Corporation	Transportation Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Oral Health Care Services
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment
FRAMES	**Arlene**	Unaffiliated consumer	No Ryan White or prevention contracts
FULLER	**LUCKIE**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			Nutrition Support
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
GONZALEZ	**Felipe**	Unaffiliated consumer	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated consumer	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
GREEN	**Joseph**	Unaffiliated consumer	No Ryan White or prevention contracts
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
KOCHEMS	**Lee**	Unaffiliated consumer	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
MAGANA	**Jose**	The Wall Las Memorias, Inc.	HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MARTINEZ	**Eduardo**	AIDS Healthcare Foundation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Mental Health
			Oral Healthcare Services
			STD Screening, Diagnosis and Treatment
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
			Medical Subspecialty
			HIV and STD Prevention Services in Long Beach
MARTINEZ (PP&A Member)	**Miguel**	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
			Promoting Healthcare Engagement Among Vulnerable Populations
MAULTSBY	**Leon**	Charles R. Drew University	HIV Testing Storefront
			HIV Testing Social & Sexual Networks

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MILLS	**Anthony**	Southern CA Men's Medical Group	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences (No Affiliation)	No Ryan White or prevention contracts
MOLLETTE	**Andre**	Southern CA Men's Medical Group	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
MURRAY	**Derek**	City of West Hollywood	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
NELSON	**Katja**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			Nutrition Support
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Nutrition Support
OROZCO	**Jesus ("Chuy")**	HOPWA-City of Los Angeles	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
ROBINSON	**Mallery**	We Can Stop STDs LA (No Affiliation)	No Ryan White or prevention contracts
ROBINSON	**Redeem**	All Souls Movement (No Affiliation)	No Ryan White or prevention contracts
ROSALES	**Ricky**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SAN AGUSTIN	**Harold**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
SPENCER	**LaShonda**	Oasis Clinic (Charles R. Drew University/Drew CARES)	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
STALTER	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
VALERO	**Justin**	No Affiliation	No Ryan White or prevention contracts
WEEDMAN	**Jonathan**	ViaCare Community Health	Biomedical HIV Prevention

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave, 14th Floor, Los Angeles, CA 90020
TEL. (213) 738-2816
WEBSITE: hiv.lacounty.gov | EMAIL: hivcomm@lachiv.org

ALL COMMITTEE MEETINGS ARE HELD VIRTUALLY UNTIL FURTHER NOTICE

COMMITTEE ASSIGNMENTS

Updated: March 21, 2023
Assignment(s) Subject to Change

EXECUTIVE COMMITTEE		
Regular meeting day: 4th Thursday of the Month Regular meeting time: 1:00-3:00 PM Number of Voting Members= 13 | Number of Quorum= 7		
COMMITTEE MEMBER	**MEMBER CATEGORY**	**AFFILIATION**
Bridget Gordon	**Co-Chair, Comm./Exec.***	**Commissioner**
Alexander Fuller	**Co-Chair, Comm./Exec.***	**Commissioner**
Everardo Alvizo	Co-Chair, Operations	Commissioner
Al Ballesteros	Co-Chair, PP&A	Commissioner
Danielle Campbell	At-Large	Commissioner
Erika Davies	Co-Chair, SBP	Commissioner
Kevin Donnelly	Co-Chair, PP&A	Commissioner
Joe Green	At-Large	Commissioner
Lee Kochems	Co-Chair, Public Policy	Commissioner
Katja Nelson, MPP	Co-Chair, Public Policy	Commissioner
Mario Pérez, MPH	DHSP Director	Commissioner
Kevin Stalter	Co-Chair, SBP	Commissioner
Justin Valero	Co-Chair, Operations	Commissioner

OPERATIONS COMMITTEE		
Regular meeting day: 4th Thursday of the Month Regular meeting time: 10:00 AM-12:00 PM Number of Voting Members= 7 | Number of Quorum= 4		
COMMITTEE MEMBER	**MEMBER CATEGORY**	**AFFILIATION**
Everardo Alvizo	**Committee Co-Chair***	**Commissioner**
Justin Valero	**Committee Co-Chair***	**Commissioner**
Miguel Alvarez	*	Commissioner
Jayda Arrington	*	Commissioner
Danielle Campbell	*	Commissioner
Joseph Green	*	Commissioner
Jose Magaña	*	Alternate

PLANNING, PRIORITIES & ALLOCATIONS (PP&A) COMMITTEE		
Regular meeting day: 3rd Tuesday of the Month Regular meeting time: 1:00-4:00 PM Number of Voting Members= 1 4| Number of Quorum= 8		
COMMITTEE MEMBER	**MEMBER CATEGORY**	**AFFILIATION**
Kevin Donnelly	**Committee Co-Chair***	Commissioner
Al Ballesteros	**Committee Co-Chair***	Commissioner
Felipe Gonzalez	*	Commissioner
Joseph Green	*	Commissioner
Karl Halfman, MA	*	Commissioner
William D. King, MD, JD, AAHIVS	*	Commissioner
Miguel Martinez, MPH	**	Committee Member
Anthony Mills, MD	*	Commissioner
Derek Murray	*	Commissioner
Jesus "Chuy" Orozco	*	Commissioner
Redeem Robinson	*	Commissioner
LaShonda Spencer, MD	*	Commissioner
Jonathan Weedman	*	Commissioner
Michael Green, PhD	DHSP staff	DHSP

PUBLIC POLICY (PP) COMMITTEE		
Regular meeting day: 1st Monday of the Month Regular meeting time: 1:00-3:00 PM Number of Voting Members= 11 | Number of Quorum= 6		
COMMITTEE MEMBER	**MEMBER CATEGORY**	**AFFILIATION**
Lee Kochems, MA	**Committee Co-Chair***	Commissioner
Katja Nelson, MPP	**Committee Co-Chair***	Commissioner
Alasdair Burton	*	Commissioner
Mary Cummings	*	Commissioner
Pearl Doan	*	Commissioner
Felipe Findley, MPAS, PA-C, AAHIVS	*	Commissioner
Jerry Gates, PhD	*	Commissioner
Eduardo Martinez	**	Alternate
Leon Maultsby	*	Commissioner
Paul Nash	*	Commissioner
Ricky Rosales	*	Commissioner

STANDARDS AND BEST PRACTICES (SBP) COMMITTEE

Regular meeting day: 1st Tuesday of the Month
Regular meeting time: 10:00AM-12:00 PM
Number of Voting Members = 11 | Number of Quorum = 6

COMMITTEE MEMBER	MEMBER CATEGORY	AFFILIATION
Kevin Stalter	**Committee Co-Chair***	**Commissioner**
Erika Davies	**Committee Co-Chair***	**Commissioner**
Danielle Campbell	*	Commissioner
Mikhaela Cielo, MD	*	Commissioner
Arlene Frames	*	Commissioner
Mark Mintline, DDS	*	Committee Member
Andre Molette	*	Commissioner
Mallery Robinson	*	Alternate
Harold Glenn San Agustin, MD	*	Commissioner
Martin Sattah	*	Commissioner
Wendy Garland, MPH	DHSP staff	DHSP

CONSUMER CAUCUS

Regular meeting day/time: 2nd Thursday of Each Month; Immediately Following Commission Meeting
Co-Chairs: Alasdair Burton & Damone Thomas
Open membership to consumers of HIV prevention and care services

AGING CAUCUS

Regular meeting day/time: 1st Tuesday of Each Month @ 1pm-3pm
Co-Chairs: Kevin Donnelly & Paul Nash
Open membership

TRANSGENDER CAUCUS

Regular meeting day/time: 4th Tuesday of Every Other Month @ 10am-12pm
Co-Chairs: Isabella Rodriguez & Xelestial Moreno
Open membership

WOMEN'S CAUCUS

Regular meeting day/time: Virtual - 3rd Monday of Each Quarter @ 2-4:00pm
The Women's Caucus Reserves The Option of Meeting In-Person Annually
Next Meeting Scheduled For April 17th, 2023
Co-Chairs: Shary Alonzo & Dr. Mikhaela Cielo
Open membership

PREVENTION PLANNING WORKGROUP

Regular meeting day/time: 4th Wednesday of Each Month @ 5:30pm-7:00pm
Chair: Miguel Martinez, Dr. William King & Greg Wilson
Open membership

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

510 S. Vermont Avenue, 14th Floor, Los Angeles CA 90020 • TEL (213) 738-2816
EMAIL: hivcomm@lachiv.org • WEBSITE: http://hiv.lacounty.gov

While not required of meeting participants, signing-in constitutes public notice of attendance. Presence at meetings is recorded solely based on sign-in sheets, and not signing-in constitutes absence for Commission members. Only members of the Commission on HIV are accorded voting privileges, thus Commissioners who have not signed in cannot vote. Sign-in sheets are available upon request.

COMMISSION ON HIV (COH) MEETING MINUTES

510 S. Vermont Ave
Terrace Level Conference Room A (TK11)
Los Angeles, CA 90020

TELECONFERENCE SITE:
California Department of Public Health, Office of AIDS
1616 Capitol Ave, Suite 75-61, Sacramento, CA 95814

March 9, 2023

COMMISSION MEMBERS P=Present | A=Absent | EA=Excused Absence									
Miguel Alvarez	P	Everardo Alvizo, MSW	P	Jayda Arrington	P	Al Ballesteros, MBA	A	Alasdair Burton (*Alt*)	P
Danielle Campbell, MPH	P	Mikhaela Cielo, MD	P	Mary Cummings	A	Erika Davies	P	Pearl Doan	A
Kevin Donnelly	P	Felipe Findley, PA-C, MPAS, AAHIVS	P	Arlene Frames	P	Luckie Fuller	P	Jerry D. Gates, PhD	P
Bridget Gordon	P	Joseph Green	A	Felipe Gonzalez	P	Karl Halfman, MA	P	William King, MD, JD, AAHIVS	P
Lee Kochems, MA	P	Jose Magaña *(Alt)*	A	Eduardo Martinez *(Alt)*	A	Anthony Mills, MD	P	Andre Molette	P
Derek Murray	P	Paul Nash, CPsychol, AFBPsS, FHEA	P	Katja Nelson, MPP	EA	Jesus "Chuy" Orozco	P	Mario J. Pérez, MPH	P
Mallery Robinson *(Alt)*	A	Reverend Redeem Robinson	P	Ricky Rosales	P	Harold Glenn San Agustin, MD	A	Martin Sattah, MD	P
LaShonda Spencer, MD	P	Kevin Stalter	P	Justin Valero, MPA	P				

COMMISSION STAFF & CONSULTANTS
Cheryl Barrit, MPIA; Catherine Lapointe, MPH; Lizette Martinez, MPH; Dawn McClendon; Jose Rangel-Garibay, MPH; and Sonja Wright, BA, MSOM, LAc, Dipl. OM, PES
DIVISION OF HIV AND STD PROGRAMS (DHSP) STAFF
No DHSP staff in attendance.

**Commission members and Members of the public may confirm their attendance by contacting Commission staff at hivcomm@lachiv.org*
***Meeting minutes may be corrected up to one year from the date of Commission approval.*

Meeting agenda and materials can be found on the Commission's website at:
https://hiv.lacounty.gov/meetings/

MEET, GREET & RECONNECTION RECEPTION
Commissioners and meeting attendees were given the opportunity to reconnect, reengage, and support each other to rebuild a sense of community and continue their work in ending the HIV epidemic.

1. ADMINISTRATIVE MATTERS

A. CALL TO ORDER & MEETING GUIDELINES/REMINDERS
Luckie Fuller, Commission on HIV (COH) co-chair, called the meeting to order at 9:30 AM and reviewed meeting guidelines and reminders. See meeting packet.

B. INTRODUCTIONS, ROLL CALL, & CONFLICT OF INTEREST STATEMENTS
Commissioners were asked to introduce themselves and state their conflicts of interest. James Stewart, Parliamentarian, conducted roll call.

ROLL CALL (PRESENT): M. Alvarez, E. Alvizo, J. Arrington, A. Burton, M. Cielo, E. Davies, K. Donnelly, F. Findley, A. Frames, J. Gates, F. Gonzalez, K. Halfman, W. King, L. Kochems, A. Molette, D. Murray, P. Nash, J. Orozco, R. Robinson, R. Rosales, M. Sattah, L. Spencer, K. Stalter, J. Valero, L. Fuller, and B. Gordon.

C. ASSEMBLY BILL 2449 ATTENDANCE NOTIFICATION FOR "EMERGENCY CIRCUMSTANCES"
MOTION #1: Approve Remote Attendance by Member(s) Pursuant to Assembly Bill 2449 Attendance Notification for "Emergency Circumstances", as presented. *No vote held.*

D. APPROVAL OF AGENDA
MOTION #2: Approve meeting agenda, as presented or revised. ✓*Passed by Consensus.*

E. APPROVAL OF MEETING MINUTES
MOTION #3: Approve meeting minutes, as presented or revised. ✓*Passed by Consensus.*

F. COUNTY LAND ACKNOWLEDGEMENT
Cheryl Barrit, Executive Director, informed the COH that the Board of Supervisors (BOS) adopted a County Land Acknowledgement to recognize the land originally and still inhabited

and cared for by the Tongva, Tataviam, Kizh, and Chumas Peoples. Bridget Gordon, COH Co-Chair, read the land acknowledgement to the group; see meeting packet.

MOTION #4: Approve opening all COH meetings with the reading of the County's Land Acknowledgement, as adopted by the Board of Supervisors (BOS) at their December 1, 2022 meeting, as presented or revised. ✓*Passed by Roll Call Vote.*

G. CONSENT CALENDAR

MOTION #5: Approve Consent Calendar, as presented or revised. ✓*Passed by Consensus.*

2. REPORTS – I

A. EXECUTIVE DIRECTOR/STAFF REPORT

(1) County/Commission Operations | UPDATES

C. Barrit thanked all for attending the meeting. She introduced COH staff, including Dawn McClendon, Sonja Wright, Jose Rangel-Garibay, Lizette Martinez, and Catherine Lapointe, to the group. C. Barrit informed the COH that the Vermont Corridor building is a Los Angeles County (LAC) building that holds offices for the Department of Mental Health, Department of Human Resources (HR), Department of Economic Development, Department of Workforce Development, the Human Relations Commission, and Commission on Disabilities. All full-body COH and Committee meetings will be held at the Vermont Corridor. If a reservation is unavailable, some meetings may be held at St. Anne's Conference Center.

Derek Murray noted that the current meeting space is not accessible for those who are hard of hearing. C. Barrit responded that COH staff will work with the LAC technology team to improve the sound in the room.

(2) Reimagining COH Meetings

C. Barrit informed the COH that the Executive Committee has been discussing changes to the meeting schedule and frequency for 2023. The Committee will continue their discussion at their March meeting.

B. CO-CHAIRS' REPORT

(1) Welcome

L. Fuller invited commissioners to introduce themselves and share their thoughts on how to recalibrate, considering the excitement and anxiety they may be feeling about the resumption of in-person meetings.

(2) Recognition of National Women & Girls HIV/AIDS Awareness Day (NWGHAAD)

B. Gordon provided a statement in recognition of NWGHAAD. The theme for NWGHAAD 2023 is "Prevention and Testing at Every Age. Care and Treatment at Every Stage." B. Gordon recognized the work of the Women's Caucus in bringing to the forefront the HIV and STD challenges confronted by women and girls in LAC.

(3) February 9, 2023 COH Meeting | FOLLOW-UP & FEEDBACK

Commissioners discussed the following feedback from the February 9, 2023 COH meeting:

- Justin Valero noted that the last meeting lost quorum during the Black History Month panel presentation. He stated that the return to in-person meetings may help with audience retention.
- Derek Murray commented that future meetings should practice better meeting management by following the time allotted on the agenda.
- Kevin Donnelly commented that the presentations on housing and Mpox brought up many questions and concerns, which extended the meeting time. He suggested that having more frequent updates would result in less questions and would therefore be less time consuming.
- Jerry Gates apologized to commissioners for his comments on the Black History Month panel presentation.
- Miguel Alvarez shared that the comments made at the last meeting were disrespectful to the panelists. Commissioners should be there to listen when others are speaking.
- Felipe Gonzalez shared that he did not appreciate the comments that were made, and that the COH should be a safe space for everyone.
- Felipe Findley commented that everyone should be fully present at COH meetings moving forward.
- Danielle Campbell commented that the COH should be accountable for staying within the allotted agenda time.

(4) Conferences, Meetings & Trainings | OPEN FEEDBACK

Commissioners were given the opportunity to report back on conferences, meetings, or trainings attended and share key ideas that would improve planning efforts. Feedback from the group included the following:

- Dr. Anthony Mills reported that he attended the Conference on Retroviruses and Opportunistic Infections (CROI). The conference discussed access to injectable pre-exposure prophylaxis (PrEP). CROI attendees expressed excitement for injectable PrEP in reducing HIV infection.

- Dr. LaShonda Spencer attended CROI as well and shared that the conference lacked attention to women living with and at-risk for HIV.
- Alasdair Burton shared that he attended the Ending the HIV Epidemic (EHE) Steering Committee meeting, where he was able to represent the voice of the COH.
- Jesus "Chuy" Orozco reported that he attended a United to House Los Angeles (ULA) meeting, which discussed building new housing units for low-income individuals and providing support for seniors.

(5) Member Vacancies & Recruitment

a. Executive At-Large Seats Open Nomination & Elections

MOTION #6: Approve candidate(s) for Executive At-Large seat(s), as elected. ✓Passed by Consent Calendar

Commissioners D. Campbell and Joseph Green were elected for Executive At-Large seats.

L. Fuller reported that there are 10 vacant unaffiliated consumer seats on the COH. Unaffiliated consumers must meet the following criteria set by federal funders: 1) a person living with HIV; and 2) a Ryan White Program (RWP) client; and 3) NOT employed by an agency receiving funding for RWP Part A. L. Fuller encouraged commissioners to continue to promote membership applications to the COH.

(6) Bylaws Review Task Force

MOTION #7: Approve the formation of a Bylaws Review Taskforce, at the recommendation of the Executive Committee in partnership with the Operations Committee, to review current bylaws for updates, as presented or revised. ✓Passed by Consent Calendar

C. CALIFORNIA OFFICE OF AIDS (OA) REPORT (PART B REPRESENTATIVE)

(1) OAVoice Newsletter Highlights

Karl Halfman reported that effective January 1, 2023, clinicians no longer need to apply for an X-Waiver to prescribe buprenorphine for opioid use disorder. He also reported that the California Department of Housing and Community Development is seeking public comments on their 2022-2023 Annual Action Plan. The public comment period is open through April 7, 2023. See meeting packet for full OAVoice report.

D. LA COUNTY DEPARTMENT OF PUBLIC HEALTH REPORT (PART A REPRESENTATIVE)

(1) Division of HIV/STD Programs (DHSP) Updates

a. Programmatic and Fiscal Updates

- Mario Perez, Director, DHSP, reported that there were 900 COVID-19 infections as of March 8, 2023.
- Dr. William King inquired if COVID-19 vaccines will still be accessible after the lifting of the emergency order. M. Perez stated that the County will continue to make vaccines accessible to all.
- Damone Thomas inquired how doxycycline affects STD treatment. Dr. King responded that doxycycline has not been associated with treatment resistance and that the benefits outweigh the negatives. Dr. Martin Sattah commented that doxycycline has been effective in treating chlamydia. Dr. LaShonda Spencer commented that data show that doxycycline is effective in treating STDs.

b. HRSA Site Visit Follow-Up

M. Perez reported that DHSP staff met with COH staff to discuss the feedback from the HRSA site visit and to plan for areas of improvement.

c. Mpox Briefing Update

- M. Perez reported that there have been 1-2 reported mpox cases in the past five weeks. Among all mpox cases in LAC, 42% were among people living with HIV (PLWH); however, PLWH make up only 23.5% of all persons vaccinated for mpox. More severe cases of mpox have been seen disproportionately among Black/African American individuals.
- J. Valero inquired if there are any differences in mpox severity among PLWH who are virally suppressed and PLWH who are not virally suppressed. M. Perez noted that those who are virally suppressed have better health outcomes. Dr. Mills noted that CD4 count also affects mpox severity.
- Dr. King asked how many patients have received both vaccines. M. Perez responded that 68% of patients have received their second dose.
- Dr. Martin Sattah commented that the mpox vaccine is long-lasting.
- Kevin Stalter inquired if there is a way to anonymously report STDs to sexual partners via text messaging. Dr. Mills stated that https://tellyourpartner.org/ is available to anonymously report STDs to sexual partners.

E. HOUSING OPPORTUNITIES FOR PEOPLE LIVING WITH AIDS (HOPWA) REPORT

C. Orozco reported that about 719 people received housing and subsidy assistance. HOPWA also provided 2,098 people with supportive services. A more thorough report will be provided at the April 2023 COH meeting. HOPWA will be receiving a 5% increase in funding beginning July 2023. HOPWA will also be offering about $2 million in rental, mortgage, and utility assistance. The program will cover up to 24 months in back rent.

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

- Part C: *No report provided.*

- Part D: Dr. Cielo reported that there will be a joint event between the Oasis Clinic and Maternal, Child, and Adolescent (MCA) Clinic in commemoration of NWGHAAD. On March 15th, there will be a hike to the Griffith Observatory at 10 AM. Childcare will be provided. On March 16th, there will be a dinner. The Los Angeles Women's Task Force will be hosting a Women's Summit on May 17th at the California Endowment. Please contact Dr. Cielo for more information.

- Part F: *No report provided.*

G. CITIES, HEALTH DISTRICTS, SERVICE PLANNING AREA (SPA) REPORTS

- City of Long Beach:
    - Everardo Alvizo reported that the Long Beach Health Department is offering mpox vaccines. E. Alvizo noted that Dr. Anissa Davis, City Health Officer, presented images on how mpox appears on different skin colors. Please contact E. Alvizo for access to the images.

    - The City of Long Beach will be hosting the Gender Wonder Fest on March 31st at Bixby Park in commemoration of Transgender Day of Remembrance. The Long Beach HIV Planning Council is seeking a co-chair. All who are interested are encouraged to apply.

- City of West Hollywood: Derek Murray reported that the Eviction Prevention and Defense Program renewal applications are now open. The program provides free legal representation for West Hollywood residents who are facing eviction. Priority is given to older adults and people with disabilities.

- City of Pasadena: Erika Davies reported that the Pasadena City Council removed their COVID-19 emergency order. Vaccines are still accessible through the Health Department.

- City of Los Angeles: Ricky Rosales reported that the City of Los Angeles is in the middle of their budget season. He requested an increase to the HIV and Homelessness Program. The request in under negotiation.

- Service Planning Area (SPA) 6: K. Donnelly reported that he and Jayda Arrington attended the SPA 6 stakeholder meeting. J. Arrington represented the COH at the meeting.
- SPA 2: K. Donnelly reported he attended the SPA 2 meeting. The meeting focused primarily on injectable PrEP. SPA 2 requested a representative from the COH. K. Donnelly will refer them to the Operations Committee.

3. REPORTS – II

A. OPERATIONS COMMITTEE

J. Valero provided the report. The Committee held its last meeting on February 23rd from 10AM-12PM. The Committee agreed to continue with its standing meeting time and frequency. The next meeting will be held in-person on March 23, 2023 from 10AM-12PM. The Committee will reassess its meeting schedule at their next meeting.

(1) Membership Management

Five membership application interviews were conducted on March 2nd. The Committee conducted its quarterly attendance review and recommended that attendance letters be sent to three members with excessive unexcused absences. At its next meeting, Operations will approve a seat change for Jose Magana from Alternate to Provider #1 seat. At the February meeting, J. Arrington shared for the "Getting to Know You" exercise. M. Alvarez will share at the March meeting.

a. Membership Applications

- **Jonathan Weedman | Representative, Board Office #5**
  MOTION #8: Approve membership application for Jonathan Weedman, to occupy Board Representative 5 Seat, as presented or revised, and forward to BOS for appointment. ✓Passed by Consent Calendar

- **Leon Maultsby, MHA | Part C Representative**
  MOTION #9: Approve membership application for Leon Maultsby, to occupy Part C Representative seat, as presented or revised, and forward to BOS for appointment ✓Passed by Consent Calendar

(2) Policy and Procedure Review

a. Proposed Revision to Policy #09.4205 (Commission Membership Evaluation, Nomination and Approval Process)

MOTION #10: Approve revisions to Policy # 09.4205 (Commission Membership Evaluation, Nomination and Approval Process), as presented or revised. ✓Passed by Consent Calendar

(3) 2023 Training Series Development

The Operations Committee finalized their 2023 Training Series at its February meeting. The flyer can be found here. All trainings will continue to be virtual. Commissioners are required to either attend the live sessions or view the recordings. A link will be published on the COH website. The General Orientation will take place on March 29th from 3-4:30PM.

(4) Recruitment, Outreach & Engagement

The Committee continues to identify opportunities and support members to participate in outreach, recruitment, and engagement activities, to promote the COH and its work.

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

K. Donnelly provided the report. He reported that he and A. Ballesteros were re-elected as co-chairs. At its last meeting, C. Orozco shared information on the short-term rent, mortgage, and utility bill assistance program through the City of Los Angeles.

(1) 2023 Committee Workplan Development

K. Donnelly noted that the 2023 Committee Workplan can be found in the meeting packet. At its last meeting, K. Donnelly reiterated the focus on reframing PP&A planning, priority setting, and resource allocation using a status neutral approach.

(2) DHSP Funding Table

At its last meeting, Victor Scott, DHSP, provided an overview of the updated funding table that DHSP draws upon for funding HIV prevention and care activities as well as STI funding; see meeting packet for funding table.

C. STANDARDS AND BEST PRACTICES (SBP) COMMITTEE

(1) Oral Healthcare Service Standards | UPDATES

E. Davies reported that the SBP Committee discussed the public comments received for the Oral Health Care Service Standards. At the March 7th meeting, the Committee moved to approve the Oral Health Care Service Standards and elevate to the Executive Committee for approval.

(2) Universal Service Standards and Patient Bill of Rights | REVIEW

The Committee initiated its review of the Universal Service Standards by conducting a read-through of the document. The Committee recommended to update language with the DHSP client satisfaction program information, update outdated language regarding substance use, include information on lived experience as a staffing qualification, and include information on the Undetectable = Untransmittable campaign.

(3) 2023 DHSP Solicitation Priorities

COH staff shared with the Committee an initial solicitation schedule for 2023 provided by DHSP staff to consider additions to the Committee's 2023 workplan. The Committee decided to add the Nutrition Support Service Standards and the Prevention Services standards to their service standard review pipeline for 2023.

D. PUBLIC POLICY COMMITTEE (PPC)

(1) County, State and Federal Policy, Legislation, and Budget

a. 2023-2024 Legislative Docket Development

L. Kochems reported that the PPC is working on populating their 2023-2024 workplan.

b. 2023-2024 Policy Priorities

The PPC met on February 6th and held a robust discussion regarding their 2023 draft workplan and the 2023-2024 Policy Priorities document.

c. Presidential Advisory Council on HIV/AIDS (PACHA) Resolution on MSM Blood Donation Deferral Policy

The PPC reviewed the PACHA Resolution on Men who Have Sex with Men (MSM) Blood Donation Deferral Policy and heard a report from COH staff regarding the recent Food and Drug Administration (FDA) proposed guidelines that would eliminate current restrictions based on sexual orientation and replace them with a risk-based questionnaire for all blood donors.

The Los Angeles County Board of Supervisors (BOS) had a motion on their February 7, 2023 meeting agenda requesting the Chief Executive Officer to send a five-signature letter to FDA Commissioner Robert M. Califf in support of the newly proposed FDA guidelines which eases the discriminatory blood donor policy that prevents many gay and bisexual men form becoming blood donors. The motion was approved, and the five-signature letter was sent on February 9, 2023.

d. DPH Response Letter to BOS STD Motion

On February 6, the Committee deferred discussion on the COH Coordinated Response to the STD Crisis since the Committee was awaiting a response from County departments regarding the BOS motions to address the STD crisis in Los Angeles County and the Act Now Against Meth (ANAM) platform. On February 7, the Department of Public Health (DPH) submitted a memo responding to Los Angeles County's STD Crisis. The Committee will discuss the memo at their April 3, 2023 meeting.

E. CAUCUS, TASK FORCE AND WORKGROUP REPORTS

(1) Aging Caucus | April 4, 2023 @ 1-3PM **Virtual meeting*

K. Donnelly reported that at its last meeting, the Aging Caucus heard from two long-term survivors/older adults living with HIV to hear their challenges with homelessness, aging, and accessing services. Their stories underscore that the safety net does not have a way to catch older adults with HIV when they lose stable housing. It was recommended that educational workshops on services in all places where HIV and senior program are offered.

At the last Aging Caucus meeting, DHSP reported that they are in the process of finalizing an agreement with an agency to provide peer support for PLWH over 50 years old. DHSP staff are reviewing the Medical Care Coordination (MCC) assessments against the assessments recommended by the Aging Caucus.

The Aging Caucus began planning for an event/activity to commemorate National HIV/AIDS and Aging Awareness Day.

a. Addendum Recommendations: Addressing the Needs of Individuals who Acquired HIV Perinatally and Long-term Survivors under 50

MOTION #11: Approve Aging Caucus' Recommendations Addendum, *Addressing the Needs of Individuals who Acquired HIV Perinatally and Long-term Survivors under 50,* as presented or revised. ✓Passed by Consent Calendar

(2) Black/African American Caucus | March 16, 2023 @ 4-5PM **Virtual meeting*

Dawn McClendon reported that the Black/African American Caucus met on February 23rd and re-elected D. Campbell and Gerald Garth as its 2023 co-chairs. The Caucus will continue to meet on the third Thursday of each month virtually from 3-4 PM. Please note that the March 16th regular meeting will be rescheduled to March 23rd at 4-5PM due to a scheduling conflict with the workforce conference hosted by DHSP.

At the last meeting, Julie Tolentino provided an update on the Caucus' organizational capacity needs assessment and shared that DHSP is finalizing its contract with Raniyah Copeland, who will be leading the implementation of the assessment and related activities. The Caucus reviewed its workplan and members were requested to recommend additional items to add to the work plan. Shawn Griffith presented on the "What We Think" project. J. Tolentino announced a call for artists to participate in an upcoming PrEP Marketing Campaign focused on Black communities in LAC.

(3) Consumer Caucus | March 9, 2023 @ 2-4PM **Hybrid meeting (in-person & virtual)*

D. Thomas reported that the Caucus met on February 9th following the COH meeting and debriefed on the discussions of the meeting, including the ongoing concerns related to HOPWA. The Caucus discussed a coordinated strategy in preparation for the HRSA closed listening session to address concerns with the RWP. The Caucus also discussed recruitment strategies. SBP co-chairs E. Davies and K. Stalter provided an overview of the Oral Health Care Service Standards.

The Caucus agreed to hold hybrid meetings at 2PM, or immediately following the COH meeting. Those with lived experience were encouraged to join the Caucus and be part of a unified effort to help improve HIV prevention and care service delivery in LAC.

(4) Prevention Planning Workgroup | March 22, 2023 @ 4-5:30PM **Virtual meeting*

Dr. King reported that the PPW re-elected Dr. King, Miguel Martinez, and Greg Wilson as 2023 co-chairs. The PPW decided to move to a bimonthly schedule and will continue to meet virtually with one in-person meeting in 2023. At the last meeting, C. Barrit provided background on the PPW, noting it was established as a subset of the PP&A Committee to bring prevention efforts into planning strategies. She noted that the PPW is not intended to be permanent.

(5) Transgender Caucus | April 25, 2023 @ 10AM-12PM **In person meeting*

Yara Tapia reported that the Transgender Caucus met on January 24th and elected Yara Tapia as one of the two co-chairs. A second election was held on February 28th, but no additional nominations were received. The Caucus also discussed their 2023 meeting schedule and decided to continue meeting virtually monthly with three in-person learning sessions to be held at the Vermont Corridor.

(6) Women's Caucus | April 17, 2023 @ 2-4PM **Virtual meeting*

Shary Alonzo reported that the Women's Caucus last met on January 23rd and re-elected S. Alonzo and Dr. Cielo as 2023 co-chairs. The Caucus decided to continue meeting virtually on a quarterly basis. The Caucus developed its 2023 workplan to include

suggestion topics for its Virtual Lunch and Learn series which included addressing the impact of HIV on women's cognition and addressing grief in a manner that promotes health and wellness. The Caucus provided feedback to Paulina Zamudio, DHSP, regarding recommendation in developing a Request for Proposal (RFP) for a women's peer support group as part of a Psychosocial Support Services Program.

(7) Policy #08.1104 (Co-Chair Terms & Elections) Workgroup | TBD **Virtual meeting*
D. McClendon reported that the Policy #08.1104 Workgroup met on February 8th and recommended proposed updates to the Co-Chair Terms & Elections. The Workgroup will present the updates to the Executive Committee for approval. Once approved, the updates will move to the full COH for approval.

4. MISCELLANEOUS

A. PUBLIC COMMENT: ***Opportunity for members of the public to address the Commission on items of interest that are within the jurisdiction of the Commission. For those who wish to provide public comment may do so in person, electronically here, or by emailing hivcomm@lachiv.org.***

Lilieth Connelly shared her difficulties accessing HIV medications.

B. COMMISSION NEW BUSINESS ITEMS: ***Opportunity for Commission members to recommend new business items for the full body or a committee level discussion on non-agendized matters not posted on the agenda, to be discussed and (if requested) placed on the agenda for action at a future meeting, or matters requiring immediate action because of an emergency, or where the need to act arose after the posting of the agenda.***

Dr. King requested if the COH could recognize the disproportionate affect of HIV on Native American communities in addition to the Land Acknowledgement.

C. ANNOUNCEMENTS: ***Opportunity for members of the public to announce community events, workshops, trainings, and other related activities. Announcements will follow the same protocols as Public Comment.***

J. Arrington shared that she was invited to attend conference in Washington D.C. to provide a presentation on global health.

Dr. Spencer announced that Drew Cares will be hosting an event in collaboration with Christie's Place for their 2023 Women's HIV/AIDS Conference on Saturday, March 11th. The conference

will be held at the Martin Luther King Jr. Center for Public Health. Please contact Dr. Spencer or Shellye Jones if interested in attending.

Alejandra Aguilar announced that the East Los Angeles Women's Center will be holding their 5th Annual Health and Resource Fair in commemoration of NWGHAAD and National Women's Day. The event will take place on Saturday, March 11th from 9AM-1PM.

D. ADJOURNMENT AND ROLL CALL: ***Adjournment in memoriam of Mary Lucey and Nancy MacNeil, and for all those who lost their lives to, were and continue to be impacted by COVID-19, for the meeting of March 9, 2023.***

The meeting was adjourned by L. Fuller at 12:55PM. J. Stewart conducted roll call.

ROLL CALL (PRESENT): M. Alvarez, E. Alvizo, J. Arrington, A. Burton, M. Cielo, E. Davies, K. Donnelly, F. Findley, A. Frames, J. Gates, F. Gonzalez, K. Halfman, W. King, L. Kochems, A. Mills, A. Molette, D. Murray, J. Orozco, M. Perez, R. Rosales, M. Sattah, L. Spencer, K. Stalter, J. Valero, L. Fuller, and B. Gordon

MOTION AND VOTING SUMMARY		
MOTION 1: Approve remote attendance by Member(s) Pursuant to Assembly Bill 2449 Attendance Notification for "Emergency Circumstances", as presented.	No vote held.	**NO VOTE HELD**
MOTION 2: Approve meeting agenda, as presented or revised.	Passed by Consensus.	**MOTION PASSED**
MOTION 3: Approve meeting minutes, as presented or revised.	Passed by Consensus.	**MOTION PASSED**
MOTION 4: Approve opening all COH meetings with the reading of the County's Land Acknowledgement, as adopted by the Board of Supervisors (BOS) at their December 1, 2022 meeting, as presented or revised.	Passed by Roll Call Vote. **YES:** M. Alvarez, E. Alvizo, J. Arrington, A. Burton, D. Campbell, M. Cielo, E. Davies, K. Donnelly, F. Findley, A. Frames, J. Gates, F. Gonzalez, K. Halfman, W. King, L. Kochems, A. Mills, D. Murray, P. Nash, J. Orozco, R. Robinson, R. Rosales, M. Sattah, L. Spencer, K. Stalter, J. Valero, L. Fuller, and B. Gordon	**MOTION PASSED**

MOTION AND VOTING SUMMARY		
	NO: 0 **ABSTENTIONS:** 0	
MOTION 5: Approve Consent Calendar, as presented or revised.	Passed by Consensus.	**MOTION PASSED**
MOTION 6: Approve candidate(s) for Executive At-Large seat(s), as elected.	Passed by Consent Calendar	**MOTION PASSED**
MOTION 7: Approve the formation of a Bylaws Review Task Force, at the recommendation of the Executive Committee in partnership with the Operations Committee, to review current bylaws for updates, as presented or revised.	Passed by Consent Calendar	**MOTION PASSED**
MOTION 8: Approve membership application for Jonathan Weedman, to occupy Board Representative 5 seat, as presented or revised, and forward to the BOS for appointment.	Passed by Consent Calendar	**MOTION PASSED**
MOTION 9: Approve membership application for Leon Maultsby, to occupy Part C Representative seat, as presented or revised, and forward to the BOS for appointment.	Passed by Consent Calendar	**MOTION PASSED**
MOTION 10: Approve Aging Caucus' Recommendations Addendum, *Addressing the Needs of Individuals who Acquired HIV Perinatally and Long-term Survivors under 50,* as presented or revised.	Passed by Consent Calendar	**MOTION PASSED**

POLICY/PROCEDURE #08.2107	Consent Calendar	Page 1 of 3

NO PROPOSED CHANGES, 4/10/2008

ADOPTED, 1/10/2008

SUBJECT: **"Consent Calendar" procedures at Commission and other meetings.**

PURPOSE: **To provide instructions for the "Consent Calendar" procedures at the Los Angeles County Commission on HIV and other, related Commission meetings.**

BACKGROUND:

- The Commission regularly takes action on multiple items at its monthly meetings. As a result, the Commission is pressured to give complex actions adequate consideration and due diligence, but must rush through motions in order to conclude the meetings on time.

- At the November 2, 2007 Commission meeting, members suggested using a Consent Calendar to expedite the motions that have unanimous support and do not necessitate discussion or debate. The Executive Committee formally endorsed the Consent Calendar practice at its December 3, 2007 meeting.

POLICY:

1) The "Consent Calendar" is a procedural mechanism to expedite Commission business by allowing the body to approve all motions on the consent calendar collectively without debate or dialogue.

2) Commission members or members of the public may set aside (or "pull") an item from the Consent Calendar for any reason in order for the body to discuss and/or vote on it at its appointed time on the agenda. Reasons for setting aside an item include an accompanying presentation, a desire to discuss, address and/or review the item, to register a contrary or opposing vote, and/or to propose an amendment to the motion.

3) Any item that would generate an opposing vote must be removed from the Consent Calendar and returned to its normal place on the agenda.

4) Those items that remain on the Consent Calendar (that have not been "pulled") will be approved collectively in the single Consent Calendar motion. The Consent Calendar motion must be approved unanimously by quorum of the voting membership that is present.

5) The motions that have been set aside will be addressed according to their order on the agenda. Removing an item from the Consent Calendar does not preclude a later vote on that item, nor its approval at a later point on the agenda.

6) Voting members are allowed to register their abstentions from individual items on the Consent Calendar during the Consent Calendar vote.

PROCEDURE(S):

1. **Consent Calendar**: All "action" motions on the Commission's (or other meetings') agendas are automatically placed on the Consent Calendar. "Procedural" motions (e.g., approval of the agenda, approval of the minutes) are not part of the Consent Calendar.

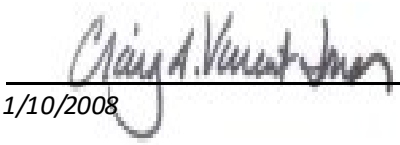
2. **Setting Aside Consent Calendar Items**: An item may be "pulled" from the Consent Calendar by any Commission member, member of the public, or staff member for any reason. The most common reasons for setting aside a Consent Calendar item are:
   a) There is a presentation that accompanies the item.
   b) The member has a question or would like information about the item.
   c) The member would like to see to discuss the item or see it discussed.
   d) The member would like to amend/substitute the motion.
   e) There is an opposing vote.

3. **Items Removed from the Consent Calendar**: "Pulling" an item from the Consent Calendar does not preclude that motion from being considered at a later point on the agenda:
   a) Setting aside a Consent Calendar item returns that item to its regular place on the agenda, where it is addressed at its appointed time.
   b) That motion will be voted on, in agendized order, unless the body chooses to postpone, amend or substitute it when it is considered.

4. **Approving the Consent Calendar**: The Consent Calendar approval vote must be unanimous.
   a) There is no discussion about the Consent Calendar approval, except to pull specific items.
   b) As with all Commission motions, a quorum must be present to vote on it.
   c) As a vote without objections, the Consent Calendar motion does not necessitate a roll call.
   d) Items that generate an opposing vote for the Consent Calendar approval must be removed from the Consent Calendar for later consideration on the agenda.
   e) Voting members may register "abstentions" for individual items on the Consent Calendar.

DEFINITIONS:

- **Abstain/Abstention**: when a voting member acknowledges his/her presence, but declines to vote "aye" or "no" on a motion.
- **"Action" Item/Motion**: a motion that leads to action by the Commission. In the context of this policy, "action" motions are placed on the Consent Calendar.
- **Consent Calendar**: a procedural vehicle for a public voting body to collectively approve all of its "action" motions that do not require discussion or debate.
- **Motion**: the proposed decision or action that the Commission formally moves and votes on.
- **"Procedural" Item/Motion**: a motion necessary for meeting procedural requirements (approving the agenda or minutes). In the context of this policy, "procedural" motions are not placed on the Consent Calendar.
- **"Pull" (an Item/Motion)**: removing or setting aside an item/motion from the Consent Calendar and returning it to its original place on the agenda for discussion/consideration.

NOTED AND APPROVED:  **EFFECTIVE DATE:** January 10, 2008

Original Approval: 1/10/2008 *Revision(s):*

Conflict of Interest and Affiliation Disclosure Form

Consistent with the Los Angeles County Code 3.29.046 (Conflict of Interest), the Los Angeles County Commission on HIV (Commission), members are required to abide by the Conflict of Interest and Disclosure requirements of the Commission, the County of Los Angeles, the State of California (including Government Code Sections 87100, 87103, and 1090, et seq.), the Ryan White Program, as outlined in Human Resources & Services Administration (HRSA) and relevant Center of Disease Control (CDC) prevention grant guidance. ***Please note that this Conflict of Interest and Affiliation Disclosure Form is not affiliated with and is separate from the County's Statements of Economic Interests - Form 700 required by the State of California Fair Political Practices Commission.***

Conflict of Interest, for purposes of the Ryan White Program, is defined as having a financial interest in, serving as a board member, being employed by, having been employed by, or having a contract or agreement with, an organization, partnership, or any other entity, whether public or private, that receives Ryan White Part A funds. These provisions extend to direct ascendants and descendants, siblings, spouses and domestic partners of Commission members and non-Commission Committee-only members*.

Additionally, as an integrated HIV prevention and care planning body for Los Angeles County, the Commission extends disclosure to those having a financial interest in, serving as a board member, being employed by, having been employed by, or having a contract or agreement with, an organization, partnership, or any other entity, whether public or private, that receives CDC HIV-prevention funding from Los Angeles County.**

**If you, a family member, or a member of your household also have a role as an employee or a Board member of an organization or agency that has received or is seeking Part A Program funds from Los Angeles County, please disclose that information below.*

***If you have a role as an employee or a Board member of an organization or agency that has received or is seeking CDC HIV-prevention funding through Los Angeles County, please disclose that information.*

If you are a client and your only relationship with an organization or agency is that you receive, or are eligible for, services or you participate on a client or consumer advisory board, that would not be considered a conflict of interest.

Commission Member Name: _____

As defined above, do you have a Conflict of Interest(s): ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

Conflict of Interest and Affiliation Disclosure Form

Affiliation Disclosure

Regarding Ryan White Program Part A funding, please check the entities with which you (or your ascendants, descendants, siblings, spouses, or domestic partners) have been professionally affiliated with in the past twelve (12) months. Regarding CDC HIV-prevention funding, please check the entities with which you have been professional affiliated with in the past twelve (12) months. ****DO NOT CHECK AGENCIES WHERE YOU VOLUNTEER OR ARE A CLIENT***

- ☐ AIDS Healthcare Foundation
- ☐ African American AIDS Policy and Training Institute (d.b.a. Black AIDS Institute)
- ☐ Alliance for Housing and Healing
- ☐ AltaMed Health Services Corporation
- ☐ APLA Health & Wellness
- ☐ Asian American Drug Abuse Program
- ☐ Automated Case Management Services, Inc.
- ☐ Being Alive: People with AIDS Coalition
- ☐ Bienestar Human Services, Inc.
- ☐ Center for Health Justice, Inc.
- ☐ Central City Community Health Center
- ☐ Charles R. Drew University of Medicine & Science
- ☐ Children's Hospital of Los Angeles
- ☐ City of Long Beach, Dept of Health & Human Services
- ☐ City of Pasadena Public Health Department
- ☐ Coachman Moore & Associates, Inc.
- ☐ Community Health Alliance of Pasadena
- ☐ Dignity Health (dba St. Mary Medical Center)
- ☐ East Los Angeles Women's Center
- ☐ East Valley Community Health Center, Inc.
- ☐ El Centro del Pueblo
- ☐ El Proyecto del Barrio, Inc.
- ☐ Entercom California, LLC
- ☐ Essential Access Health
- ☐ Focus International, Inc. d.b.a. Focus Interpreting
- ☐ Friends Research Institute, Inc.
- ☐ Greater Los Angeles Agency on Deafness, Inc.
- ☐ Healthcare Staffing Solutions, Inc.
- ☐ Heluna Health
- ☐ In The Meantime Men's Group
- ☐ Inner City Law Center
- ☐ JWCH Institute, Inc.
- ☐ LAC+USC Foundation Medical Center Foundation, Inc.
- ☐ Los Angeles Centers for Alcohol & Drug Abuse
- ☐ Los Angeles LGBT Center
- ☐ Men's Health Foundation
- ☐ Minority AIDS Project
- ☐ Northeast Valley Health Corporation
- ☐ Project Angel Food
- ☐ Project New Hope
- ☐ Public Health Foundation Enterprises, Inc. (dba Heluna Health)
- ☐ Realistic Education in Action Coalition to Foster Health (dba REACH LA)
- ☐ Special Service for Groups
- ☐ St. John's Well Child and Family Center
- ☐ T.H.E. Clinic, Inc.
- ☐ Tarzana Treatment Centers, Inc.
- ☐ The Center Long Beach (One in Long Beach, Inc.)
- ☐ The Regents of California, University of Los Angeles (UCLA)
- ☐ The Salvation Army
- ☐ The Wall Las Memorias, Inc.
- ☐ University of Southern California
- ☐ USC- MCA Center Keck School of Medicine
- ☐ Venice Family Clinic
- ☐ Via Care Community Health Center, Inc.
- ☐ Watts Healthcare Corporation
- ☐ Westside Family Health Center
- ☐ Other Agency/Organization Not listed: _____

Conflict of Interest and Affiliation Disclosure Form

All members are expected to comply with the foregoing disclosure of conflicts of interest and affiliations, as defined and in accordance with governing authority, to ensure that planning activities and decisions by the Commission are performed in a manner that promotes transparency in meeting the needs of people living with and impacted by HIV in Los Angeles County.

By signing below, you are acknowledging that all the information provided on this form is true and accurate and that you have described any and all relationship with Ryan White Part A and CDC HIV-prevention funded providers.

Print Name: _____

Signature:_____Date: ____/____/_____

Los Angeles County Commission on HIV (COH)
Proposed 2023 Meeting Schedule
DRAFT Version 04.7.23 – FOR DISCUSSION /IDEA GENERATION PURPOSES ONLY

- **Bylaws:** Section 5. Regular meetings. In accordance with Los Angeles County Code 3.29.060 (Meetings and committees), the Commission shall meet at least ten (10) times per year. Commission meetings are monthly, unless cancelled, at a time and place to be designated by the Co-Chairs or the Executive Committee. The Commission's Annual Meeting replaces one of the regularly scheduled monthly meetings during the fall of the calendar year.
- The Executive Committee may choose to form a smaller group of Commissioners to review, refine and adjust meeting schedule, topics, and discussion format (e.g., listening sessions, panels, break out groups)
- Topics listed below are not in any particular order; may be rearranged by the Co-Chairs/Executive Committee.
- Months without meetings may be used to complete desired outcomes and action steps that arise from discussions.

Proposed Meeting Schedule and Topics - Commission Meetings		
Month	**Community Discussion Topic**	**Suggested Prompts/Facilitation Questions**
~~March~~	~~• First in-person meeting since March 2020~~ ~~• Finish motions from Feb. 9 meeting~~ ~~• Present new meeting approach and meeting schedule to full council for feedback and public comment~~	
April	Unmet Needs Estimate presentation and discussion from DHSP	• How do we use unmet needs estimate to address the needs of priority populations and key geographic areas? • Identify key realistic action items for the Commission as result of the discussion.
May	**Cancel full COH meeting; Convene meeting(s) with other County Commissions for collaborative opportunities**	
June	Housing	• Identify discussion objectives and desired outcomes • Understand services available via RW and HOPWA (Program Overviews)

		• How can HOPWA and RW services work and complement each other to keep PLWH housed and link them to housing if experiencing homelessness? • Identify key realistic action items for the Commission as result of the discussion.
July	HIV and Native Americans	
August	Mental Health	• Identify discussion objectives and desired outcomes • Understand services available via RW and other County-funded programs (Program Overviews) • Gain an understanding of how individuals can access mental health services. • Identify key realistic action items for the Commission as result of the discussion.
September	**Cancel**	
October	Methamphetamine and HIV/Substance Use	• Identify discussion objectives and desired outcomes • Understand services available via RW and other County-funded programs (Program Overviews) • Gain an understanding of how individuals can access services. • Identify key realistic action items for the Commission as result of the discussion.
November	**ANNUAL CONFERENCE**	Theme and topics TBD
December	**TBD or Cancel**	

LIST OF LOS ANGELES COUNTY COMMISSIONS FOR HIV PARTNERSHIPS (3.14.23)

NAME	ROLE/PURPOSE
HEALTH	
Public Health Commission https://phcommission.ph.lacounty.gov/	The mission of the County of Los Angeles Public Health Commission is to review, study, advise and make recommendations to the Los Angeles County Board of Supervisors, the Director of Public Health and Health Officer, the Chief Deputy of Public Health and Department of Public Health Programs on all matters related to public health as established by Ordinance 4099 of the Administrative Code 1. The Public Health Commission plays an integral role in the work that DPH conducts through their inquiry, oversight, review, and recommendations. The Public Health Commission members are active in their respective roles in their communities, lending a voice to DPH's work that supports the Department's mission to protect health, prevent disease and promote the health and well-being of all persons in Los Angeles County. The Public Health Commission examines the management of delivery of public health services to all cities and unincorporated areas in Los Angeles County as well as the management and response to emerging public health issues. This provides a necessary level of accountability and oversight for DPH, the Board of Supervisors, and the residents of Los Angeles County.
Community Prevention and Population Health Task Force http://publichealth.lacounty.gov/plan/taskforce/index.htm	Report to the Board of Supervisors with priority recommendations to promote health, equity, and community well-being in Los Angeles County with a focus on population health improvement. Make recommendations to the Board of Supervisors, the Alliance for Health Integration, and the Department of Public Health on public health priorities, initiatives and practices that will achieve health equity and healthy communities. Serve as the advisory body to the Center for Health Equity (CHE). Provide leadership and strategic direction for community health planning in Los Angeles County, including the Community Health Improvement Plan (CHIP) , and other strategic efforts to promote strong population health, health equity, and racial justice.

Commission on Alcohol and Other Drugs (CAOD) http://publichealth.lacounty.gov/sapc/public/commission-on-alcohol.htm	Advises and makes recommendations to the Board of Supervisors on alcohol and drug related issues with the goal of reducing the negative impact of substance use disorders on the quality of life for individuals and their families residing in Los Angeles County.
Mental Health Commission https://dmh.lacounty.gov/about/mental-health-commission/	Advises the Los Angeles County Board of Supervisors and Department of Mental Health Director on issues impacting the County mental heal Reviews and approves the procedures used to ensure community and professional involvement at all stages of the planning process.
HEALTHCARE	
Hospitals and Health Care Delivery Commission https://dhs.lacounty.gov/who-we-are/hospital-and-health-care-delivery-commission/	Consults with and advises the Director of Health Services and the Board of Supervisors on all matters pertaining to patient care policies and programs.
LA Care Health Plan (aka Local Initiative Health Authority Governing Board) https://www.lacare.org/about-us/about-la-care/board-governors	Organizes, administers, and arranges for the provision of managed health care services for the targeted Medi-Cal population consistent with the State's plan.
HOUSING	
Housing Advisory Committee	Reviews and makes recommendations on Section 8 and public housing policies and procedures.
Los Angeles Housing Authority Commission https://www.lahsa.org/commission	Has authority to make budgetary, funding, planning and program policies.

Other Partner(s) (Non-county): Community Clinic Association of Los Angeles County https://wdacs.lacounty.gov/commissions/laccoa/

HIV Information and Youth

- In the United States, 20% of new HIV diagnoses in 2020 were among young people aged 13-24.
- Getting tested for HIV is important for prevention since only 6% of high school students have ever been tested for HIV.

Youth Need to Know their HIV Status to Stay Healthy

Almost half of young people (aged 13-24) with human immunodeficiency virus (HIV) do not know they have it. For youth who test negative, testing services can connect them to HIV prevention resources. Youth who test positive can be connected to health services and take medicine to treat HIV.

Treating HIV means taking medicine to lower the amount of virus in the blood—so low that a test can't measure it. This is the best thing to do to stay healthy.

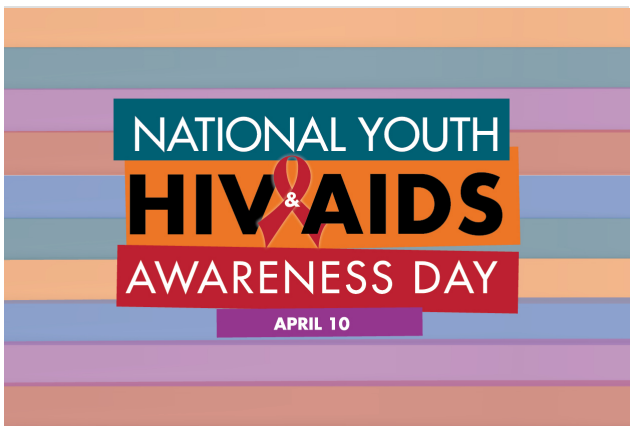
Sexual Risk Behaviors Can Lead to HIV, STDs, and Pregnancy

CDC data show declines in sexual risk behaviors among high school students from 2011 to 2021. Fewer students are currently sexually active. And fewer have ever had sex—down from 47% in 2011 to 30% in 2021.

However, many youth engage in health risk behaviors and experiences that can result in unintended outcomes. According to CDC data:

- **Condom use is down.** Condom use among sexually active students decreased from 60% in 2011 to 52% in 2021. This is a serious health risk for HIV and STDs.
- **Substance use can lead to high-risk behaviors.** When youth are under the influence of drugs or alcohol, they may engage in high-risk behaviors, such as sex without a condom or not taking medicine to prevent or treat HIV.
- **Some youth are at higher risk.** Some youth—including lesbian, gay, bisexual, and questioning (LGBQ+) youth—are at greater risk for negative health outcomes. For example, about 1 in 5 LGBQ+ students experienced sexual violence in the past year, compared to 1 in 10 of their heterosexual classmates. LGBQ+ students (21%) were also more likely to have ever used illegal drugs than heterosexual students (21%).

NYHAAD Toolkit



Use this toolkit to raise awareness of partners, stakeholders, and media about HIV prevention, treatment, and care of young people.

Campaign Resources

- HIV.gov
- Let's Stop HIV Together

Social Media

- Twitter: @CDC_DASH
- Facebook: CDC HIV
- Pinterest: CDC Healthy Youth

NYHAAD Button

Post this web button on your site.

The data show there is work to be done to support healthy adolescent development. Addressing HIV in youth means teaching them skills to reduce their risk, make healthy decisions, and get treatment and care if needed.

Schools Can Help Prevent HIV

The nation's schools reach millions of students every day. Schools are a place for students to learn about the dangers of unhealthy behaviors, and to practice skills that promote a healthy lifestyle. They are in a unique position to help youth adopt behaviors that reduce their risk for HIV.

What are ways to encourage youth to stay healthy?

- Teach students the basics about HIV and other STDs.
- Promote communication between youth and their parents or families.
- Support student access to confidential HIV counseling and testing services.

How can schools encourage students to get tested for HIV?

- Use health risk behavior data to prioritize needs for health education or services.
- Connect students to health services that include HIV testing and counseling.
- Encourage students and their parents or families to talk about HIV.

What Youth Can Do

Youth need to understand their risk and know how to protect themselves against HIV.

- **Get educated.** Learn the basic facts about HIV transmission, testing, and prevention.
- **Get talking.** Talk with parents, families, teachers, doctors, and other trusted adults about HIV and sexual health.
- **Get tested.** CDC recommends that everyone aged 13 to 64 get tested for HIV at least once as part of routine health care. Contact a health care provider about testing.
- **Get medicine.** If you test positive for HIV, get support, seek treatment, and stay in care to remain healthy and prevent passing the virus to others.

More Information

- HIV Basics
- HIV by Age
- HIV Risk and Prevention
- Health Services for Teens

References

- CDC. Diagnoses of HIV infection in the United States and dependent areas, 2020. *HIV Surveillance Report* 2021;33.
- CDC. Youth Risk Behavior Survey: Data Summary & Trends Report: 2011-2021 . Atlanta: Centers for Disease Control and Prevention; 2023.

Last Reviewed: March 16, 2023

Adolescent and School Health

NYHAAD Fact Sheets

These materials provide information to help audiences understand how to support and protect adolescents at risk for HIV.

NYHAAD Toolkit

Education Agencies

Parents

Healthcare Providers

Individuals

Education Agencies

- CAPS: Things to Consider
- Developing a Scope and Sequence for Sexual Health Education
- How Schools Can Support HIV Testing Among Adolescents
- Parental Monitoring
- Parent Engagement for School Districts and School Administrators
- Parent Engagement Overview
- Promoting Parent Engagement in Schools to Prevent HIV and other STDs Among Teens
- Sexual Health Education Scope and Sequence
- Sexual Health Services (SHS)
- What Works: Overview
- What Works: Safe and Supportive School Environments
- What Works: Sexual Health Education
- What Works: Sexual Health Services

Parents

- Parental Monitoring
- Ways to Engage in Your Child's School to Support Student Health and Learning
- Supporting One on One Time with a Healthcare Provider
- Talking with Your Teens about Sex
- What Fathers Can Do

Healthcare Providers

- Developing a Referral System for Sexual Health Services
- HIV Resources for Clinicians
- Sexual Health Services (SHS) Fact Sheet

Individuals

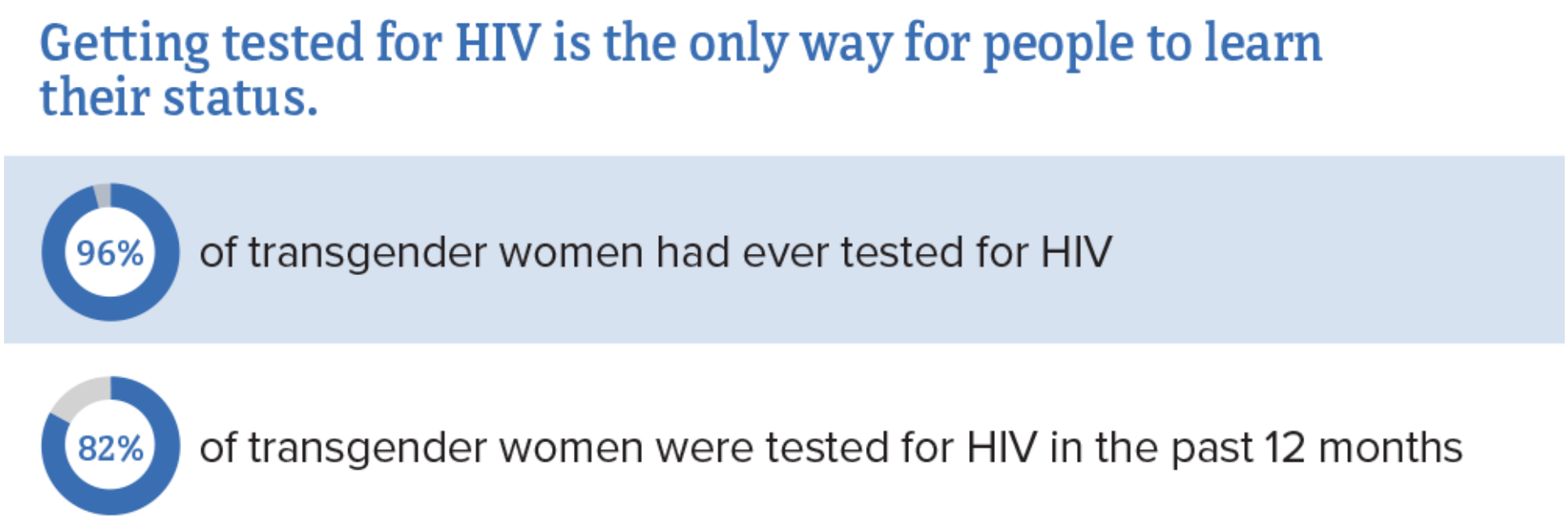
- Condom Do's & Don't
- HIV Basics
- HIV Prevention
- Ways to Prevent STDs

Last Reviewed: March 16, 2023

HIV and Transgender People: HIV Testing

HIV testing is the gateway to care for people who have HIV and to prevention services for people who don't have HIV. CDC recommends that everyone between the ages of 13 and 64 get tested for HIV at least once as part of routine health care. People with certain risk factors should get tested at least once a year. A recent study found that transgender women have high rates of recent and lifetime HIV testing.

HIV Testing Among Transgender Women in 7 US Cities, 2019-2020*



* Among people aged 18 and older.

Source: CDC. HIV infection, risk, prevention, and testing behaviors among transgender women–National HIV Behavioral Surveillance–7 U.S. Cities, 2019-2020 . *HIV Surveillance Special Report* 2021.

Download or share:

Bibliography

1. CDC. HIV infection, risk, prevention, and testing behaviors among transgender women–National HIV Behavioral Surveillance–7 U.S. Cities, 2019-2020 [PDF - 2 MB]. *HIV Surveillance Special Report* 2021.
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4. CDC. Selected national HIV prevention and care outcomes [PDF - 2 MB] (slides).
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20. New York City Department of Health and Mental Hygiene. Surveillance slide sets: HIV among people identified as transgender in New York City, 2015-2019 . December 2020. Accessed March 22, 2021.
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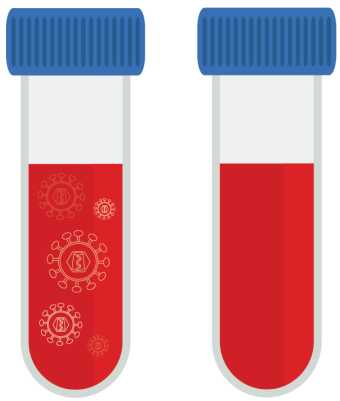
30. National Center for Transgender Equality; Annual report 2016. The T's Not Silent .

Terminology

HIV Testing

HIV



HIV Diagnoses

HIV Prevalence

Viral Suppression

Prevention Challenges

What CDC Is Doing

Last Reviewed: March 23, 2023

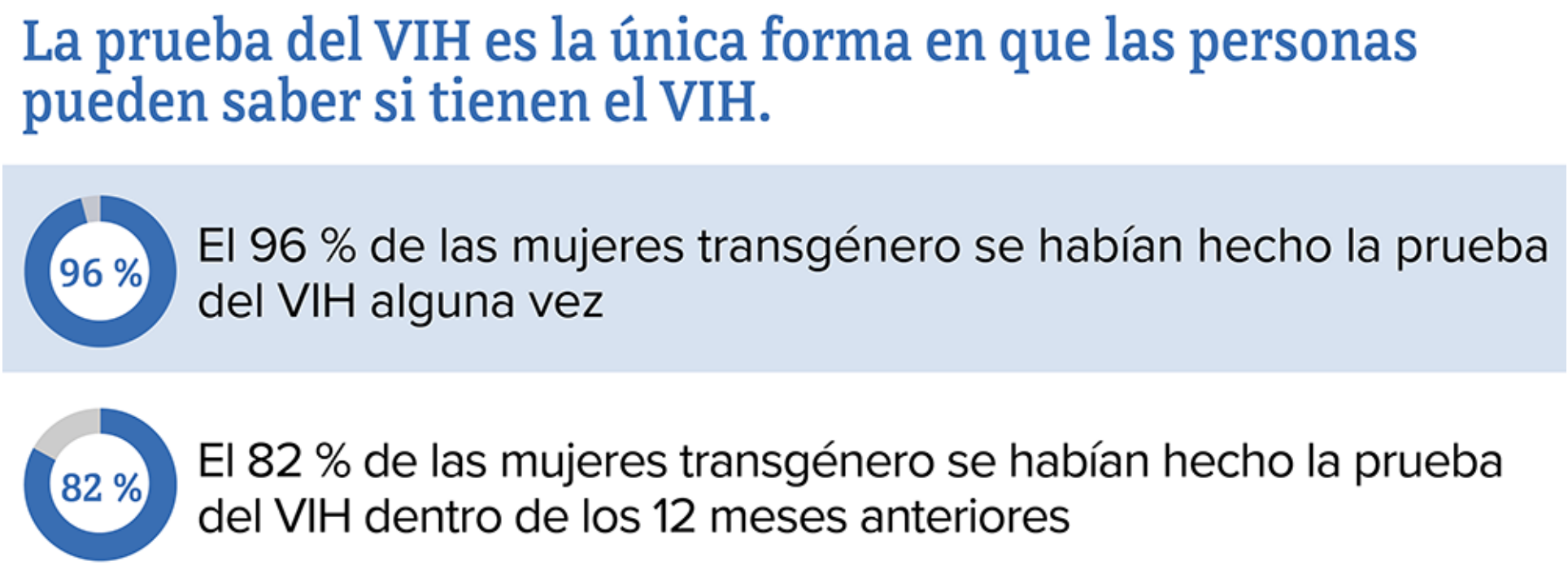
VIH

VIH Home

El VIH y las personas transgénero: Pruebas del VIH

Las pruebas del VIH son la vía de acceso a la atención médica para las personas que tienen el VIH, y a los servicios de prevención para las personas que no lo tienen. Los CDC recomiendan que todas las personas entre los 13 y 64 años de edad se hagan la prueba del VIH al menos una vez como parte de su atención médica de rutina. Las personas con ciertos factores de riesgo deben hacerse la prueba al menos una vez al año. En un estudio reciente se halló que las mujeres transgénero tienen tasas altas de haberse hecho la prueba del VIH recientemente o en la vida.

Pruebas del VIH entre las mujeres transgénero en 7 ciudades de los EE. UU, 2019-2020*



*Entre las personas de 18 años de edad o más.

Fuente: CDC. HIV infection, risk, prevention, and testing behaviors among transgender women–National HIV Behavioral Surveillance–7 U.S. Cities, 2019-2020 [PDF – 2 MB]. *HIV Surveillance Special Report* 2021.

Descargue y comparta esta infografía

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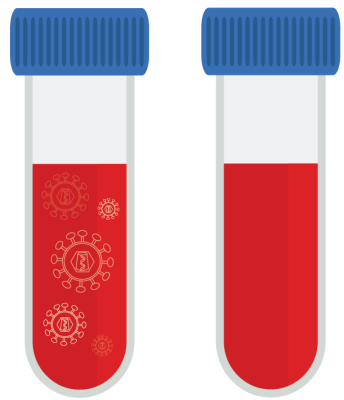
Terminología

Pruebas del VIH

Prevención de la infección por el VIH



Diagnósticos

Prevalencia del VIH

Supresión viral

Desafíos para la prevención

Qué están haciendo los CDC

Esta página fue revisada: el 19 de julio del 2022

LOS ANGELES COUNTY
COMMISSION ON HIV

DUTY STATEMENT

AT-LARGE MEMBER, EXECUTIVE COMMITTEE

(APPROVED 3-28-17)

In order to provide effective direction and guidance for the Commission on HIV, there are three At-Large members of the Executive Committee, elected annually by the body, to provide the following representation, leadership and contributions:

COMMITTEE PARTICIPATION:

① Serve as a member of the Commission's Executive and Operations Committees, and participates, as necessary, in Committee meetings, work groups and other activities.

② As a standing member of the Executive Committee, fill a critical leadership role for the Commission; participation on the Executive Committee requires involvement in key Commission decision-making:

- Setting the agenda for Commission regular and special meetings;
- Advocating Commission's interests at public events and activities;
- Voting and determining urgent action between Commission meetings;
- Forwarding and referring matters of substance to and from other Committees and to and from the Commission;
- Arbitrating final decisions on Commission-level grievances and complaints;
- Discussing and dialoguing on a wide range of issues of concern to the HIV/AIDS community, related to Commission and County procedure, and involving federal, state and municipal laws, regulations and practices.

REPRESENTATION:

① Understand and voices issues of concern and interest to a wide array of HIV/AIDS and STI-impacted populations and communities

② Dialogue with diverse range perspectives from all Commission members, regardless of their role, including consumers, providers, government representatives and the public

③ Contribute to complex analysis of the issues from multiple perspectives, many of which the incumbent with which may not personally agree or concur

④ Continue to be responsible and accountable to the constituency, parties and stakeholders represented by the seat the member is holding

⑤ As a more experienced member, with a wider array of exposure to issues, voluntarily mentor newer and less experience Commission members

⑥ Actively assist the Commission and Committee co-chairs in facilitating and leading Commission discussions and dialogue

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 Program, Ryan White Program (RWP), and other general HIV/AIDS and STI policy and information
② LA County Comprehensive HIV Plan and Comprehensive HIV Continuum
③ LA County's HIV/AIDS 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 **Minimum of one year's active Commission membership prior to At-Large 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, take-charge, "doer", action-oriented
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

the OA Voice

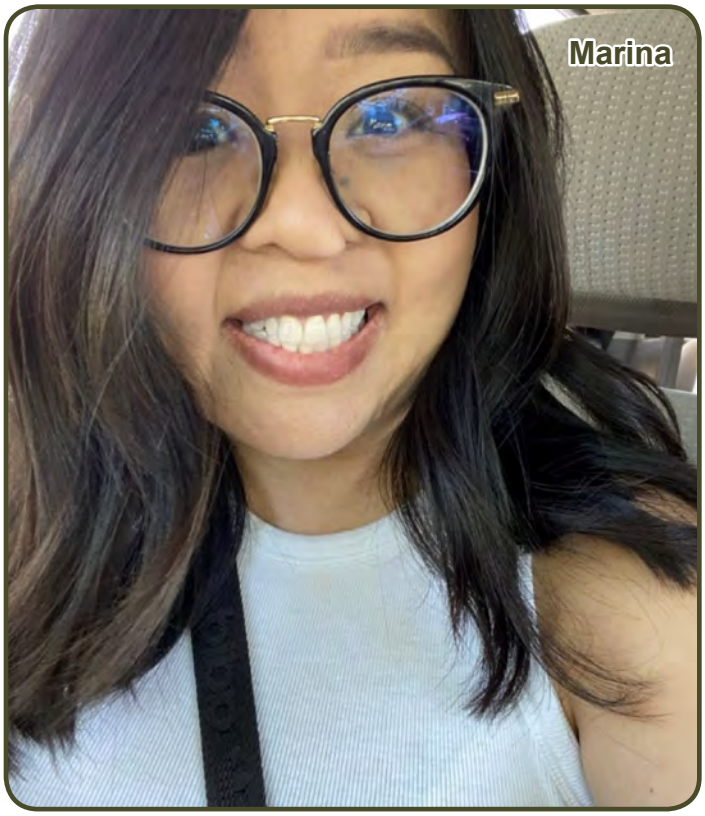
Issue: April 2023

INSIDE:

- HIV Awareness
- General Updates
- Strategic Plan
- Strategy A
- Strategy B
- Strategy J
- Strategy K

This newsletter is organized to align the updates with Strategies from the ***Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention, and Care Plan*** (Integrated Plan). The Integrated Plan is available on the Office of AIDS' (OA) website.

STAFF HIGHLIGHT



Congratulations to **Marina Chinn**, our new Quality Assurance and Training Coordinator/ Associate Governmental Program Analyst (AGPA) within the AIDS Drugs Assistance Program (ADAP) Branch's Quality Assurance and Training (QAT) Unit. Marina has been a Contracts Manager/AGPA for the Program Integrity and Operations Section/Contracts and Grants Unit of the ADAP Branch for the last three years. During this time, she oversaw the contracting of ADAP and Pre-Exposure Prophylaxis Assistance Program (PrEP-AP) Enrollment sites, Clinical Provider sites, and processed scopes of work, budgets, exhibits, and invoices. She has also led the ADAP Team Building Workgroup for the past two years, helping to organize team building events and initiatives for ADAP staff. Prior to joining ADAP, Marina spent 16 years in the education sector, including five years as a Safety Committee Member and Safety Coordinator for the CA Montessori Project, where she created annual trainings for new and existing staff, assisted in training both staff and students, and coordinated staff meetings. This work eventually led Marina to the start of her State service with Department of Education as a Contracts Analyst, before she found her home in ADAP, where she is able to combine her love of training with the deeply meaningful mission of the OA.

In her free time, Marina enjoys crafting, creating custom keychains and silverware through metal stamping, and loves to bake cookies and bread!

COMMUNITY PARTNER SPOTLIGHT

Rachel Anderson, co-founder of SANE, one of California's longest running syringe services programs (SSPs) passed away recently. Rachel was an executive director, researcher, trainer, and a voice for people who use drugs

and their vital roles as leaders of California's harm reduction and health justice movements.

While working in HIV research at UC Davis in the early '90s, Rachel saw the need for a syringe exchange program in Sacramento and launched the Sacramento Area Needle Exchange (SANE, now called Safer Alternatives through Networking and Education) in 1993. She boldly navigated a hostile law enforcement climate, finally receiving legal authorization from the City of Sacramento after more than 15 years of frontline, "underground" work.

Rachel's philosophy of empowerment for people who use drugs had a profound influence on policy throughout the entire state. She spent many hours with the OA Community HIV Planning Group, helping to write the guidance OA uses for funding SSPs, as well as the regulations in CA law. Her work on the California Syringe Exchange Programs (CASEP) research study in the early 2000s laid the groundwork for passage of laws that over the past 20 years have legalized syringe exchange, permitted possession of syringes for personal use, and allowed state funds to be used to support syringe services programs. OA extends our condolences to Rachel's many loved ones, colleagues and mentees, and our gratitude for her many contributions to our collective work.

HIV AWARENESS

April 10th is National Youth HIV/AIDS Awareness Day (NYHAAD). HIV education is paramount to awareness and prevention. NYHAAD is meant to raise awareness and help promote conversations about the impact of HIV on young people. Engaging in such conversations provides increased knowledge of HIV prevention techniques, helps one develop and maintain safe behaviors, in addition to helping reduce stigma against those living with HIV.

California Department of Public Health (CDPH) is committed to ensuring its youth have access to information, prevention and treatment services. For more information visit the OA Youth Community Health in California webpage.

GENERAL UPDATES

COVID-19

OA is committed to providing updated information related to COVID-19. We have disseminated a number of documents in an effort to keep our clients and stakeholders informed. Please refer to our OA website to stay informed.

Mpox

OA is committed to providing updated information related to mpox. We have partnered with the Division of Communicable Disease Control (DCDC), a program within the Center of Infectious Diseases and have disseminated a number of documents in an effort to keep our clients and stakeholders informed. Please refer to the DCDC website to stay informed.

Update: Spanish mpox digital assets are now available for LHJs and CBOs.

Racial Justice and Health Equity

The Racial & Health Equity (RHE) workgroup aims to gain insight and understanding of racial and health equity efforts throughout the CDPH and take next steps towards advancing RHE in our work. The workgroup has formed subcommittees to address community stakeholder engagement challenges, improve OA policy and practices to support RHE and increasing OA knowledge and attitude on RHE among leadership and staff.

HIV/STD/HCV Integration

Please refer to the OA website to stay informed.

OA and the STD Control Branch are pleased to report that the roll-out of the ***California Strategic Plan*** to address the syndemic of HIV, HCV and STIs continues in April as we prepare to release our phase-2 *Implementation Blueprint*, the accompanying document to our plan. The activities in this customizable *Implementation Blueprint* were the result of community input from across all regions of California and they help us drill down into specific goals under our 30 strategies organized over 6 social determinants of health: racial equity, health access for all, housing first, mental health and substance use, economic justice, and stigma free. Once we release the final document, we will host a series of webinars that will help local health jurisdictions customize this plan for their communities.

The URL below documents our work, including the phase-1 roadmap, the recording of our Statewide Town Hall, and the list of completed regional listening sessions:

- **https://facenteconsulting.com/work/ending-the-epidemics/**

Thank you for engaging with this strategic planning process and helping us make it better.

In addition, we'd like to thank the Sacramento HIV Health Services Planning Council, who hosted a Strategic Plan and Implementation Blueprint discussion during their March HIV Health Services Planning Council meeting!

Ending the HIV Epidemic (EHE)

We appreciate the ongoing work of the six counties funded through the EHE Initiative: Alameda, Orange, Riverside, Sacramento, San Bernardino, and San Diego. As a group the counties have expanded routine opt out and focused testing, home delivered HIV/HCV/STI integrated testing, enhanced status-neutral linkages to care and prevention services and implemented special intervention-pilots focused on EHE priority populations at intersections of mental health, substance use and housing security. OA wishes to applaud their efforts and progress made in the most difficult of circumstances. Common to their work in March has been their efforts to launch EHE-focused social media campaigns.

OA has selected Peregrine Media, a contractor with national expertise that has worked with Emory University and the Center for Disease Control and Prevention (CDC), on social media implementation and metrics. Peregrine Media is providing services to the six California Consortium Phase I Counties to implement tailored social media campaigns, utilizing the CDC's "Let's Stop HIV Together" media campaign materials. Information on the outcomes of these campaigns will be reported in future editions of the *OA Voice*.

STRATEGY A

Improve Pre-Exposure Prophylaxis (PrEP) Utilization:

≥ PrEP-Assistance Program (AP)

As of March 29, 2023, there are 203 PrEP-AP enrollment sites covering 189 clinics that currently make up the PrEP-AP Provider network.

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

Data on active PrEP-AP clients can be found in the three tables displayed on page 5 of this newsletter.

STRATEGY B

Increase and Improve HIV Testing:

OA has expanded its Building Healthy Online Communities (BHOC) self-testing program to allow for rapid OraQuick test orders in all jurisdictions in California. The program, TakeMeHome®, (https://takemehome.org/) is advertised on gay dating apps, where users see an ad for home testing and are offered a free HIV-home test kit.

In February, 326 individuals in 36 counties ordered self-test kits, with 255 individuals ordering 2 tests. Most individuals ordering tests identify as cisgender men (80.6% of those sharing gender) and Hispanic/Latinx (47.1% of those sharing race or ethnicity). Twenty-one (6.4%) orders came in through the Spanish language portal. One-quarter of participants reported never having tested for HIV before (25.8%); another third had not tested for HIV in at least one year (36.2%). OA is excited to help make HIV testing more accessible through this program.

OA's existing TakeMeHome Program continues in the six California Consortium Phase I Ending the HIV Epidemic in America counties. In the first 30 months, between September 1, 2020, and February 28, 2023, 4955 tests have been distributed. This month, mail-in lab tests (including dried blood spot tests for HIV, syphilis, and Hepatitis C, as well as 3-site tests for gonorrhea and chlamydia) accounted for 158 (72.8%) of the 217 total tests distributed.

Of individuals ordering a test in February, 40.0% reported never before receiving an HIV test, and 48.39% were 18 to 29 years of age. Among individuals reporting race or ethnicity, 40.7% were Hispanic/Latinx, and of those reporting sexual history, 40.1% indicated 3 or more partners in the past 12 months. To date, 546 recipients have completed an anonymous follow up survey, with 94.7% indicating they would recommend TakeMeHome HIV test kits to a friend. The most common behavioral risks of HIV exposure reported in the follow up survey were being a man who has sex with men (72.2%) or having had more than one sex partner in the past 12 months (63.7%).

OA has published an infographic describing the implementation of BHOC TMH in California.

STRATEGY J

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

As of March 29, 2023, the number of ADAP clients enrolled in each respective ADAP Insurance Assistance Program are shown in the chart at the top of page 6.

Active PrEP-AP Clients by Age and Insurance Coverage:

Current Age	PrEP-AP Only		PrEP-AP With Medi-Cal		PrEP-AP With Medicare		PrEP-AP With Private Insurance		TOTAL	
	N	%	N	%	N	%	N	%	N	%
18 - 24	247	7%	---	---	---	---	27	1%	274	8%
25 - 34	1,063	31%	1	0%	1	0%	254	7%	1,319	39%
35 - 44	836	25%	---	---	2	0%	178	5%	1,016	30%
45 - 64	450	13%	1	0%	20	1%	104	3%	575	17%
65+	21	1%	---	---	184	5%	10	0%	215	6%
TOTAL	**2,617**	**77%**	**2**	**0%**	**207**	**6%**	**573**	**17%**	**3,399**	**100%**

Active PrEP-AP Clients by Age and Race/Ethnicity:

Current Age	Latinx		American Indian or Alaskan Native		Asian		Black or African American		Native Hawaiian/ Pacific Islander		White		More Than One Race Reported		Decline to Provide		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
18 - 24	150	4%	---	---	37	1%	9	0%	1	0%	52	2%	4	0%	21	1%	274	8%
25 - 34	768	23%	---	---	118	3%	84	2%	2	0%	269	8%	10	0%	68	2%	1,319	39%
35 - 44	650	19%	3	0%	81	2%	39	1%	1	0%	198	6%	6	0%	38	1%	1,016	30%
45 - 64	378	11%	2	0%	28	1%	15	0%	---	---	137	4%	---	---	15	0%	575	17%
65+	21	1%	1	0%	3	0%	4	0%	---	---	181	5%	---	---	5	0%	215	6%
TOTAL	**1,967**	**58%**	**6**	**0%**	**267**	**8%**	**151**	**4%**	**4**	**0%**	**837**	**25%**	**20**	**1%**	**147**	**4%**	**3,399**	**100%**

Active PrEP-AP Clients by Gender and Race/Ethnicity:

Gender	Latinx		American Indian or Alaskan Native		Asian		Black or African American		Native Hawaiian/ Pacific Islander		White		More Than One Race Reported		Decline to Provide		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Female	173	5%	---	---	4	0%	9	0%	---	---	14	0%	---	---	1	0%	201	6%
Male	1,609	47%	6	0%	245	7%	140	4%	4	0%	802	24%	17	1%	129	4%	2,952	87%
Trans	169	5%	---	---	17	1%	2	0%	---	---	13	0%	1	0%	4	0%	206	6%
Unknown	16	0%	---	---	1	0%	---	---	---	---	8	0%	2	0%	13	0%	40	1%
TOTAL	**1,967**	**58%**	**6**	**0%**	**267**	**8%**	**151**	**4%**	**4**	**0%**	**837**	**25%**	**20**	**1%**	**147**	**4%**	**3,399**	**100%**

All PrEP-AP charts prepared by: ADAP Fiscal Forecasting Evaluation and Monitoring (AFFEM) Section, ADAP and Care Evaluation and Informatics Branch, Office of AIDS. Client was eligible for PrEP-AP as of run date: 03/31/2023 at 12:01:17 AM Data source: ADAP Enrollment System. Site assignments are based on the site that submitted the most recent application.

ADAP Insurance Assistance Program	Number of Clients Enrolled	Percentage Change from February
Employer Based Health Insurance Premium Payment (EB-HIPP) Program	484	- 1.02%
Office of AIDS Health Insurance Premium Payment (OA-HIPP) Program	5,786	- 2.29%
Medicare Part D Premium Payment (MDPP) Program	1,281	- 14.77%
Total	**7,551**	**- 3.13%**

Source: ADAP Enrollment System

STRATEGY K

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

SAVE THE DATE! 2023 Harm Reduction Showcase in San Jose

Join the Santa Clara Department of Public Health, May 4th for an opportunity to learn about their harm reduction services and how local service providers can integrate harm reduction principles and practices into their work. E-mail, harmreduction@phd.sccgov.org for additional information.

Learn more about their program at https://publichealth.sccgov.org/services/harm-reduction-program.

End of the X-Waiver: A New Frontier in Addiction Treatment

Wednesday, April 19 | 10:00 am -11:00 pm PT
The recent elimination of the X-Waiver, a requirement that involved additional training for clinicians to prescribe medication for opioid use disorder (MOUD), presents new opportunities for expanding MOUD. Join the National Overdose Prevention Network (NOPN) for a conversation breaking down the change, what it means for providers, and steps to take to get more clinicians to prescribe addiction treatment in your community.

Register at https://nopn.org/webinars/end-of-the-x-waiver-a-new-frontier-in-addiction-treatment

PrEP for People Who Inject Drugs (PWUD): New On-Demand e-Learning Module

Health HIV released a learning module that aims to educate and motivate clinicians and other providers working in substance use disorder (SUD) centers to increase their clients' awareness of and access to PrEP and counsel PWUD regarding HIV prevention, including PrEP options and comprehensive harm reduction. This module is intended for addiction center clinical staff (MDs, NPs, PAs, RNs), counselors, social workers, case managers, peer educators, peer advocates, medical assistants, and nonclinical office staff.

Register at https://healthhiv.org/training/bridgeprep/?eType=EmailBlastContent&eId=f77ede37-f397-4b76-a2a2-6004ded9a204

For questions regarding this issue of *The OA Voice*, please send an e-mail to angelique.skinner@cdph.ca.gov.

Characterizing Late Diagnoses: Results from Health Resources and Services Administration-HIV/AIDS Bureau's Updated Approach

Wendy Garland, MPH
Chief Epidemiologist
Program Monitoring & Evaluation
Division of HIV and STD Programs

Los Angeles County Commission on HIV
April 13, 2023

Presentation Overview

- Follow up to presentation at annual meeting on updated approach to estimate unmet need

- One of three presentations to discuss estimates
  - **Late diagnoses (April 2023)**
  - Unmet need for medical care (May 2023)
  - In care but not virally suppressed (June 2023)

- Define of unmet need measures and populations, present results and discuss how to use in our work

What is Unmet Need?

- Defined by HRSA HIV/AIDS Bureau as:

  " the need for HIV-related health services by individuals with HIV who are aware of their status, but are not receiving regular primary [HIV] health care."
- Estimated Unmet Need has been a reporting requirement for RWHAP recipients since 2005
- Data and methods to estimate unmet need have evolved with improvements in HIV care and data quality
- New and expanded methodology released 2021 and implemented in 2022

1."HRSA/HAB Definitions Relate to Needs Assessment," prepared for the Division of Service Systems, HIV/AIDS Bureau by Mosaica: The Center for Nonprofit Development and Pluralism, June 10, 2002.

Evolving Definition of Unmet Need

2005

- Focus on people aware of their HIV/AIDS diagnosis but not in regular HIV medical care
- People living with diagnosed HIV and AIDS with no evidence of care (at least one **viral load [VL]** or **CD4 test** or **ART prescription**) in past 12 months

2017

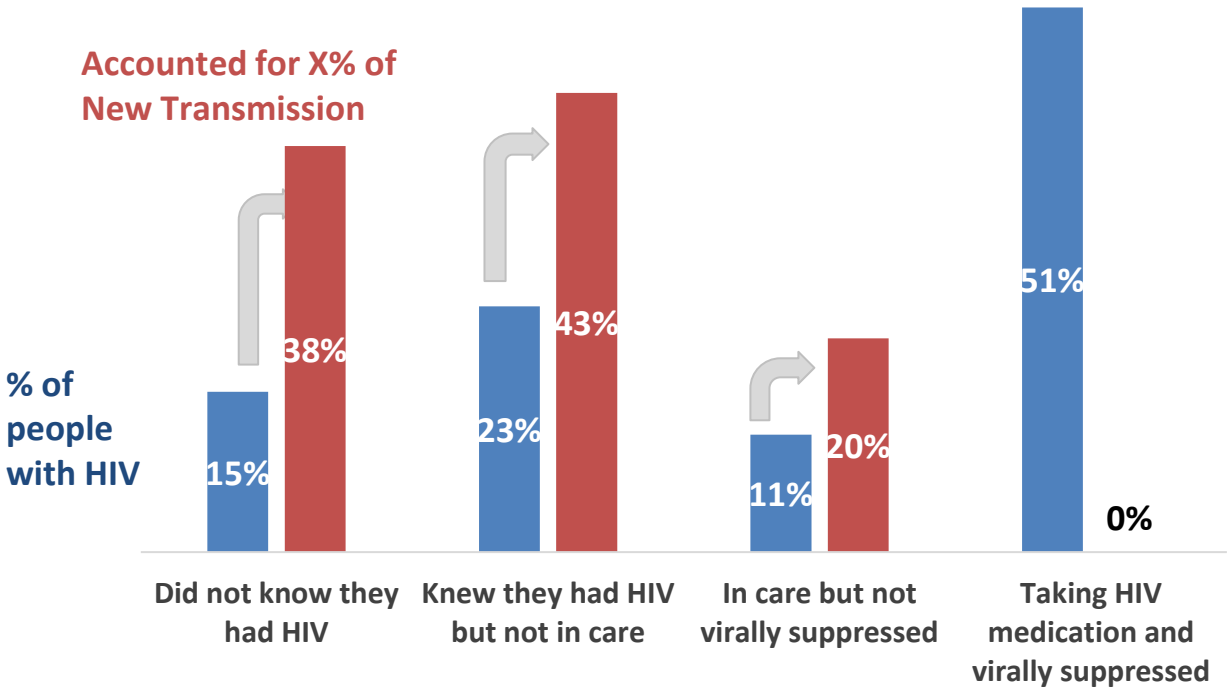
- Care markers updated to align with HIV Care Continuum Definitions
- People living with diagnosed HIV and AIDS with no evidence of care (2 or more **medical visits** or **VL** or **CD4 tests** at least 90 days apart) in past 12 months

2021

- Revised care markers and expanded populations
- People living with **diagnosed HIV** with no evidence of care (at least one **VL or CD4 test**) in the past 12 months
- Adds two new indicators:
  - Persons diagnosed with HIV in the past 12 months with **LATE DIAGNOSIS (Stage 3 (AIDS)** diagnosis or an **AIDS-defining condition** ≤ 3 month after HIV diagnosis**)**
  - Persons living with diagnosed HIV **IN MEDICAL CARE** (at least one VL or CD4 test) who were **NOT VIRALLY SUPPRESSED** in the past 12 months

Unmet need estimates attempt to measure the gaps between the HIV care continuum

- To reduce HIV transmission

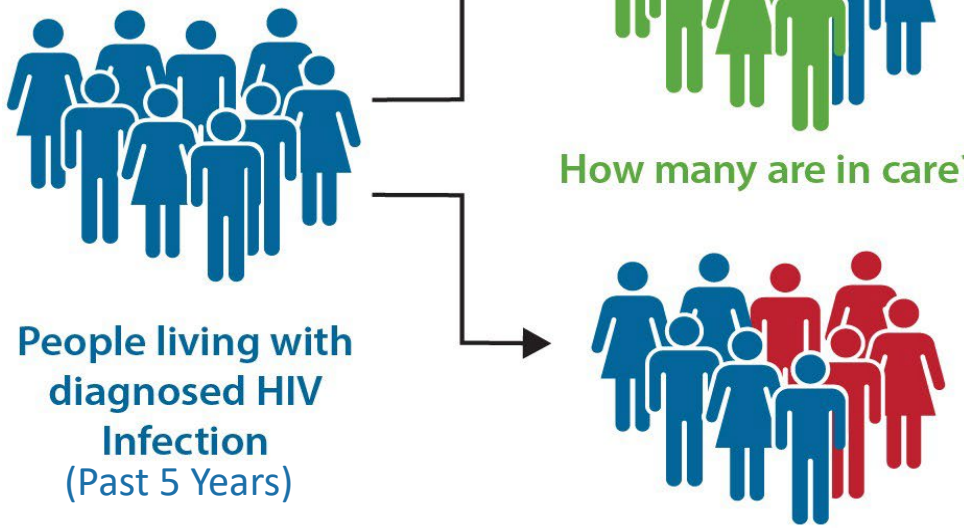


HIV Transmissions in the United States, 2016[1]

- To improve health outcomes among PLWDH
  - Start ART early in infection
  - Reduce HIV comorbidities, coinfections and complications
  - Slow disease progression
  - Extend life expectancy
  - Reduce HIV-related mortality

1. Li Z, Purcell DW, Sansom SL, Hayes D, Hall HI. *Vital Signs:* HIV Transmission Along the Continuum of Care — United States, 2016. MMWR Morb Mortal Wkly Rep 2019;68:267–272. DOI: http://dx.doi.org/10.15585/mmwr.mm6811e1 .
2. National HIV/AIDS Strategy for the United States (2022-2025). https://files.hiv.gov/s3fs-public/NHAS-2022-2025.pdf

LAC Populations for Estimates of Unmet Need



What do the data look like for three priority populations (chosen by jurisdiction)?

1. Hollywood-Wilshire HD
2. Central HD
3. Long Beach HD

Approaches to Identify Disparities and Gaps - Examples

Across Group Comparison*

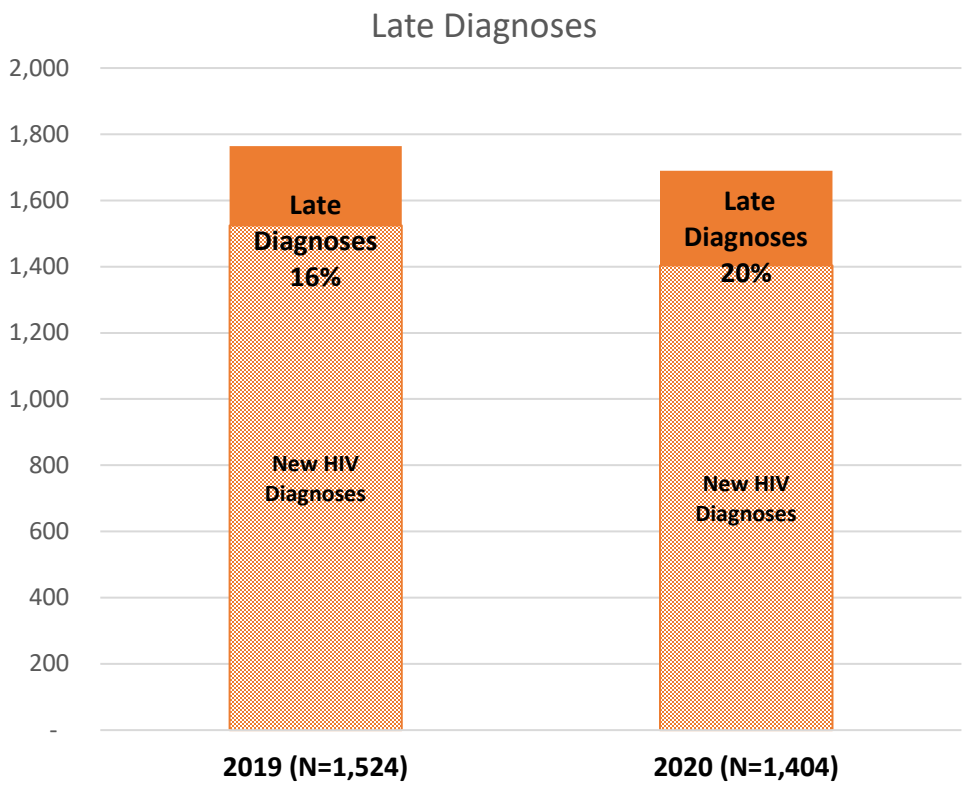
- Helpful for describing a population
  - Latino males made up 24% of LAC residents in 2020
- Identify disparities across populations
  - Latino males made up 53% of LAC residents newly diagnosed HIV in 2020
  - Proportional difference between residents who were Latino males (24%) to compared to new diagnoses who were Latino males (53%)

Within Group Comparisons*

- Helpful to understand how specific groups are impacted compared to each other
  - Linkage to care among 170 newly diagnosed Hollywood-Wilshire HD residents (85%) compared to among 126 newly diagnosed among Central HD residents (67%) compared to 92 newly diagnosed Long Beach HD residents (80%)

*Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2021. http://publichealth.lacounty.gov/dhsp/Reports/HIV/2021AnnualHIVSurveillanceReport.pdf.

Considerations when thinking about this data



- These data represent the characteristics of LAC residents with confirmed new HIV diagnoses in 2020 reported to DHSP
- These data do not reflect
  - How, where and to whom HIV testing services are available or accessed
  - Testing behaviors or frequency among LAC residents
- For example, changes in new diagnoses and late diagnoses from 2019 to 2020 may be due to
  - Decreased testing access or availability due to COVID-19
  - Fewer people seeking testing services

Unmet Need Estimate: Late Diagnoses in LAC, 2020

Context for Late Diagnoses

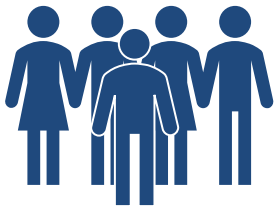
- National goal: reduce late diagnoses by 25%
  - In LAC that means decreasing the percent of late diagnoses from 24% to 18% by 2025[1]

- On average, it takes 8 years to progress to late stage disease from time of infection to diagnosis[2]

- Identification of late diagnoses is not done at point of care – providers are not likely to know degree of disease progression at time of testing
  - Helpful to track how well our care system is identifying infection early and across populations but cannot guide services

1.Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2021. http://publichealth.lacounty.gov/dhsp/Reports/HIV/2021AnnualHIVSurveillanceReport.pdf.
2.Lodi S, et al. Time from human immunodeficiency virus seroconversion to reaching CD4+ cell count thresholds <200, <350, and <500 cells/mm(3): assessment of need following changes in treatment guidelines. *Clin Infect Dis*. 2011;53(8):817–825.

Late Diagnosis Estimate in LAC, 2020



1,404 New Diagnoses

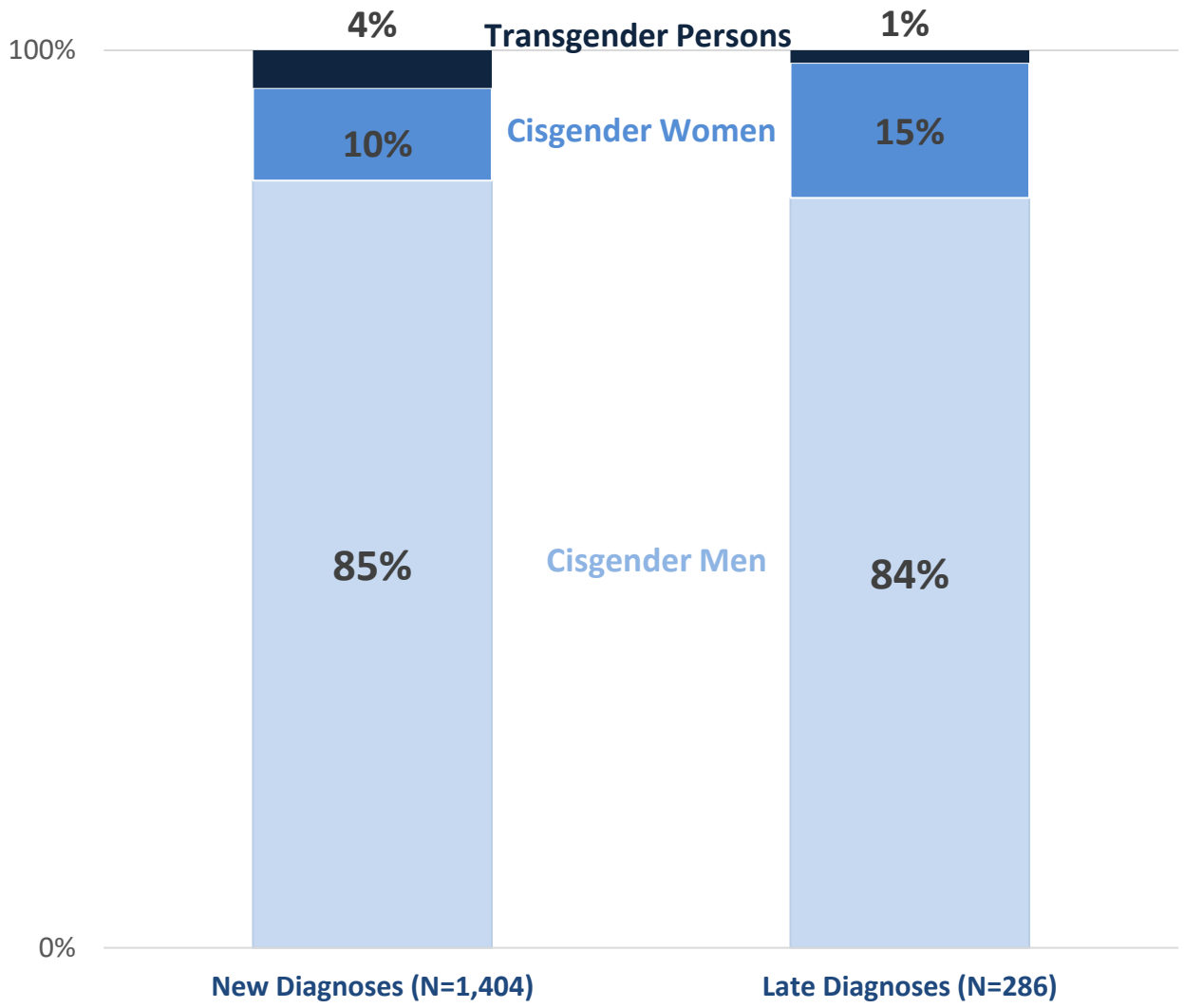
20% Late Diagnoses (N=286)

PART A Geographic Priority Populations

- **15%** Hollywood-Wilshire HD (N=171)
- **15%** Central HD (N=19)
- **15%** Long Beach HD (N=14)

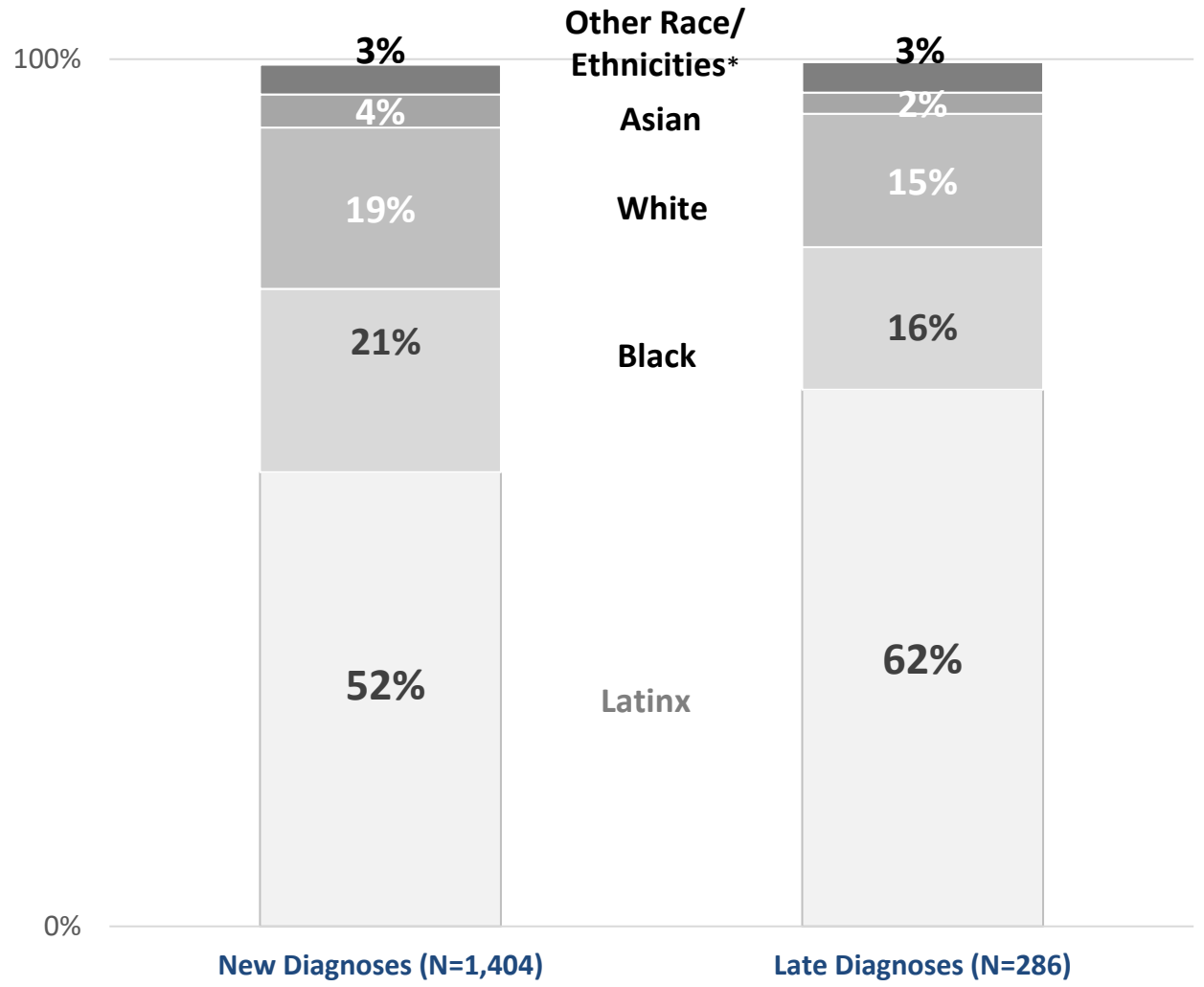
New and Late HIV Diagnoses by Gender Identity, 2020

- The largest percent of new diagnoses and late diagnoses were among cisgender men
- While 10% of new diagnoses were among cisgender women, they represented 15% of late diagnoses



New and Late HIV Diagnoses by Racial/Ethnic Group, 2020

- The largest percent of new diagnoses and late diagnoses were among Latinx residents
- While 52% of new diagnoses were among Latinx residents, they represented 62% of late diagnoses

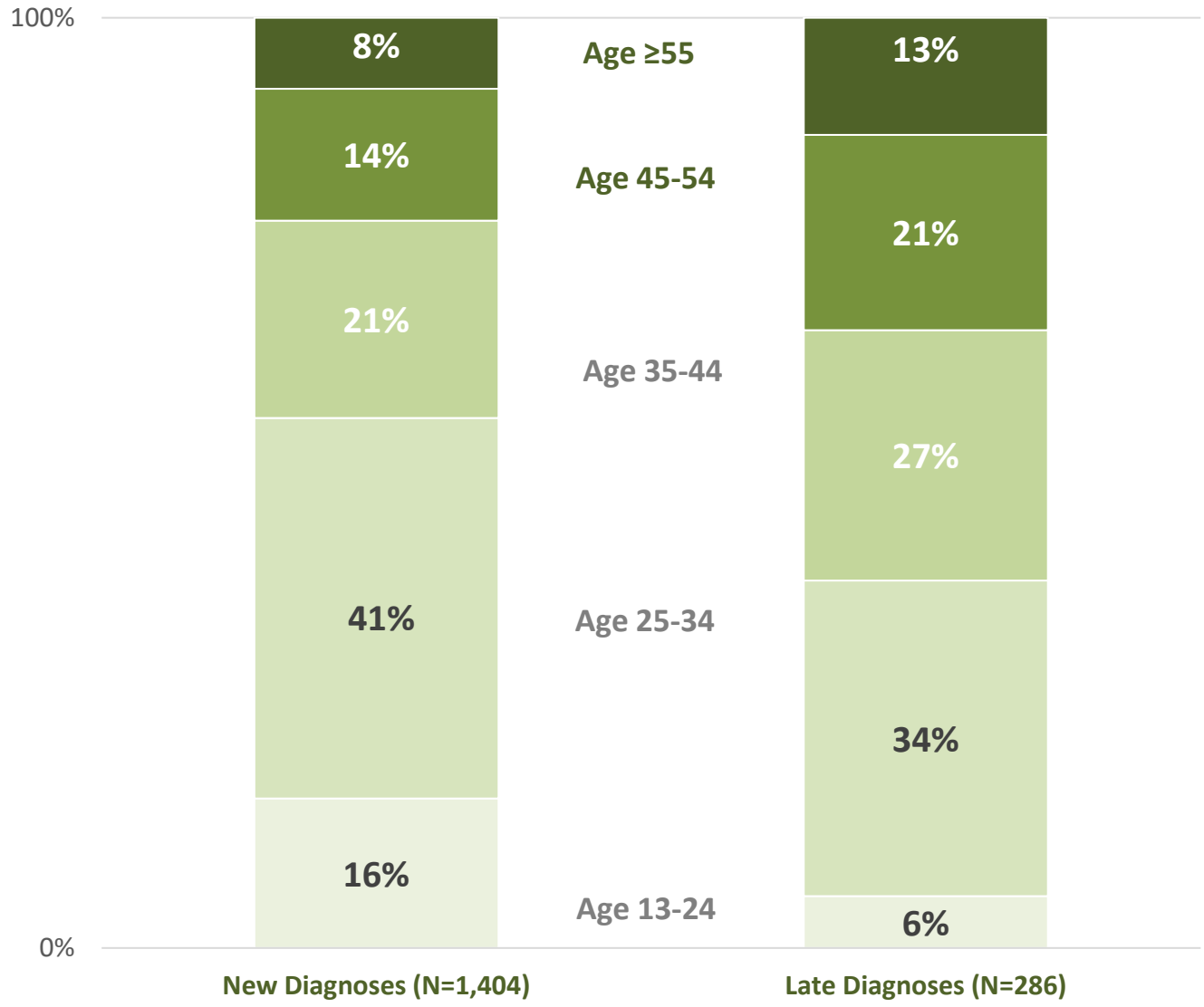


*Among new diagnoses, persons of other racial/ethnic groups include: Multiple race (n=42), American Indian/Alaska Native (n=5), and Native Hawaiian/Pacific Islander (<5). Race/ethnicity was not reported for 9 cases.

New and Late HIV Diagnoses by Age Group, 2020

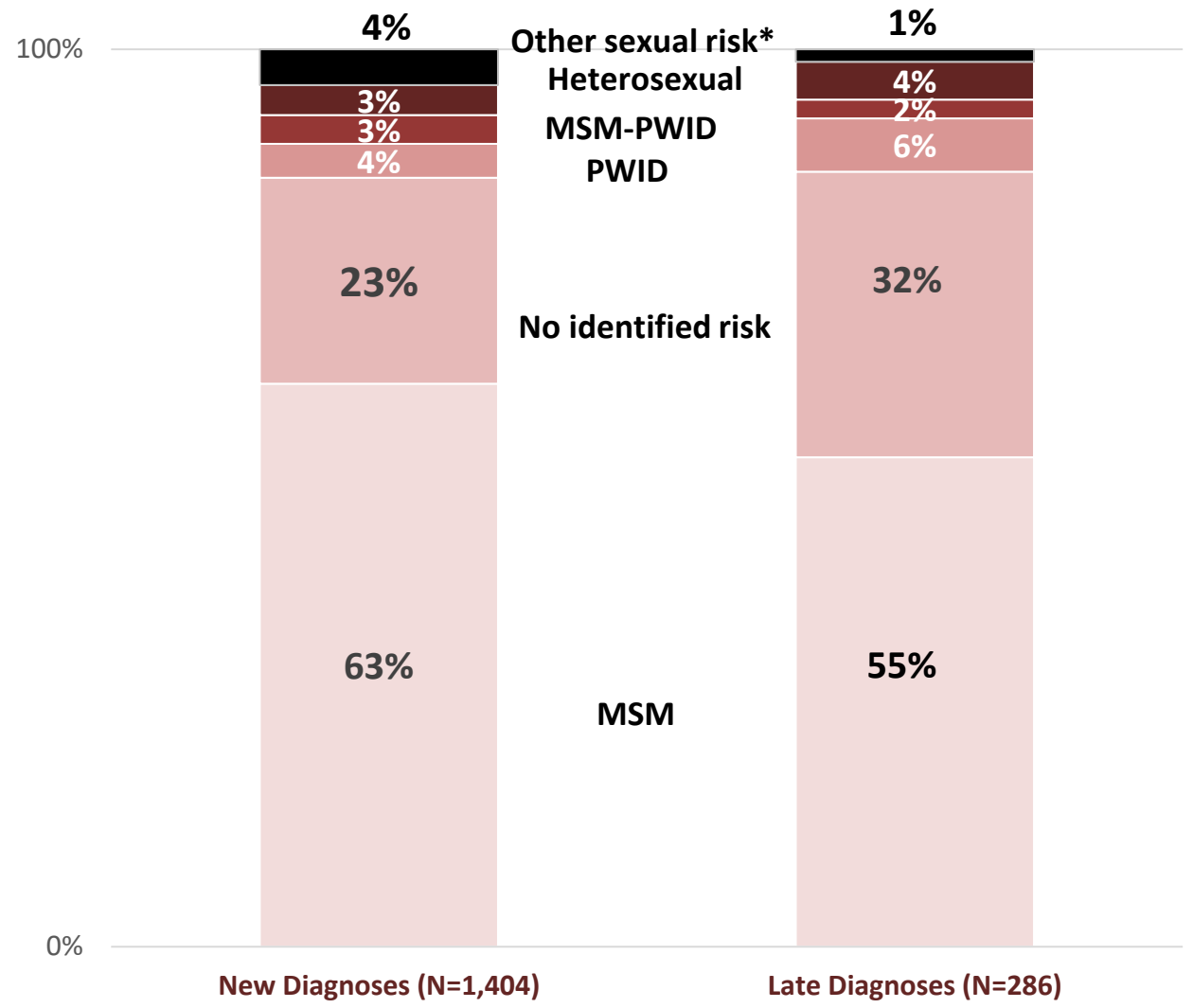
- The largest percent of new diagnoses and late diagnoses were among residents age 25-34 represent the largest percent of new diagnoses (62%) and late diagnoses (61%)

- Older age groups represent larger percentages of late diagnoses compared to residents in younger age groups



New and Late HIV Diagnoses by Exposure Category, 2020

- The largest percent of new diagnoses and late diagnoses were among men who have sex with men (MSM)
- While 23% of new diagnoses were among persons with no identified risk exposure reported, they represented 32% of late diagnoses



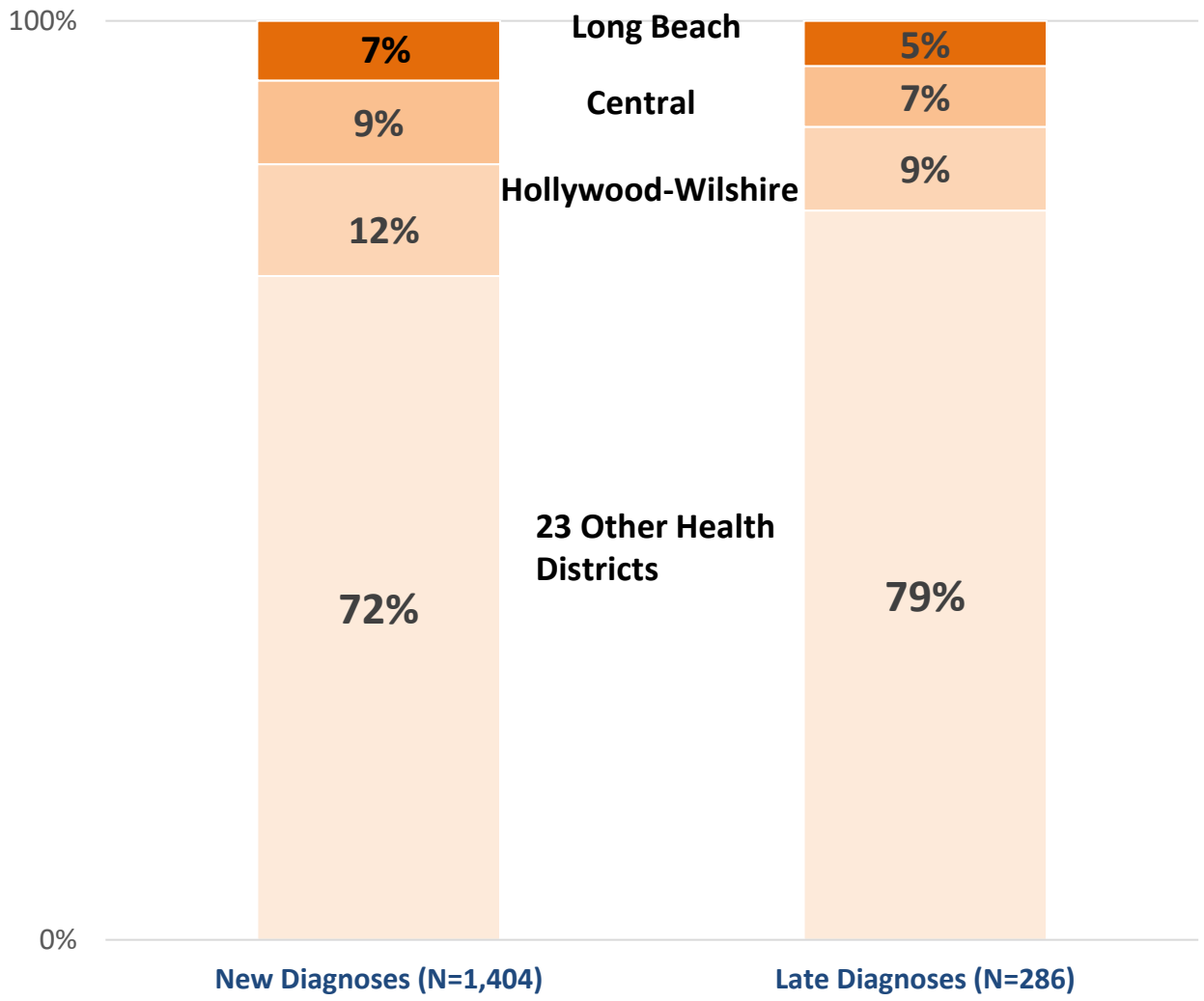
Definitions: MSM: Men who have sex with men; PWID: People who inject drugs

*Among new diagnoses, other sexual risk includes: sexual contact among transgender individuals(n=48), sexual contact and PWID among trans individuals (n=8).

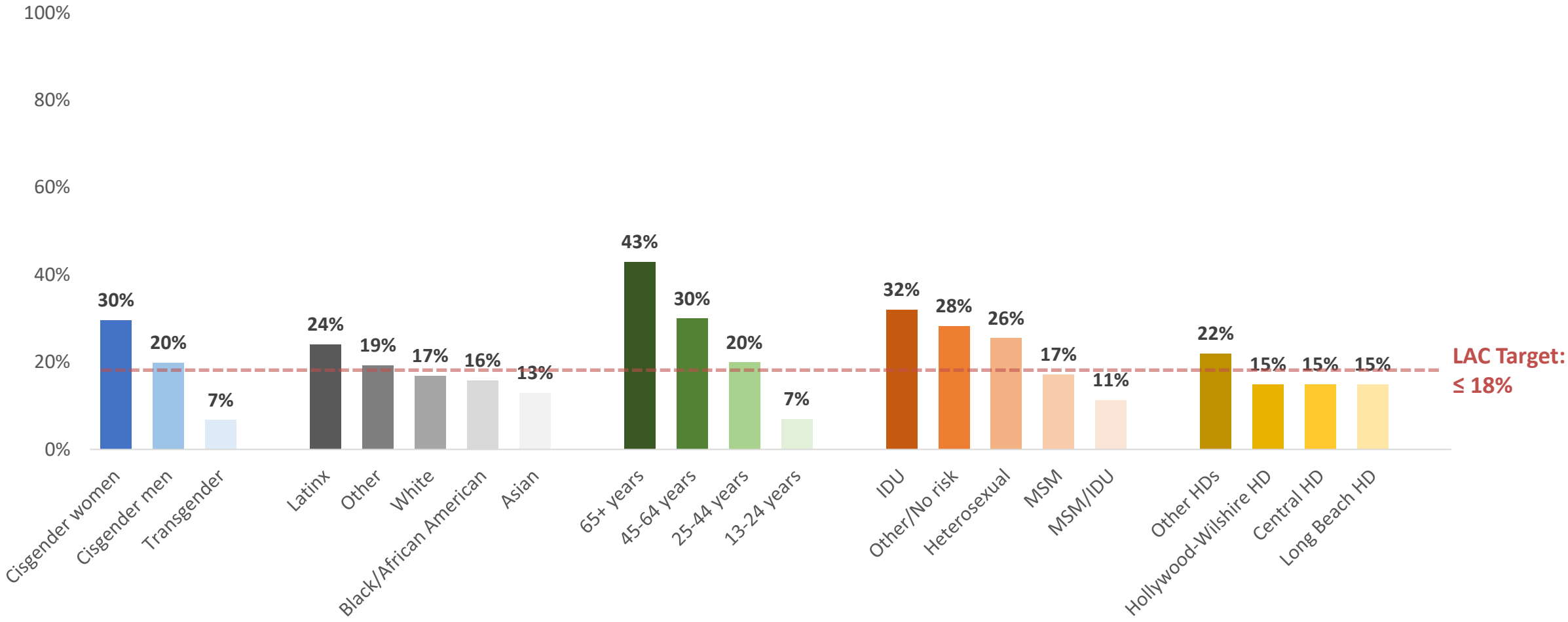
New and Late HIV Diagnoses by Health District, 2020

- The largest percent of new diagnoses and late diagnoses were reported for residents in other health districts

- Nearly 30% -- or 1 out of every 3 new diagnoses was among residents of Hollywood-Wilshire, Central and Long Beach HD



Late diagnoses within each category were highest among cisgender women, Latinx, PLWDH aged 65+ and injection drug users (IDU)



Los Angeles County PLWDH Population-Level Late Diagnoses Estimates within Categories of Age, Gender, Race/Ethnicity and Transmission/Risk Categories, 2020.

Key Takeaways

The majority of new diagnoses were timely - 80% identified soon after infection

- How can we build on what is working?

Identified disparities in late diagnoses

- How and where can we improve for impacted populations?

Largest burden of late diagnoses

- Cisgender men
- Latinx
- Age 25-34
- MSM

Unequal % of late vs all diagnoses

- Cisgender women
- Latinx
- Age ≥ 35
- No identified HIV risk

Highest % of late diagnoses within population

- Cisgender women
- Latinx
- Age ≥ 45
- PWID

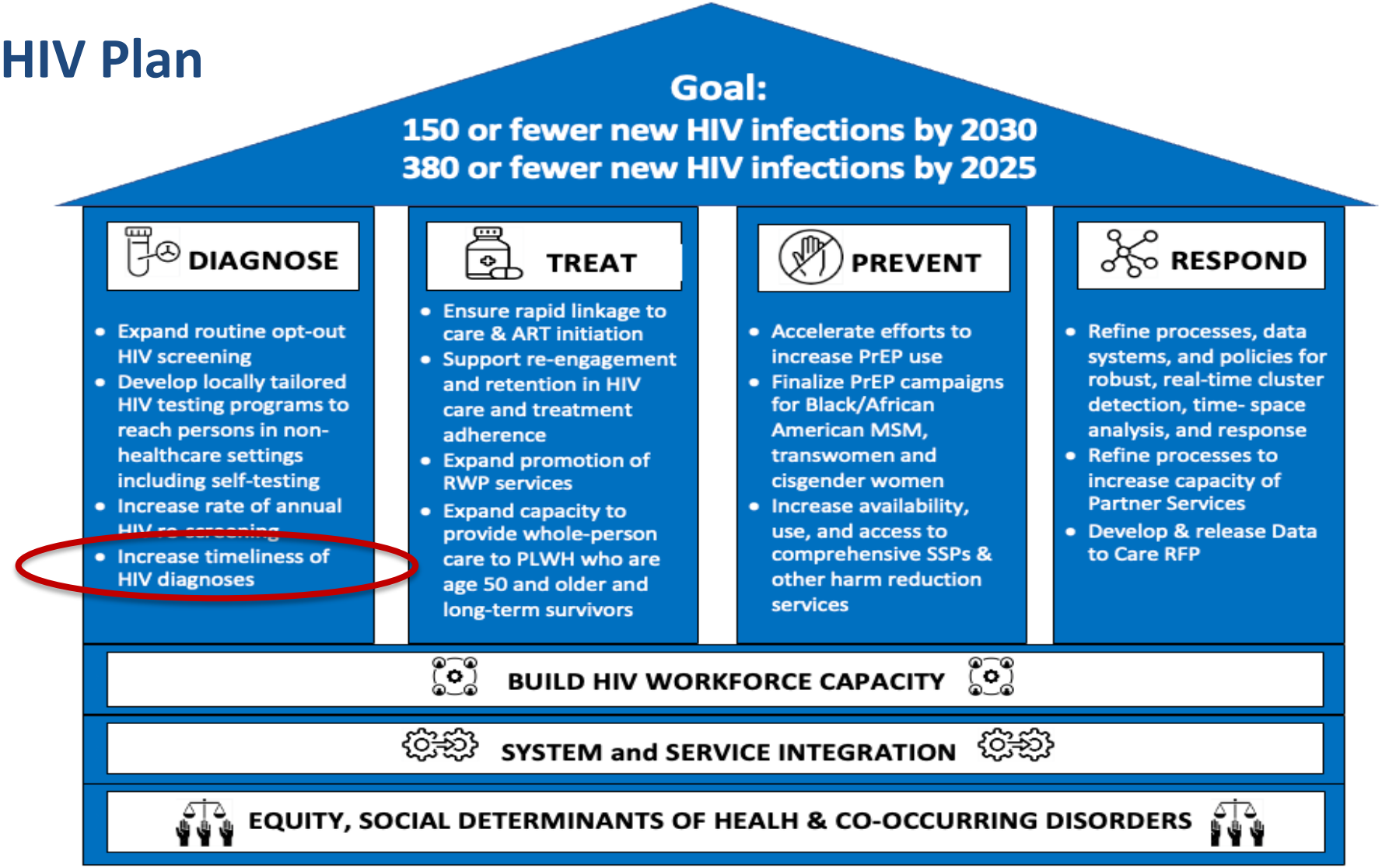
Questions

Discussion – using the late diagnosis estimate for planning

LAC Comprehensive HIV Plan Snapshot

Priority Populations

- Latinx MSM
- Black/African American MSM
- Transgender persons
- Cisgender women of color
- PWID
- Persons < age of 30
- PLWH ≥age 50



Los Angeles County Commission on HIV and the Los Angeles County Department of Public Health Division of HIV and STD Programs. Los Angeles County Comprehensive HIV Plan (2022- 2026), December 2022: 1-136.

What are strategies to improve diagnosis timeliness?[1]

- Focus on those populations that account for a large portion of residents who are unaware of their HIV infection
  - LAC: persons age 13-34 and Latinx[2]
- Focus on targeting and routine testing for younger age groups to reach people earlier in infection
- Identify barriers to HIV testing and stigma among older populations
- Work with providers to promote routine testing in health care settings
  - DPH Sexual Health Clinics (formerly STD Clinics)
  - Vaccine programs (COVID, Mpx)

HIV TESTING RECOMMENDATIONS

US Preventative Services Task Force (2019)

- Persons age 15-65
- <15 and >65 based on risk
- All pregnant women

CDC (2006)

- General population: ≥ 1 ever
- Persons with risk factors: ≥ 1 annually

1.Krueger A, et al. 2019. HIV Testing, Access to HIV-Related Services, and Late-Stage HIV Diagnoses Across US States, 2013-2016. doi: 10.2105/AJPH.2019.305273. PMCID: PMC6775941
2.Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2021. http://publichealth.lacounty.gov/dhsp/Reports/HIV/2021AnnualHIVSurveillanceReport.pdf.
3.Traynor SM, Rosen-Metsch L, Feaster DJ. 2018. Missed opportunities for HIV testing among STD clinic patients. doi: https://link.springer.com/article/10.1007/s10900-018-0531-z

How can our services improve timely diagnoses and HIV awareness?

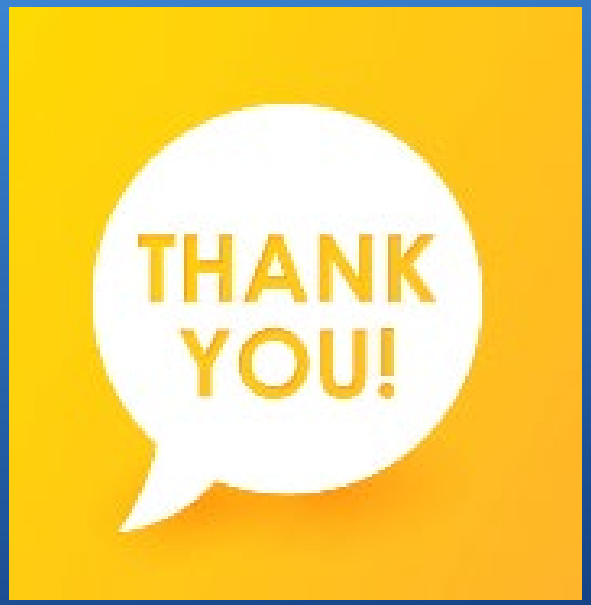
- More testing programs?
  - Routine vs. targeted
  - Clinical vs. non-clinical
- Rescreening
- Expand existing access points
  - Storefront and social and sexual network programs
  - Mobile or street-based
  - HIV self testing
  - Public health clinics
  - Emergency rooms
- New access points
  - Pharmacies?
  - Other non-clinical settings?
- Linguistically and culturally appropriate services
- Service promotion

Next Steps for Unmet Need Estimates

- Continue measure-focused presentations to COH
  - Unmet Need (Out of Care)– May
  - In Care but Not Virally Suppressed – June
  - Will include separate analyses for Ryan White Clients

- Further analyses are needed to
  - Identify predictors of late diagnoses among LAC residents
  - Describe care continuum outcomes for late compared to timely diagnoses

- Summary report completed mid-2023



Special thanks to the following people without whom this presentation would not be possible:

Sona Oksuzyan, PhD

Janet Cuanas, MPP

Virginia Hu, MPH

Michael Green, PhD, MHSA

References and Resources

- Webinar video and slides: Enhanced Unmet Need Estimates and Analyses: Using Data for Local Planning https://targethiv.org/library/enhanced-unmet-need-estimates-and-analyses-using-data-local-planning

- Webinar video and slides: https://targethiv.org/library/updated-framework-estimating-unmet-need-hiv-primary-medical-care

- Methodology for Estimating Unmet Need: Instruction Manual https://targethiv.org/library/methodology-estimating-unmet-need-instruction-manual

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POLICY/PROCEDURE #08.1104	**PROPOSED REVISIONS FOR 2/23/23 OPERATIONS COMMITTEE REVIEW/APPROVAL** Commission and Committee Co-Chair Elections and Terms	Page 1 of 8

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

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

BACKGROUND:

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

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

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

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

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

POLICY: **I would make seprate sections of the Commission Chairs, The Committee Chairs, and the Exec. Comm.**

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

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

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

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

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

6. ~~Co-Chairs are elected through a sequential voting process until there are only one or two candidates remaining, as need dictates. The Commission/committee must approve the final candidate(s) through a consent vote of approval or through individual roll call votes~~. (Redundant, covered by Robert's) All Co- Chairs must be elected by a majority of the voting membership. ~~A~~ IF no Co-Chair candidate's ~~failure to earn~~ receives a ~~a~~ majority vote after a number of reounds of voting equal to the number of candidates, further voting is postponed until the next regular meeting ~~disqualifies that member as a Co-Chair candidate for that term, closes the election for that meeting, extends the nominations period, and postpones the election to the subsequent meeting.~~

Commented [MD1]: For Committee Consideration:

Although not the purview of the workgroup, a suggestion was made to replace "stakeholders" with "members" given only members are eligible for nominations/election.

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~~8.~~7. Commission and Committee Co-Chair terms are allowed to be extended to accommodate delayed meeting schedules, lack of suitable candidates, or when the body cannot determine definitive, final Co-Chair candidates. A single Co-Chair may also continue to serve, when needed, until a second Co-Chair candidate is identified and elected.

PROCEDURE(S):

1. **Terms of Office**: The Commission Co-Chairs are elected to office for staggered two-year terms. Aside from the Executive Committee, standing committee Co-Chairs are elected for two-year terms.
   a. Commission Co-Chair terms expire in alternate years to ensure leadership continuity. The Commission Co-Chairs also serve as Co-Chairs of the Executive Committee and serve in those roles for the duration of their tenure as Commission Co-Chairs.
   b. The four, remaining standing committees [Public Policy (PP), Operations, Priorities Planning and Allocations (PP&A) and Standards and Best Practices (SBP)] elect their Co-Chairs for one-year terms that expire concurrently.
   c. Commission Co-Chair terms expire in December of the calendar year, unless the November and/or December monthly Commission meeting(s) are cancelled, quorum is not achieved at the meeting at which the Co-Chair is scheduled to be elected, or by majority vote of the Commission to accommodate an extension of the Co-Chair election process.
   d. Committee Co-Chair terms expire in February of the calendar year, but may be extended, if needed, until new Co-Chairs are elected to fill the leadership positions.
   e. In the case of a mid-term vacancy in one of the Commission Co-Chair seats, the Commission Co-Chair is subsequently elected to fill the unfinished term resulting from the vacancy. Likewise, committee Co-Chairs elected to fill mid-term vacancies are elected for the respective unfinished terms.
   f. Commission Co-Chairs are considered voting members of all Committees and subcommittees but are not counted towards quorum unless present.
2. Co-Chair Nominations: ~~Outside the rare possibility of immediate vacancies in both Commission Co-Chair seats,~~ all Commission and Committee Co-Chair elections must follow a nominations period opened at the respective body's prior regular meeting. The nominations period is designed to give potential candidates the opportunity to consider standing for election and the responsibility of assuming a leadership position. Candidates may nominate themselves or participants may nominate other members. Any stakeholder may nominate Co-Chair candidates.

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

Commented [MD2]: Review for Accuracy/Consistency:

Inconsistent w/ current & past practices and with "Policy, Section 1" and "Procedures, Section 1(b)"

Commented [JS3R2]: This line makes no sense as the Comm Co Chairs are two years and the committee co-chairs are one. IF they are both going to be two years (wich I agree with) the line is unneeded.

Commented [MD4]: For Committee Consideration:

Although not the purview of the workgroup, a recommendation was made to require Committee Co-Chairs serve staggered two-year terms.)

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Upon being nominated, if the candidate was not present and/or did not accept or reject the nomination, staff shall notify the candidate via email and telephone within 72 hours (3 days) of the nomination. If the candidate does not acknowledge receipt of the email and/or does not accept or decline the nomination, staff shall notify current Co-Chairs at least 72 hours before the election so that the Co-Chair(s) may contact the candidate to secure their response. Should a candidate not accept or decline a nomination by the time the election is held, ~~a "no response" will be recorded, and the nomination will not move forward.~~ The members of the Commission shall be informed of the non-response or declination. ~~In the event a nomination is submitted less than one week from the date of the election, staff will notify the candidate via email and telephone.. If a response is not received by the start of the election, the candidate must be present at the time the election is held to accept the nomination and be considered for election.~~

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

3. **Commission Co-Chair Election Process**: Normally—unless adjusted for unexpected circumstances—the Commission Co-Chair elections proceed according to the following schedule:
    a. The Co-Chairs are elected by a majority vote of Commissioners or Alternates present at a regularly scheduled Commission meeting **at least four months prior to the start date of their term**, after nominations periods opened at the prior regularly scheduled meeting.
    b. The term of office begins at the start of the calendar year. When a new Co-Chair is elected, this individual shall be identified as the Co-Chair-Elect and will have four months of mentoring and preparation for the Co-Chair role.
    c. The Co-Chairs delegate facilitation of the Co-Chair election to the Parliamentarian, Executive Director, or other designated staff, who will lead Commission voting to elect the new Commission Co-Chair
    d. Commission members who have been nominated, meet the qualifications, and who accept their nominations are presented for Commission vote.
    ~~e. The Parliamentarian (or Executive Director/staff) leads Commission voting to elect the new Commission Co-Chair.~~
    d. Following the new Co-Chair's election, the Commission Co-Chairs and the Executive Director must determine Commission members' final committee assignments by the end of December to open committee Co-Chair nominations the following month.

Commented [MD5]: Alternate language proposed: ". . . *may* not move forward."

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Commented [MD6]: For Committee Discussion:

Should a candidate be required to be present at the time the election is held if they have not acknowledged or provided a response accepting/declining their nomination. ***Seeking Parliamentarian review to ensure alignment w/ Robert's Rules of Order***

Alternate Consideration:

A list of all candidates and their nomination status will be read on the record prior to the start of the election, allowing nominees who have not yet acknowledged and/or accepted or declined their nomination to do so at that time. If a candidate does not accept or decline their nomination in writing or on the record by the start of the election, their nomination will not be considered for election.

Commented [JS7R6]: The suggested language does not comply with Robert's and violate the members rights.

Commented [MD8]: Entire section moved up from #5 to #2 for flow/organizational purposes.

Commented [JS9R8]: If there is a vacancy, a co-chair pro tem can be elected for a one or two meeting perod

Commented [MD10]: Added language from "e" for conciseness.

Commented [MD11]: Deleted & combined w/ "c" for conciseness

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

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

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

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

Commented [MD12]: For Committee Consideration:

Although not the purview of the workgroup, a recommendation was made to update pronoun references to "they/their" for purposes of inclusivity. **Only one reference to "his/her" was found in this policy, however, recommendation applies across all policies**

6. **Co-Chair Election Voting Procedures**: Co-Chairs are elected by a majority vote:
    a. Roll call voting for elections requires each voting member to state the name of the candidate for whom he/she is voting, or to abstain, in each round of votes.

    b. If there are more than two candidates nominated for Commission Co-Chair, voting will proceed in sequential roll calls until a final candidate earns a majority of votes and is elected by a consent or roll call vote. If no candidates earn a majority of votes in a single round, the candidate earning the least number of votes will be eliminated from the subsequent round of roll call voting. The process continues until there is a majority vote for one candidate, or only one candidate remains, and the others have been eliminated. Once the final candidate has been selected, the Commission must approve that candidate for the Co-Chair seat in a consent or roll call vote.

    c. When there is only one Commission Co-Chair candidate, the vote serves as approval or rejection of the nominated candidate.
        i. A consent vote may be used to approve the final candidate(s) for the Co-Chair seat(s). A roll call vote is not necessary for a final candidate unless there are objections to the election of the candidate.

    d. If there are two Commission Co-Chair vacancies to fill, voting adheres to the process outlined above except that the final two candidates are identified as the final Co-Chair candidates. A consent vote may be used to approve both final candidates, but a subsequent roll call vote is necessary to identify which candidate will fill the longer term; the candidate earning more votes fills the seat with the longer term.
        i. A roll call vote to approve both candidates to fill the Co-Chair seats is not necessary unless there are objections to the election of one or both candidates.
        ii. When there are objections to the election of one or both candidates, each candidate must be approved by a majority through an individual roll call vote.

    e. If there are three or more candidates nominated for the two Committee Co-Chair seats, the same process described for Commission Co-Chair election voting (Procedure #4a) is followed. If there are only two Committee Co-Chair candidates, the Committee is entitled to unanimously accept the "slate of Co-Chair nominees"; otherwise, an individual roll call vote is necessary to approve the election of each candidate to a Co- Chair seat.

    f. In the case of a tie, the vote shall be retaken. ~~during the final vote, the members of the body can re-cast its their vote to accommodate changes in voting.~~ If the body cannot resolve the tie after ~~a new vote,~~ as many rounds of voting as there are candidates, the current Co- Chair(s) remain in office, voting is closed, nominations remain open until the subsequent meeting, and a new election is resumed at that meeting. The process will repeat monthly until a clear majority vote-earner is identified.

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Commented [MD13]: For Committee Consideration:

Although not under the purview of the workgroup, this is a recommendation for clarification purposes.

Commented [JS14R13]: There is no 'final' vote unless there is a stated number of rounds of voting. I suggest the number of candidates as the number of rounds

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

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Commented [JS15]: As above, there is no final vote until someone is elected, or you set a limit on the number of rounds, the stated situation cannot happen

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7. **Co-Chair Election Contingencies**: A number of factors may impede the normal Co-Chair election timelines outlined in Procedures #2, #3 and #6. Following are potential challenges that can result in process delays, and how those challenges should be resolved:
    a. **Inadequate Number of Qualified Co-Chair Candidates**: The Co-Chair whose term has expired may continue in the seat with the term extended until a new Co-Chair is elected. If the Co-Chair does not choose to continue, or has resigned, a Commission or Committee Co-Chair may temporarily serve as a single Co-Chair until a second Co-Chair can be identified and elected. Co-Chair nominations will remain open indefinitely until qualified candidate(s) are identified and elected.
    b. **Cancelled Meeting(s) or Quorum(s) Not Realized**: Nominations can be opened at a subsequent meeting and/or extended to accommodate the cancelled meeting(s) or absence of quorum(s). If the meeting for which the election is scheduled is cancelled or a quorum is not present, nominations remain open an additional month and the election proceeds the following month.

NOTED AND APPROVED: Cheryl A Barrit **EFFECTIVE DATE:** September 12, 2019

Original Approval:

**Revision(s):10/19/16; 7/24/17; 9/12/19; Proposed Revisions 01/17/23*

3/13/2023

Assessment of the Administrative Mechanism (AAM)

Ryan White Program Year 31
(March1, 2020-February 28, 2021

Final Draft

LOS ANGELES COUNTY
COMMISSION ON HIV

Assessment of the Administrative Mechanism
Ryan White Program Year 31
(March 1, 2020-February 28, 2021)

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I. Introduction and Purpose of Report

As a Ryan White Part A planning council, the Los Angeles County Commission on HIV ("the Commission") is required by Health Resources and Services Administration (HRSA) to conduct a regular "Assessment of the Administrative Mechanism" (AAM). The AAM is meant to evaluate the speed and efficiency with which Ryan White Program funding is allocated and disbursed for HIV services in Los Angeles County. The Operations Committee of the Commission led the development, implementation, and analysis of the AAM for Ryan White Program Year 31. The purpose of this report is to present the findings of this assessment. Outlined in the sections below is the assessment methodology, and findings.

II. Assessment Methodology

The AAM covers 2 areas: 1) an assessment of the Commissioners' understanding of the priority setting and resource allocation process and 2) harnessing feedback from contracted agencies on the efficiency of Los Angeles County's administrative mechanisms (such as contracts, procurement, solicitations) to rapidly disburse funds to support HIV services in the community. The Operations Committee used an anonymous questionnaire via SurveyMonkey to elicit responses from Commissioners and contracted agencies. The Operations Committee of the Commission led the AAM and utilized the same questionnaire used for the previous AAMs as they have been tested and used in previous studies.

Online Survey of Commissioners:

Commissioners were invited to respond to the survey between April 4 to May 2022. At that time, there were 35 members (1 was on a leave of absence) and 8 alternates (1 was on a leave of absence) for a total of 41 possible respondents. Several follow-up emails were sent to ensure a high response rate. Nineteen responses were recorded at close of survey, generating a response rate of 46%.

Online Survey Contracted Providers:

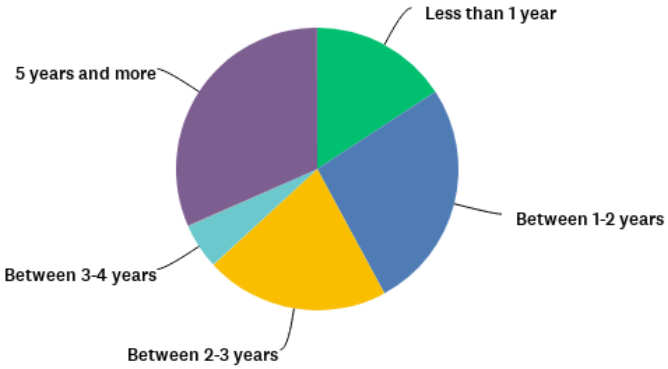
All 43 County-contracted HIV prevention and care providers were invited to participate in the AAM survey between August 18-September 15, 2022. 11 agencies completed the survey. Agencies were asked to provide one response per agency.

Limitations: The Operations Committee discussed and acknowledged the possibility of a low response rate for the Commissioner and provider surveys due to multiple local, statewide, and national surveys in circulation in 2022, including those related to the development of the federally required Integrated Plan. Another limitation of this AAM is the lag time between the program year cycle focus of the survey and the time of when the survey was released—this may have impacted memory recall of events and data presentations delivered to the Commission. Readers should not make broad interpretations with the results of the AAM but rather, use the information as a record of perceptions and responses from those individuals and agencies who completed the survey.

III. Assessment Responses

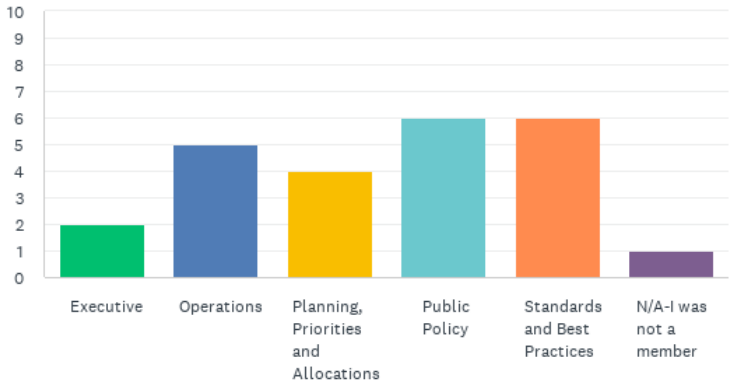
A. Survey of Los Angeles County Commission on HIV Commissioners[1]

Q1 For how long have you served as a Commissioner and/or Alternate on the Los Angeles County Commission on HIV?



Of the 19 individuals who responded to the survey, 3 indicated they have been a member of the Commission for less than a year; 5 between 1 to 2 years; 4 between 2 to 3 years; 1 between 3 to 4 years; and 6 for 5 years or more.

Q2 During the Ryan White Program Year 30 (March 1, 2020 – February 28, 2021) priority setting and resource allocation process, which committee(s) were you a member of?

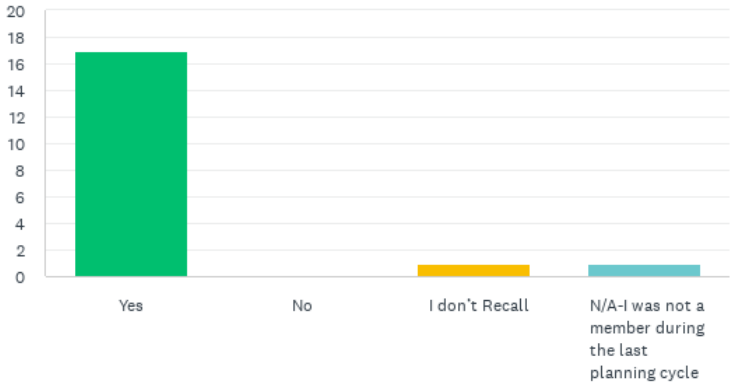


During the PY 30 priority setting and resource allocation (PSRA) process, 2 individuals indicated that they were assigned to the Executive Committee; 5 were members of Operations; 4 were members of the Planning, Priorities and Allocations; 6 were assigned to Public Policy; 6 were assigned to Standards and

[1] N=19

Best Practices; and 1 noted that they did not have a committee assignment at the time of the survey - this individual may have just been recently onboarded to the Commission and was awaiting confirmation of their committee assignment at the time that the survey was conducted.

Q3 During the Ryan White Program Year 30 (March 1, 2020 – February 28, 2021) priority setting and resource allocation planning cycle, did the Commission on HIV review/study an appropriate amount and type of data on an ongoing basis to determine community needs?

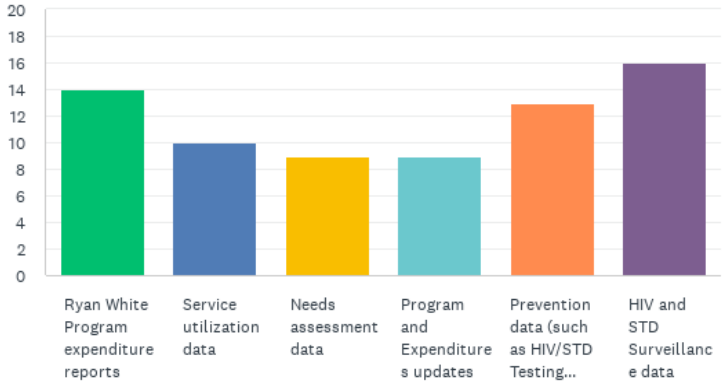


During the PY 30 PSRA planning cycle, 17 individuals who responded to the survey agreed that the Commission reviewed an appropriate amount and type of data on an ongoing basis to determine community needs; 1 indicated "I do not recall", and 1 responded that they were not a part of the planning cycle.

Comments:

- I think a greater amount of data/service resource and funding direct from the independent CA Health Jurisdictions in LA County.

Q4 During the Ryan White Program Year 30 (March 1, 2020 – February 28, 2021) planning cycle, do you recall any of the following DHSP reports being provided as a part of the priority setting and resource allocation process?

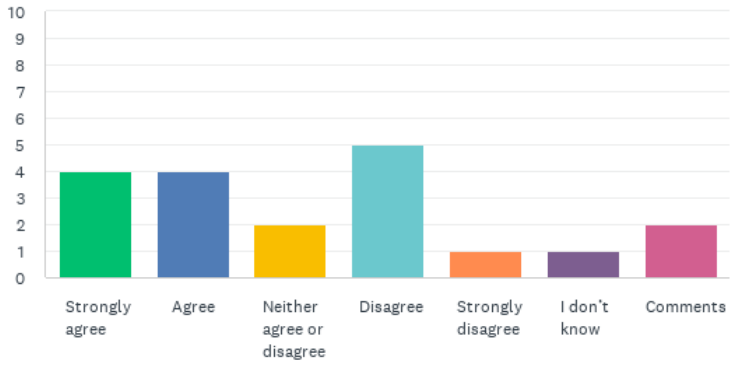


The data types most remembered by survey participants in ranked order were 1) HIV and STD surveillance (84.21%); 2) Ryan White Program expenditures report (73.68%); 3) prevention data (68.42%); 4) service utilization (52.63%); 5) needs assessment and program/expenditures updates (both at 47.37%). Prevention data included HIV/STD testing services; National HIV Behavioral Surveillance; LAC Apps-based survey; contracted biomedical services; contracted HIV education and risk reduction services; contracted vulnerable populations services).

Comments:

- Not sure on the one item. It may well have been done, I just don't remember.
- We could use more INTERSECTIONAL data on HIV HOUSING, HIV mental health, HIV SUBSTANCE USE INCLUDING HARM REDUCTION, especially related to methanol hatsmine (sp) use, AND a significant update on LGBTQI stigma/discrimination, and data that better shows the increasing needs of Seniors infected with HIV.
- I don't remember the specific reports. We were still receiving LACHAS reports and gearing up for the EHE. I don't remember a lack of data.
- Seen reports but not sure on time frame; also not sure how No 1 and 4 differ.

Q5 Please indicate the degree to which you agree with the following statement: There is adequate consumer participation and input in the planning, priority setting and resource allocation process.

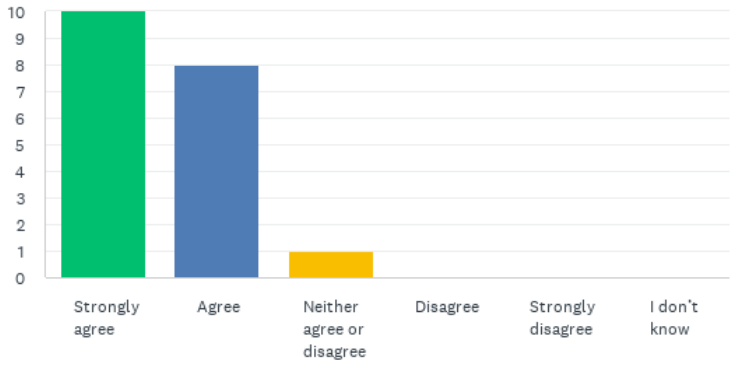


Regarding adequate consumer participation in the PSRA and planning process, 4 individuals "strongly agreed"; 4 "agreed"; 3 "neither agreed or disagreed"; 5 "disagreed"; 1 "strongly disagreed"; 1 replied "I don't know"; and 2 provided comments (listed below).

<u>Comments:</u>

- "Adequate" however is insufficient, and consumers need much more support to participate especially elderly and long-term survivors, and people of color – especially Native American Representatives
- Agree, but we could do more with consumer involvement.

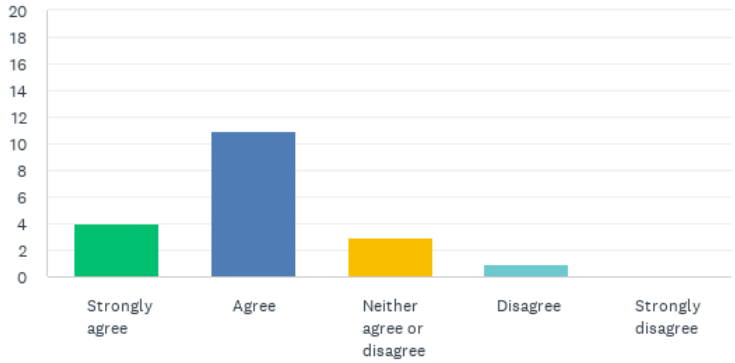
Q6 Please indicate the degree to which you agree with the following statement: During the last planning cycle, I was adequately notified of planning, priority setting and resource allocation activities and meetings.



When asked to rate their agreement/disagreement with the statement, “during the last planning cycle, I was adequately notified of planning, PSRSA activities and meetings”, 10 individuals “strongly agreed”; 8 “agreed”; and 1 neither agreed or disagreed.”

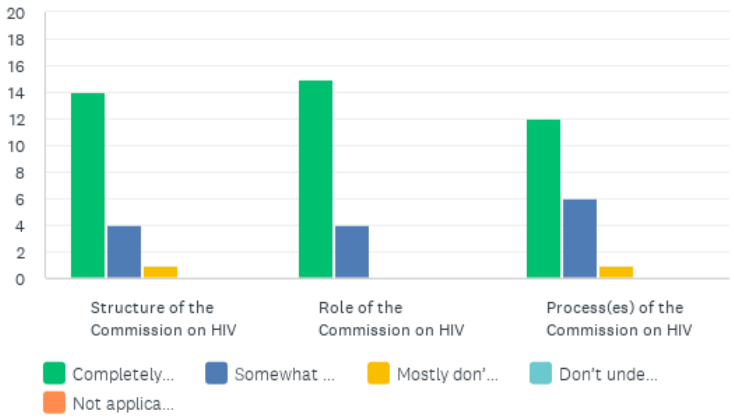
Comments: none

Q7 Please indicate the degree to which you agree with the following statement: In terms of structure and process, the Commission on HIV is effective as a planning body.



When asked to rate their agreement/disagreement with the statement, “in terms of structure and process, the Commission on HIV is effective as a planning body”, 4 individuals “strongly agreed”; 11 “agreed”; 3 “neither agreed or disagreed”; and 1 “disagreed”.

Q8 Please indicate the degree to which you understand the following:



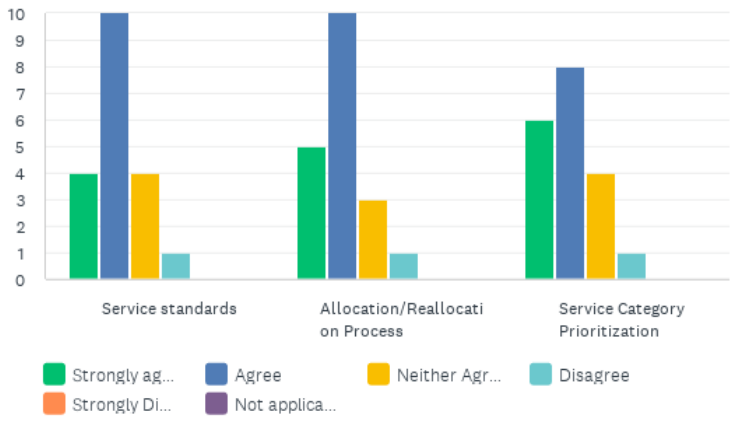
Regarding the Commissioners understanding of the structure, role and processes of the Commission, survey participants responded in the following manner:

- Structure of the Commission – 14 answered "completely understand"; 4 "somewhat understand"; and 1 "mostly don't understand"
- Role of the Commission – 15 answered completely understand" and 4 "somewhat understand";
- Process(es) of the Commission – 12 answered completely understand"; 6 "somewhat understand"; 1 "mostly don't understand"

Comments:

- We participate in creating plans. We don't lack for plans. Success in the metrics we use is incremental. We can't keep doing the same things and expect different results.
- The COH has done an excellent job helping me learn and understand my role as a commissioner.

Q9 Please indicate the degree to which you agree with the following statements: The Commission on HIV has prepared me to make decisions related to:



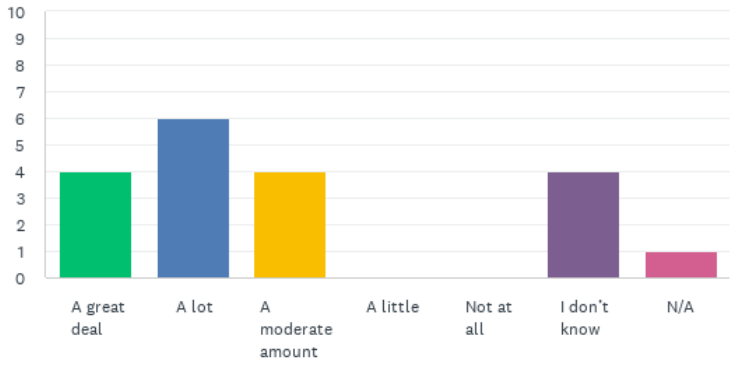
When asked to rate the degree to which the Commission has prepared members to make decisions related to service standards, PSRA and service category prioritization, survey participants responded in the following manner:

- Service standards – 4 "strongly agreed"; 10 "agreed"; 4 "neither agreed nor disagreed"; and 1 "disagreed"
- PSRA process – 5 "strongly agreed"; 10 "agreed"; 3 neither agreed nor disagreed"; and 1 "disagreed"
- Service category prioritization – 6 "strongly agreed"; 8 "agreed"; 4 neither agreed nor disagreed"; and 1 "disagreed"

<u>Comments:</u>

- As part of the Commission, I believe there is always room for improvement and increased knowledge.
- We have the knowledge and experience around the table. We need more direct consumer feedback and involvement.

Q10 Please indicate the degree to which you believe the priorities and allocations established by the Commission on HIV in the Ryan White Program Year 30 (March 1, 2020 – February 28, 2021) were followed by DHSP.



When queried to rate the degree to which the priorities and allocations established by the Commission for the Ryan White PY 30 were followed by the DHSP (the grantee), 4 responded "a great deal"; 6 " a lot"; 4 "a moderate amount; 4 "I don't know"; and 1 "N/A".

Comments: none

Observations and Recommendations

While this study has limitations such as low response rate and the likelihood of poor memory recall due to the lag in time frame from date of the priority setting meetings and the date of the study, the responses from the Commissioners offer insights on opportunities for improvement , training and learning. Key observations and recommendations are listed below:

Key Observations:

- There appears to be recognition and recall of the range of programmatic, fiscal, surveillance, service utilization and care continuum data provided to the Commission and its committees during PY 30. A participant noted that they would like to see more data that shows the intersection of HIV with morbidities such as mental, substance use, seniors and social conditions such as stigma and discrimination. More data sharing from the independent health jurisdictions (Long Beach and Pasadena) was also noted by a respondent.

- There is a need for a more robust, direct, and highly visible participation and engagement of consumers in the Commission's priority setting, resource allocation process and decision-making.

- Eighteen of the 19 respondents strongly agreed/agreed that they were "adequately notified of PSRA meetings and activities during the PY 30 planning cycle. The response may be due to the Commission's open meetings which allows for broad community participation. In addition, data presentations are disseminated in advance to the PP&A Committee and materials are posted on

the Commission's website.

- In terms of structure and process, 15 respondents indicated that they strongly agreed/agreed that the Commission is effective as a planning body; while 3 responded neither agreed or disagreed and 1 disagreed. The continues cycle of planning may also be factor in the desire to execute different approaches to community planning.

Key Recommendations:

- Facilitate a more structured collaboration process for the Operations Committee and Consumer Caucus to develop customized a training and coaching plan for consumers on how decisions are made on the Commission and make data presentations more accessible to consumers.

- In order to better prepare Commissioners with planning and decision making, the Commission should continue efforts around ongoing education and training on COH structure, role and processes. In addition, the Commission should consider periodic assessment/review of its structure, processes (such as service standards development, allocations/reallocations, and service category prioritization) and define desired outcomes and examples of what an "effective planning body" constitutes.

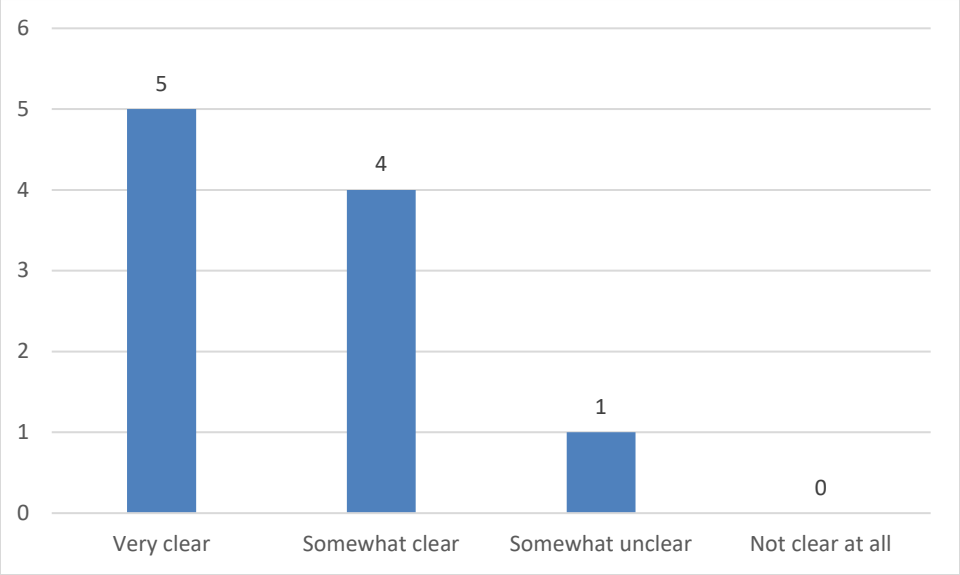
- Collaborate with the Consumer Caucus to identify strategies aimed at increasing ongoing participation of consumers in PP&A discussions, especially among consumers who identify as people of color, elderly, long-term survivors, Native Americans, and other communities disproportionately affected by HIV.

B. Assessment with Contracted Providers Responses[2]

Q1. Please describe the level of guidance you get from DHSP with respect to invoicing, budget development and budget modifications.

1. The process involves a lot of back and forth and detail that is unusual, and the spreadsheets are cumbersome.
2. Ongoing oversight on all dimensions. Usually high level of guidance provided, medium level during the COVID Era.
3. We receive sufficient guidance regarding invoicing, budget development and budget modification.
4. We've received very good, clear guidance from DHSP on budget development and modifications. They are highly responsive regarding invoicing, so there has been some lack clarify around invoicing for PFP portion of contract.
5. Our DHSP Program Managers and Finance Managers have always been accessible and more than willing to assist our program when needed.
6. Our DHSP team is most prompt and helpful when needed.
7. My project officer has been very helpful with all bud mods and invoicing
8. DHSP program managers are always available to assist and provide guidance.
9. DHSP gives adequate guidance in this area when needed.
10. Minimal
11. Guidance is generally provided when something needs to be revised. Over the years the budget process has become more tedious compared with funds that come directly from a federal source (HRSA, CDC, SAMSHA).

Q2. With respect to the process of program monitoring, how clear are you on the expectations prior to the site visit and monitoring?



Comments:

1. No information regarding audit has been provided yet.
2. Usually preparation materials are sent in advance.
3. There could have been clearer outlining of expectations prior to the site visit. Additionally, the site visit did not occur until the beginning of year 3, which was problematic.
4. Program managers convey expectations clearly prior to monitoring.
5. It seems that things are always changing. One year you get a great audit score and the next its terrible.
6. Seems like each year the expectations change. Moreover, not clear why a program that is in compliance needs to be reviewed every year. Moreover, there is a constant change in Program Managers. This creates a disconnect with understanding how a program operates. Program Managers need to go out into the field and witness programs in action.

Q3. Does DHSP regularly provide feedback on your performance? If so, is the feedback helpful? What is helpful about the feedback?

1. Feedback is always helpful. The more specific it is, the better.
2. Yes, DHSP provides feedback on performance that is helpful.
3. There is not regular feedback on the performance.
4. Our DHSP Managers regularly provide feedback on our performance. The feedback has always been helpful to improve our program policies and procedures.
5. We get regular communication from our program monitor. Updates and questions from finance are asked as needed.
6. Yes. The quarterly report is very helpful
7. Yes, DHSP provides helpful feedback to improve in areas of less strength. Also, if there is any programmatic issue, the feedback allows us to get back on track to achieve contractual goals.
8. DHSP provides feedback and about performance, goals etc.
9. No, and I think it would be nice to have a working relationship with all the program managers.
10. Feedback is generally provided in written form following a program review or if a grievance was submitted to DHSP.

Q4. Do you get feedback or technical assistance from DHSP on barriers and challenges reported on progress reports? If so, is that feedback or TA helpful? Please elaborate.

1. Yes, DHSP has been providing feedback and assisting us when we have questions. In particular, DHSP invited us to an MCC meeting where most providers were present so we could discuss our services and the referral process.
2. Needs to be on an ongoing basis. During the COVID period staff were redeployed to address the COVID Pandemic.
3. I don't recall a specific incident. However, I do believe they have been supportive regarding barriers and challenges.
4. No feedback is given on any challenges or anything specific that's reported in the monthly reports.

5. Feedback from our monthly progress reports is usually discussed during our annual program reviews. DHSP Program Managers often give examples of what other community facility programs with similar barriers and challenges are experiencing and how they are improving.
6. Our program monitor is most supportive and helpful.
7. None
8. Yes, we get feedback. DHSP always offers TA when needed, especially after a programmatic review, to address any issues identified.
9. Yes, TA is provided when requested. It has proven to be helpful taking a deeper dive into the contract expectations and clarify areas where we may have questions.
10. no- no feedback or suggestions.
11. Despite repeated requests for TA, no. One particular program continues to be challenged with reporting on one of the domains, and although we have requested TA, there has been no follow up.

Q5. With respect to the development of your DHSP contract, how would you describe the level of technical assistance and support provided by your assigned program manager and fiscal representative? (Please reference which RFP or service category you are referring to).

1. As it pertains to the fiscal portion, the process involves a lot of back and forth and detail that is unusual, and the spreadsheets are cumbersome. In addition, we had a lot of back and forth with the prior program manager. The service category is HIV Legal Services.
2. Education and Prevention-High TCM-Medium
3. Both assigned program manager and fiscal representative have been helpful. RCFCI service category.
4. N/A Were not involved in the development of the contract
5. XXXX* currently has three DHSP contracts: Medical Care Coordination Services, Ambulatory Outpatient Medical Services and Transportation Services. The transportation services contract is fairly new and was implemented during the pandemic. Unfortunately, we experienced a lack of guidance and/or communication with DHSP when trying to set up individual contracts with Metro. At the time, we didn't know who our assigned Transportation Program Manager was and could not get any response from calls and emails. We later found out that several managers had been temporarily reassigned to work on COVID-19 projects and/or were working from home. We currently have an amazing, supportive Transportation Program Manager!
6. We have an HE/RR contract and have had that contract for many years. The level of technical assistance is beneficial when needed - especially around audits.
7. I appreciate the offer of TA
8. At the beginning of 2022, we submitted our proposal for the HIV Biomedical PrEP Prevention RFP. During the application process, DHSP provided TA through webinars, provided an email address to submit any questions related to the RFP, and then posted the answers. Those tools allowed us to have a better understanding of submitting our proposal.
9. Technical assistance has been provided surrounding Benefits Specialty Services and has been helpful for frontline staff in delivering services, as well as managing the contract.
10. XXXX*- non existent but ok during audit XXXX*- minimal PH003772- great XXXX*- current is great, past was non existent XXX*- great

11. Most contracts have been in place for a number of years. Program Managers adhere to a strict definition of the contract language, but no very little how a program actually operates.

    **XXXX = used to replace contract numbers to maintain anonymity.*

Q6. Do the RFPs provide clear instructions, directions, and/or guidance? If yes, how so? If no, in what ways are they unclear? What was your role in developing the application in response to the RFP? Please elaborate.

1. We did not reply to an RFP. We were asked to assume the delegation of duties from a current contract.
2. Multiple year funding, directions have been similar over the years. Was the lead on the application, and worked with staff on all stages of the submissions.
3. I do not recall. I was part of an in-house team that responded to the last RFP.
4. Did not develop the application. Were not employed with the organization at that time.
5. To my knowledge, the RFP instructions, directions and/or guidance seem to be clear. As the Program Manager, my role includes reporting, client numbers, etc.
6. N/A We have maintained the HE/RR contract for many years.
7. The administrative guidance and task are extremely cumbersome and take way too much time from our time
8. The RFP provided clear instructions regarding the staff required to implement and roll out the program and priority populations. However, it did not explain how the goals would be calculated. It was the program manager who explained that goals are calculated based on the assigned FTEs.
9. Yes, RFPs provide clear instructions. I have provided support in developing RFP application responses.
10. The RFPs are clear. The auditing is not consistent especially in BSS and MH. I was the main contact for the response.
11. As noted above, many contracts have been in place for many years. In my capacity at our organization, I wrote most of the applications. I have found the RFP's to be generally very clear.

Q7. Do you feel the county's process of awarding contracts for services is fair? Please explain.

1. Yes. It is transparent and provides due consideration of experience with the clients and area of service.
2. Yes. I believe there is an outside, independent County review panel.
3. Yes. In my experience for RCFCI services the RFP appeared fair.
4. Don't have sufficient information to answer this question.
5. I feel the process is fair. Contracts and funding are usually awarded to those areas and SPAs that need it.
6. Understanding what difficulty it must be to streamline processes and use pre-authorized agencies, it seems fair.
7. Yes. DHSP, in this last cycle has been fair.
8. I understand there is a review committee that evaluates each proposal. However, I am unaware

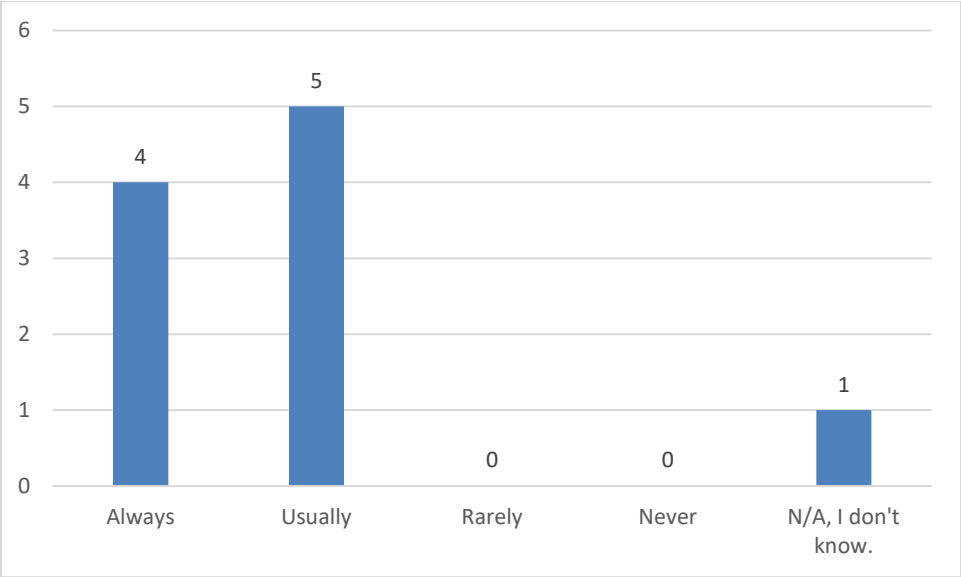
of how the review panel is chosen and how someone becomes part of it. I consider it should be more transparent to ensure there are no biases.

9. Yes, to my knowledge our agency has experienced fairness in awarding of contracts.
10. Yes
11. Yes; however, there continues to be some agencies funded that have a history of under-performing.

Q8. What are the most effective practices implemented by your agency to ensure that Ryan White program funds are spent efficiently? Please elaborate.

1. The team is established and is ready to receive referrals on trains, partners and the community.
2. Regular supervision meetings. Our award amount has remained basically the same for the past 14 years without a cost of living increase.
3. Ensuring that we have a full house and are able to bill for all available beds.
4. Internal controls on grant money spent provide a framework to ensure efficient use of program funds. These include internal approval processes, monthly financial reporting and accounts payable controls.
5. In-house audits.
6. The HE/RR contract is very specific. The guidelines are clear and reporting for both programming and financials are direct and easy to complete.
7. Targeting the right populations
8. Our agency has compliance tools that are reviewed quarterly to ensure all practices are followed, and funds are spent according to the contractual guidelines. Additionally, we submit our invoices and request feedback from the program manager or fiscal representative. If a discrepancy is identified, our accounting and program administrator correct the issue.
9. Continuous Quality Improvement efforts, through program monitoring, communication with DHSP, agency administration, management (finance, director etc) and frontline staff.
10. We have a dedicated fiscal manager. Programmatically we conduct internal audits.
11. Having finance and program administration staff who understand the contract, allowed expenses, and who work as a team to monitor expenses and respond in a timely manner with submitting budget mods.

Q9. DHSP issues payments within 30 days following submission of complete, accurate invoices, and submitted in a timely manner as stipulated by the DHSP contract.



Comments:

1. Payments are generally received in 45-60 days.
2. Much better than in the past.
3. However, it takes forever to receive an executed contract; often well-beyond the 90-days an agency is expected to "float" a program.

Q10. Are there other comments or feedback you would like to share about the County's procurement, contracting, and invoicing process? Please provide specific examples and suggestions for improvement.

1. No/None
2. Honor the agencies' individual Negotiated Indirect Cost Agreements (NICRAs). A 10% ceiling is too low.
3. N/A
4. I know that sometimes the payment takes longer than 30 days, regardless of submitting the invoice on time.
5. DHSP staff often inform an agency that they have 24-48 hours to respond to a request; however, it often takes DHSP many months to execute a contract or approve a budget modification. There have been occasions when a budget mod was approved after a contract ended. Agencies should be allowed to submit a final budget mod, with parameters, upon submission of a final invoice. DHSP staff need to go out into the field and gain an understanding of the programs they monitor. Most program staff at funded agencies returned to the office in 2021, yet DHSP staff continued to work at home. The optics of this was/is not great. This further demonstrates the disconnect with what happens in the field.

C. Key Themes

Sufficient to Very Good Guidance on Invoicing, Budget Development and Budget Modifications

With regard to the level of guidance received from DHSP around invoicing, budget development and budget modifications, comments ranged from "sufficient" to "very good" and "clear guidance." Some respondents also appreciated the accessibility and assistance from program and fiscal managers for questions and technical assistance.

Mixed Reactions around Communication of Expectations Prior to Site Visits and Program Monitoring

While some of responses noted that program managers conveyed expectations clearly prior to site visits, there were also comments that alluded to the need for clearer communication of expectations for program monitoring prior to the site visit and better explanation for changes in expectations from year to year. Some participants commented that frequent changes in program managers "create a disconnect on how a program operates."

Contractors Receive Regular Feedback on Performance and Technical Assistance (TA) on Barriers and Challenges

In general, the majority of the comments, appear to show that DHSP regularly provides feedback on contractor performance and that the feedback is helpful in improving program policies, procedures, and assisting the agencies meet their contractual goals.

Some participants noted that the TA provided by DHSP has been helpful; an example was cited where an agency was able to interact with other providers to identify solutions to challenges and barriers.

A few participants indicated that they have not received TA or feedback on challenges they have reported in progress reports at the time when the survey was conducted.

Inconsistency with the Level of TA and Support Provided by Assigned Program Manager and Fiscal Representative

While many respondents described receiving helpful TA from their program/fiscal managers, some described inconsistencies with regard to guidance and communication. Some agencies with multiple service contracts are assigned different program managers.

Experience with the County's Request for Proposals (RFP) Process

Several participants noted that their contracts have been in place for several years and remarked that the County's RFP instructions appear to be clear, however, directions regarding auditing could be more uninformed across service categories and how service target goals are calculated for contracts could be better explained to agencies.

The County's Process for Awarding Contracts for Services is Fair

Overall, the participants noted that the County's process of awarding contracts is fair and transparent.

Agencies Have Established Internal Practices to Ensure that Ryan White Program (RWP) Funds are Spent Efficiently

Based on comments provided under question #8, it appears that contracted agencies have developed organizational and administrative practices to ensure that RWP funds are utilized efficiently. These practices include internal audits and compliance tools, continuous quality improvement efforts, regular supervision meetings, and targeting the right client populations.

Payments within 30 Days Have Improved

Respondents noted that DHSP issues payments in general, within 30 days, following submission of complete and accurate invoices; one comment indicated that the payment turnaround time has improved.

Suggestions for Improvement

The survey participants offered the following suggestions for improving the County's procurement, contracting and invoicing process:

- Continue to improve payment turnaround cycles within 30 days.
- Expedite or shorten the length of time it takes to execute a contract or approve a budget modification.
- Ensure uniformity in the information communicated by program and fiscal managers to contracted agencies.
- Ensure timeliness and consistency of technical assistance provided to agencies regarding programmatic and fiscal challenges and questions.

The general comments collected from this AAM reflect the recurring themes from previous AAMs, such as consistency of information received from DHSP, setting clear expectations for audits/site visits; and lengthy RFP process. It is important to note that the lengthy RFP process cited by some survey participants is a County-wide issue. The Los Angeles County Board of Supervisors (BOS) has charged the Quality and Productivity Commission, in consultation with the Small Business Commission, and Citizen's Economy and Efficiency Commission, to seek innovative ways to streamline the County's contracting process, assist businesses, and identify potential cost savings to County operations. As a short-term response, the County's *Doing Business* site was revamped to make it more community friendly and the County hosts quarterly technical assistance events for the public and vendors. In addition, DHSP has an ongoing collaboration with the Commission on HIV's Black Caucus to address and strengthen the organizational capacity of Black-led and Black-serving agencies so that they can be better prepared to successfully compete for and maintain HIV prevention and care contracts with DHSP. Despite the bureaucratic challenges associated with a

large municipal government the size of Los Angeles County, DHSP continues to improve various administrative mechanisms to ensure that life-saving services reach people living with HIV in a timely and efficient manner.

[2] n=11 providers

LOS ANGELES COUNTY
COMMISSION ON HIV

2023 Training Schedule

- All trainings are open to the public.
- Click on the training topic to register.
- Recordings will be available on our website for those unable to join live trainings.
- Certifications of Completion will be provided.
- All trainings are virtual.

Topic	Date
General Orientation and Commission on HIV Overview *	March 29 3:00 - 4:30 PM
Priority Setting and Resource Allocation Process & Service Standards Development *	April 12 3:00 - 4:30 PM
Tips for Making Effective Written and Oral Public Comments	May 24 3:00 - 4:00 PM
Ryan White Care Act Legislative Overview Membership Structure and Responsibilities *	July 19 3:00 - 4:30 PM
Public Health 101	August 16 3:00 - 4:30 PM
Sexual Health and Wellness	September 20 3:00 - 5:00 PM
Health Literacy and Self-Advocacy	October 18 3:00 - 4:30 PM
Policy Priorities and Legislative Docket Development Process *	November 15 3:00 - 4:30 PM
Co-Chair Roles and Responsibilities	December 6 4:00 - 5:00 PM

Mandatory core trainings for all commissioners.

Commission Training Opportunities Identified via KAB Survey Results

- PreP Overview
    - Effectiveness
    - Administration (pill and injection)
    - Access including where to locate and cost
- STIs – General overview
    - Potential for population specific sub-training(s) in collaboration with Caucuses
    - Testing/treatment resources
- HIV status neutral training – models for prevention to complement care services
- Overview of health districts and how to use them for planning efforts
- Prevention data for planning purposes

* Health literacy – not identified in KAB survey. Priority area identified in the Comprehensive HIV Plan.

ISSUE BRIEF

Status Neutral HIV Care and Service Delivery Eliminating Stigma and Reducing Health Disparities

Today, powerful HIV prevention and treatment tools can keep people healthy and help end the HIV epidemic. Combining these tools in a status neutral approach can help people maintain their best health possible, while also improving outcomes in HIV prevention, diagnosis, care, and treatment. A status neutral approach to HIV-related service delivery aims to deliver high-quality, culturally affirming health care and services at every engagement, supporting optimal health for people with and without HIV. This approach is especially important now to reduce the unacceptably high number of annual HIV infections and help close the persistent gaps along the HIV prevention and care continuum, which indicate that not enough people are being engaged or retained in HIV prevention and treatment.

Many Barriers May Keep People from Being Engaged in HIV Care.

- **HIV testing, treatment, and prevention services are often offered separately,** can be challenging to navigate, and further emphasizes a division between people with HIV and people who could benefit from prevention.
- **Separating HIV services from other routine healthcare** misses opportunities to engage people in HIV testing, prevention, and treatment when they seek sexual health or other non-HIV-focused services.
- Providing critical support services—like housing, food, and transportation assistance—is essential to keeping someone in ongoing care, but these **services are not necessarily offered** alongside what are considered "traditional" HIV care and prevention services.
- **Stigma** embedded in the experience of many people seeking HIV treatment and prevention services can stop people from visiting health care providers labeled as "HIV" or "STD" clinics.
- Everyone has **implicit biases** that affect their perceptions of others. The HIV care or prevention services someone receives may be affected by healthcare and other service providers' implicit biases on race/ethnicity, sexual orientation, gender identity, age, and other factors. These biases, in some cases, may be why a person does not return for care and services.

Many HIV prevention experts believe a status neutral approach can help improve care and service provision and eliminate structural stigma by meeting people where they are, offering a "whole person" approach to care, and putting the needs of the person ahead of their HIV status. The status neutral approach aims to advance health equity and drive down disparities by embedding HIV prevention and care into routine care. Integrating HIV prevention and care with strategies that address social determinants of health can help reduce barriers to accessing and remaining engaged in care.

The status neutral approach also aims to increase efficiency, since the clinical and social services that prevent or treat HIV are nearly identical and can be unified in a single service plan rather than different plans based on an individual's HIV status. Adopting a status neutral approach is one way to help deliver better prevention and care and ultimately decrease new HIV infections and support the health and quality of life of people living with HIV in the United States.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

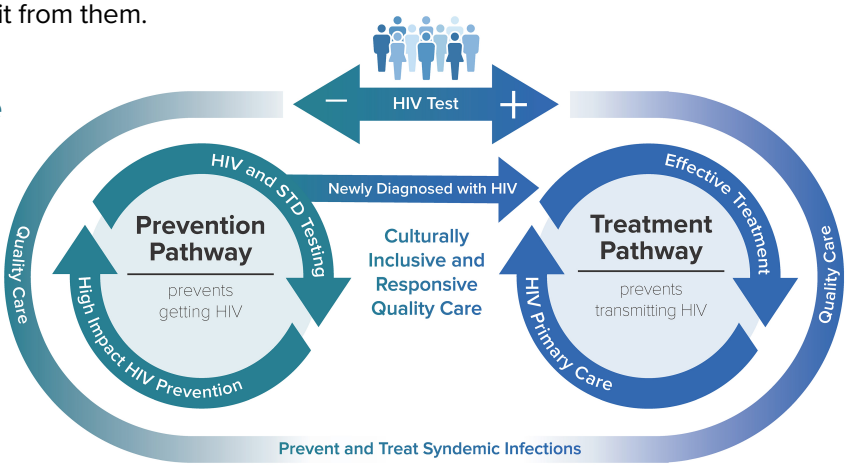
Understanding Status Neutral HIV Care

The status neutral framework provides care for the whole person by offering a "one-door" approach: people with HIV and people seeking HIV prevention services can access treatment, prevention, and other critical services in the same place. Normalizing HIV treatment and prevention helps to destigmatize both. In a status neutral approach to care, a provider continually assesses and reassesses a person's clinical and social needs. The goal is to optimize a person's health through continuous engagement in treatment and prevention services without creating or deepening the divide between people with HIV and people who could benefit from prevention.

A status neutral approach is unique because both of the harmonized pathways promote continual assessment of each person's needs and ongoing engagement in HIV prevention and care, including access to support services, for anyone who could benefit from them.

Status Neutral HIV Prevention and Care

People whose HIV tests are **negative** are offered powerful prevention tools like PrEP, condoms, harm reduction (e.g. SSPs), and supportive services to stay HIV negative.



People whose HIV tests are **positive** enter primary care and are offered effective treatment and supportive services to achieve and maintain viral suppression.

Follow CDC guidelines to test people for HIV. Regardless of HIV status, quality care is the foundation of HIV prevention and effective treatment. Both pathways provide people with the tools they need to stay healthy and stop HIV.

Status neutral HIV service delivery is:

- **Healthcare** that encompasses HIV testing, treatment, and prevention services.
- **HIV treatment and prevention** that is offered alongside other local medical healthcare services frequently used by the community—for example, sexual health, transgender and other LGBTQ-focused care, healthcare for people who use drugs, and general primary care.
- **Service delivery** that recognizes and includes broader social services that support the path to optimal HIV and other health outcomes—like housing, food, transportation, employment assistance, harm reduction services, and mental health and substance use disorder services—regardless of the HIV status of the people seeking care.
- **Culturally affirming, stigma-free HIV treatment and prevention,** delivered by supportive and accepting providers who have been trained to recognize and address implicit racial/ethnic, sexual orientation, and other biases (thoughts and feelings that providers are not consciously aware of), and provided in settings that consider and prioritize a positive experience for the person seeking services.

Status neutral service begins with an HIV test—the pathway to prevention and treatment. In a status neutral approach, an HIV test spurs action regardless of the result by recognizing the opportunity created by a negative or positive result for an individual to achieve better health:

- **If a person receives a negative HIV test result,** the provider engages the person in HIV prevention and offers powerful tools that prevent HIV, such as pre-exposure prophylaxis (PrEP). The prevention pathway emphasizes a consistent re-evaluation of the engaged person to match prevention and social support strategies to the individual's needs. Being engaged in such preventive services also means expedited connection to HIV care in the event of a new positive HIV test result. Condoms and harm reduction services are also an important part of this prevention pathway, especially for people who are not ready or eligible for PrEP.
- **If a person receives a positive HIV test result,** the provider offers a prescription for effective treatment to help them become virally suppressed and maintain an undetectable viral load as well as other clinical and support services to help support general health and achieve a high quality of life. Studies have shown that people with an undetectable viral load do not transmit HIV to their sexual partners, this is often referred to as "U=U."

Why a Status Neutral Approach Is Needed

HIV treatment and prevention services have not been fully used by all who need them: Only 66 percent of people with diagnosed HIV in the United States are virally suppressed. PrEP remains greatly underused—just 23 percent of the estimated one million Americans who could benefit are using the intervention. Stigma and structural barriers are major obstacles that deter people from seeking HIV prevention and care. People with HIV and people who could benefit from HIV prevention are not two distinct populations, but rather one group with similar medical and social service needs. Adopting a status neutral and "whole person" approach to **people in need of prevention and care services can address these similar needs, along with HIV-related stigma.**

Health departments implementing models of status neutral HIV care have reported benefits such as:

- **Decreasing new HIV infections.** A status neutral approach to care and service delivery means that regardless of HIV status, people have access and support to stay on highly effective public and personal health interventions like PrEP and HIV treatment. When people are supported to fully use these interventions, the outcome is the same—HIV infections and other infections are identified, prevented, and treated. For example, New York City's status neutral approach to HIV prevention and care, first introduced in 2016, contributed to annual declines in new HIV diagnoses thereafter. New York City saw a 22% decrease in new HIV diagnoses from 2016 to 2019.

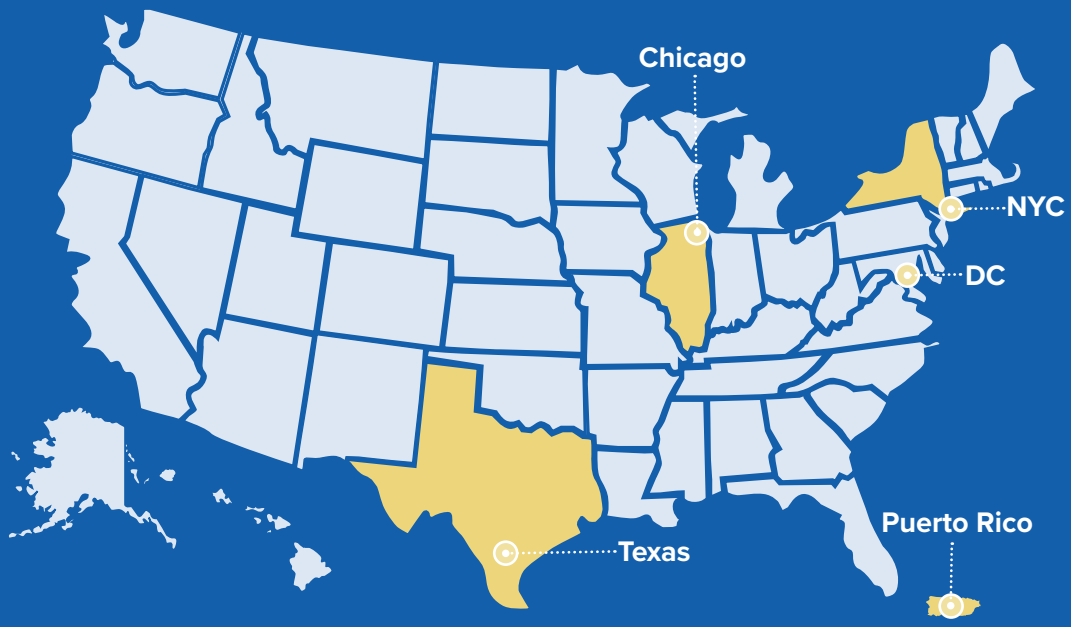
- **Supporting and enabling optimal health through continual engagement in comprehensive, "whole person" care.** By offering HIV services alongside other local health care and social support services used by the community, HIV prevention and treatment can become part of the fabric of holistic care designed to meet the needs of each person. As their needs evolve, a person can be seamlessly connected to new services. Potential outcomes include improved HIV care, as well as better overall health and social stability for every individual. For example, Chicago has created comprehensive status neutral health homes that offer the same services to people with HIV and people who could benefit from prevention services. Services include primary care, medications, care coordination, and behavioral health.

- **Opportunities for more efficient service delivery.** Parallel services and structures historically created for people with HIV or people who could benefit from prevention services can impede the most efficient use of resources. This can also inadvertently hinder connection to care by maintaining stigmatizing structures in health care. Identifying opportunities to resolve these divisions allows for more streamlined and integrated care. Washington, D.C. has seen increased capacity and improved outcomes and engagement at organizations using a status neutral approach. Using this approach has increased viral suppression rates 3% across all funded jurisdictions and increased linkage to preventive services like PrEP and harm reduction for people who tested negative for HIV.

- **Improving health equity.** The status neutral framework integrates HIV and prevention services to better address social determinants of health regardless of HIV status. The framework also encourages the delivery of culturally affirming care by ensuring providers recognize and address their implicit biases on issues like race, ethnicity, sexual orientation, or gender identity. These biases sometimes prevent people from returning for care and other services. Likewise, countering stigma is essential to ensure that people with HIV are not defined by their status, and that people seeking HIV prevention and care services are empowered to access these tools without facing judgment or being reduced to the result of a lab test. Addressing racial bias and stigma results in better care experiences for patients and increases the likelihood that they remain in care and stay healthy.

SPOTLIGHT: Status Neutral HIV Care in Action

Here's how some jurisdictions across the country are integrating a status neutral approach into their HIV care services:



- **Chicago: Integrating all HIV and sexually transmitted infection (STI) services**. The Chicago Department of Public Health recently restructured its entire HIV services portfolio to adopt a status neutral approach. Based on feedback from its community members over a two-year community engagement process, the portfolio now integrates HIV and STI funding to deliver comprehensive care that links people to healthcare services like STI screening, substance use disorder treatment, mental health, housing, financial assistance, and psychosocial support in addition to HIV treatment and prevention. Anyone can access these services regardless of HIV status.

- **New York City: Expanding sexual health and rebranding to reduce stigma.** Stigma associated with HIV and STIs can prevent people from seeking care in STI clinics. To address this, the New York City Department of Health and Mental Hygiene rebranded its STI clinics as sexual health clinics and transformed services so that they fully meet clients' sexual health needs. These changes have resulted in more diverse populations visiting the clinic for care.

- **Puerto Rico: Delivering affirming, trauma-informed care for transgender people**. Centro Ararat in Ponce, Puerto Rico delivers integrated, tailored sexual health and primary care to the transgender community. The center's innovative clinic provides comprehensive, trauma-informed health services for transgender people alongside HIV and STI care. These services include hormone therapy and level testing, mental health services, support with name changes, and assistance finding trans-sensitive housing.

- **Texas: Improving access to social services for all people.** *Achieving Together* is the community plan to end the HIV epidemic in Texas. It lays out a vision for status neutral HIV care that supports all people in accessing services that meet their priority needs. This approach addresses social determinants of health, including housing, transportation, and food assistance, helps with insurance navigation, and increases access to mental health and substance use disorder treatment.

- **Washington, D.C.: Eliminating HIV prevention and treatment barriers early.** DC Health developed a status neutral approach through its regional early intervention services initiative, which supports engaging people early in HIV care and prevention services throughout the DC metropolitan area. The initiative has made strides in integrating prevention and treatment services, which previously operated independently, and consists of five pillars to promote equity and whole person health spanning HIV outreach, education, testing, and linkage to and retention in care.

What CDC Is Doing to Advance Status Neutral HIV Care

CDC is providing funding, conducting implementation science to improve programs, and partnering with organizations across the U.S. to support integrated, status neutral approaches to HIV care:

- **Encouraging grantees to deliver integrated services.** Several of CDC's major funding programs provide flexible resources for health department and community-based organization (CBO) partners to deliver integrated HIV prevention services. Additionally, CDC encourages health departments that receive funding through CDC's flagship prevention and surveillance program to use these resources to support programs that adopt status neutral approaches to HIV prevention and treatment.

  - ***Ending the HIV Epidemic* initiative implementation:** In July 2021, CDC awarded the second major round of EHE funding — approximately $117 million — to health departments representing 57 prioritized jurisdictions to scale up focused, local efforts designed to address the unique barriers to HIV prevention in each community. CDC encourages grantees to coordinate with STD and viral hepatitis programs, LGBTQ health centers, criminal justice and correctional facilities, and other providers to deliver HIV services. In addition, the new program provides funding to a subset of jurisdictions to strengthen HIV testing, prevention, and treatment services at dedicated STD clinics.

  - **High-impact HIV prevention through CBOs and health departments:** CDC funded more than 90 CBOs to develop high-impact HIV prevention programs and partnerships, beginning in 2021. These CBOs are required to create HIV programs with the greatest potential to address social and structural determinants of health. CBOs can use CDC funding to help clients navigate essential support services. The program will also support integrated screening for STIs, viral hepatitis, and TB, and referrals for subsequent treatment.

- **Conducting implementation science.** CDC is conducting a pilot program to evaluate a project designed to deliver status neutral HIV services to transgender people. The pilot will support transgender healthcare providers and CBOs in integrating HIV, STI, viral hepatitis, and harm reduction services alongside transgender-specific healthcare. The pilot aims to establish best practices for creating a "one-door" approach for testing and other interventions that can improve the health of transgender people.

- **Building partnerships.** CDC is working with other federal agencies and organizations focused on issues that intersect with HIV and affect health outcomes, like sexual health, mental health, housing, incarceration, employment, and substance use disorder to advance status neutral approaches to HIV prevention and care. For example, the HIV National Strategic Plan incorporates the status neutral framework, creating opportunities to improve systems so they support the provision of status neutral services in the national HIV response. These partnerships will enable the sharing of knowledge and best practices that translates to better implementation science, programs, and services. These partnerships can also support better integration of programmatic efforts in communities.

The Way Forward

It will take time for a status neutral approach to be adopted across the country. Federal agencies, state and local health departments, healthcare providers, and CBOs can take steps now to begin promoting and integrating this approach into their programs and service delivery models if appropriate for their organization or jurisdiction and supported by their community:

- Federal health agencies can provide training, support, and technical assistance to state and local health departments, healthcare providers, and CBOs looking to implement status neutral HIV care. They should prioritize strategies that support front-line providers in more easily creating and implementing status neutral programs. They should also promote cross-agency collaboration to integrate HIV treatment and prevention services over time with other primary care, behavioral health, and social services.

- State and local health departments can review their current funding and care delivery models to further integrate HIV into STI and primary care settings, especially community health centers, sexual health clinics, and health access points for people who use drugs. They should also identify ways to braid funding from multiple sources, and work with CBOs and other providers to gather and share best practices and lessons learned in implementing status neutral HIV care.

- Healthcare providers and CBOs can offer dynamic, supportive care that integrates culturally affirming messages and prioritizes each patients' individual needs. They can consider providing non-HIV services that can improve patients' overall health, such as STI and viral hepatitis screening, mental health care, and substance use counselling, as well as linkage to social services. They can also participate in regular trainings on recognizing and addressing implicit racial/ethnic and other biases.

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January 17, 2023

Dear Grantee:

The Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) encourage public health partners to implement status neutral approaches to HIV care and prevention. Status neutral service provision is an example of a syndemic approach to public health, weaving together resources from across infectious disease areas and incorporating social determinants of health to deliver whole-person care, regardless of a person's HIV status. Thanks to a robust toolbox that includes antiretrovirals for prevention such as pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) as well as for treatment [Treatment as Prevention (TasP) or Undetectable= Untransmittable (U=U)], and syringe service programs (SSPs), there are more tools than ever to prevent HIV. However, to realize the full potential of these tools, we need to ensure they can be accessed by every person who could benefit from them by removing barriers to services. Employing a status neutral approach and providing comprehensive care for all people, regardless of HIV status, can help reduce HIV stigma, prioritize health equity, and turn the tide on HIV-related disparities.

Historically, HIV care has often focused on specific service categories based on a person's HIV status rather than providing comprehensive services that everyone needs to get and stay healthy. A status neutral approach:

- Creates "one door" for both HIV prevention and treatment services.
- Addresses institutionalized HIV stigma by integrating prevention and care rather than supporting separate systems, which can deepen the divide between people with HIV and people who can benefit from HIV prevention services.
- Enables people to know their status by making HIV testing and subsequent actions more accessible and routine.

Furthermore, a status neutral framework encourages a comprehensive, whole-person assessment of a person's unique situation, allowing for more tailored—and therefore likely more successful—interventions.

To meet national HIV prevention goals and advance health equity, CDC and HRSA HAB recognize the importance of adopting new and innovative ways of delivering HIV prevention and care services to all who could benefit from them. This involves reframing how we think about and complement traditional HIV service models to better reach people where they are with services they need, regardless of HIV status with the goal of optimizing their health and quality of life. Implementing a status neutral framework does not require an overhaul of existing care systems. For example, incorporating status neutral approaches could include:

- Implementing HIV prevention and treatment activities in places where people seek other health services, such as sexual health services, mental health and recovery services, and transgender care.
- Making it easy for people to access care in alternative, convenient health care settings that do not require an appointment, like pharmacies and mobile health units.

For more details on how jurisdictions across the country are integrating a status neutral approach into their HIV care services, we encourage you to review CDC's issue brief on status neutral HIV care.

CDC and HRSA HAB support the use of braided funding to reduce barriers to implementation and to help extend the reach of status neutral services. Beyond CDC and HRSA, it is important to look across public and private funding streams to identify ways to also braid other funds into service delivery to achieve a more robust status neutral suite of services where feasible and appropriate. This funding approach can also increase programmatic efficiency. CDC encourages grantees to request technical assistance, if needed, on how best to braid funding from different sources.

To request technical assistance from CDC on the implementation of status neutral services:

- CDC's directly funded health department and CBO partners may request technical assistance support by submitting a request in the CBA Tracking System.
- Organizations not directly funded by CDC may contact their local health department for assistance in submitting a training request.
- For additional questions or assistance, partners may contact HIVCBA@cdc.gov.

Since HRSA's Ryan White HIV/AIDS Program (RWHAP) legislation provides grant funds to be used for the care and treatment of *people diagnosed with HIV,* thus prohibiting the use of RWHAP funds for medical services for HIV-negative clients who are at substantial risk for HIV, HRSA HAB encourages recipients to leverage the existing RWHAP infrastructure, such as risk reduction counseling and targeted HIV testing and referral, to support a status neutral approach within the parameters of the RWHAP legislation.

Similarly, HRSA's Bureau of Primary Health Care (BPHC) supports health centers to deliver comprehensive, culturally competent, high-quality primary health care services to systemically marginalized communities, including more than 200,000 people with HIV each year. HRSA BPHC encourages health centers to utilize Health Center Program funding to expand access to medication to prevent HIV (including PrEP and related services), connect people to care, and ensure services are well coordinated. Grant recipients can leverage BPHC resources and the health center network to promote, adopt, and optimize status neutral approaches while expanding access to high-quality, primary care for the communities they serve.

HRSA BPHC supported health centers seeking additional information on HIV care and treatment best practices – including how to implement a status neutral approach– can leverage the following training and technical assistance (T/TA) resources:

- HRSA's National Training and Technical Assistance Partners (NTTAPs) provide free national-level T/TA to support existing and potential health centers to improve operations and deliver comprehensive primary care services for special and vulnerable populations.
- The Health Center Resource Clearinghouse provides an up-to-date selection of high-quality TA resources relevant to health centers.
- HRSA's State/Regional Primary Care Associations (PCAs) provide T/TA based on statewide and regional needs to help health centers improve programmatic, clinical, and financial performance and operations.

HRSA and CDC are committed to developing and sharing status neutral training opportunities, resources, and tools for partners and grantees, and we look forward to continued collaboration on this effort.

Sincerely,

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Health Resources and Services Administration

DRAFT FOR EXECUTIVE COMMITTEE APPROVAL

SERVICE STANDARDS FOR ORAL HEALTH CARE SERVICES

LOS ANGELES COUNTY
COMMISSION ON HIV

REVIEWED AND UPDATED BY THE SBP COMMITTEE ON 10/4/22-3/6/23.

APPROVED BY THE SBP COMMITTEE ON 3/6/23.

APPROVED BY THE EXECUTIVE COMMITTEE ON 3/23/23

FOR COH APPROVAL 4/13/23

SERVICE STANDARDS: ORAL HEALTH CARE SERVICES

IMPORTANT: The service standards for Oral Health Care Services adhere to requirements and restrictions from the federal agency, Health Resources and Services Administration (HRSA). The key documents used in developing standards are as follows:

Human Resource Services Administration (HRSA) HIV/AIDS Bureau (HAB) Policy Clarification Notice (PCN) # 16-02 *(Revised 10/22/18)*: Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds

HRSA HAB, Division of Metropolitan HIV/AIDS Programs: National Monitoring Standards for Ryan White Part A Grantees: Program – Part A

Service Standards: Ryan White HIV/AIDS Programs

INTRODUCTION

Service standards for the Ryan White HIV/AIDS Part A Program (RWHAP) outline the elements and expectations a service provider should follow when implementing a specific service category. The standards are written for providers for guidance on what services may be offered when developing their Ryan White Part A programs. The standards set the minimum level of care Ryan White-funded agencies offer to clients, however, providers are encouraged to exceed these standards. The Los Angeles County Commission on HIV (COH) developed Oral Health Care Services standards to establish the minimum services necessary to provide oral health care services to people living with HIV. The development of the standards includes guidance from service providers, people living with HIV, the Los Angeles County Department of Public Health Division of HIV and STD Programs (DHSP), members of the Los Angeles County COH Standards and Best Practices Committee (SBP), caucuses, and the public-at-large.

SERVICE DESCRIPTION

Oral health care services are an integral part of primary medical care for all people living with HIV. Most HIV infected patients can receive routine, comprehensive oral health care in the same manner as any other person. All treatment will be administered according to published research and available standards of care. In addition, the COH developed a Dental Implants addendum to provide specific service delivery guidance to Ryan White Part A-funded agencies regarding the provision of dental implants. For more information, see the Oral Health Care Service Standard Addendum.

Service shall include (but not limited to):

- Routine dental care and oral health education and counseling
- Obtaining a comprehensive medical and oral hygiene history and consulting primary medical providers as necessary
- Providing educational, prophylactic, diagnostic and therapeutic dental services to patients with a written confirmation of HIV status

- Providing medication appropriate to oral health care services, including all currently approved drugs for HIV-related oral manifestations
- Providing or referring patients, as needed, to health specialists including, but not limited to, periodontists, prosthodontists, endodontists, oral surgeons, oral pathologists, oral medicine practitioners and registered dietitians
- Maintaining individual patient dental records in accordance with current standards
- Complying with infection control guidelines and procedures established by the California Occupation Safety and Health Administration (Cal-OSHA)

The following are priorities for HIV oral health treatment:

1. Prevention of oral and/or systemic disease where the oral cavity serves as an entry point
2. Elimination of presenting symptoms
3. Elimination of infection
4. Preservation of dentition and restoration of functioning

Recurring themes in this standard include:

- Good oral health is an important factor in the overall health management of people living with HIV.
- Treatment modifications should only be used when a patient's health status demands them.
- Comprehensive evaluation is a critical component of appropriate oral health care services.
- Treatment plans should be made in conjunction with the patient.
- Collaboration with primary medical providers is necessary to provide comprehensive dental treatment.
- Prevention and early detection should be emphasized.

GENERAL CONSIDERATIONS: **There is no justification to deny or modify dental treatment based on the fact that a patient has tested positive for HIV**. Further, the magnitude of the viral load is not an indicator to withhold dental treatment for the patient. If, however, a patient's medical condition is compromised, treatment adjustments, as with any medically compromised patient, may be necessary.

SERVICE/ORGANIZATIONAL LICENSURE CATEGORY

HIV/AIDS oral health care services shall be provided by dental care professionals who have applicable professional degrees and current California State licenses. Dental staff can include dentists, dental assistants, dental assistants in extended functions, dental hygienists, and dental hygienists in extended practice. Clinical supervision shall be performed by a licensed dentist responsible for all clinical operations.

Dentists: A dentist must complete a four-year dental program and possess a Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) degree. Additionally, dentists must pass a

three-part examination as well as the California jurisprudence exam and a professional ethics exam. Dentists are regulated by the California Dental Board (please see Dental Board of California for further information).

Registered Dental Assistants (RDA): RDAs must possess a diploma or certificate in dental assisting from an educational program approved by the California Dental Board, or 18 months of satisfactory work experience as a dental assistant. RDAs are regulated by the California Dental Board (please see Dental Board of California for further information).

Unlicensed Dental Assistants (DA): Unlicensed dental assistants are not licensed by the Dental Board of California, but they are subject to certain laws governing their conduct. Section 150.1 is the statute governing the duties that unlicensed dental assistants are allowed to perform. Unless a specific duty is listed in that regulations, the dental assistant is NOT allowed to perform that duty. A dental assistant may only expose radiographs after successful completion of a board-approved radiation safety course. Dental assistants with certain experience or educational backgrounds may qualify to apply for Registered Dental Assistant (RDA) licensure.

Registered Dental Assistants in Extended Functions (RDAEF)[1]: RDAEF holds a current licensure as a Registered Dental Assistant or has completed the requirements for licensure as a RDA, completed a Board-approved course in the application of Pit & Fissure Sealants, completed a Board-approved RDAEF program, passed a written examination administered by the Board, and submitted fingerprint clearances from both the Department of Justice and the Federal Bureau of Investigation. RDAEFs are regulated by the California Dental Board (please see Dental Board of California for further information).

Registered Dental Hygienists (RDH): RDHs must have been granted a diploma or certificate in dental hygiene from an approved dental hygiene educational program. RDHs are regulated by the California Dental Board (please see Dental Board of California for further information).

Registered Dental Hygienists in Extended Functions (RDHEF)[2]: RDHEF holds a current license as a registered dental hygienist in California, completed clinical training approved by the dental hygiene board in a facility affiliated with a dental school under the direct supervision of the dental school faculty, performed satisfactorily on an examination required by the dental hygiene board, and completed an application form and paid all application fees required by the dental hygiene board. RDHEF are regulated by the California Dental Board (please see Dental Board of California for further information).

[1] Registered Dental Assistant in Extended Functions Applicants - Dental Board of California
[2] Codes Display Text (ca.gov)

SERVICE STANDARDS

All contractors must meet the Universal Standards of Care approved by the COH in addition to the following Oral Health Care Services standards. The Universal Standards of Care can be accessed at: https://hiv.lacounty.gov/service-standards

SERVICE COMPONENT	STANDARD	DOCUMENTATION
INTAKE	Intake process will begin during first contact with client.	Intake took in client file to include (at minimum): • Documentation of HIV status • Proof of LA County residency • Verification of financial eligibility • Date of intake • Client name, home address, mailing address and telephone number • Emergency and/or next of kin contact name, home address and telephone number
	Confidentiality Policy and Release of Information will be discussed and completed.	Release of Information signed and dated by client on file and updated annually.
	Consent for Services will be completed.	Signed and dated Consent in client file.
	Client will be informed of Rights and Responsibilities and the Division on HIV and STD Programs (DHSP) Customer Support Program[3].	Signed, dated forms in client file.
EVALUATION When presenting for dental services, people living with HIV should be given a comprehensive oral	A comprehensive oral evaluation will be given to patients living with HIV and will include: • Documentation of patient's presenting complaint	Signed, dated evaluation on file in patient chart.

[3] The program aims to assist consumers of HIV and STD services who have experienced difficult accessing services from DHSP-funded providers throughout Los Angeles County.

evaluation. When indicated, diagnostic tests relevant to the evaluation of the patient should be performed and used in diagnosis and treatment planning. In addition, full medical status information from the patient's medical provider, including most recent lab work results, should be obtained, and considered by the dentist	• Caries charting • Radiographs or panoramic and bitewings and selected periapical films • Complete periodontal exam or PSR (Periodontal Screening Record) • Comprehensive head and neck exam • Complete intra-oral exam, including evaluation for HIV-associated lesions • Pain assessment	
	As indicated, diagnostic tests relevant to the evaluation will be used in diagnosis and treatment planning. Biopsies of suspicious oral lesions will be taken.	Signed, dated evaluation in patient chart to detail additional tests.
	Full medical status information will be obtained from the patient's medical provider and considered in the evaluation. The medical history and current medication list will be updated regularly to ensure all medical and treatment changes are noted.	Signed, dated evaluation in patient chart to detail medical status information.
	Obtain a thorough medical, dental, and psychosocial history to assess the patient's oral hygiene habits and periodontal stability and determine the patient's capacity to achieve dental implant success and the possibility of dental implant failure.	Client Chart/Treatment Plan/Provider Progress Notes
	Clinician, after patient assessment, will make necessary referrals to specialty programs including, but not limited to smoking cessation	

	programs; substance use treatment; medical nutritional therapy, thereby increasing patients' success rate for receiving dental implants.	
	The clinicians referring patients to specialty Oral Healthcare services will complete a referral form, educate the patient, and discuss treatment plan alternatives with patient.	
TREATMENT PLANNING In conjunction with the patient, each dental provider shall develop a comprehensive, multidisciplinary treatment plan. The patient's primary reason for the visit should be considered by the dental professional when developing the dental treatment plan. Treatment priority should be given to the management of pain, infection, traumatic injury, or other emergency conditions. Dental provider will support and reinforce patient understanding, agreement, and education in the patient's treatment plan. Ensure patient understanding that dental implants are for medical necessity (as determined by the dental provider through assessments and evaluation) and would lead to improved	A comprehensive, multidisciplinary treatment plan will be developed in conjunction with the patient.	Treatment plan dated and signed by both the provider and patient in patient file.
	Patient's primary reason for dental visit should be addressed in treatment plan.	Treatment plan dated and signed by both the provider and patient in the patient file to detail.
	Patient strengths and limitations will be considered in development of treatment plan.	Treatment plan dated and signed by both the provider and patient in patient file to detail.
	Treatment priority will be given to pain management, infection, traumatic injury, or other emergency conditions.	Treatment plan dated and signed by both the provider and patient in patient file to detail.
	Treatment plan will include consideration of the following factors: • Tooth and/or tissue supported prosthetic options • Fixed protheses, removable prostheses or combination • Soft and hard tissue characteristics and morphology, ridge relationships, occlusion and occlusal forces, aesthetics, and parafunctional habits	Treatment plan dated and signed by both the provider and patient in file to detail.

HIV health outcomes. Reinforce that Ryan White funds cannot be used to provide dental implants for cosmetic purposes.	• Restorative implications, endodontic status, tooth position and periodontal prognosis • Craniofacial, musculoskeletal relationships	
	Six-month recall schedule will be used to monitor any changes. A three-month recall schedule may be considered to limit disease progression and maintain healthy periodontal tissues in advanced cases of periodontitis or caries.	Signed, dated progress note in patient file to detail.
	Treatment plans will be updated as deemed necessary.	Signed, dated progress note in patient file to detail.
	The receiving clinician will review the referral, consider the patient's medical, dental, and psychosocial history to determine treatment plan options that offer the patient the most successful outcome based on published literature. The clinician will discuss with patient dental implant options with the goal of achieving optimal health outcomes.	Referral in Client Chart/Treatment Plan/Provider Progress Notes
	The clinician will consider the patient's perspective in deciding which treatment plan to use.	Client Chart/Treatment Plan/Provider Progress Notes
	The clinician will discuss treatment plan alternatives with the patient and collaborate with the patient to determine their treatment plan.	
	The clinician and the patient will revisit the treatment plan periodically to determine if any	

	adjustments are necessary to achieve the treatment goal.	
	The clinician will educate patients on how to maintain dental implants and the importance of routine care.	
INFORMED CONSENT Patients will sign an informed consent document for all dental procedures. This informed consent process will be ongoing as indicated by the dental treatment plan.	As part of the informed consent process, dental professionals will provide the following before obtaining consent: • Diagnostic information • Recommended treatment • Alternative treatment • Benefits and risks of treatment • Limitations of treatment	Signed, dated progress note or informed consent in patient field to detail.
	Dental providers will describe all options for dental treatment and allow the patient to be part of the decision-making process.	Signed, dated progress note or informed consent in client file to detail.
	After the informed consent discussion, patients will sign an informed consent for all dental procedures.	Signed, dated informed consent in client file.
	This informed consent process will be ongoing as indicated by the dental treatment plan.	Ongoing signed, dated informed consents in client file (as needed).
MEDICAL CONSULTATION AND PRIMARY CARE PARTICIPATION Dentists can play an important part in reminding patients of the need for regular primary medical care and CBC, CD4, viral load tests every three to six months depending on the past history of HIV infection and level of suppression achieved	Primary care physicians will be consulted when providing dental treatment.	Signed, dated progress note to detail consultations.
	Primary care physicians will be consulted when providing dental treatment depending on the medical needs of the patient. Consultation with medical providers will be: • To obtain the necessary laboratory test results • When there is any doubt about the accuracy of the	Signed, dated progress note to detail consultations.

and encouraging patients to adhere to their medication regimens. However, even the highest number of viral copies has no impact on the provision of dental care. If a patient is not under the regular care of a primary care physician, the patient should be urged to seek care and a referral to primary care will be made.	information provided by the patient • When there is a change in the patient's general health, determine the severity of the condition and the need for treatment modifications • If after evaluating the patient's medical history and the laboratory tests, the oral health provider decides that treatment should occur in a hospital setting • New medications are indicated to ensure medication safety and prevent drug/drug interactions • Oral opportunistic infections are presents	
	Dentists will encourage consistent medical care in their patients and provide referrals as necessary. Under certain circumstances, dental professionals may require further medical information to determine safety and appropriateness of care.	Signed, dated progress notes to detail referrals and discussion.
	Programs may decide to discontinue oral health services if a client has not engaged in primary medical care. Patients will be made aware of this policy at time of intake into the program.	Signed, dated progress notes to detail referrals and discussion. Policy on file at provider agency. Intake materials will also state this policy.
	Under certain circumstances, dental professionals may require further medical information to determine	Signed, dated progress notes to detail discussion.

	safety and appropriateness of care.	
PREVENTION/EARLY INTERVENTION Dental professionals will emphasize prevention and early detection of oral disease by educating patients about preventive oral health practices, including instruction in oral hygiene. In addition, dental professionals may provide counseling regarding behaviors (e.g., tobacco use, unprotected oral sex, body piercing in oral structures) and general health conditions that can compromise oral health. The impact of good nutrition on preserving good oral health should be discussed.	Dental professionals will educate patients about preventive oral health practices.	Signed, dated progress note in patient file to detail education efforts.
	Routine examinations and regular prophylaxis will be scheduled twice a year.	Signed, dated progress note or treatment plan in patient file to detail schedule.
	Dental professionals will provide basic nutritional counseling to assist in oral health maintenance. Referrals to an RD and others will be made, as needed.	Signed, dated progress note to detail nutrition discussion and referrals made.
	Root planing/scaling will be offered as necessary, either directly or by referral.	Signed, dated progress note or treatment plan in patient file to detail.
SPECIAL TREATMENT CONSIDERATIONS	As indicated, the following modifications to standard dental treatment should be considered: • Bleeding tendencies may determine whether or not to recommend full mouth scaling and root planning or multiple extractions in one visit. • In severe cases, patients may be treated more sagely in a hospital environment where blood transfusions are available. • Deep block injections should be avoided in patients with bleeding tendencies. • A pre-treatment antibacterial mouth rinse	Signed, dated process note or treatment plan in patient file to detail treatment modifications and referrals.

	should be used for those patients with periodontal disease. • Patients with salivary hypofunction should be closely monitored for caries, periodontitis, soft tissue lesions and salivary gland disease. • Fluoride supplements should be prescribed for those with increase caries and salivary hypofunction. Referral to dental professional experiences in oral mucosal and salivary gland diseases should be made in severe cases of xerostomia.	
	Routine examinations and regularly prophylaxis will be scheduled twice a year.	Signed, dated progress note or treatment plan in patient file to detail scheduled.
	Root planning/scaling will be offered as necessary, either directly or by referral.	Signed, dated progress note or treatment plan in patient file to detail.
TRIAGE, REFERRAL, COORDINATION On occasion, patients will require a higher level of oral health treatment services than a given agency is able to provide. Coordinating oral health care with primary care medical providers is vital. Regular contact with a client's primary care clinic will ensure integration of services and better client care. Train referring dental providers on how to	As needed, dental providers will refer patients to full range of oral health care providers, including: • Periodontists • Endodontists • Prosthodontists • Oral surgeons • Oral pathologists • Oral medicine practitioners	Signed, dated progress note to document referrals in patient chart.
	Providers will attempt to contact a client's primary care clinic if required or as clinically indicated to coordinate and integrate care.	Documentation of contact with primary medical clinics and providers to be placed in progress notes. In

adequately complete referral forms to allow more flexibility in treatment planning for receiving specialty dental providers.		
OUTREACH Programs providing dental care for people living with HIV will actively promote their services through known linkages and direct outreach.	Programs will promote dental services for people living with HIV through linkages or outreach.	Service promotion/outreach plan on file at provider agency.
CLIENT RETENTION	Programs shall develop a broken appointment policy to ensure continuity of service and retention of clients.	Written policy on file at provider agency.
	Programs shall provide regular follow-up procedures to encourage and help maintain a client in oral health treatment services.	Documentation of attempts to contact in signed, dated progress notes. Follow-up may include: • Telephone calls • Written correspondence • Direct contact • Text messaging
STAFFING REQUIREMENTS AND QUALIFICATIONS	Provider will ensure that all staff providing oral health care services will possess applicable professional degrees and current California state licenses.	Documentation of professional degrees and licenses on file.
	Providers shall be trained and oriented before providing oral health care services both in general dentistry and HIV specific oral health services. Training will include: • Basic HIV information • Office and policy orientation • Infection control and sterilization techniques	Training documentation on file maintained in personnel record.

	• Methods of initial evaluation of the patient living with HIV disease • Health maintenance education and counseling • Recognition and treatment of common oral manifestations and complications of HIV disease • Recognition of oral signs and symptoms of advanced HIV disease	
	Oral health care providers will practice according to California state law and the ethical codes of their respective professional organizations.	Chart review will ensure legally and ethically appropriate practice.
	Dentist in charge of dental operations shall provide clinical supervision to dental staff.	Documentation of supervision on file.
	Dental care staff will complete documentation required by program.	Periodic chart review to confirm.
	Providers will seek continuing education about HIV disease and associated oral health treatment considerations.	Documentation of trainings in employee file.

ACRONYMS

AIDS *Acquired Immune Deficiency Syndrome*
CAL-OSHA *California Occupation Safety and Health Administration*
CD4 *Cluster Designation 4*
DDS *Doctor of Dental Surgery*
DHSP *Division of HIV and STD Programs*
HBV *Hepatitis B Virus*
HIPAA *Health Insurance Portability and Accountability Act*
HIV *Human Immunodeficiency Virus*
RDA *Registered Dental Assistant*
RDAEF *Registered Dental Assistant in Extended Functions*
RDH *Registered Dental Hygienists*
RDHEF *Registered Dental Hygienist in Extended Functions*
STI *Sexually Transmitted Infection*

DEFINITIONS AND DESCRIPTIONS

Client registration and intake is the process that determines a person's eligibility for oral services.

Oral prophylaxis is a preventive dental procedure that includes the complete removal of calculus, soft deposits, plaque, and stains from the coronal portions of the tooth. This treatment enables a patient to maintain healthy hard and soft tissues.

Direct supervision is supervision of dental procedures based on instructions given by a licensed dentist who must be physically present in the treatment facility during performance of those procedures.

General supervision is the supervision of dental procedures based on instructions given by a licensed dentist, but not requiring the physical presence of the supervising dentist during the performance of those procedures.

Basic supportive dental procedures are the fundamental duties or functions which may be performed by an unlicensed dental assistant under the supervision of a licensed dentist because of their technically elementary characteristics, complete reversibility, and inability to precipitate potentially hazardous conditions for the patient being treated.

Standard precautions are an approach to infection control that integrates and expands the elements of universal precautions (human blood and certain human body fluids treated as if known to be infectious for HIV, Hepatitis B Virus (HBV) and other blood-borne pathogens). Standard precautions apply to contact with all body fluids, secretions, and excretions (except for sweat), regardless of whether they contain blood, and to contact with non-intact skin and mucous membranes.

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Explaining Litigation Challenging the ACA's Preventive Services Requirements: Braidwood Management Inc. v. Becerra

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Since the enactment of the Affordable Care Act (ACA) in 2010, more than 2,000 legal challenges (https://www.law.georgetown.edu/georgetown-law-journal/wp-content/uploads/sites/26/2020/06/Gluck-Reagan-Turret_The-Affordable-Care-Act%E2%80%99s-Litigation-Decade.pdf) have been filed in state and federal courts contesting part or all of the ACA. The most recent challenge involves the ACA requirement that most private insurance plans cover recommended preventive care services without cost sharing. In this case, *Braidwood Management v. Becerra*, Christian owned businesses and six individuals in Texas assert that (1) the requirements in the law for specific expert committees and a federal government agency to recommend covered preventive services is unconstitutional, and that (2) the requirement to cover preexposure prophylaxis (PrEP), medication for HIV prevention, violates their religious rights. If the plaintiffs prevail on either the constitutional or the religious claims, the government's ability to require insurance plans to cover evidence-based preventive services without cost-sharing may be limited.

On September 7, 2022, Judge Reed O'Connor at the US District Court in the Northern District of Texas ruled (https://affordablecareactlitigation.files.wordpress.com/2022/09/gov.uscourts.txnd_.330381.92.0_1.pdf) partly in favor of the plaintiffs and partly in favor of the Department of Health and Human Services (HHS), which is defending the ACA. On March 30, 2023, Judge O'Connor issued a ruling (https://storage.courtlistener.com/recap/gov.uscourts.txnd.330381/gov.uscourts.txnd.330381.114.0.pdf) for the remedy (https://storage.courtlistener.com/recap/gov.uscourts.txnd.330381/gov.uscourts.txnd.330381.113.0.pdf) in this case, *Braidwood Management v. Becerra*, striking down part of the ACA's

requirement for no cost coverage of preventive services recommended or updated by the U.S. Preventive Services Task Force (USPSTF) on or after March 23, 2010 and finding that the requirement to cover PrEP medications for HIV prevention violates the rights of the plaintiffs who have religious objections to PrEP. This order immediately blocks the requirement nationwide to cover preventive services recommended or updated by USPSTF after March 2010. The federal government is appealing this decision to the 5th Circuit Court of Appeals. This brief explains the preventive services coverage requirements, the basis of the lawsuit, next steps in the litigation, and the potential implications.

Preventive Services Provision

The ACA requires most private health insurance plans to cover a range of recommended preventive services (https://www.kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/) without any patient cost-sharing. Preventive services include a range of services including screening tests, immunizations, behavioral counseling, and medications that can prevent the development or worsening of diseases and health conditions. The preventive services that private plans and Medicaid expansion programs must cover are based on those receiving an A or B level recommendation by the U.S. Preventive Services Task Force (USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations)), vaccines recommended by the Advisory Committee on Immunization Practices (ACIP (http://www.cdc.gov/vaccines/hcp/acip-recs/index.html)), and the Health Resources and Services Administration (HRSA (https://www.hrsa.gov/womens-guidelines-2016/index.html)) based on recommendations issued by the Women's Preventive Services Initiative (https://www.womenspreventivehealth.org/recommendations/) and issued by the Bright Futures for Children program. As new recommendations are issued or updated, coverage must commence in the next plan year that begins on or after exactly one year from the recommendation's issue date.

Judge Reed O'Connor has heard multiple challenges to the ACA

U.S District Judge Reed O'Connor, an appointee of President George W. Bush, has been the "go-to" judge for plaintiffs challenging the ACA. In 2018, he ruled that the entire ACA was unconstitutional because Congress zeroed out the tax penalty. The Supreme Court ultimately ruled the other way and upheld the ACA. In June 2019, Judge O'Connor issued a permanent injunction against the ACA's contraceptive coverage requirement, blocking the federal government from enforcing it against employers and individuals who object to contraceptive coverage. Judge O'Connor has also ruled in favor of the plaintiffs in challenges to the ACA Section 1557 (https://www.kff.org/report-section/the-trump-administrations-final-rule-on-section-1557-non-discrimination-regulations-under-the-aca-and-current-status-tables/).

Preventive Services Litigation

In the current case, *Braidwood Management Inc. v. Becerra*, the plaintiffs claim that the preventive services requirements for private health insurance are unconstitutional and the requirement to cover PrEP-specific coverage requirement violates the Religious Freedom Restoration Act (RFRA) (**Table 2**). The plaintiffs are six individuals and Christian owned businesses. Braidwood Management, a for-profit closely held organization, owned by a trust, with Dr. Steven F. Hotze, a religious Christian, as the sole trustee and beneficiary. Braidwood is self-insured and provides health insurance it its 70 employees. The other plaintiff is Kelley Orthodontics, a Christian professional association owned by plaintiff John Kelley. The plaintiffs are asserting both economic harm for having to pay more money for a health plan that includes services they do not want or need, and religious harm for having to include services they object to.

Plaintiff Claims

POSITION 1: THE PREVENTIVE SERVICES PROVISION VIOLATES THE APPOINTMENTS CLAUSE

The plaintiffs contend that the ACA provisions violate the Appointments Clause of the US Constitution, which provides that "officers of the United States" may only be appointed by the president, subject to the advice and consent of the Senate. They claim that the members of USPSTF, ACIP and HRSA are "officers of the United States" who have not been appointed in conformity with the Appointments Clause because they were not nominated by the President and approved by the Senate. Rather, members of these bodies are appointed by the heads of agencies within HHS (**Table 1**). The plaintiffs are asking the court to declare all preventive-care mandates based on recommendations or guidelines issued by USPSTF, ACIP or HRSA after March 23, 2010 (the day the ACA was signed into law) as unconstitutional. The plaintiffs contend that the ACA does not allow the Secretary of HHS or the directors of the agencies within HHS to reject the recommendations made by the committees and is thus insufficient oversight.

Conversely, HHS contends (https://affordablecareactlitigation.files.wordpress.com/2021/03/kelley-us-mo-dism.pdf) that "there are numerous statutes that incorporate by reference independent recommendation without creating any requirements that the heads of the recommending bodies be appointed as officers of the United States." They cite examples such as a public health regulation (https://www.law.cornell.edu/uscode/text/42/6293) related to water standards for consumer products that outsources the development of those standards to a non-governmental organization. Similarly, they cite a law (https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title4-section119&num=0&edition=prelim) requiring states and designated database providers

to use a format for an electronic database approved by an expert panel (https://x12.org/#:~:text=What%20is%20X12%3F,upholding%20America's%20electronic%20information%20exchange.) that is not subject to approval by the head of a federal agency.

Table 1: Committees Issuing Recommendations for Preventive Services

Recommending Entity	Role of the Agency	Process for Appc Oversi
United States Preventive Services Task Force (USPSTF)	The U.S. Preventive Services Task Force (https://www.uspreventiveservicestaskforce.org/uspstf/) is an independent, volunteer panel of national experts in disease prevention and evidence-based medicine. The Task Force works to improve the health of people nationwide by making evidence-based recommendations about clinical preventive services.	• USPSTF memb appointed by of AHRQ to se terms. • USPSTF recom are not subjec oversight or a
Advisory Committee on Immunization Practices (ACIP)	The ACIP (https://www.cdc.gov/vaccines/acip/committee/charter.html) shall provide advice and guidance to the Director of the CDC regarding use of vaccines and related agents for effective control of vaccine-preventable diseases in the civilian population of the United States.	• The Secretary Department o Human Servic members follo application ar process. • Recommenda the ACIP are r the CDC Direc adopted, are p official CDC/H recommendat determines in coverage polic
Health Resources and Services Administration (HRSA) – Women's Preventive Services Initiative	HRSA (https://www.hrsa.gov/about) is an agency of the U.S. Department of Health and Human Services that operates programs intended to provide equitable health care to people who are geographically isolated and economically or medically vulnerable.	• HRSA contract external organ currently ACO a panel of exp Women's Prev Services Initia make and upd recommendat women's prev services. • HRSA can acce recommendat determines in coverage requ
HRSA — Bright Futures for Children	HRSA (see above)	• HRSA uses the developed by Futures Progr (https://mchb.hr

		impact/program futures) to iden informed guic preventive ca and routine vi newborns thr adolescents u The American Pediatrics (AA experts in pec with support f review scienti and recomme

PLAINTIFF POSITION 2: THE PREVENTIVE SERVICES PROVISION VIOLATES THE NONDELEGATION DOCTRINE

The plaintiffs contend the ACA's preventive services provisions violate the nondelegation doctrine – based on the theory that since Article I of the Constitution vests legislative power in Congress, there are limits to the authority that Congress can delegate to federal administrative agencies. The current caselaw precedent requires statutes that delegate authority to agencies to supply an "intelligible principle" to guide and provide a boundary or limit on the agency's discretion. The plaintiffs contend that an "intelligible principle" is lacking: "Yet there is nothing in the text of section 300gg-13(a) that purports to guide the discretion of [US]PSTF, ACIP or HRSA when choosing the preventive care that private insurance must cover." The plaintiffs contend that this constitutional nondelegation problem can be averted if the phrase "current recommendations is construed to refer to the recommendations that existed when the ACA was signed into law."

The plaintiffs point to comments in the Supreme Court's opinion in *Little Sisters of the Poor* (https://www.scotusblog.com/case-files/cases/little-sisters-of-the-poor-saints-peter-and-paul-home-v-pennsylvania/), as evidence that the current majority believes there could be a constitutional issue with delegation to HRSA for preventive services for women, including contraception: "On its face, then, the provision grants sweeping authority to HRSA to craft a set of standards defining the preventive care that applicable health plans must cover. But the statute is completely silent as to what those "comprehensive guidelines" must contain, or how HRSA must go about creating them. The statute does not, as Congress has done in other statutes, provide an exhaustive or illustrative list of the preventive care and screenings that must be included." While the Little Sisters case, challenging the contraceptive coverage regulations, was not decided based on the nondelegation doctrine, there is growing speculation (https://www.healthaffairs.org/content/forefront/us-supreme-court-strike-down-aca-s-preventive-services-coverage-requirement) that the Supreme Court is poised to revisit the nondelegation doctrine to make it more difficult for Congress to delegate authority to federal agencies to address major policy details.

PLAINTIFF POSITION 3: THE PREVENTIVE SERVICES PROVISION VIOLATES THE RELIGIOUS FREEDOM RESTORATION ACT

The plaintiffs assert the requirements to cover PrEP violates the Religious Freedom Restoration Act. Relying on the Supreme Court's ruling in *Burwell v. Hobby Lobby* (https://casetext.com/case/burwell-v-hobby-lobby-stores-inc-1), the plaintiffs contend that employers are left with a "Hobson Choice" to provide health insurance that covers these medications and services that violate their religious beliefs or refuse to offer any health insurance to its employees. Notably, the plaintiffs state the requirement to cover PrEP "imposes a substantial burden on the religious freedom of those who oppose homosexual behavior on religious grounds" claiming further that PrEP drugs "facilitate and encourage homosexual behavior, prostitution, sexual promiscuity, and intravenous drug use." The plaintiffs also contend the provision violates individuals who have religious objections and wish to purchase health insurance without PrEP coverage.

District Court's Decision

Finding that Braidwood has standing to pursue its claims, on September 7, 2022, Judge O'Connor ruled (https://www.courthousenews.com/wp-content/uploads/2022/09/braidwood-becerra-ruling-usdc-texas.pdf) that that the ACA's delegation to U.S. Preventive Services Task Force violates the Appointments Clause because the Secretary cannot direct USPSTF to give a specific preventive service an "A" or "B" rating . The Court finds that the Secretary does not have any authority to direct which services are covered under § 300gg-13(a)(1) and concludes that USPSTF members are officers of the United States and that their selection does not comply with the Appointments Clause procedures. However, the Court also found that the ACA's delegation to ACIP and HRSA are not in violation of the Appointments Clause since the Secretary of HHS effectively has the authority to ratify or not the ACIP and HRSA recommendations.

The court rejected the plaintiff's nondelegation doctrine claims stating that the preventive care law met the criteria set out in prior Fifth Circuit cases on when Congress has properly provided an "intelligible principle" to guide agency discretion. Judge O'Connor noted that the Supreme Court might soon "reexamine or revive" the nondelegation doctrine, but it's too early to predict a change in the nondelegation criteria from comments made in the *Little Sisters* case.

Relying on the reasoning in the Supreme Court's decision in Hobby Lobby (https://casetext.com/case/burwell-v-hobby-lobby-stores-inc-1), the District Court also found that the requirement to cover PrEP violates Braidwood's religious rights under the Religious Freedom Restoration Act (RFRA).

On March 30, 2023, District Court Judge O'Connor issued a ruling (https://storage.courtlistener.com/recap/gov.uscourts.txnd.330381/gov.uscourts.txnd.330381.114.0.pdf) for the remedy (https://storage.courtlistener.com/recap/gov.uscourts.txnd.330381/gov.uscourts.txnd.330381.113.0

.pdf) in the case, *Braidwood Management v. Becerra*, striking down part of the ACA's coverage requirement for preventive services. Effective immediately nationwide, the ruling blocks the federal government from requiring health plans to cover services recommended or updated by the U.S. Preventive Services Task Force (USPSTF) on or after March 23, 2010. The ruling did not affect coverage requirements for USPSTF services (https://www.kff.org/policy-watch/qa-implications-of-the-ruling-on-the-acas-preventive-services-requirement/) recommended prior to that date and also did not affect the requirement for plans to cover Women's Preventive Services recommended by Health Resources and Services Administration (HRSA) or vaccines recommended by the CDC's Advisory Committee on Immunization Practices (ACIP). Additionally, the judge ruled that the requirement to cover PrEP medications for HIV prevention violates the rights of the plaintiffs who have religious objections to PrEP. The federal government is appealing (https://storage.courtlistener.com/recap/gov.uscourts.txnd.330381/gov.uscourts.txnd.330381.115.0.pdf) this decision to the United States Court of Appeals for the 5th Circuit. It is not yet known whether the district court's ruling will be blocked while the litigation proceeds. For more details about how this ruling impacts no-cost coverage of preventive services, please see the KFF Q&A: Implications of the Ruling on the ACA's Preventive Services Requirement. (https://www.kff.org/policy-watch/qa-implications-of-the-ruling-on-the-acas-preventive-services-requirement/)

Implications for Coverage and Access to Preventive Services in Private Health Insurance

Even if the Court's ruling upholds the authority of HRSA and ACIP, USPSTF recommendations include a broad range of services across multiple populations and health conditions. This includes cancer screenings, preventive medications for chronic conditions such as cardiovascular disease, counseling on health behaviors related to nutrition and weight management, alcohol and drug use, tobacco cessation services, screening for depression, and prenatal services, Elimination of the coverage requirements for USPSTF recommendations would invalidate the requirement to cover all of these services without cost sharing.

Religious Objections to PrEP Coverage

The ACA's contraceptive coverage provision has been one of the most litigated parts of the law, with three cases brought by employers who object to the coverage on religious grounds reaching the Supreme Court. The Court's ruling on the PrEP coverage requirement is the first time a court has ruled in favor of plaintiffs challenging another preventive service based on religious objections.

If employers who object to including coverage for PrEP in their plans are allowed to exclude the coverage, employees could lose coverage for a medication that could prevent the transmission of HIV and HIV related morbidity and mortality. PrEP reduces the risk (https://www.cdc.gov/hiv/basics/prep/prep-effectiveness.html) of acquiring HIV by approximately 99% through sex and 74% through injection drug. Given that

over 80% (https://www.cdc.gov/mmwr/volumes/67/wr/mm6741a3.htm#T1_down) of PrEP users are covered by commercial insurers, this could have significant ramifications for cost and access should the ruling be applied broadly. The cash price for generic PrEP (Emtricitabine / Tenofovir), which is about 99% effective (https://www.cdc.gov/hiv/basics/prep/prep-effectiveness.html)at preventing HIV through sex, is approximately $30 per month (https://www.goodrx.com/truvada?form=tablet&dosage=200mg-300mg&quantity=30&label_override=emtricitabine-tenofovir). This compares to an estimated lifetime HIV treatment cost (https://journals.lww.com/stdjournal/Fulltext/2021/04000/Estimated_Lifetime_HIV_Related_Medical_Costs_in.15.aspx)of $420,285 ($1,079,999 undiscounted).

In addition, allowing employers to exclude PrEP because of religious objections has the potential to open the door to employers objecting to other services, such as vaccines.

Implications for Access to Preventive Services in Medicaid & Medicare

While the plaintiffs in Braidwood are only challenging the preventive services required in private health insurance plans, Medicaid and Medicare also have requirements for coverage of preventive services. States that have expanded Medicaid eligibility under the ACA must cover Essential Health Benefits (EHBs) as defined by the ACA. One of the categories of EHBs is *preventive services*, which CMS (https://www.cms.gov/cciio/resources/files/downloads/ehb-faq-508.pdf) has defined to include the same services as required for private insurance plans. As a result, all states must cover the preventive services recommended by USPSTF, ACIP and HRSA for enrollees who qualify through the Medicaid expansion pathway. If this litigation is successful in challenging any of the preventive services required in private health insurance plans, the requirement for preventive services for enrollees who qualify through the Medicaid expansion pathway would be left to individual states to determine based on their state private insurance benchmark plan, which may not include all the services currently required.

While Medicaid relies on the same agencies to determine the recommended services as private insurance plans must cover, the process is slightly different under Medicare. In that case, under the national coverage determination process, the Secretary of HHS has the authority to determine coverage for preventive services for Medicare beneficiaries. The ACA eliminated Medicare cost sharing, including coinsurance and deductibles, for most preventive benefits that are rated A or B by the USPSTF, beginning in 2011, and authorized the Secretary of HHS to add coverage for new preventive services, using the national coverage determination process, if they are: reasonable and necessary for prevention or detection of illness; rated A or B by the USPSTF; and appropriate for Medicare beneficiaries. Coverage under Medicare for several preventive services (https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-

section1395x&num=0&edition=prelim), including some rated A or B by the USPSTF, predated the ACA and is specified in statute, and therefore would not be affected by any ruling on the current litigation.

The current litigation is brought by employers and individuals who allege economic and religious harm from the preventive services requirements in private health insurance. Any litigation challenging the preventive services requirements under Medicaid or Medicare would need to be brought by plaintiffs who suffer a tangible harm to establish legal standing.

Broader Implications

Overturning the preventive services requirement broadly would have significant implications for coverage of a broad range of clinical preventive services. Should the final decision for this case be found in favor of the plaintiffs, and applied nationwide, then millions of people (https://aspe.hhs.gov/sites/default/files/documents/786fa55a84e7e3833961933124d70dd2/preventive-services-ib-2022.pdf) may be vulnerable to loss of guaranteed coverage of preventive services without cost sharing. It will again be at the discretion of plans and employers to determine what preventive services will be covered and whether they will charge cost-sharing, lowering premiums in some cases, but likely creating a patchwork of coverage for these services. This could widen access barriers for groups that already face increased barriers dure to cost, including low-income people and people of color.

Should this case reach the US Supreme Court, the broader implications of a final decision in favor of the plaintiffs will depend on the basis for the ruling. The Court could rule in favor of the plaintiffs based on the Appointments Clause argument, similar to Judge O'Connor's decision, finding that USPSTF members are officers of the United States who have not been properly appointed.

The potential implications are much broader, however, if the Supreme Court revisits and revises the nondelegation doctrine and restricts Congress' ability to delegate the development of very precise standards to federal agencies. Without allowing the agencies to update the recommended preventive services, Congress would have to pass a new law every time the USPSTF recommends a new preventive service in order for it to be covered without cost-sharing. Any decision that changes the standard for Congress' delegation could limit agency discretion to address a broad range of health and other issues through regulation.

Beyond preventive care, much of health policy and law has been developed through the delegation of authority to federal agencies to develop standards to address complex public policy and technical requirements—from the prescription drug approval process of the FDA to the apparatus set up to review and annually update the Medicare fee schedule. The ACA itself specifically left it up to the Secretary of HHS to define the essential health benefits that insurers must cover in the individual and small group insurance markets within the framework of the ten

categories of items and services that Congress set out. The authority Congress gave to HHS to temporarily waive certain healthcare requirements during the COVID public health emergency is probably the best example of how delegated authority has functioned to benefit public health as well as access to public and private health insurance coverage. Any movement by the Court to restrict Congress' authority to delegate in these areas could have a profound effect on the daily lives of Americans.

We do not know how quickly the United States Court of Appeals for the 5th Circuit will rule on this case. Ultimately, the partis are likely to appeal to the Supreme Court.

Table 2: *Braidwood v. Becerra*: Litigation Challenging the ACA's Preventive Services Provision: Summary of the Plaintiffs' and Government's Position

Claim: The ACA preventive services provisions (42 U.S.C. § 300gg-13(a)(1)–(4)) Violate The Appointments Clause because the members of the committees act as "officers of the United States" and have not be properly appointed

The Appointments Clause provides: [The President] shall have Power, by and with the Advice and Consent of the Senate, to . . . appoint Ambassadors, other public Ministers and Consuls, Judges of the supreme Court, and all other Officers of the United States, whose Appointments are not herein otherwise provided for, and which shall be established by Law: but the Congress may by Law vest the Appointment of such inferior Officers, as they think proper, in the President alone, in the Courts of Law, or in the Heads of Departments.

U.S. Const. art. II § 2. Y

Plaintiffs' Position:	*Government's Position:*
• 42 U.S.C. § 300gg-13(a)(1) – (4) allow the members of the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices, and the Health Resources and Services Administration to unilaterally determine the preventive care that private insurers must cover • These individuals are "officers of the United States," because they "occupy a continuing position established by law" and exercise "significant authority pursuant to the laws of the United States." Yet none of these officers have been appointed in conformity with the Appointments Clause.	• The secretary's ratification of the current preventive services coverage requirements defeats plaintiffs' appointments clause claim • HRSA and the CDC (which ACIP Advises) are components of the HHS that exercise the secretary's power and are under the secretary's control. • The USPSTF is an independent body that does not exercise Executive Power. Its independent recommendations about the quality of evidence backing the effectiveness of certain preventive services is separate from any judgment about what should or should not be covered by health insurance, which latter judgment was made by Congress.

Claim: The ACA preventive services provisions (42 U.S.C. § 300gg-13(a)(1)–(4)) violate the nondelegation doctrine because Congress did not provide any details to guide the recommendations for preventive services

Plaintiffs' Position:	*Government's Position:*
• There is nothing in the text of section 300gg-13(a) that purports to guide the discretion of USPSTF, ACIP or HRSA when choosing the preventive	• "Delegations are constitutional so long as Congress 'lay[s] down by legislative act an intelligible principle to which the person or body

care that private insurance must cover.	authorized [to exercise the authority] is directed to conform." • The grants of authority under 42 U.S.C. § 300gg-13(a) fall well within the wide range of delegations approved by the Supreme Court and the Fifth Circuit and are consistent with established limits on Congress's power to delegate. • Congress did not "delegate" power to PSTF at all but instead incorporates its work.

Claim: Certain provisions of the ACA's preventive services coverage requirements violate the Religious Freedom Restoration Act (https://www.justice.gov/sites/default/files/jmd/legacy/2014/07/24/act-pl103-141.pdf)**: requires the government to show the law in question, in this case the requirement that plans include coverage of PrEP without cost sharing, furthers a "compelling interest" in the "least restrictive means" when it "substantially burdens a person's exercise of religion."**

Plaintiffs' Position:	*Government's Position:*
• The compulsory coverage of PrEP drugs, the HPV vaccine and the screenings and behavioral counseling for STDS and drug use violate the Religious Freedom Restoration Act (RFRA). • Plaintiffs are opposed for religious reasons to sexual activity outside of marriage between one man and one woman. • Requiring for providing Coverage of PrEP drugs facilitates and encourages homosexual behavior, intravenous drug use and sexual activity outside of marriage between one man and one woman.	• The plaintiffs have failed to demonstrate the PrEP coverage requirement substantially burdens their religious beliefs. • The plaintiffs cannot identify any impact on their health insurance premiums arising from the requirement to cover PrEP drugs. • Even if the plaintiffs could show a substantial burden, the government has a compelling interest in countering the spread of HIV infections, and the plaintiffs have not argued that there is a less restrictive way of meeting this compelling interest (requiring private health insurance to cover PrEP without cost sharing).

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LOS ANGELES COUNTY
COMMISSION ON HIV

****COMMISSION MEMBER 30-DAY COMMENT PERIOD**
3/23/23 - 4/23/23**

(PROPOSED) VISION

An equitable system of HIV prevention and care that is comprehensive, sustainable, and accessible empowering and educating all communities to make informed decisions about their sexual health needs to maximize life expectancy and optimize quality of life.

(PROPOSED) MISSION

To plan, promote, and advocate for equitable policies, programs, and services that address the HIV epidemic in Los Angeles County. The Commission works to ensure that Los Angeles residents have access to quality sexual healthcare, including HIV prevention, testing, treatment, and support services.

The Commission strives to eliminate stigma and discrimination associated with all sexually-transmitted diseases and to promote sexual health awareness and education to the public, particularly in underserved communities. Utilizing an approach that addresses both the mental and physical health of the whole person as well as social determinants of health, the Commission collaborates with and seeks input from people with lived experience, planners, and stakeholders to coordinate efforts and leverage resources to ensure that its work is responsive to the needs of those impacted by the epidemic, regardless of socioeconomic status.