LOS ANGELES COUNTY
COMMISSION ON HIV

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

COMMISSION ON HIV MEETING

Thursday, May 10, 2018
9:00 AM - 12:00 PM

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV



VISION

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

MISSION

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

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

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GUIDELINES FOR CONDUCT

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

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

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

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

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

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

1. APPROVAL OF THE AGENDA:

A. Agenda **(MOTION #1)**
B. Membership Roster
C. Committee Assignments
D. Commission Member Conflict of Interest
E. Geographic Maps
F. May – August 2018 Meeting Calendars

LOS ANGELES COUNTY
COMMISSION ON HIV

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

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

THURSDAY, MAY 10, 2018, 9:00 AM – 12:00 PM

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

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

AGENDA POSTED: Original posted May 4, 2018; revised posted May 7, 2018

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

ACCOMMODATIONS: Interpretation services for the hearing impaired and translation services for languages other than English are available free of charge with at least 5 business days' notice before the meeting date. To arrange for these services, please contact Dina Jauregui at (213) 738-2816 or via email at djauregui@lachiv.org.

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

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

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

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

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

	Call to Order and Roll Call		9:00 A.M. – 9:03 A.M.
	I. ADMINISTRATIVE MATTERS		
1.	Approval of Agenda	**MOTION #1**	9:03 A.M. – 9:04 A.M.
2.	Approval of Meeting Minutes	**MOTION #2**	9:04 A.M. – 9:06 A.M.
3.	Consent Calendar	**MOTION #3**	9:06 A.M. – 9:07 A.M.
4.	**II. 2018 COLLOQUIA SERIES**		
	"Rise, a Community-Based Culturally Congruent Adherence Intervention for Black Americans Living with HIV"		9:07 A.M. – 9:55 A.M.
	Laura M. Bogart, RAND Corporation; Matt G. Mutchler, APLA & California State University–Dominguez Hills; Sean J. Lawrence, APLA; and Damone Thomas, APLA		
	III. REPORTS		
5.	Executive Director's Report		9:55 A.M. – 10:05 A.M.
6.	Co-Chair's Report A. Membership Recruitment		10:05 A.M. – 10:15 A.M.
7.	Housing Opportunities for People Living with HIV/AIDS (HOPWA) Report		10:15 A.M. – 10:20 A.M.
8.	**IV. BREAK**		10:20 A.M. – 10:30 A.M.
	V. DISCUSSION		10:30 A.M. – 10:40 A.M.
9.	Los Angeles County HIV/AIDS Strategy (LACHAS) A. April 12, 2018 LACHAS Community Meeting Follow-Up B. 2018 LACHAS Community Meeting Schedule (1) June 14, 2018 10am-12pm (Lambert Park Auditorium 11431 McGirk Ave, El Monte)		

VI. REPORTS

10 Vaccine Preventable Disease Control Program — 10:40 A.M. – 10:45 A.M.
LA County Department of Public Health

11. Division of HIV/STD Programs (DHSP) Report — 10:45 A.M. – 10:55 A.M.
LA County Department of Public Health

12. California Office of AIDS (OA) Report — 10:55 A.M. – 11:05 A.M.

13. Standing Committee Reports: — 11:05 A.M. – 11:35 A.M.

A. Operations Committee
   1. Policies and Procedures
      a. Revised Policy #09.4205: **MOTION #4**
         Commission Membership Evaluation and Nomination Process
   2. Membership Management
      a. 2018 Membership Slate Preparation
      b. Vacate José Muñoz, Unaffiliated Consumer, **MOTION #5**
         Supervisorial District 1 seat
   3. Community Advisory Board (CAB) Outreach
   4. Recruitment and Retention
      a. Recruitment Efforts

B. Public Policy Committee
   1. Healthcare Access
   2. Federal, State and County Budget
   3. Federal, State and County Legislation/Policy
      a. Proposed 2018 COH Legislative Docket **MOTION #6**

C. Planning, Priorities and Allocations (PP&A) Committee
   1. Comprehensive Program Directives Update (Integrates MAI Allocations Plan and Prevention Plan)
   2. Drug Medi-Cal Program, Substance Abuse Prevention and Control

D. Standards and Best Practices (SBP) Committee
   1. Prevention Services Standards
   2. Legal Assistance Services Standards | **20-Day Public Comment Period (Exp. 5/30)**
   3. Quality Improvement Overview & Roles

14. Caucus, Task Force and Work Group Reports — 11:35 A.M. – 11:40 A.M.

15. City/Health District Reports — 11:40 A.M. – 11:42 A.M.

16. SPA/District Reports — 11:42 A.M. – 11:44 A.M.

17. AIDS Education/Training Centers (AETCs) — 11:44 A.M. – 11:46 A.M.

VII. PUBLIC COMMENT — 11:46 A.M. – 11:52 A.M.

18. Opportunity for members of the public to address the Commission on items of interest that are within the jurisdiction of the Commission.

VIII. COMMISSION COMMENT 11:50 A.M. – 11:56 A.M.

19. Non-Agendized or Follow-Up

IX. ANNOUNCEMENTS 11:56 A.M. – 11:58 A.M.

20. Opportunity for members of the public and the committee to make announcements.

X. ADJOURNMENT AND ROLL CALL 11:58 A.M.– 12:00 P.M.

21. Adjournment for the meeting of May 10, 2018.

PROPOSED MOTION(s)/ACTION(s): PROCEDURAL MOTION(S):	
MOTION #1:	Approve the Agenda Order, as presented or revised.
MOTION #2:	Approve the Commission meeting minutes, as presented or revised.
MOTION #3:	Approve the Consent Calendar, as presented

CONSENT CALENDAR:	
MOTION #4:	Approve Revised Policy #09.4205: Commission Membership Evaluation and Nomination Process, as presented or revised.
MOTION #5:	Approve Recommendation to Vacate José Muñoz, Unaffiliated Consumer, Supervisorial District 1 seat, as presented.
MOTION #6:	Approve Proposed 2018 COH Legislative Docket, as presented or revised.

All Commission meetings will begin at their appointed times. Participants should make every effort to be prompt and ready. All agenda items are subject to action. Public comment will be invited for each item. All "action" (non-procedural) motions are included on the consent calendar and are approved when the consent calendar is approved. A motion can be "pulled" from the consent calendar if there are objections to it, or if it is to be presented or discussed later in the meeting.

COMMISSION ON HIV MEMBERS:			
Ricky Rosales, Co-Chair	Grissel Granados, MSW, Co-Chair	Traci Bivens-Davis	Al Ballesteros, MBA
Jason Brown	Joseph Cadden, MD	Danielle Campbell, MPH	Raquel Cataldo
Deborah Owens Collins, PA, MSPAS, AAHIVS	David Cunningham (Alternate)	Michele Daniels	Kevin Donnelly
Susan Forrest (Alternate)	Aaron Fox, MPM	Marcos Garcilazo (Alternate)	Jerry D. Gates, PhD
Joseph Green	Terry Goddard II, MA	Bridget Gordon	William King, MD, JD
Lee Kochems, MA	Bradley Land	David P. Lee, MPH, LCSW (Alternate)	Eric Paul Leue
Abad Lopez	Andrew Lopez (Alternate)	Eduardo Martinez (Alternate)	Miguel Martinez, MSW, MPH
Anthony Mills, MD	Katja Nelson, MPP	Derek Murray	Frankie Darling-Palacios
Raphael Peña	Mario Pérez MPH	Juan Preciado	Ace Robinson, MPH
Rebecca Ronquillo	Martin Sattah, MD	LaShonda Spencer, MD	Kevin Stalter
Yolanda Sumpter	Greg Wilson	Russell Ybarra	
MEMBERS:	**42**		
QUORUM:	**22**		

LOS ANGELES COUNTY
COMMISSION ON HIV
COMMISSION ON HIV MEMBERSHIP ROSTER
APPROVED BY COH ON 07/13/2017 | APRIL 13, 2018

MEMBERSHIP SEAT #	MEMBERSHIP SEAT	Commissioners Seated	Committee Assignment	COMMISSIONER	AFFILIATION *(if any)*	TERM BEGINS	TERM ENDS	ALTERNATE
1	Medi-Cal representative			***Vacant***		July 1, 2017	June 30, 2019	
2	City of Pasadena representative	1	SBP	Erika Davies	City of Pasadena Department of Public Health	July 1, 2016	June 30, 2018	
3	City of Long Beach representative	1	PP&A	Deborah Owens Collins, PA, MSPAS, AAHIVS	Dept. of Health and Human Services, City of Long Beach	July 1, 2017	June 30, 2019	
4	City of Los Angeles representative	1	EXC	Ricky Rosales	AIDS Coordinator's Office, City of Los Angeles	July 1, 2016	June 30, 2018	
5	City of West Hollywood representative	1	PP&A	Derek Murray	City of West Hollywood	July 1, 2017	June 30, 2019	
6	Director, DHSP	1	EXC|PP&A	Mario Pérez, MPH	DHSP, LA County Department of Public Health	July 1, 2016	June 30, 2018	
7	Part B representative			***Vacant***		July 1, 2016	June 30, 2018	
8	Part C representative	1	EXC|PP	Aaron Fox, MPM	Los Angeles Gay and Lesbian Center (LAGLC)	July 1, 2016	June 30, 2018	
9	Part D representative	1	PP&A	LaShonda Spencer, MD	LAC + USC MCA Clinic, LA County Department of Health Services	July 1, 2017	June 30, 2019	
10	Part F representative	1	PP	Jerry D. Gates, PhD	Keck School of Medicine of USC	July 1, 2016	June 30, 2018	
11	Provider representative #1	1	EXC|SBP	Joseph Cadden, MD	Rand Shrader Clinic (SPA1), LA County Department of Health Services	July 1, 2017	June 30, 2019	
12	Provider representative #2			***Vacant***		July 1, 2016	June 30, 2018	
13	Provider representative #3	1	PP&A	Miguel Martinez, MSW, MPH	Children's Hospital Los Angeles	July 1, 2017	June 30, 2019	
14	Provider representative #4	1	EXC|OPS	Raquel Cataldo	Tarzana Treatment Center	July 1, 2016	June 30, 2018	
15	Provider representative #5	1	EXC|PP	Terry Goddard, MA	Alliance for Housing and Healing	July 1, 2017	June 30, 2019	
16	Provider representative #6	1	PP&A	Anthony Mills, MD	Southern CA Men's Medical Group	July 1, 2016	June 30, 2018	
17	Provider representative #7	1	PP&A	Frankie Darling-Palacios	Los Angeles Gay and Lesbian Center (LAGLC)	July 1, 2017	June 30, 2019	
18	Provider representative #8	1	PP	Martin Sattah, MD	Rand Shrader Clinic (SPA1), LA County Department of Health Services	July 1, 2016	June 30, 2018	
19	Unaffiliated consumer, SPA 1	1	OPS	Michele Daniels	*Unaffiliated Consumer*	July 1, 2017	June 30, 2019	
20	Unaffiliated consumer, SPA 2	1	PP&A	Abad Lopez	*Unaffiliated Consumer*	July 1, 2016	June 30, 2018	
21	Unaffiliated consumer, SPA 3	1	EXC|PP&A	Jason Brown	*Unaffiliated Consumer*	July 1, 2017	June 30, 2019	
22	Unaffiliated consumer, SPA 4			***Vacant***		July 1, 2016	June 30, 2018	Susan Forrest
23	Unaffiliated consumer, SPA 5	1	PP&A	Yolanda Sumpter	*Unaffiliated Consumer*	July 1, 2017	June 30, 2019	
24	Unaffiliated consumer, SPA 6			***Vacant***		July 1, 2016	June 30, 2018	David Lee, MPH, LCSW
25	Unaffiliated consumer, SPA 7	1	PP&A	Raphael Péna	*Unaffiliated Consumer*	July 1, 2017	June 30, 2019	
26	Unaffiliated consumer, SPA 8			***Vacant***		July 1, 2016	June 30, 2018	
27	Unaffiliated consumer, Supervisorial District 1			***Vacant***		July 1, 2017	June 30, 2019	Marcos Garcilazo
28	Unaffiliated consumer, Supervisorial District 2			***Vacant***		July 1, 2016	June 30, 2018	Andrew Lopez
29	Unaffiliated consumer, Supervisorial District 3			***Vacant***		July 1, 2017	June 30, 2019	Eduardo Martinez
30	Unaffiliated consumer, Supervisorial District 4	1	EXC|OPS	Kevin Donnelly	*Unaffiliated Consumer*	July 1, 2016	June 30, 2018	David Cunningham
31	Unaffiliated consumer, Supervisorial District 5			***Vacant***		July 1, 2017	June 30, 2019	
32	Unaffiliated consumer, at-large #1	1	PP&A	Russell Ybarra	*Unaffiliated Consumer*	July 1, 2016	June 30, 2018	
33	Unaffiliated consumer, at-large #2	1	EXC|OPS	Joseph Green	*Unaffiliated Consumer*	July 1, 2017	June 30, 2019	
34	Unaffiliated consumer, at-large #3	1	EXC|OPS|SBP	Kevin Stalter	*Unaffiliated Consumer*	July 1, 2016	June 30, 2018	
35	Unaffiliated consumer, at-large #4	1	OPS	Bridget Gordon	*Unaffiliated Consumer*	July 1, 2017	June 30, 2019	
36	Representative, Board Office 1	1	EXC|PP&A	Al Ballesteros, MBA	JWCH Institute, Inc.	July 1, 2016	June 30, 2018	
37	Representative, Board Office 2	1	EXC|OPS	Traci Bivens-Davis	N/A	July 1, 2017	June 30, 2019	
38	Representative, Board Office 3	1	PP	Katja Nelson, MPP	APLA	July 1, 2016	June 30, 2018	
39	Representative, Board Office 4	1	EXC|SBP	Ace Robinson, MPH	No Affiliations	July 1, 2017	June 30, 2019	
40	Representative, Board Office 5	1	SBP	Bradley Land	*Unaffiliated Consumer*	July 1, 2016	June 30, 2018	
41	Representative, HOPWA	1	PP&A	Rebecca Ronquillo	City of Los Angeles, HOPWA	July 1, 2017	June 30, 2019	
42	Behavioral/social scientist	1	PP	Lee Kochems	*Unaffiliated Consumer*	July 1, 2016	June 30, 2018	
43	Local health/hospital planning agency representative			***Vacant***		July 1, 2017	June 30, 2019	
44	HIV stakeholder representative #1	1	EXC	Grissel Granados, MSW	Children's Hospital Los Angeles	July 1, 2016	June 30, 2018	
45	HIV stakeholder representative #2	1	PP	Greg Wilson	In the Meantime Men's Group	July 1, 2017	June 30, 2019	
46	HIV stakeholder representative #3	1	OPS	Juan Preciado	Northeast Valley Health Corporation	July 1, 2016	June 30, 2018	
47	HIV stakeholder representative #4	1	EXC|PP	Eric Paul Leue	Free Speech Coaltion	July 1, 2017	June 30, 2019	
48	HIV stakeholder representative #5	1	OPS	Danielle Campbell, MPH	UCLA/MLKCH	July 1, 2016	June 30, 2018	
49	HIV stakeholder representative #6			***Vacant***	N/A	July 1, 2017	June 30, 2019	
50	HIV stakeholder representative #7	1	PP&A	William D. King, MD, JD, AAHIVS	W. King Health Care Group	July 1, 2016	June 30, 2018	
51	HIV stakeholder representative #8			***Vacant***		July 1, 2017	June 30, 2018	
	TOTAL:	**38**						

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

☐ = Vacant

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COMMISSION ON HIV

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COMMITTEE ASSIGNMENTS
(Updated 5/8/18)

Committee Member Name/ Alternate	Member Category	Affiliation
* = *Primary Committee Assignment*	** = *Secondary Committee Assignment*	
EXECUTIVE COMMITTEE		
Regular meeting day: 4th Thursday of the month	**Regular meeting time:** 1:00pm–3:00pm	
Number of Voting Members: **14**	***Number of Quorum:*** **8**	
Grissel Granados, MSW	**Co-Chair, Comm./Exec.***	Commissioner
Ricky Rosales	**Co-Chair, Comm./Exec.***	Commissioner
Al Ballesteros, MBA	Co-Chair, PP&A	Commissioner
Traci Bivens-Davis	Co-Chair, Operations	Commissioner
Jason Brown	Co-Chair, PP&A	Commissioner
Joseph Cadden, MD	Co-Chair, SBP	Commissioner
Raquel Cataldo	At-Large Member*	Commissioner
Kevin Donnelly	At-Large Member*	Commissioner
Aaron Fox, MPM	Co-Chair, Public Policy	Commissioner
Joseph Green	At-Large Member*	Commissioner
Terry Goddard, MA	Co-Chair, PPC	Commissioner
Mario Pérez, MPH	DHSP Director	Commissioner
Ace Robinson, MPH	Co-Chair, SBP	Commissioner
Kevin Stalter	Co-Chair, Operations	Commissioner

OPERATIONS COMMITTEE		
Regular meeting day: 4th Thursday of the month	**Regular meeting time:** 10:00am-12:00pm	
Number of Voting Members: **10**	***Number of Quorum:*** **6**	
Traci Bivens-Davis	**Committee Co-Chair***	Commissioner
Kevin Stalter	**Committee Co-Chair***	Commissioner
Danielle Campbell, MPH	*	Commissioner
Raquel Cataldo	*	Commissioner
Michele Daniels	*	Commissioner
Kevin Donnelly	*	Commissioner
Bridget Gordon	*	Commissioner
Joseph Green	*	Commissioner
Marcos Garcilazo	*	Alternate
Juan Preciado	*	Commissioner

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

PLANNING, PRIORITIES and ALLOCATIONS (PP&A) COMMITTEE		
Regular meeting day: 3rd Tuesday of the month	**Regular meeting time:** 1:00-4:00 PM	
Number of Voting Members: **15**	***Number of Quorum:*** **8**	
Al Ballesteros, MBA	**Committee Co-Chair***	Commissioner
Jason Brown	**Committee Co-Chair***	Commissioner
Susan Forrest	*	Commissioner
William D. King, MD, JD, AAHIVS	*	Commissioner
Abad Lopez	*	Commissioner
Miguel Martinez, MPH, MSW	*	Commissioner
Anthony Mills, MD	*	Commissioner
Derek Murray	*	Commissioner
Deborah Owens Collins, MPA, MSPAS, AAHIVS	*	Commissioner
Frankie Darling Palacios	*	Commissioner
Raphael Pena	*	Commissioner
Rebecca Ronquillo	*	Commissioner
LaShonda Spencer, MD	*	Commissioner
Yolanda Sumpter	*	Commissioner
Russell Ybarra	*	Commissioner
TBD	DHSP staff	DHSP Staff

PUBLIC POLICY COMMITTEE		
Regular meeting day: 1st Monday of the month	**Regular meeting time:** 1:00 pm-3:00pm	
Number of Voting Members: **11**	***Number of Quorum:*** **6**	
Aaron Fox, MPM	**Committee Co-Chair***	Commissioner
Terry Goddard, MA	**Committee Co-Chair***	Commissioner
Jerry Gates, PhD	*	Commissioner
Lee Kochems, MA	*	Commissioner
Eduardo Martinez	*	Alternate
Eric Paul Leue	*	Commissioner
Andrew Lopez	*	Commissioner
Katja Nelson	*	Commissioner
Martin Sattah, MD	*	Commissioner
Greg Wilson	*	Commissioner
Kyle Baker	DHSP staff	DHSP representative

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

STANDARDS AND BEST PRACTICES (SBP) COMMITTEE		
Regular meeting day: 1st Thursday of the month	**Regular meeting time:**	10:00am-12:00pm
***Number of Voting Members*: 6**	***Number of Quorum*: 4**	
Joseph Cadden, MD	**Committee Co-Chair***	Commissioner
Ace Robinson, MPH	**Committee Co-Chair***	Commissioner
Erika Davies	*	Commissioner
Bradley Land	*	Commissioner
Kevin Stalter	**	Commissioner
Wendy Garland, MPH	**DHSP staff**	**DHSP representative**

CONSUMER CAUCUS		
***Regular meeting day*:** Following Comm. mtg.	***Regular meeting time*:**	1:00pm–3:00pm
Open membership to consumers of HIV prevention and care services*		
Joseph Green	**Co-Chair**	Commissioner
Yolanda Sumpter	**Co-Chair**	Commissioner
Raphael Péna	**Co-Chair**	Commissioner
Al Ballesteros, MBA	Member	Commissioner
Jason Brown	Member	Commissioner
Michele Daniels	Member	Commissioner
Kevin Donnelly	Member	Commissioner
Grissel Granados, MSW	Member	Commissioner
Bridget Gordon	Member	Commissioner
Lee Kochems, MA	Member	Commissioner
Brad Land	Member	Commissioner
Abad Lopez	Member	Commissioner
Eduardo Martinez	Member	Alternate
Anthony Mills, MD	Member	Commissioner
Kevin Stalter	Member	Commissioner

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

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

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

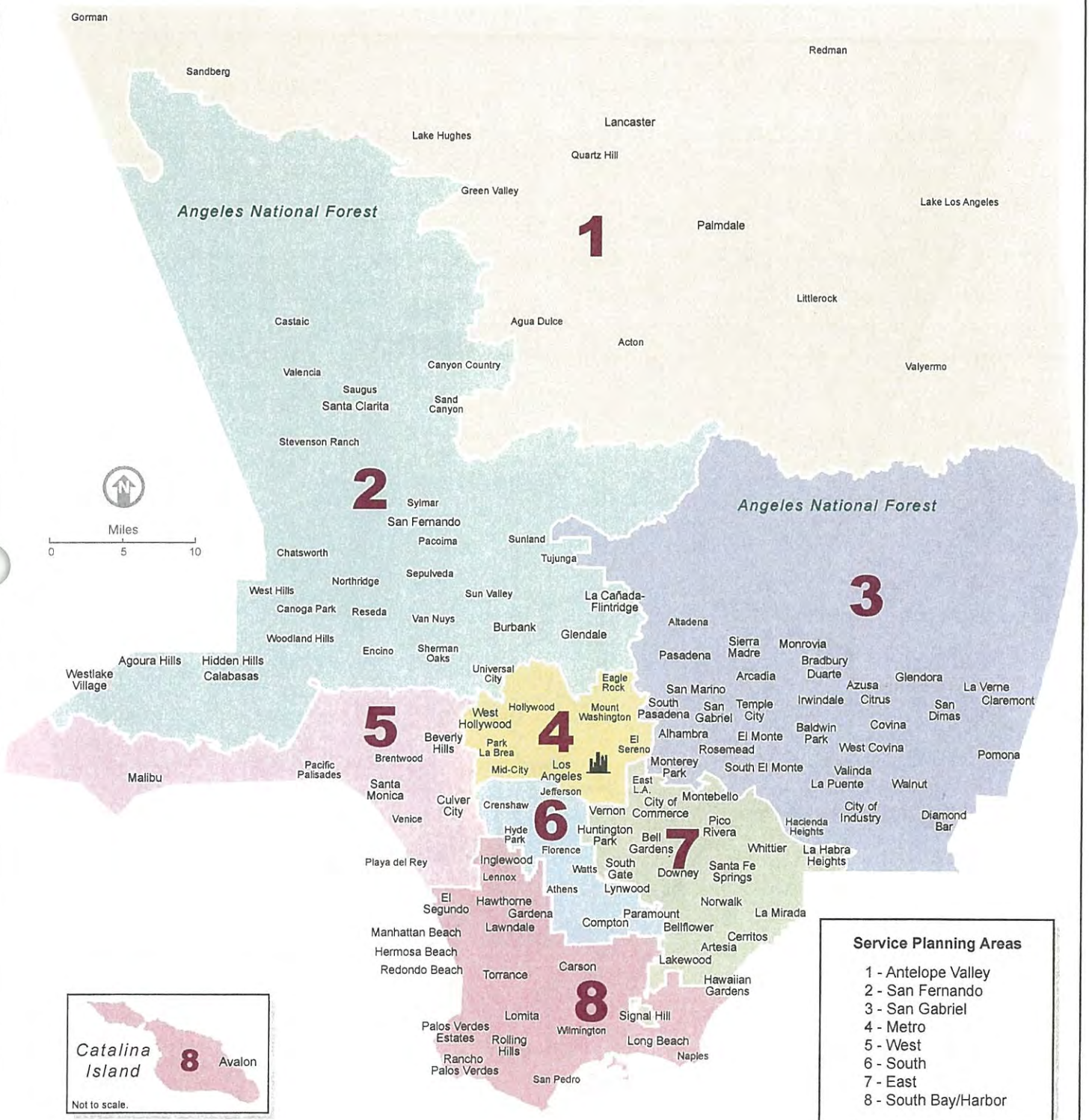
COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
BROWN	**Jason**	Unaffiliated consumer	No Ryan White or prevention contracts
BALLESTEROS	**Al**	JWCH, INC.	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Case Management, Transitional
			Health Education/Risk Reduction (HERR)
			HIV Counseling and Testing (HCT)
			Medical Care Coordination (MCC)
			Mental Health, Psychotherapy
			Mental Health, Psychiatry
			Oral Health
			Biomedical Prevention
BIVENS-DAVIS	**Traci**	No Affiliation	No Ryan White or prevention contracts
CADEN	**Joseph**	Rand Schrader Health & Research Center	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination
			Mental Health, Psychiatry
CAMPBELL	**Danielle**	UCLA/MLKCH	HIV/AIDS Oral Health Care (Dental) Services
			HIV/AIDS Medical Care Coordination Services
			HIV/AIDS Ambulatory Outpatient Medical Services
			HIV/AIDS Medical Care Coordination Services
			nPEP Services
CATALDO	**Raquel**	Tarzana Treatment Center	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Health Education/Risk Reduction (HERR)
			HIV Counseling and Testing (HCT)
			Medical Care Coordination (MCC)

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
			Case Management, Home-Based
			Case Management, Transitional - Jails
			Medical Transportation
			Mental Health, Psychotherapy
			Oral Health
			Substance Abuse, Residential
			Substance Abuse, Transitional
			Substance Abuse, Detox
			Biomedical Prevention
			Medical Nutrition Therapy
CUNNINGHAM	**David**	Unaffiliated consumer	No Ryan White or prevention contracts
DANIELS	**Michele**	Unaffiliated consumer	No Ryan White or prevention contracts
DARLING-PALACIOS	**Frankie**	Los Angeles Gay & Lesbian Center	Ambulatory Outpatient Medical (AOM)
			Health Education/Risk Reduction (HERR)
			HIV Counseling and Testing (HCT)
			Medical Care Coordination (MCC)
			Mental Health, Psychiatry
			Mental Health, Psychotherapy
			Non-Occupational HIV PEP
			Biomedical Prevention
			STD Screening and Treatment
DAVIES	**Erika**	City of Pasadena	HIV Counseling and Testing (HCT)
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
FORREST	**Susan**	Los Angeles Center for Alcohol and Drug Abuse	HIV/AIDS Health Education
			HIV/AIDS Substance Abuse
			Risk Reduction Prevention Services
			Residential Rehabilitation Services
FOX	**Aaron**	Los Angeles Gay & Lesbian Center	Ambulatory Outpatient Medical (AOM)
			Health Education/Risk Reduction (HERR)
			HIV Counseling and Testing (HCT)
			Medical Care Coordination (MCC)
			Mental Health, Psychiatry
			Mental Health, Psychotherapy
			Non-Occupational HIV PEP
			Biomedical Prevention
			STD Screening and Treatment

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
GARCILAZO	Marcos	UCLA Center for Behavioral and Addiction Medicine	Medical Care Coordination Services
GATES	Jerry	Keck School of Medicine of USC	No Ryan White or prevention contracts
GODDARD II	Terry	Alliance for Housing and Healing	Residential Care Facilities for the Chronically Ill (RCFCI)
GORDON	Bridget	Unaffiliated consumer	No Ryan White or prevention contracts
GRANADOS	Grissel	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			Case Management, Transitional - Youth
			Health Education/Risk Reduction (HERR)
			HIV Counseling and Testing (HCT)
			Medical Care Coordination (MCC)
			Biomedical Prevention
GREEN	Joseph	Unaffiliated consumer	No Ryan White or prevention contracts
KOCHEMS	Lee	Unaffiliated consumer	No Ryan White or prevention contracts
KING	William	W. King Health Care Group	No Ryan White or prevention contracts
LAND	Bradley	Unaffiliated consumer	No Ryan White or prevention contracts
LEE	David	Charles R. Drew University of Medicine and Science	HIV/AIDS Benefits Specialty Services
			HIV Counseling, Testing, and Referral Prevention Services
LEUE PAUL	Eric	Free Speech Coalition	No Ryan White or prevention contracts
LOPEZ	Abad	Unaffiliated consumer	No Ryan White or prevention contracts
LOPEZ	Andrew	Friends Research Institute	Health Education/Risk Reduction and HIV Testing Services
MARTINEZ	Eduardo	AIDS Healthcare Foundation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			MH, Psychiatry
			MH, Psychotherapy
			Medical Specialty
			Oral Health
			HIV Counseling and Testing (HCT)
			STD Screening and Treatment
MARTINEZ	Miguel	Children's Hospital, Los Angeles	Ambulatory Outpatient Medical (AOM)
			Case Management, Transitional - Youth
			Health Education/Risk Reduction (HERR)
			HIV Counseling and Testing (HCT)
			Medical Care Coordination (MCC)
			Biomedical Prevention
MILLS	Anthony	Southern CA Men's Medical Group	Biomedical Prevention
			Medical Care Coordination (MCC)

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MUNOZ	**Jose**	Unaffiliated consumer	No Ryan White or prevention contracts
MURRAY	**Derek**	City of West Hollywood	No Ryan White or prevention contracts
NELSON	**Katja**	APLA Health & Wellness	Benefits Specialty Case Management, Non-Medical (LCM) Case Management, Home-Based Health Education/Risk Reduction (HERR) HIV Counseling and Testing (HCT) Mental Health, Psychotherapy Nutrition Support Oral Health Biomedical Prevention Medical Care Coordination (MCC)
OWENS COLLINS	**Deborah**	Long Beach Department of Health & Human Services	Benefits Specialty
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
PEÑA	**Raphael**	Unaffiliated consumer	No Ryan White or prevention contracts
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
PRECIADO	**Juan**	Northeast Valley Health Corporation	Mental Health, Psychotherapy
			Benefits Specialty
			Mental Health, Psychiatry
			Oral Health
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
ROBINSON	**Ace**	No Affiliation	No Ryan White or prevention contracts
RONQUILLO	**Rebecca**	City of Los Angeles, HOPWA	No Ryan White or prevention contracts
ROSALES	**Ricky**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Mental Health, Psychiatry
SPENCER	**LaShonda**	LAC & USC MCA Clinic	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
STALTER	**Kevin**	The Brotherhood IMPACT Fund	No Ryan White or prevention contracts
SUMPTER	**Yolanda**	Unaffiliated consumer	No Ryan White or prevention contracts
WILSON	**Gregory**	In the Meantime Men's Group, Inc.	HIV/AIDS Health Education/Risk Reduction Prevention Services
YBARRA	**Russell**	Capitol Drugs	No Ryan White or prevention contracts

Los Angeles County
Service Planning Areas



Service Planning Areas

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

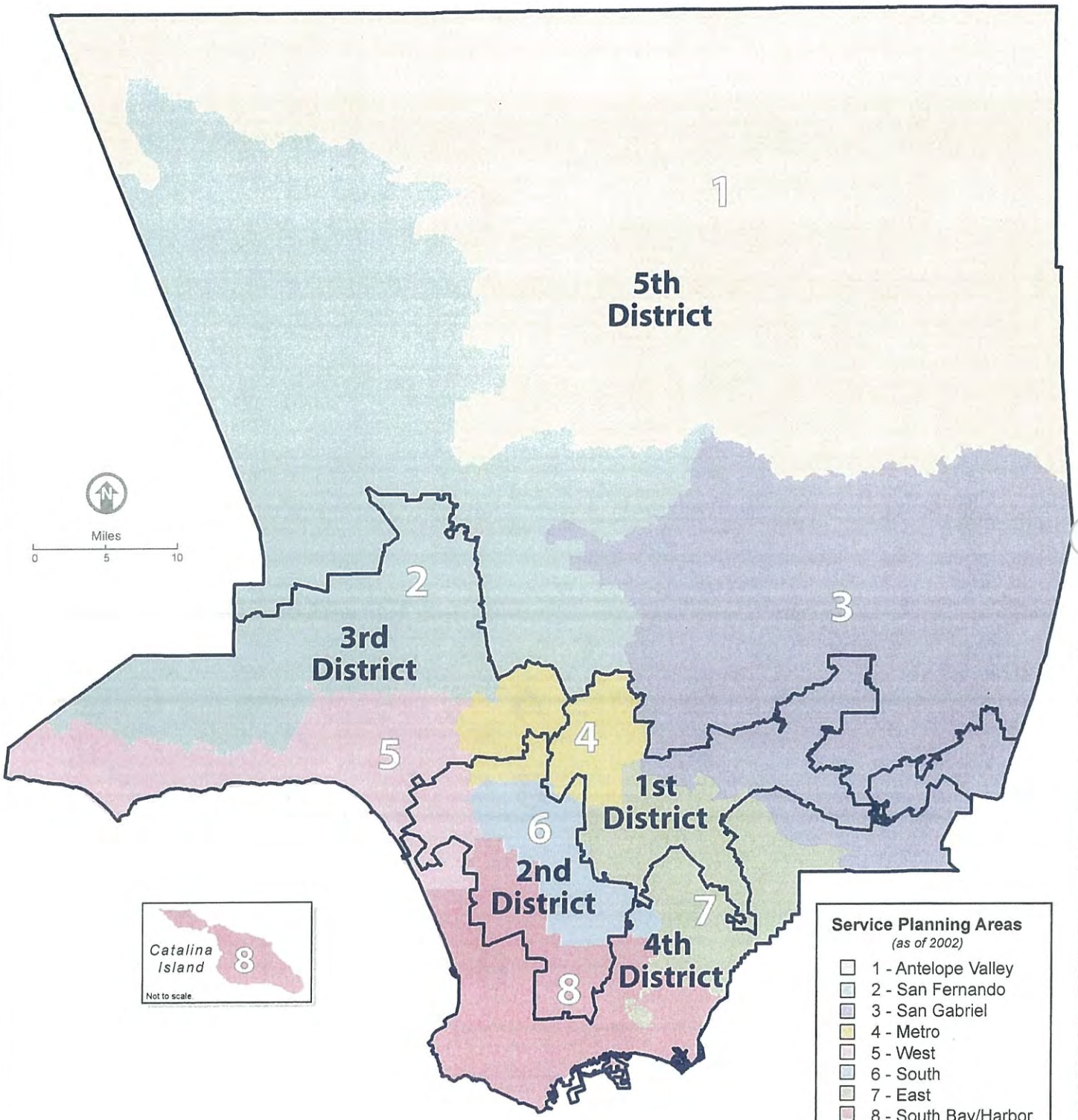
American Indian Children's Council covers all SPAs

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

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

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

Los Angeles County Service Planning Areas by Supervisorial District



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

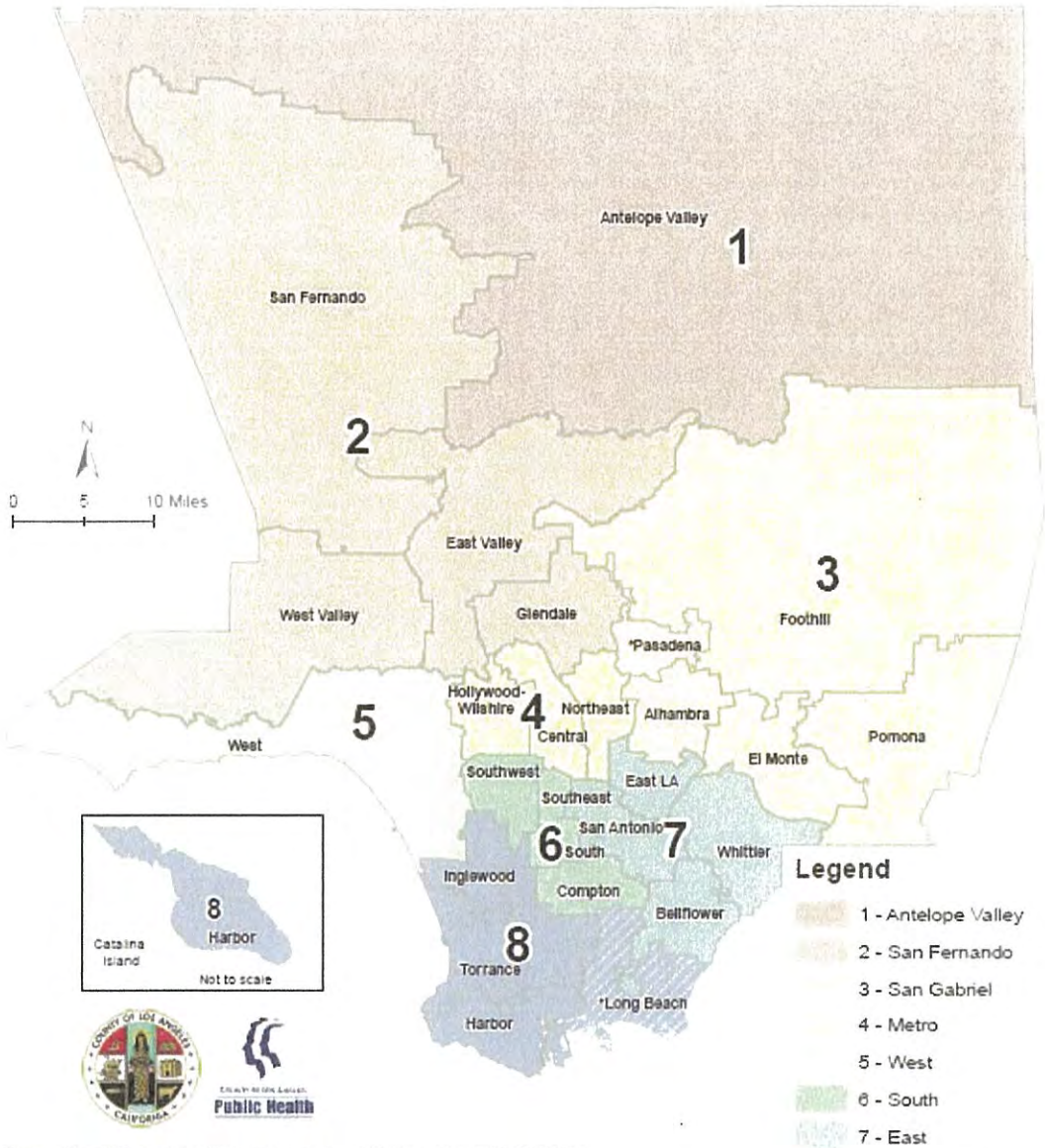
August, 2002
Los Angeles County
Children's Planning Council
Data Partnership (213) 893-0421

Los Angeles County Commission on HIV-For Planning and Training Use

LA County HIV/AIDS Strategy - Health District Disease Burden

Los Angeles County Map

26 Health Districts and 8 Service Planning Areas (SPAs)



Created by: Office of Health Assessment and Epidemiology. 07/05/2012.
Source: SPA and HD boundaries were released in 2012 based on 2010 Census TIGER/Line Shapefiles, U.S. Census Bureau, Geography Division, Geographic Products Branch.
*Long Beach and Pasadena are their own health jurisdictions.

HIV Calendar

May 2018

Sun	Mon	Tue	Wed	Thu	Fri	Sat
29 Week 18	30	**1** 9:30 AM Board of Supervisors (BOS) 1:00 PM CHP | Goals & Objectives Workgroup	**2** 9:30 AM BOS Agenda Review	**3** 10:00 AM Standards & Best Practices (SBP)	**4**	**5**
6 Week 19	**7** 1:00 PM Public Policy Committee	**8** 9:30 AM Board of Supervisors (BOS)	**9** 9:30 AM BOS Agenda Review	**10** 9:00 AM Commission Meeting	**11**	**12**
13 Week 20	**14**	**15** 9:30 AM Board of Supervisors (BOS) 1:00 PM Planning, Priorities & Allocations (PP&A)	**16** 9:30 AM BOS Agenda Review	**17**	**18**	**19**
20 Week 21	**21**	**22** 9:30 AM Board of Supervisors (BOS)	**23** 9:30 AM BOS Agenda Review	**24** 10:00 AM Operations Committee Meeting 1:00 PM Executive Committee Meeting	**25**	**26**
27 Week 22	**28**	**29** 9:30 AM Board of Supervisors (BOS)	**30** 9:30 AM BOS Agenda Review	**31**	1	2

HIV Calendar

June 2018

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

HIV Calendar

July 2018

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

HIV Calendar

August 2018

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

2. APPROVAL OF THE MEETING MINUTES:

A. March 8, 2018 Meeting Minutes **(MOTION #2)**

4. 2018 COLLOQUIA SERIES:

A. "Rise, a Community-Based Culturally Congruent Adherence Intervention for Black Americans Living with HIV"

Rise
COMMUNITY-BASED HEALTH EMPOWERMENT

Rise, a Community-Based Culturally Congruent Adherence Intervention for Black Americans Living with HIV

Laura M. Bogart, RAND Corporation
Matt G. Mutchler, APLA & California State University–Dominguez Hills
Sean J. Lawrence, APLA
Damone Thomas, APLA



Background

- Discrimination from racism, sexual minority stigma, and HIV stigma is related to disparities
  - Nonadherence
  - Disease progression
  - Worse mental health
- Direct pathway to low adherence/poor health
  - Increases stress responses
- Indirect pathways
  - Maladaptive coping (e.g., substance use)
  - Medical mistrust

Earnshaw, Bogart, et al. 2013

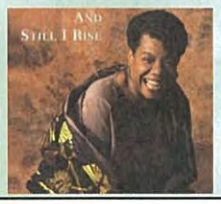
Background

- Relatively few HIV adherence interventions have shown effects on adherence or viral suppression
- Adherence interventions have generally not been culturally tailored for Black Americans, yet many have large percentages of Black participants
  - Not customized to fit patients' values, beliefs, traditions, etc.

Amico et al 2006; Charania et al 2014; CDC, 2015; Langebeek & Nieuwkerk, 2015;

Purpose of Project Rise

- To develop and conduct a randomized controlled trial (RCT) of a culturally congruent HIV treatment adherence intervention for Black men and women living with HIV
  - Intervention named after Maya Angelou poem, *And Still I Rise*
  - Consistent with LAC HAS GOAL III: Increase the Proportion of Diagnosed PLWH who are Virally Suppressed to 90% by 2022



Rise Components

- Client-centered counseling
  - Motivational interviewing style
    - Non-confrontational, empathetic
  - Increases motivation for adherence
  - Builds adherence knowledge and skills
  - Addresses adherence barriers
- Assistance with linkage to social services
  - Referrals to services (mental health, substance use treatment, food assistance, transportation)
  - Follow-up on referrals and barriers to receiving services

How is Rise Culturally Congruent?

- Counselor acknowledges past and current racism that has led to HIV disparities and adherence issues
  - Psychosocial barriers, e.g., mistrust, stigma, discrimination, substance use, stress
  - Structural barriers, e.g., poverty
- Placement in a trusted community organization
- Trained lay peer counselors knowledgeable about (and from) clients' local community
  - Not viewed as part of medical system

How was Rise developed?

Pilot research at APLA Health

- Process evaluation of treatment education/advocacy program
  - Interviews with providers and clients: strong enthusiasm for program
  - Surveys with clients suggested effects on adherence
- Developed Rise with CAB and APLA Health staff
- Conducted a randomized controlled trial

Rise Structure

5-9 individual sessions over 24 weeks

- Three Core Sessions (first 4 weeks)
  - Goal: for counselor and client establish a plan and develop tools to help with adherence
- Maintenance Sessions (remaining 20 weeks)
  - Booster sessions at weeks 12 and 20
  - Up to 4 additional sessions depending on adherence level
  - Goal: for counselor to follow up on strategies and progress with adherence

Example:

Empathetic approach, acknowledging discrimination as reason for mistrust

Given the mistreatment that African Americans have faced in healthcare, it sometimes makes sense to believe that anything is possible. There are so many past examples of discrimination in the US, especially in healthcare settings, where we have heard about unethical medical experiments, like Tuskegee, and segregation in healthcare, when African Americans were forced to get lower quality and separate services. So it is understandable to be cautious about healthcare, and wonder if the medications really work.

Example: Addressing Mistrust

It is true that drug companies, like all for-profit companies, want to make a profit, and companies have made a lot of money from antiretroviral drugs. However, if the government or drug companies had a cure, there would be no reason to withhold it. A cure would make more money for them than anything else. Also, many people have done very well on the new HIV medications. I have personally seen many clients dramatically improve their health after taking the medications.

Methods: Rise 1.0



- 215 participants (107 intervention, 108 control)
- Recruited via flyers and presentations to staff and clients at ~20 relevant organizations and clinics in LAC
- Eligibility
  - 18 years or older
  - Black American
  - On ART
  - Self-reported adherence problems (e.g., missed at least one dose in past month) AND/OR detectable viral load
  - Willing to use electronic adherence monitoring
  - Not in another adherence intervention

Methods: Rise 1.0

- Electronically monitored adherence using Medication Event Monitoring System (MEMS)
  - Data downloaded from bottle cap at 1.5, 3, 4.5, and 6 months post-baseline
  - Past 2-week adherence calculated at each time-point
  - Adjustment for use of cap (e.g., pocketed doses)



Methods: Rise 1.0

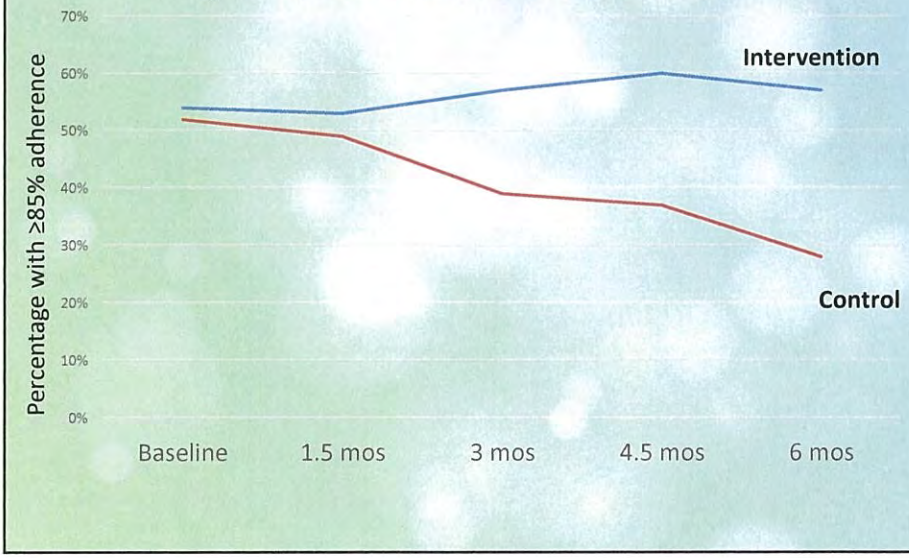
March 2018

Mon	Tue	Wed	Thr	Fri	Sat	Sun
			1 0	2 1	3 0	4 0
5 1	6 0	7 1	8 0	9 0	10 0	11 0
12 1	13 0	14 0	15 0	16 1	17 0	18 0
19 0	20 0	21 0	22 1	23 2	24 0	25 0
26 1	27 0	28 0	29 0	30 0		

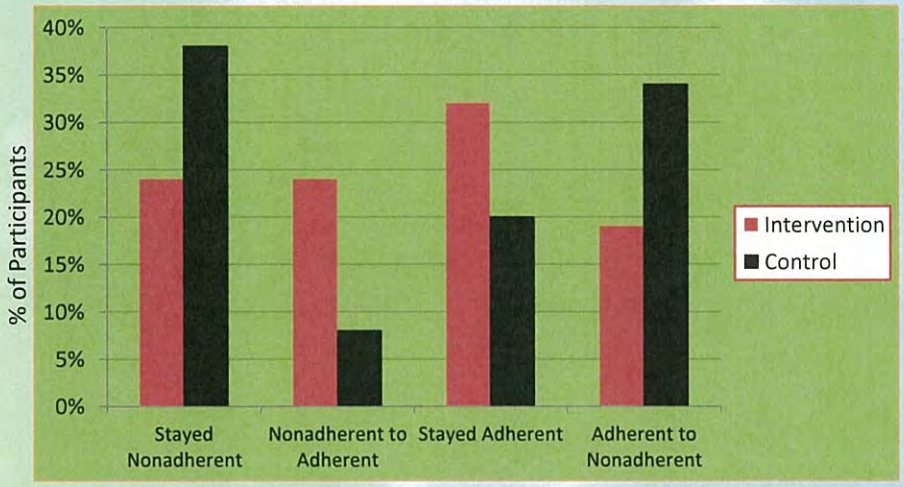
Methods: Rise 1.0 Participants

- Age M (SD) = 48.6 (10.2) years
- 73% male
- 64% sexual minority
- 19% <high school degree
- 65% <$10,000 annual income
- 94% not working
- 30% not stably housed
- 55% ever incarcerated
- Diagnosed with HIV M (SD) = 15.5 (8.3) years
- Baseline self-reported adherence
  - M (SD) = 79% (22%); 53.1% adherent to ≥85% of doses

Percentage of Adherent Participants (At Least 85% Adherence)



Non-Adherence Patterns from Baseline to 6-Month Follow-Up



Discussion: Rise 1.0

- *Rise* resulted in superior adherence for participants in the intervention group (relative to that of participants in the control group)
- *Rise* showed a large effect
  - Mainly due to decreased adherence in control group
- Viral suppression and long-term adherence not examined in Rise 1.0
  - Necessary to demonstrate for dissemination (CDC guidelines)

Amico et al 2006; Langebeek & Nieuwkerk, 2015

Next Steps: Rise 2.0!

- Rise 2.0: New RCT
  - Refined program manual to strengthen counseling strategies
  - Monitoring adherence for 13 months
    - Starting 1 month pre-intervention
  - Assessing viral load with blood draws
  - Analyzing cost effectiveness

Rise 2.0

Recruitment – 350 participants (175 intervention, 175 control)

Eligibility Requirements

- Identify as Black American (multiracial OK)
- 18 years-old or older
- HIV-positive
- Prescribed HIV medications at least 6 months ago
- Self-reported adherences issues and/or detectable viral load (>200 copies/microliter, based on lab results within last 6 mos)

Rise 2.0



Join us for Project Rise.

This study provides Black/African American individuals living with HIV a **confidential and safe** space to receive advice and support.

- Discuss topics such as taking your medications and how to talk to your doctor
- Complete interviews and blood draws over 13 months
- Receive up to 9 counseling sessions
- Receive up to $320 in gift card

Rise COMMUNITY-BASED HEALTH EMPOWERMENT

Call or email to participate:
(213) 201-1324
ProjectRise@apla.org

Project Rise is being conducted by APLA Health and the RAND Corporation.

Rise 2.0: Remuneration

Rise COMMUNITY-BASED HEALTH EMPOWERMENT

Control/Intervention – Up to $230 for:

- Medication Adherence Assessment: Electronic cap on HIV medication bottle; records time and date bottle is opened
- Surveys: Baseline, immediately post-intervention (7 months post-baseline) and 13 months post-baseline
- Blood Draws: Immediately before the intervention, 7 months post-baseline, and 13 months post-baseline, to test viral load.
- Four check-ins for adherence and contact information updates

Intervention – Up to $90 additional ($10/intervention session)

Rise 2.0: Next Steps

- The new RCT will help to determine long-term intervention effects on adherence and health outcomes
  - If effective the next step would be to determine ways to disseminate and sustain Rise in community organizations
- Discussion Questions
  - How might Rise be best disseminated, if found to be effective?
  - What recruitment strategies do you suggest?
  - Other questions/feedback?

Acknowledgments

- APLA Health Rise CAB
- Other Study Team Members:
  - Glenn Wagner, Sebastian Linnemayr (RAND)
  - William Cunningham (UCLA)
  - Kathy Goggin (Children's Mercy & University of Missouri, Kansas City)
- Other collaborators
  - Jeff Bailey (APLA)
  - Kieta Mutepfa (CAB)
  - Nikki Rachal (APLA)
  - Brian Risley (APLA)
- Funding: National Institute of Health
  - R21 NR010284, R01 MD006058, R01 MD006058

6. CO-CHAIRS' REPORT:

A. Membership Recruitment

LOS ANGELES COUNTY
COMMISSION ON HIV

Join us & make a difference in your community!

WHO: The Los Angeles County Commission on HIV serves as the local planning council for HIV prevention and treatment services across the County. The Commission is composed of 51 members including consumers, providers, community based organizations, and other key stakeholders.

WHAT: The full Commission is responsible for:

- Evaluating effectiveness of service delivery
- Recommending best practices
- Promoting & coordinating services
- Policy development and advocacy efforts
- Identifying gaps and barriers in prevention and care
- Annual needs assessments
- Advising the Department of HIV and STD Programs on HIV funding priorities

The Commission has 5 subcommittees:

- Executive Committee
- Operations Committee
- Planning, Priorities & Allocations Committee
- Public Policy Committee
- Standards & Best Practices Committee

WHEN: The Commission meets on every 2nd Thursday of the month. Subcommittees meet monthly. **All meetings are open to the public.** We hope to see you soon!

WHERE: Commission meetings are held every other month at St. Anne's at 155 N. Occidental Blvd, Los Angeles, CA 90026. Committee meetings are held at the Commission Office. Please check with the Commission office to confirm meeting locations.

WHY: In Los Angeles County, there were approximately 60,946 persons living with HIV/AIDS and 1,881 newly diagnosed HIV cases in 2016. Of those, approximately 8,500 individuals are not aware of their status. HIV continues to be a serious health epidemic. Our hope is to work towards ending HIV/AIDS in Los Angeles County.

For more information, visit our website at http://hiv.lacounty.gov/.

Like what we do? Apply to become a Commissioner at https://tinyurl.com/HIVCommApplication

For application assistance call (213) 738-2816

9. LOS ANGELES COUNTY HIV/AIDS STRATEGY (LACHAS)

A. April 12, 2018 LACHAS Community Meeting Follow-Up

B. 2018 LACHAS Community Meeting Schedule

(1) June 14, 2018, 10am-12pm (Lambert Park Auditorium, 11431 McGirk Ave, El Monte)

LOS ANGELES COUNTY
COMMISSION ON HIV

LA County HIV/AIDS Strategy Community Meeting
Continuing the Dialogue in San Fernando Valley
April 12, 2018

Evaluation Results

19 RESPONDENTS TOTAL

1. What best describes you? Please check only one.

   Community Member (1)
   LA County Commissioner (7)
   HIV Service Provider Staff (5)
   DHSP Staff
   Other (6)
   - Community liaison- Pharma
   - HOPWA
   - Health Educator
   - LAC Public Health

2. How would you rate the logistics of the meeting?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The meeting date and time were convenient.				15	4
The meeting location was convenient.			5	8	5
The meeting format was an effective method for sharing information and ideas.				12	7
The facilitators and presenters encouraged participation and questions.				9	10

- 79% of respondents agreed the meeting date and time were convenient, 21% strongly agreed.
- 72% either agreed or strongly agreed that the location was convenient, 28% were neutral.
- 63% agreed the meeting format was an effective method for sharing information and ideas, 37% strongly agreed.
- All participants agreed or strongly agreed the facilitators and presenters encouraged participation and questions.

3. Please rate your understanding of the LA County HIV/AIDS Strategy.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I understand the goals of the LA County HIV/AIDS Strategy.				13	6
I understand the meaning of Health Districts.		1	3	10	5
I understand how I can work towards increasing PrEP enrollment in my community.		1	3	12	2
I understand how I can help increase diagnoses in my community.		1	7	9	1
I understand how I can help increase viral suppression in my community.			3	13	2

- All respondents either agreed or strongly agreed that they understand the LACHAS goals.
- 53% agreed that they understand the meaning of Health Districts, 26% strongly agreed, 5% disagreed and 16% were neutral.
- Majority of respondents agree they understand how to work towards increasing PrEP enrollment in their community, however 16% were neutral and 1 respondent disagreed.
- The respondent who disagreed on understanding how to increase PrEP enrollment and increase diagnoses was a Commissioner.
- A HOPWA representative, Health Educator, and Pharma Community Liaison respondents (16%) answered neutral to understanding how they can help achieve all three of the LACHAS goals (increasing PrEP enrollment, increasing diagnoses, and increasing viral suppression)
- The least understood LACHAS goal is how to help increase diagnoses in communities. 45% either disagreed or were neutral.

4. Will you bring the information presented back to your organization or community? Please check only one.

Yes, it will be useful. (16)
Yes, but it will not be useful.
I haven't decided. (1)
No, but it will be useful.
No, it will not be useful.
No answer (2)

5. If you are not able to bring the information back to your organization and/or community, please explain why.

- Still defining HOPWA/Admin role

6. What could be improved for future events?

   - Outreach/getting the word out
   - Have a local leader participate as a facilitator
   - More DHSP presence at community events
   - More advertising of Commission meetings to both provider staff and consumers
   - Visuals – difficult to read/see presentation
   - Sound – room is difficult to hear in breakouts

7. Do you need any support or technical assistance regarding implementation of the LA County HIV/AIDS Strategy? Please be specific. If so, please include your name and organization so we can reach out to assist.

   - Presentation at each SPA meeting by DHSP rep
   - Unclear/not sure yet

8. If you would like to be part of future planning efforts for the San Fernando Valley, please fill out your name and contact information below.

Name	Organization	City	Email	Phone
Joseph Leahy	Janssen	Los Angeles	JLeahy5eit3.jnj.com	310-892-6953
Ken Williams	Men's Health Foundation	Los Angeles	Ken.williams@mhfoundation.org	310-550-1010
Adriana Casas	Tarzana Treatment Centers	Tarzana	acasas@tarzanatc.org	818-996-1051 x3117
Alex Iling	Tarzana Treatment Centers	Tarzana	ailing@tarzanatc.org	909-496-8919
Stuart Slechta	Tarzana Treatment Centers	Tarzana	sslechta@tarzanatc.org	818-996-1051 x2112
Alasdair Burton	N/A	Glendale	alasdairburton@gmail.com	818-645-8585

9. Please share any additional comments or suggestions.

   - I completely agree that we need to think differently and engage new partners to achieve goals, but I strongly believe a re-engagement and empowerment of our existing SPA meetings is worth revisiting and reinvesting in – if our agencies do not understand the resources that each agency has and if we are not engaging and educating all staff at each HIV funded agency we cannot achieve the goals.
   - Great dialogue
     Announce COH vacancies at the next LACHAS meeting
   - Partner with the VA
   - Add health district map to the website



LOS ANGELES COUNTY HIV/AIDS STRATEGY FOR 2020 AND BEYOND

Continuing the Community Dialogue in San Gabriel Valley (Pasadena, Alhambra, El Monte, Pomona, and Foothill Health Districts)

Join us as we discuss the Los Angeles County HIV/AIDS Strategy. Let's work together to end the HIV epidemic, once and for all.

Thursday, June 14, 2018
10:00am – 12:00pm*
Registration begins at 9:30am;
Commission on HIV business meeting after Call to Action meeting

Lambert Park Auditorium
11431 McGirk Ave, El Monte, CA 91732

Parking information is available on the back of this flyer. For public transportation, please visit: https://www.metro.net/riding/trip-planner/.

Spanish language interpretation will be available. For more information, visit our website at http://hiv.lacounty.gov/ or call (213) 738-2816.

LOS ANGELES COUNTY COMMISSION ON HIV

COUNTY OF LOS ANGELES Public Health Division of HIV and STD Programs

LA COUNTY HIV

LOS ANGELES COUNTY
COMMISSION ON HIV

2018 Commission on HIV /Los Angeles County HIV/AIDS Strategy Meetings - Call to Action Schedule

June 2018

DAY	TIME	MEETING TYPE	LOCATION	SPA
14 THURSDAY	9 am - 1:30 pm	Commission Meeting	Lambert Park Auditorium 11431 McGirk Ave El Monte, CA 91732	3 - San Gabriel Valley (Pasadena, Alhambra, El Monte, Pomona)

July 2018

DAY	TIME	MEETING TYPE	LOCATION	SPA
12 THURSDAY	9 am - 1:30 pm	Commission Meeting	St. Anne's Conference Center 155 N. Occidental Blvd. Los Angeles, CA	
19* THURSDAY	11 am - 1 pm	Health District Community Meeting	Antelope Valley Community Clinic (AVCC) 45104 10th St W Lancaster, CA 93534	1 - Antelope Valley

August 2018

DAY	TIME	MEETING TYPE	LOCATION	SPA
9 THURSDAY	9 am - 1:30 pm	Commission Meeting	TBD	6 - South (Compton, South LA, Southeast, Southwest)
16* THURSDAY	10 am - 12 pm	Health District Community Meeting	TBD	5 - West LA

* - Additional Meetings

September 2018

DAY	TIME	MEETING TYPE	LOCATION	SPA
12 WEDNESDAY	12 pm - 2 pm	Health District Community Meeting/Long Beach HIV Planning Group	TBD	Long Beach
13 THURSDAY	10 am - 12 pm	Commission Meeting	Music Center	

October 2018

DAY	TIME	MEETING TYPE	LOCATION	SPA
11 THURSDAY	9 am - 1:30 pm	Commission Meeting	St. Anne's Conference Center 155 N. Occidental Blvd. Los Angeles, CA	4 - Metro (Hollywood-Wilshire, Central, Northeast)
18* THURSDAY	10 am - 12 pm	Health District Community Meeting	TBD	8 (Inglewood, Torrance, Harbor)

November 2018

DAY	TIME	MEETING TYPE	LOCATION	SPA
8 THURSDAY	10 am - 12 pm	Annual Commission Meeting	St. Anne's Conference Center 155 N. Occidental Blvd. Los Angeles, CA	

December 2018

DAY	TIME	MEETING TYPE	LOCATION	SPA
13 THURSDAY	9 am - 1:30 pm	Commission Meeting	TBD	7

* Additional Meetings

12. CALIFORNIA OFFICE OF AIDS REPORT:

A. April and May 2018 Monthly Reports

California Department of Public Health CDPH

OFFICE OF AIDS
California Department of Public Health

California Department of Public Health (CDPH), Office of AIDS (OA)
Monthly Report
April 2018

Please note: As part of OA's ongoing work to align all of our work and communications with *Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention, and Care Plan*, this report is now organized to align the updates with Strategies from the Plan, which is available on the OA website at www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/IP_2016_Final.pdf.

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

Pre-Exposure Prophylaxis Assistance Program (PrEP-AP)

- 119 out of 189 (63%) of the AIDS Drug Assistance Program (ADAP) enrollment sites had at least one enrollment worker attend the PrEP-AP training. 275 out of 540 (51%) of enrollment workers attended the PrEP-AP training. OA will conduct additional training within the coming weeks for enrollment sites that may have been unable to attend the previous training sessions.

- OA has executed contracts with six PrEP-AP providers. Contracts have been executed with:

Provider	Local Health Jurisdiction
San Francisco AIDS Foundation	San Francisco
Primary Care at Home Inc.	Oakland
One Community Health	Sacramento
Dignity Health- St. Mary's Med Center	Long Beach
Santa Rosa Community Health	Sonoma
West County Health Centers	Sonoma

- The go-live date for Phase I of the PrEP-AP, for uninsured clients, was April 9. On March 26, an email was sent to 79 ADAP enrollment sites who have met the criteria outlined in Management Memo 2018-01, which is available on the OA website at www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/2018-01%20PrEP-AP%20Implementation%20Plan.pdf. These enrollment sites were notified of the Phase I PrEP-AP go-live date and provided with a PrEP-AP

Enrollment Site Approval Letter and tools to assist the enrollment site in enrolling applicants.

Strategy E: Improve Retention in Care

Access, Adherence, and Navigation Program

- Phase II of the Access, Adherence, and Navigation Program is currently underway and focuses on providing ADAP clients who are not virally suppressed with resources to help achieve and maintain viral suppression.

- On March 15, Access and Adherence Navigators received an ADAP Enrollment System (AES) training on the Phase II functionalities.

- Bi-weekly check-in meetings are being held with the Access and Adherence Navigators to provide programmatic updates and answer questions.

Strategy G: Improve Availability of HIV Care

Office of AIDS Health Insurance Premium Payment (OA-HIPP) Program
The OA-HIPP Program assists with paying health insurance premiums for eligible individuals enrolled in ADAP. OA-HIPP clients are also eligible for the Medical Out-of-Pocket (MOOP) Benefit Program, which assists in paying out-of-pocket costs for outpatient visits, up to a client's annual out-of-pocket maximum.

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

Access, Adherence, and Navigation Program
Phase I of the Access, Adherence, and Navigation Program focused on getting ADAP clients into comprehensive health coverage and ADAP's OA-HIPP Program or Medicare Part D Premium Payment (MDPP) Program, if applicable. Access and Adherence Navigators are continuing to proactively enroll clients in health insurance and ADAP's insurance assistance programs for those who qualify for special enrollment periods.

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

- Dr. Karen Mark, Chief, Office of AIDS, addressed a Town Hall meeting in Eureka, California about the role that syringe services programs and harm reduction play in state and local HIV and HCV prevention efforts. The March 29th meeting convened by Senator Mike McGuire and Supervisor Virginia Bass centered on the opioid epidemic and steps local and state governments are taking to reduce its impact, including efforts to reduce syringe litter in the town of

Eureka. Other speakers included physicians, local public health officials and drug treatment and syringe services providers.

- The Merced Needle Exchange application to provide syringe exchange program (SEP) services at the Family Care Clinic in Merced has been approved by CDPH, OA. Authorization is effective from April 23, 2018, through April 23, 2020. The Family Care Clinic is a rural non-profit located in a medically underserved area. Program services will be provided on Saturdays from 10am – 2pm by resident and community physicians from the University of California Merced School of Medicine, and will include access to HIV and HCV testing, linkage to medical care and treatment for substance use disorders, HIV risk reduction supplies, and referrals to other critical services that lead to improved public health outcomes.

- The Orange County Needle Exchange Program applied to CDPH, OA to provide mobile services in Orange County. Their application is now open for public comment. They propose to provide services within a several-block area of each of the cities comprising Orange County. The 90-day public comment period was initiated on March 27, 2018, through a posting on the OA website at www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_prev_secpapp.aspx. Public comments may be sent to SEPApplication@cdph.ca.gov. Comments must be in writing and submitted to CDPH no later than 11:59 p.m. on June 25, 2018.

- The Community Outreach Harm Reduction Team (COHRT), an Oakland-based harm reduction service agency, applied to CDPH, OA to authorize a new syringe exchange program. Their application is now open for public comment. The proposed program will conduct mobile outreach and harm reduction services for Alameda County's most underserved and hard to reach populations, and will operate on Sundays and Thursdays. The 90-day public comment period was initiated on March 28, 2018, through a posting on the OA website at www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_prev_secpapp.aspx. Public comments may be sent to SEPApplication@cdph.ca.gov. Comments must be in writing and submitted to CDPH no later than 11:59 p.m. on June 26, 2018.

Strategy L: Increase General HIV Education and Awareness and Reduce Stigma around HIV, Sexual Orientation, and Gender Identity

OA has designated a representative to be part of the Adolescent Sexual Health Workgroup Steering Committee facilitated by the Department of Education.

Strategy M: Improve Usability of Collected Data

- OA is pleased to announce that it has contracted with Family Health Centers of San Diego to carry out National HIV Behavioral Surveillance (NHBS) data collection activities in San Diego. The Centers for Disease Control and Prevention (CDC) funds NHBS in more than 20 cities nationwide. Data collection staff in each jurisdiction conduct interviews and HIV testing and counseling among at least 500 people each year, rotating among groups that are especially vulnerable to getting HIV: men who have sex with men, people who inject drugs, and heterosexual people with low income or educational attainment. OA looks forward to working with Family Health Centers of San Diego to collect NHBS data!

- The HIV/AIDS adult case report form (ACRF) in the California Reportable Disease Information Exchange (CalREDIE) is now in the final stages of testing in the CalREDIE test environment. It is expected that after this final testing, the ACRF will be transitioned to the CalREDIE production environment and the rollout phase will begin. The rollout with occur in phases over an approximately five-month period. OA is currently developing the rollout schedule along with the training materials required. More detailed information with be shared as it is available.

- The Supplemental Tables to the California Surveillance Report 2015 have been released. This report contains tables with additional information about 2015 living cases and new diagnoses by race, age, ethnicity, and transmission category. The report is available on the OA website at www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_case_surveillance_reports.aspx.

Strategy N: Enhance Collaborations and Community Involvement

The California Medical Monitoring Project (MMP) is a surveillance system designed to learn more about the experiences and needs of people who are living with HIV. MMP is recruiting physicians to serve on the MMP Provider Advisory Board (PAB), and community members to serve on the MMP Community Advisory Board (CAB). PAB members are eligible to receive Continuing Medical Education (CME) or Continuing Nursing Education (CNE) credits. For more information, please contact Veronica Moore at Veronica.Moore@cdph.ca.gov or by phone at (916) 606-7174.

General OA Updates

- Dr. Juliana Grant has rejoined OA as the new Division Medical Officer. Dr. Grant was previously with OA as the Surveillance Section Chief (2013-2014) and then the Surveillance, Research, and Evaluation Branch Chief (2014-2017). She left

OA this past summer for personal reasons, and is very glad to be back with OA. Dr. Grant will be responsible for a variety of projects including overseeing changes and updates to the ADAP formulary, leading OA-wide clinical quality improvement projects, and supporting cross-branch work around PrEP and Post-Exposure Prophylaxis (PEP). Dr. Grant received her MD from the University of Colorado and Masters of Public Health from San Diego State University. She then joined the CDC as an Epidemic Intelligence Service Officer and spent the subsequent 10 years with CDC as a Medical Epidemiologist working on environmental health, tuberculosis, and HIV.

- On March 9, 2018, Majel Arnold's role as the OA HIV Care Branch Chief concluded as she left for a position with CalVet. Please join OA in thanking Majel for her two years of outstanding service with OA's HIV Care Branch. Karl Halfman is acting as the HIV Care Branch Chief while OA recruits a permanent replacement for the position. Karl has worked at OA for 13 years and in the Care Branch for almost two years as the Chief of the HIV Care Program Section.

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

California Department of Public Health CDPH

OFFICE OF AIDS
California Department of Public Health

California Department of Public Health, Office of AIDS
Monthly Report
May 2018

This report 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 OA website at www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/IP_2016_Final.pdf.

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

Pre-Exposure Prophylaxis Assistance Program (PrEP-AP)

- On March 26, OA reached out to 79 enrollment sites that met the implementation criteria communicated in Management Memo 2018-01, to communicate April 9, 2018, as their PrEP-AP go-live date. OA has since reached out to an additional 26 enrollment sites to communicate April 30, 2018, as their PrEP-AP go-live date. These enrollment sites began enrolling uninsured clients in the PrEP-AP on their respective go-live dates. Sites were provided with a PrEP-AP Enrollment Site Approval Letter and resources to assist the enrollment site in enrolling applicants.

  The Management Memo is available on the OA website at www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/2018-01%20PrEP-AP%20Implementation%20Plan.pdf.

- OA has executed contracts with 18 clinical providers who currently make up the PrEP-AP Provider Network.

Provider with Executed Contract	County	Number of clinics on contract
Primary Care At Home, Inc.	Alameda	1
Clinicas de Salud del Pueblo	Imperial	4
Dignity Health - St. Mary's Medical Center	Los Angeles	1
Desert AIDS Project, Inc.	Riverside	1
APLA Health & Wellness	Los Angeles	2
One Community Health	Sacramento	1
San Ysidro Health - San Ysidro Health Center	San Diego	2

San Francisco AIDS Foundation	San Francisco	1
Santa Rosa Community Health Center	Sonoma	1
West County Health Centers	Sonoma	4

- The OA webpage has been updated to include tools to assist enrollment workers with enrolling clients in the PrEP-AP and to help identify the closest clinical provider in the PrEP-AP Provider Network when making client referrals. These resources, along with job aids, have also been uploaded to the Enrollment Worker SharePoint site, which will house training materials available to enrollment workers.

- OA is working diligently on Phase II implementation, which will expand PrEP-AP benefits to individuals with insurance and Medicare. OA will be disseminating a management memo in mid-May with training dates and an official go-live date.

Strategy E: Improve Retention in Care

Access, Adherence, and Navigation Program

- Phase II of the ADAP Access, Adherence, and Navigation Program is currently underway and focuses on providing ADAP clients who are not virally suppressed with resources to help achieve and maintain viral suppression.
- On April 25, 2 new Access and Adherence Navigators received the Access, Adherence, and Navigation Program Policy Training and ADAP Enrollment System (AES) Training.
- Bi-weekly check-in meetings are being held with the Access and Adherence Navigators to provide programmatic updates and answer questions.

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

- Dr. Karen Mark, Chief of the Office of AIDS, recently addressed a Town Hall meeting on the opioid crisis and efforts underway to address its impact in Humboldt County. Hosted by Senator Mike McGuire and Humboldt County Supervisor Virginia Bass, the meeting included panelists from local syringe exchange and substance use disorder treatment programs, as well as police, health, and social services. Dr. Mark spoke on the link between the opioid crisis and infectious disease, particularly HIV and hepatitis C, and the important role that syringe services and harm reduction strategies can play in disease prevention and providing a bridge to other services. CDPH Office of AIDS provides supplies to three of the four syringe exchange programs in the county, and funds other HIV care, prevention and surveillance activities.

One of those programs, the Humboldt Area Center for Harm Reduction (HACHR), has applied to CDPH, OA to authorize a new syringe exchange program. Their application is now open for public comment. HACHR proposes to increase their current service hours in Eureka and Arcata and establish mobile syringe services in underserved areas throughout Humboldt County. The 90-day public comment period was initiated on April 5, 2018, through a posting on the OA website at www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_prev_secpapp.aspx. Public comments may be sent to SEPApplication@cdph.ca.gov. Comments must be in writing and submitted to CDPH no later than 11:59 p.m. on July 4, 2018.

- Members of the OA harm reduction and drug user health team traveled to San Diego to attend the fifth of six statewide listening sessions coordinated by Harm Reduction Coalition. Hearing firsthand from providers and participants of syringe exchange and naloxone distribution programs helps the OA team shape policy and define program and training priorities. Details for the San Diego listening session are included in the current issue of *Morning Coffee*, a weekly newsletter produced by Harm Reduction Coalition. The newsletter provides updates about webinars and other training resources, funding opportunities, and general harm reduction news. An upcoming issue will include details about the sixth and last listening session to be held in the Central Valley. For those interested in being added to the subscription list for the *Morning Coffee* newsletter, visit the following link: http://harmreduction.us8.list-manage.com/subscribe?u=902a267c624a31780f2479ee0&id=f14d0ac822.

Strategy M: Improve Usability of Collected Data

- The HIV/AIDS adult case report form (ACRF) in the California Reportable Disease Information Exchange (CalREDIE) has completed testing in the CalREDIE testing environment, and testing procedures for database extraction and importation has begun. This phase is expected to take approximately six weeks. When this process is complete, the ACRF will be transitioned to the CalREDIE production environment and the rollout phase will begin. The rollout with occur in phases over an approximately five-month period. OA is currently developing the rollout schedule along with the training materials required. More detailed information with be shared as it is available.

- The California HIV Surveillance Report 2016 and the Supplemental Tables to the California Surveillance Report 2016 have been released and are available on the OA website at www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_case_surveillance_reports.aspx These reports contain tables with information about 2016 new diagnoses,

living cases and deaths by race/ethnicity, age, transmission category, and local health jurisdiction.

- New fact sheets, "Viral Suppression Rates of Medi-Cal Enrollees with HIV" for 2013, 2014, and 2015 are now available on the OA website at www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_case_surveillance_reports.aspx. These fact sheets describe the continuum of care, including viral suppression rates, for people living with diagnosed HIV who are enrolled in Medi-Cal.

Strategy N: Enhance Collaborations and Community Involvement

- On May 30, 2018, OA will convene a *Getting to Zero* meeting in Berkeley, California to bring together key state, local, and community stakeholders to share progress on California's *Getting to Zero* plan and obtain input on potential strategies to address challenges. The meeting is open to the public. A preliminary agenda for the meeting is available on the OA website at www.cdph.ca.gov/Programs/CID/DOA/Pages/OAmain.aspx, under Guiding Documents. Questions regarding the meeting may be sent to Kevin Sitter at kevin.sitter@cdph.ca.gov or (916) 449-5814.

- On May 31-June 1, 2018, OA will host a California Planning Group (CPG) meeting in Berkeley, California. This meeting will provide OA staff and CPG members an opportunity to share updates, provide feedback, and conduct CPG business. The meeting is open to the public and there will be an opportunity for public comment. Information about the meeting is posted on the OA website at www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_CPG.aspx.

General OA Updates

Deadline for submission of final 2017-18 X07 HIV Care Program (HCP)/Minority AIDS Initiative (MAI) Invoices and HCP/MAI Year-End Progress Reports is May 15, 2018.

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

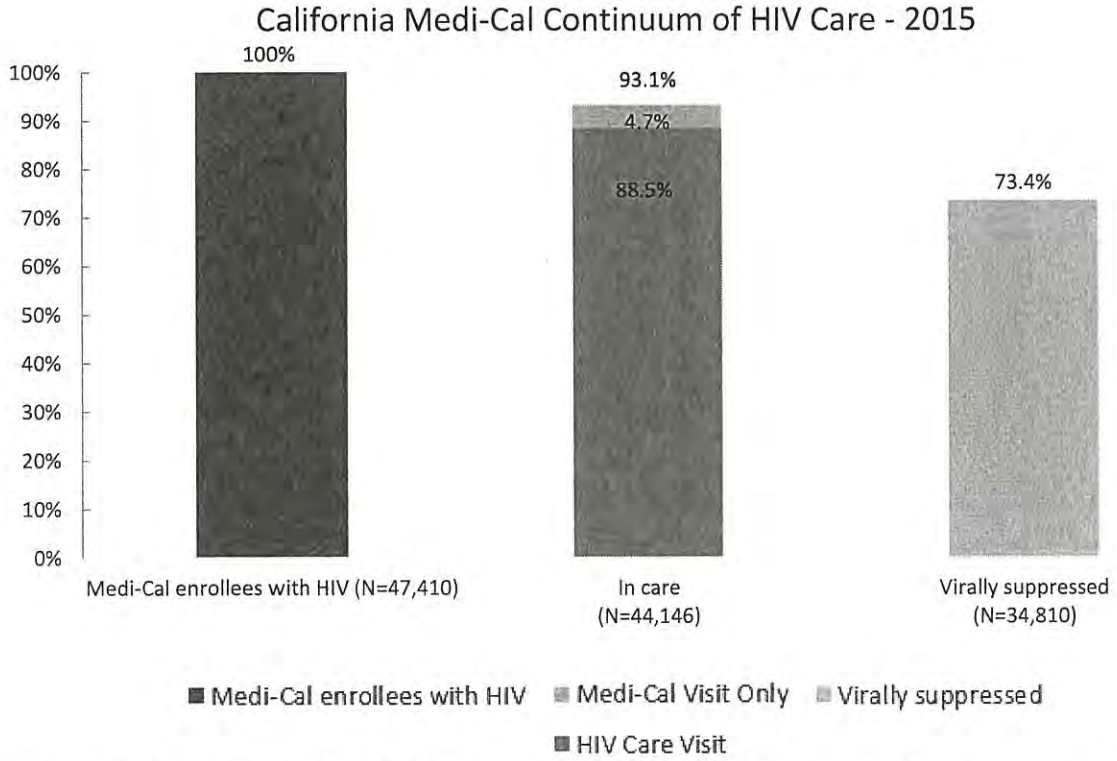
Viral Suppression Rates of Medi-Cal Enrollees with HIV, 2015

The California Department of Health Care Services (DHCS) in collaboration with the California Department of Public Health (CDPH), Office of AIDS (OA), calculated the annual HIV viral load suppression indicator for the Medi-Cal population.

Sustained HIV viral suppression virtually eliminates HIV transmission to sexual partner(s), improves the health of people living with HIV, and is used as a marker for health care quality. The HIV viral load suppression indicator[1] calculates the number and percentage of HIV-positive Medi-Cal beneficiaries who were virally suppressed among those who had received a medical visit during calendar year (CY) 2015 and were confirmed to be HIV positive by CDPH HIV surveillance data.

For the 2015 data presented in this fact sheet, DHCS provided to OA a list of all Medi-Cal HIV-positive beneficiaries along with a variable indicating whether the patient received a medical visit during CY2015 and variables necessary for matching to CDPH's HIV surveillance data.

OA matched the Medi-Cal beneficiaries with HIV-positive individuals in the CDPH HIV surveillance system to confirm HIV infection and determine whether patients were virally suppressed.



- **Medi-Cal Enrollees with HIV**: Medi-Cal data was matched to HIV surveillance cases using a probabilistic matching algorithm. Of the 73,624 Medi-Cal cases provided by DHCS, 47,410 (64.4 percent) matched to HIV surveillance cases.

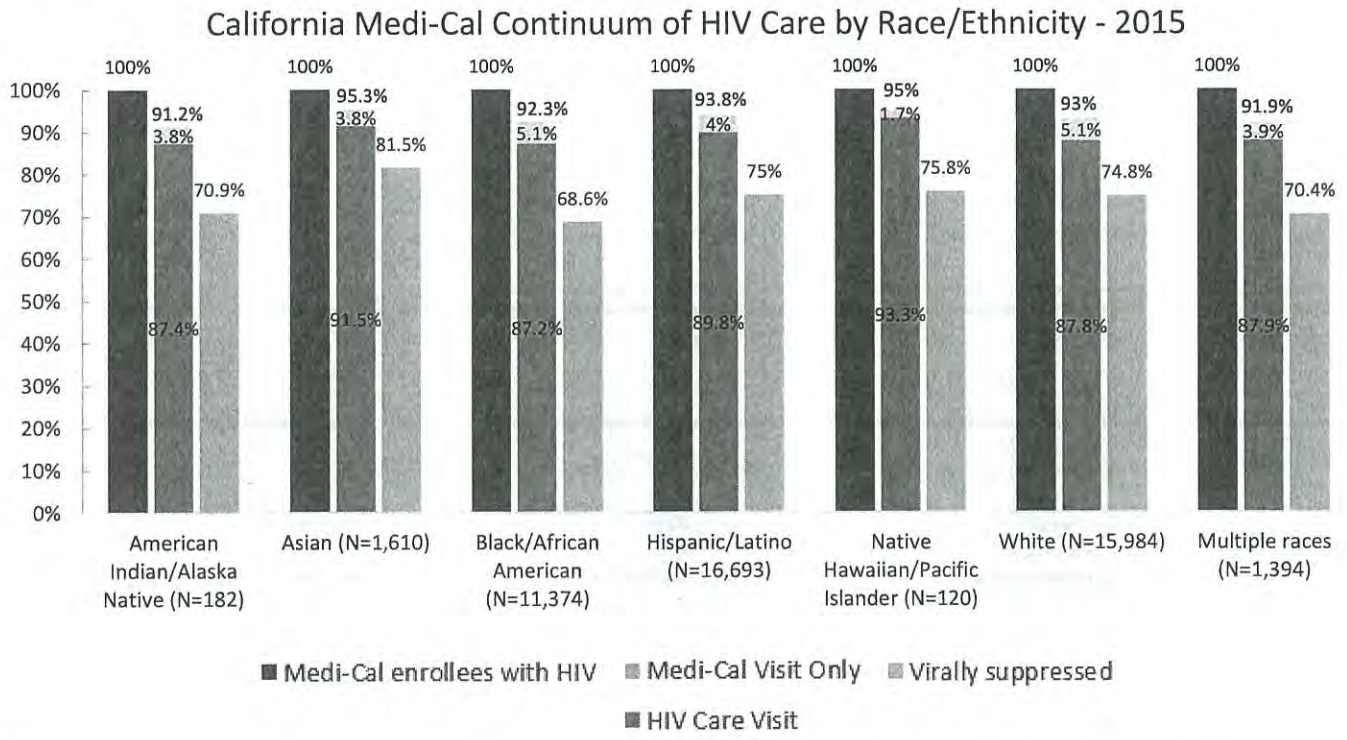
[1]Specifications defined in the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2018 Reporting.

- **In care:** Of the matched Medi-Cal enrollees with HIV, 44,146 (93.1 percent) cases had a medical visit during the year, including 88.5 percent who had at least one HIV care visit (defined as receipt of a CD4 or viral load laboratory test) and an additional 4.7 percent who only had evidence of a Medi-Cal visit (i.e., a Medi-Cal visit but no CD4 or viral load laboratory tests).
- **Virally suppressed**: 34,810 Medi-Cal enrollees with HIV were virally suppressed, determined by laboratory data indicating an HIV viral load of ≤ 200 copies/ml. This represents 73.4 percent of Medi-Cal enrollees with HIV, and 78.9 percent of the Medi-Cal enrollees receiving care.

In 2015, of all Californians living with HIV captured in HIV surveillance data, 72 percent were in HIV care and 61 percent achieved viral suppression. Compared to all persons living with HIV statewide, Medi-Cal enrollees with HIV were more likely to have received a medical visit and more likely to have achieved viral suppression, emphasizing the importance of continued access to quality health care for people living with HIV.

Medi-Cal Viral Suppression Rates by Race[2]

Of the 47,410 matched Medi-Cal enrollees with HIV, 0.4 percent were American Indian/Alaska Native, 3.4 percent Asian[3], 24 percent Black/African American, 35.2 percent Hispanic/Latino/a, 0.3 percent Native Hawaiian/Pacific Islander, 33.7 percent White, and 2.9 percent multiple races.



The percentage of Medi-Cal enrollees with HIV who were in care during CY2015 was similar among all racial/ethnic groups examined, ranging from 91 to 95 percent. In contrast, viral suppression rates varied, with Black/African American, multiple race, and American Indian/Alaska Native Medi-Cal

[2]As reported in HIV surveillance data. There were 53 persons diagnosed and living with HIV in California with an unknown race/ethnicity who are not included in the graph.

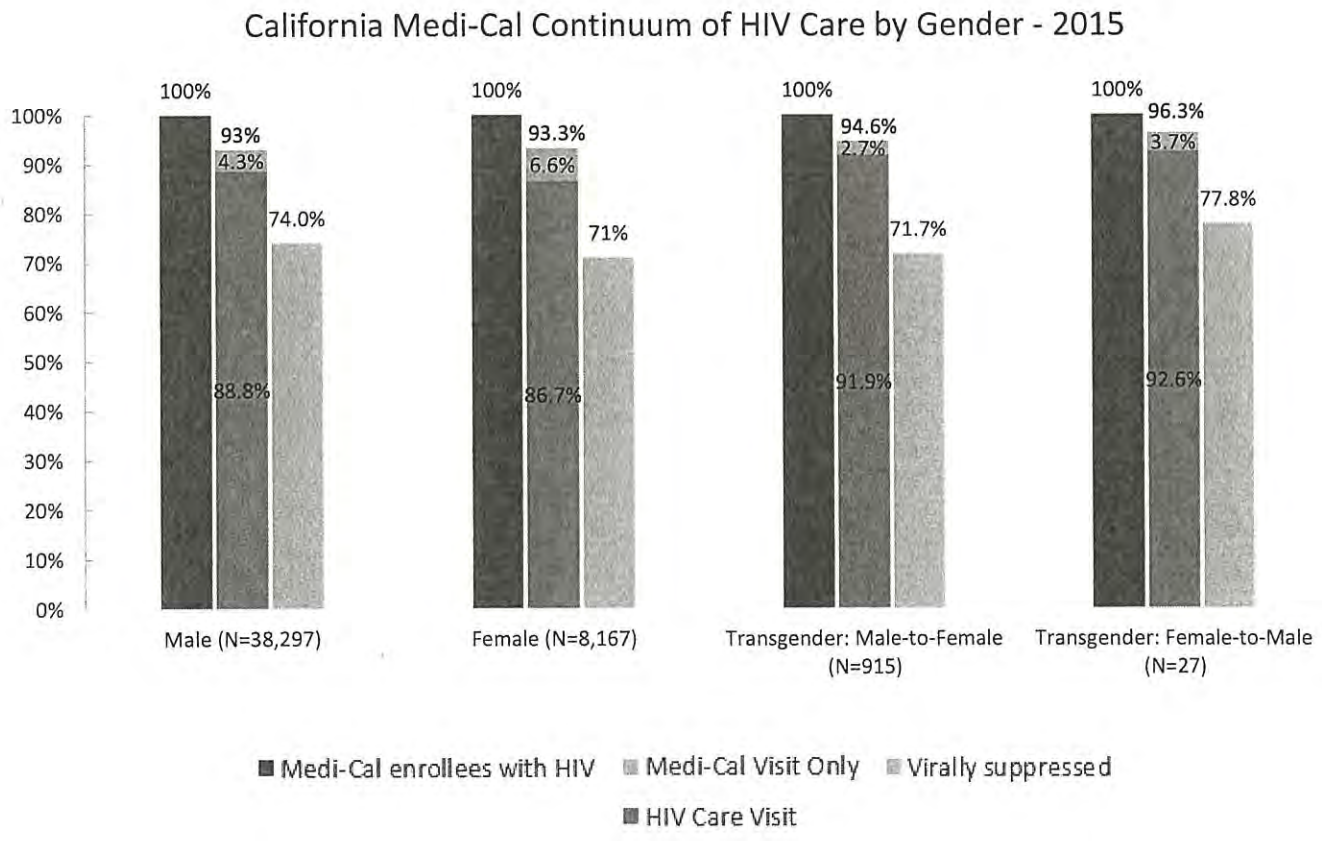
[3]Until 2003, Asian/Native Hawaiian/Pacific Islander was classified as a single category; therefore persons with race/ethnicity data only available prior to 2003 are classified as Asian because they cannot be disaggregated.

enrollees having the lowest viral suppression at 68.6 percent, 70.4 percent and 70.9 percent respectively. Asians had the highest viral suppression at 81.5 percent followed by Native Hawaiian/Pacific Islanders, Hispanic/Latinos/as, and Whites (75.8 percent, 75 percent, and 74.8 percent respectively).

For comparison, statewide, American Indian/Alaska Natives, Black/African Americans, and Hispanic/ Latinos/as had the lowest levels of engagement in care in 2015 (67-69 percent) and were less likely than Native Hawaiian/Pacific Islanders, Whites, and Asians to be virally suppressed (52 percent, 53 percent, and 58 percent respectively, compared to 61 percent for Native Hawaiian/Pacific Islanders, 66 percent for Whites and 68 percent for Asians).

Medi-Cal Viral Suppression Rates by Gender[4]

The majority of the 47,410 matched Medi-Cal enrollees with HIV were men (81 percent). Retention in care among the gender groups ranged from 93 percent to 96.3 percent with transgender men having the highest retention in care during CY2015. Transgender men achieved a higher viral suppression (77.8 percent) followed by men, transgender women, and women (74 percent, 71.7 percent, and 71 percent respectively).



The statewide viral suppression rate is lower than that of Medi-Cal enrollees. Statewide, men are more likely to be virally suppressed (61 percent) compared to transgender men, women, and transgender women (60 percent, 58 percent, and 56 percent respectively).

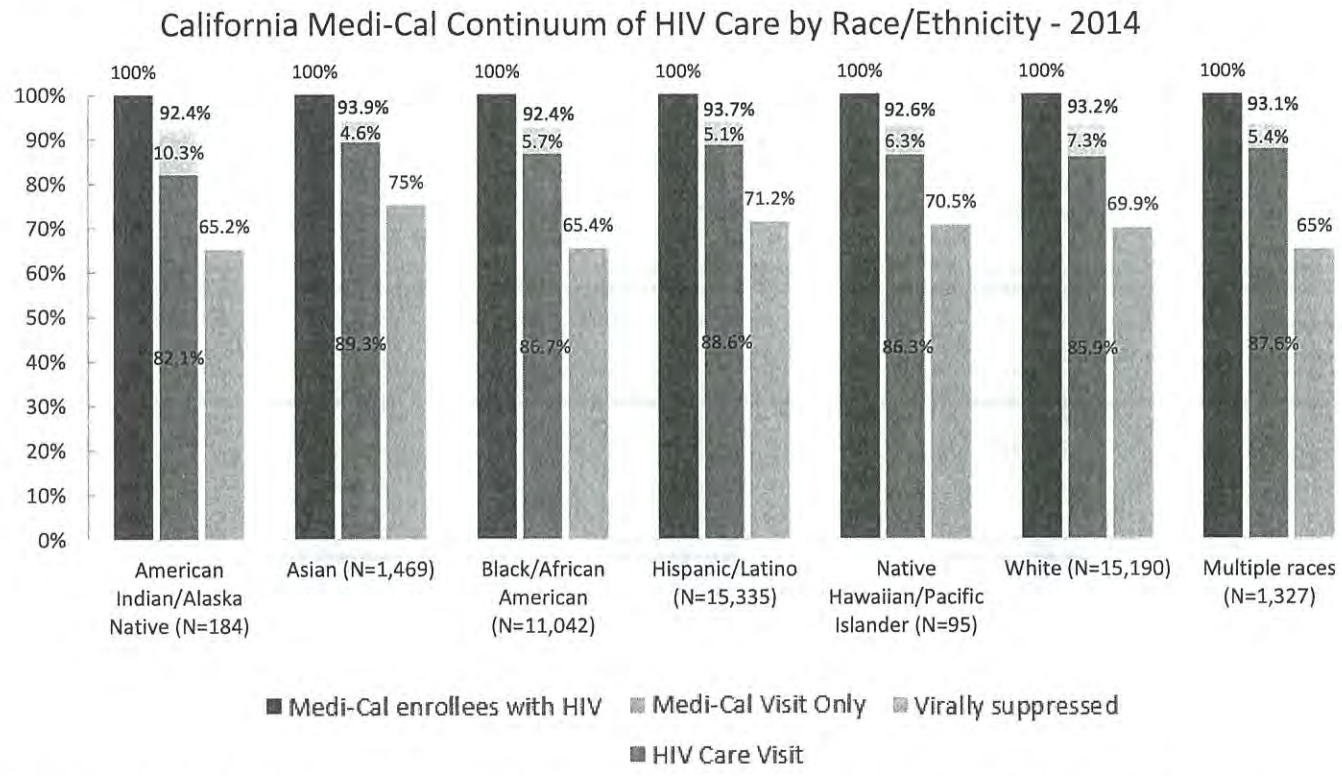
[4]As reported in HIV surveillance data. Gender was determined as of the last day of the calendar year. Persons were classified as being transgender if a case report form affirming their transgender status was present in HIV surveillance data.

- **In care:** Of the matched Medi-Cal enrollees with HIV, 41,628 (93.2 percent) cases had a medical visit during the year, including 87.1 percent who had at least one HIV care visit (defined as receipt of a CD4 or viral load laboratory test) and an additional 6.1 percent who only had evidence of a Medi-Cal visit (i.e., a Medi-Cal visit but no CD4 or viral load laboratory tests).
- **Virally suppressed**: 30,924 Medi-Cal enrollees with HIV were virally suppressed, determined by laboratory data indicating an HIV viral load of ≤ 200 copies/ml. This represents 69.2 percent of Medi-Cal enrollees with HIV, and 74.3 percent of the Medi-Cal enrollees receiving care.

In 2014, of all Californians living with HIV captured in HIV surveillance data, 71 percent were in HIV care and 57 percent achieved viral suppression. Compared to all persons living with HIV statewide, Medi-Cal enrollees with HIV were more likely to have received a medical visit and more likely to have achieved viral suppression, emphasizing the importance of continued access to quality health care for people living with HIV.

Medi-Cal Viral Suppression Rates by Race[2]

Of the 44,685 matched Medi-Cal enrollees with HIV, 0.4 percent were American Indian/Alaska Native, 3.3 percent Asian[3], 24.7 percent Black/African American, 34.3 percent Hispanic/Latino/a, 0.2 percent Native Hawaiian/Pacific Islander, 34 percent White, and 3 percent multiple races.



The percentage of Medi-Cal enrollees with HIV who were in care during CY2014 was similar among all racial/ethnic groups examined, ranging from 92 to 94 percent. In contrast, viral suppression rates varied, with multiple race, American Indian/Alaska Native, and Black/African American Medi-Cal

[2]As reported in HIV surveillance data. There were 43 persons diagnosed and living with HIV in California with an unknown race/ethnicity who are not included in the graph.

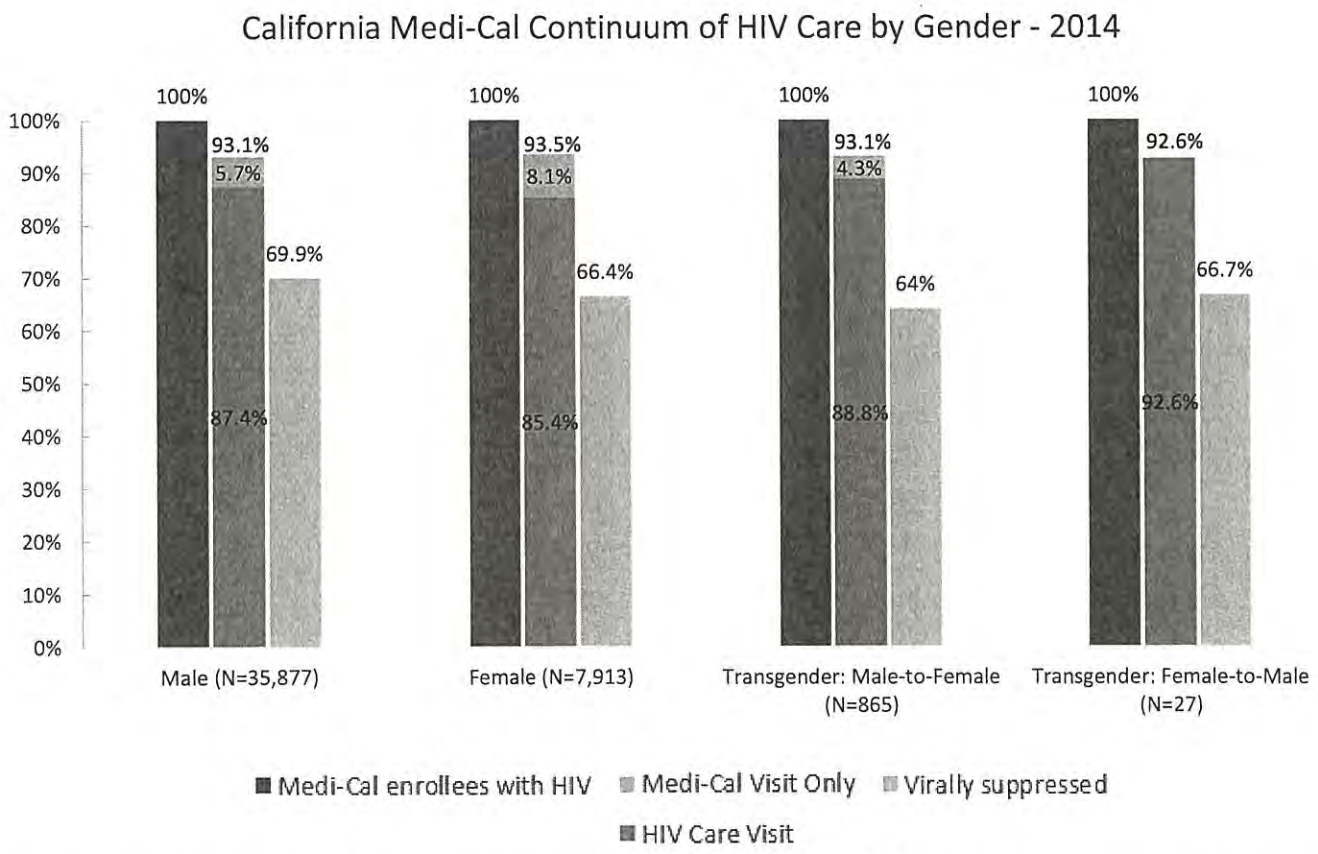
[3]Until 2003, Asian/Native Hawaiian/Pacific Islander was classified as a single category; therefore persons with race/ethnicity data only available prior to 2003 are classified as Asian because they cannot be disaggregated.

enrollees having the lowest viral suppression at 65 percent, 65.2 percent and 65.4 percent respectively. Asians had the highest viral suppression at 75 percent followed by Hispanic/Latinos/as, Native Hawaiian/Pacific Islanders, Whites, and multiple race Medi-Cal enrollees (71.2 percent, 70.5 percent, 69.9 percent, and 65 percent respectively).

For comparison, statewide, American Indian/Alaska Natives, Black/African Americans, Hispanic/Latinos/as and Native Hawaiian/Pacific Islanders had the lowest levels of engagement in care in 2014 (65-69 percent) and were less likely than Whites and Asians to be virally suppressed (48 percent, 49 percent, 54 percent, and 57 percent respectively, compared to 62 percent for Whites and 63 percent for Asians).

Medi-Cal Viral Suppression Rates by Gender[4]

The majority of the 44,685 matched Medi-Cal enrollees with HIV were men (80 percent). All gender categories were equally retained in care (about 93 percent) during CY2014, but men achieved a higher viral suppression (69.9 percent) compared to women, transgender women, and transgender men (66.4 percent, 64 percent, and 66.7 percent respectively).



Although the statewide viral suppression rate is lower than that of Medi-Cal enrollees, the difference between viral suppression among the gender groups is similar. Statewide, men are more likely to be virally suppressed (57 percent) compared to women, transgender women, and transgender men (53 percent, 51 percent, and 47 percent respectively).

[4]As reported in HIV surveillance data. Gender was determined as of the last day of the calendar year. Persons were classified as being transgender if a case report form affirming their transgender status was present in HIV surveillance data.

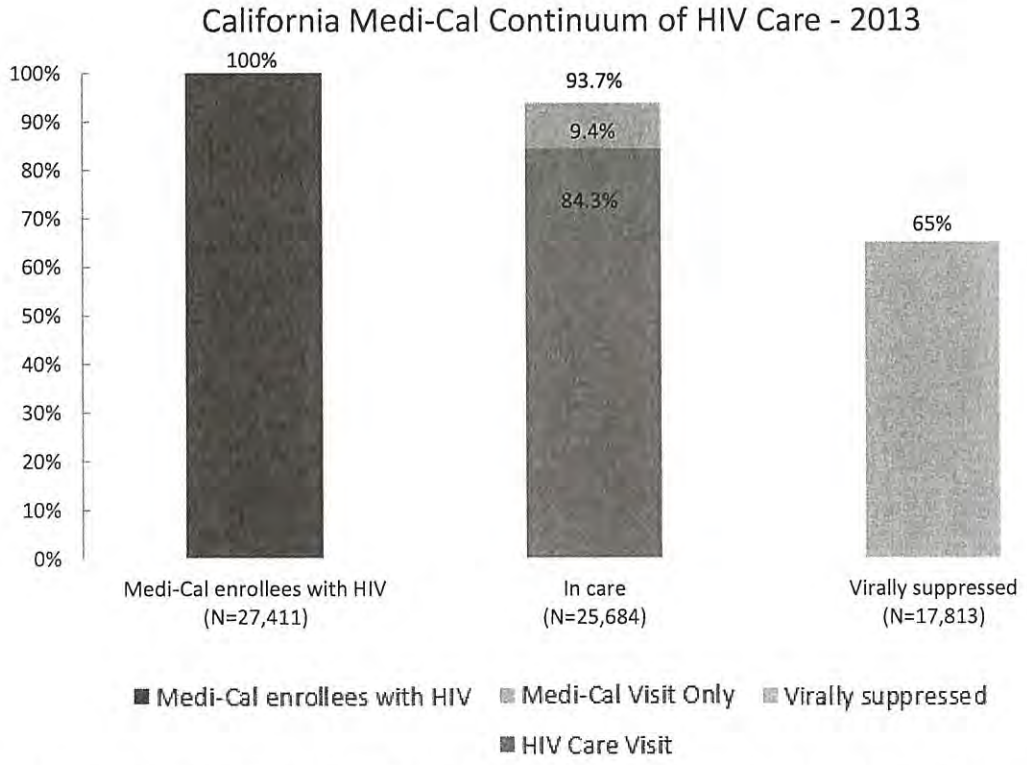
Viral Suppression Rates of Medi-Cal Enrollees with HIV, 2013

The California Department of Health Care Services (DHCS) in collaboration with the California Department of Public Health (CDPH), Office of AIDS (OA), calculated the annual HIV viral load suppression indicator for the Medi-Cal population.

Sustained HIV viral suppression virtually eliminates HIV transmission to sexual partner(s), improves the health of people living with HIV, and is used as a marker for health care quality. The HIV viral load suppression indicator[1] calculates the number and percentage of HIV-positive Medi-Cal beneficiaries who were virally suppressed among those who had received a medical visit during calendar year (CY) 2013 and were confirmed to be HIV positive by CDPH HIV surveillance data.

For the 2013 data presented in this fact sheet, DHCS provided to OA a list of all Medi-Cal HIV-positive beneficiaries along with a variable indicating whether the patient received a medical visit during CY2013 and variables necessary for matching to CDPH's HIV surveillance data.

OA matched the Medi-Cal beneficiaries with HIV-positive individuals in the CDPH HIV surveillance system to confirm HIV infection and determine whether patients were virally suppressed.



- **Medi-Cal Enrollees with HIV**: Medi-Cal data was matched to HIV surveillance cases using a probabilistic matching algorithm. Of the 42,942 Medi-Cal cases provided by DHCS, 27,411 (63.8 percent) matched to HIV surveillance cases.

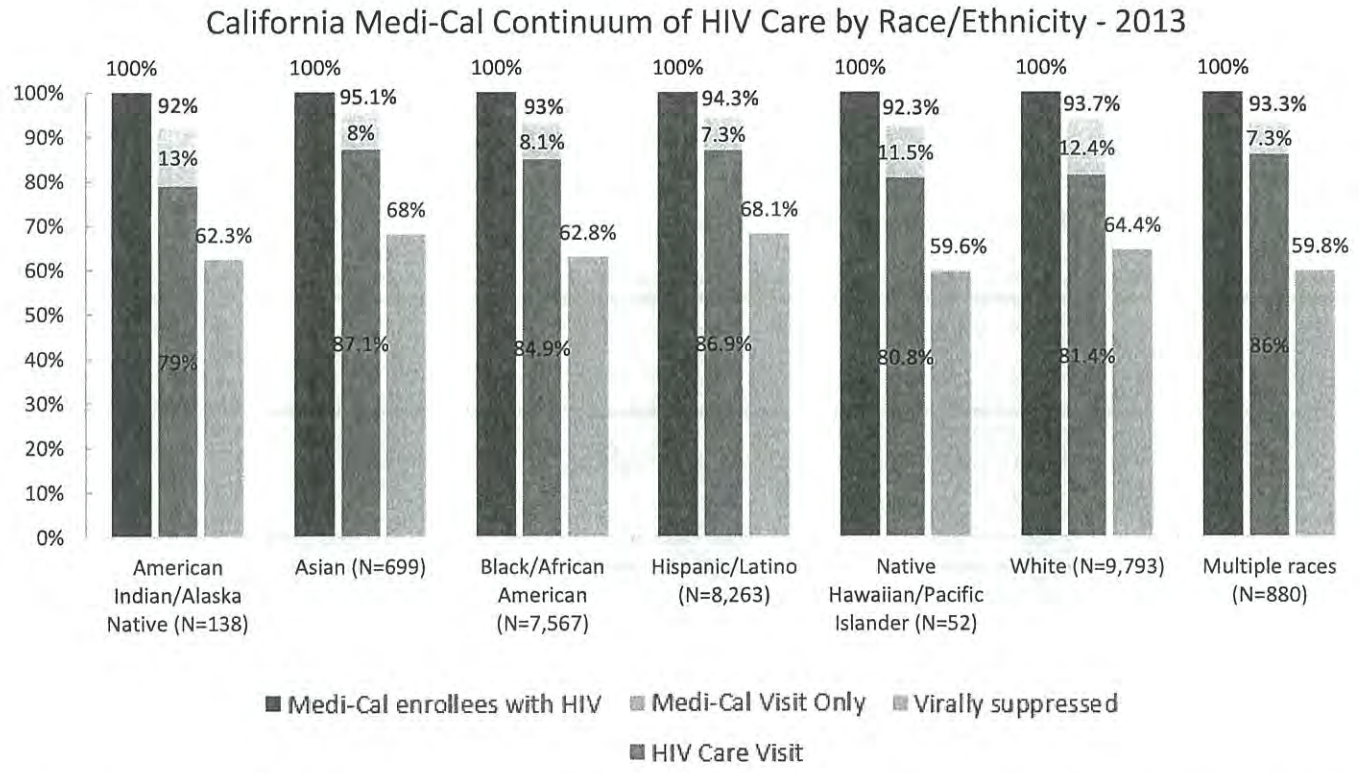
[1]Specifications defined in the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2018 Reporting.

- **In care:** Of the matched Medi-Cal enrollees with HIV, 25,684 (93.7 percent) cases had a medical visit during the year, including 84.3 percent who had at least one HIV care visit (defined as receipt of a CD4 or viral load laboratory test) and an additional 9.4 percent who only had evidence of a Medi-Cal visit (i.e., a Medi-Cal visit but no CD4 or viral load laboratory tests).
- **Virally suppressed**: 17,813 Medi-Cal enrollees with HIV were virally suppressed, determined by laboratory data indicating an HIV viral load of ≤ 200 copies/ml. This represents 65 percent of Medi-Cal enrollees with HIV, and 69.4 percent of the Medi-Cal enrollees receiving care.

In 2013, of all Californians living with HIV captured in HIV surveillance data, 67 percent were in HIV care and 53 percent achieved viral suppression. Compared to all persons living with HIV statewide, Medi-Cal enrollees with HIV were more likely to have received a medical visit and more likely to have achieved viral suppression, emphasizing the importance of continued access to quality health care for people living with HIV.

Medi-Cal Viral Suppression Rates by Race[2]

Of the 27,411 matched Medi-Cal enrollees with HIV, 0.5 percent were American Indian/Alaska Native, 2.6 percent Asian[3], 27.6 percent Black/African American, 30.1 percent Hispanic/Latino/a, 0.2 percent Native Hawaiian/Pacific Islander, 35.7 percent White, and 3.2 percent multiple races.



The percentage of Medi-Cal enrollees with HIV who were in care during CY2013 was similar among all racial/ethnic groups examined, ranging from 92 to 95 percent. In contrast, viral suppression rates varied, with Native Hawaiian/Pacific Islander, multiple race, American Indian/Alaska Native, and

[2]As reported in HIV surveillance data. There were 19 persons diagnosed and living with HIV in California with an unknown race/ethnicity who are not included in the graph.

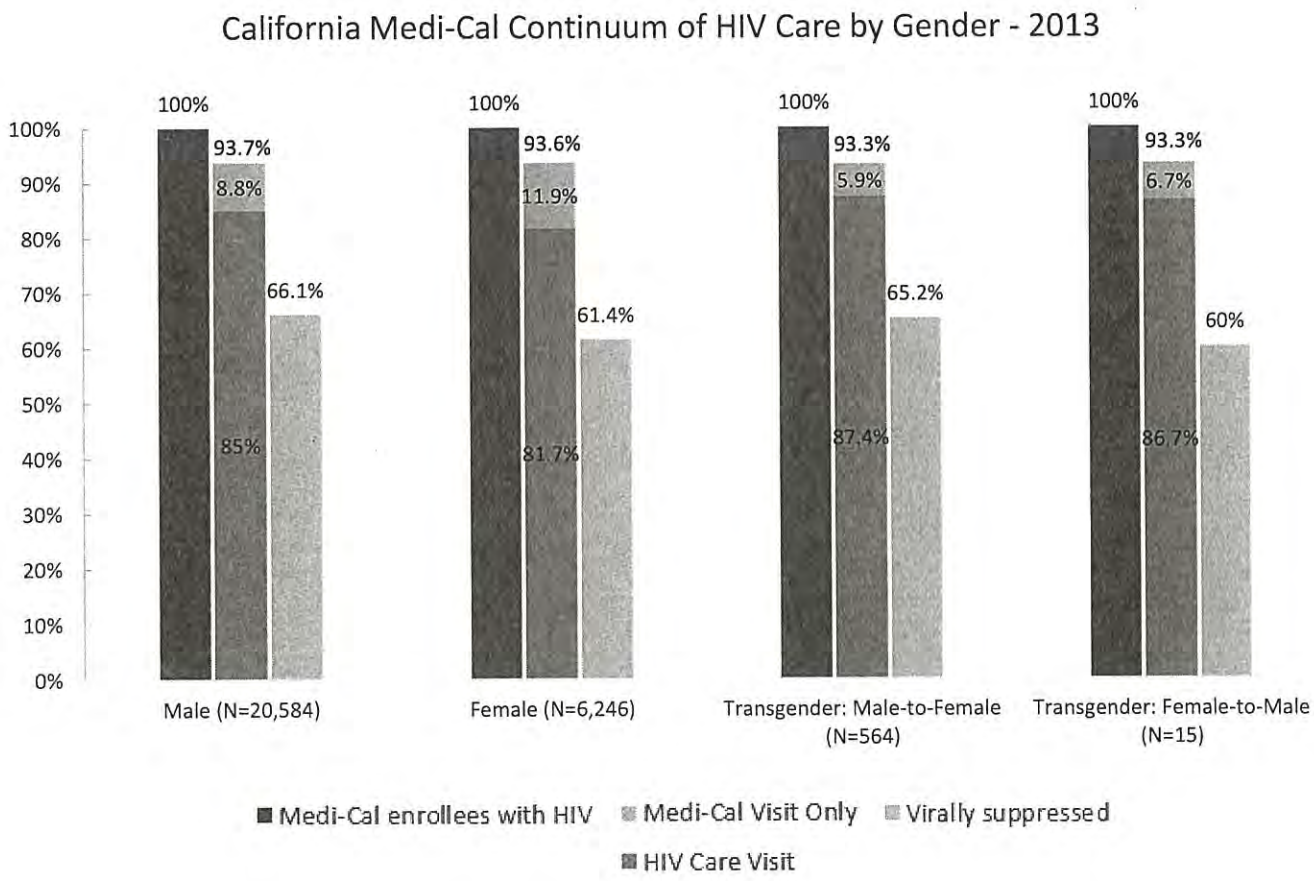
[3]Until 2003, Asian/Native Hawaiian/Pacific Islander was classified as a single category; therefore persons with race/ethnicity data only available prior to 2003 are classified as Asian because they cannot be disaggregated.

Black/African American Medi-Cal enrollees having the lowest viral suppression at 59.6 percent, 59.8 percent, 62.3 percent and 62.8 percent respectively. Hispanic/Latinos/as had the highest viral suppression at 68.1 percent followed by Asians and Whites (68 percent and 64.4 percent respectively).

For comparison, statewide, American Indian/Alaska Natives, Black/African Americans, Hispanic/Latinos/as, and Native Hawaiian/Pacific Islanders had the lowest levels of engagement in care in 2013 (60-66 percent) and were less likely than Whites and Asians to be virally suppressed (43 percent, 47 percent, 51 percent, and 51 percent respectively, compared to 57 percent for Whites and 60 percent for Asians).

Medi-Cal Viral Suppression Rates by Gender[4]

The majority of the 27,411 matched Medi-Cal enrollees with HIV were men (75 percent). All gender categories were equally retained in care (about 93 percent) during CY2013, but men achieved a higher viral suppression (66.1 percent) compared to women, transgender women, and transgender men (61.4 percent, 65.2 percent, and 60 percent respectively).



Although the statewide viral suppression rate is lower than that of Medi-Cal enrollees, the difference between viral suppression among the gender groups is similar. Statewide, men are more likely to be virally suppressed (57 percent) compared to women, transgender women, and transgender men (50 percent, 48 percent, and 45 percent respectively).

[4]As reported in HIV surveillance data. Gender was determined as of the last day of the calendar year. Persons were classified as being transgender if a case report form affirming their transgender status was present in HIV surveillance data.

13. STANDING COMMITTEE REPORTS:

A. OPERATIONS COMMITTEE:

1. Policies and Procedures
   a. Revised Policy #09.4205: Commission Membership Evaluation and Nomination Process **(MOTION #4)**
4. Recruitment and Retention
   a. Recruitment Efforts

B. PUBLIC POLICY COMMITTEE:

3. Federal, State and County Legislation/Policy
   a. Proposed 2018 COH Legislative Docket **(MOTION #6)**

D. STANDARDS AND BEST PRACTICES (SBP) COMMITTEE:

2. Legal Assistance Services Standards | **20-Day Public Comment Period (Exp. 5/30)**

13. STANDING COMMITTEE REPORTS (cont'd):

A. OPERATIONS COMMITTEE:

1. Policies and Procedures
   a. Revised Policy #09.4205: Commission Membership Evaluation and Nomination Process **(MOTION #4)**
4. Recruitment and Retention
   a. Recruitment Efforts

POLICY/PROCEDURE #09.4205	Commission Membership Evaluation and Nomination Process	Page 1 of 8

REVISIONS APPROVED 9/14/17
PROPOSED REVISIONS 4/26/18

SUBJECT: **The submission, evaluation, scoring, selection and nomination of applications/ candidates for seats on the Los Angeles County Commission on HIV.**

PURPOSE: **To outline consistent method for evaluating, scoring and selecting candidates to fill Commission seats, and for appropriate communication with those applicants before and after evaluation of the application.**

PROCEDURE(S):

1. **Membership Applications**: There are two Commission membership application forms:
   a) **New/Renewal Member Applications**: for first-time applicants for Commission membership and renewing members see Membership Application.
   b) **Community Member Application(s)**: for applicants who are applying for membership on one of the Commission's standing committees, but not for the Commission, see Policy/Procedure #09.1007 (Community Membership) for details regarding the process for evaluating and nominating community member candidates.

2. **Application Submission**: All candidates for Commission or Committee membership must complete and submit one of the two forms of membership application. Upon receipt of a completed application:
   a) Staff will initially review the application for completeness and accuracy, and will notify the candidate if there are incomplete sections or if information is not understandable/ accurate.
   b) Staff will coordinate interview and/or next steps with the Operations Co Chairs.

3. **Application Evaluation Timeline**: Provided all conditions for a Commission membership application are met, the Operations Committee will evaluate and score the application at the next available Operations Committee meeting or within 60 days of its receipt. Necessary conditions include, but are not limited to:
   a) All sections of the application are complete,
   b) Original signatures have been provided,
   c) The applicant is willing and available to sit for an interview when appropriate.
   d) Current Commissioners or Alternates who are seeking to continue their membership on the Commission are required to complete an application prior to the expiration of their membership terms. The renewal application focuses on the member's past performance, strengths and weaknesses, and methods for improving any gaps in service and/or participation.

e) Candidates for institutional seats will be not be required to sit for an interview but will be assessed for strengths and skill sets for training opportunities and placement in the appropriate committee, task force, caucus or workgroup.

4. **Candidate Interviews**: All new member candidates must sit for an interview with a panel composed of at least two Commission members or alternates in good standing with at least one member assigned to the Operations Committee. To maintain transparency and integrity of the nomination process, should an interview panelist be assigned to an interview of an applicant with which the panelist has a personal relationship, working relationship while employed by same employer, used as reference by the applicant, and/or other conflict of interest as identified by the Operations Co-Chairs and Executive Director, the panelist will be removed from the interview panel and a qualified Commission member will be selected in their stead.

   The Operations Committee, in consultation with the Commission Co-Chairs, may request an interview with a member seeking to renew his/her Commission membership. Likewise, a renewal membership candidate may request an interview with the Operations Committee. For renewing members occupying institutional seats, i.e., City/Health Districts, Medi-Cal, etc., the interview is waived in lieu of a completed self-assessment, unless Operations co-chairs or renewing member requests interview.
   a) Special meetings for interviews can be scheduled at the discretion of the Committee, in accordance with Brown Act requirements.

5. **Interview/Scoring Sequence**: Applications are always evaluated and scored following the interview. At its discretion, the interview panel may request an interview after it has scored an application, and re-score the application following the interview to incorporate any new information learned at subsequently and/or at the interview. Point scores may or may not change when an application is re-scored following an interview.

6. **Score(ing)**: The interview panel evaluates the applicant according to the appropriate "Los Angeles County Commission on HIV New Member Application Evaluation & Scoring Sheet (Final 4.24.17)."
   a) Each member of the interview panel participating in the evaluation assigns a point value to each factor of criteria.
   b) All interview panel members' scores are totaled and averaged. The final point value is the applicant's final score.

7. **Scoring Forms**: The Commission's Operations Committee is responsible for the development and revision of the Membership Candidate Evaluation/Scoring Forms. The Committee develops separate scoring forms for new member candidates and renewal candidates:

a) Scoring criteria is based on essential skills and abilities, qualities and characteristics, experience, and past performance (for renewal candidates) that the Committee determines is necessary for effective Commission member participation.
b) The Operations Committee determines those factors and their relative importance through annual membership assessments.
c) The Operations Committee is authorized to revise the scoring form as needed. To the degree that revisions are substantial or criteria are altered, the revised scoring form must be approved by the Commission.

8. **Qualification Status**: By virtue of their application scores, candidates' application will be determined to be "Qualified" or "Not Qualified" for nomination to a Commission membership seat. A minimum of 60 points qualifies the candidate for nomination consideration ("Qualified"); a score of less than 60 indicates that a candidate is "Not Qualified".
   a) If the applicant earns a "Not Qualified" score, the Operations Co-Chairs will inform the applicant accordingly and suggest opportunities of other HIV/AIDS planning or volunteer involvement as further preparation for future Commission service.

9. **New Member Candidate Eligibility**: New member candidates must also be "eligible" for Commission membership nomination. New member candidates are considered eligible if they meet the following conditions:
   a) The application score qualifies ("Qualified") the candidate for Commission membership.
   b) There is no purposefully misleading, untruthful or inaccurate information on the application.
   c) The applicant has fully participated in the evaluation/scoring process, as appropriate.
   d) The applicant does not violate the Commission's "two persons per agency" practice. To avoid potential influence and to preserve the integrity of the Commission's decision-making and planning process, the Commission's membership cannot consist of more than two agency representatives from the same agency.

10. **Renewal Candidate Eligibility**: Current Commissioners seeking re-appointment to the Commission must be "eligible" for continued Commission membership. Renewal candidates are considered eligible if they meet the following conditions:
    a) The application score qualifies ("Qualified") the candidate for Commission membership.
    b) There is no purposefully misleading, untruthful or inaccurate information on the application.
    c) The applicant has fully participated in the evaluation/scoring process, including an interview if requested, as appropriate.
    d) The applicant does not violate the Commission's "two persons per agency" practice.
    e) The candidate has fulfilled Commission member requirements in his/her prior term of service, including, but not limited to:

- ***Commission Meeting Attendance***: unless the reason for the absence falls within Policy #08.3204 Excused Absences, members cannot miss three sequential, regularly scheduled Commission or primary assignment committee meetings in a year, or six of either type of meeting in a single year. Policy 08.3204 dictate that excused absences can be claimed for the following reasons:
- personal sickness, personal emergency and/or family emergency;
- vacation; and/or
- out-of-town travel
- ***Primary Committee Assignment***: members have actively participated in the committee to which they have been assigned, including compliance with meeting attendance requirements.
- ***Training Requirements***: members are required to participate in designated trainings as a condition of their memberships.
- ***Plan of Corrective Action (PCA)***: the member must fulfill the terms of any PCA required of him/her by the Operations and/or Executive Committee(s).

11. **Nominations Matrix**: If the applicant is eligible for Commission membership, the Operations Committee will place the candidacy among those that can be nominated for available and appropriate seats on the Commission. The candidate's name is entered on the "Nominations Matrix" which lists candidates in order of scores, alongside available Commission seats and vacancies.

12. **Seat Determination**: The Committee will then determine the individual seats, if any, that are most appropriate for the available qualified candidates—based on the seats the candidates indicated in their applications, and any other seat(s) identified by Committee members that the candidate(s) are qualified to fill.
    a) Duty Statements for each seat (Policy/Procedures #07.0000) dictate requirements for each membership seat on the Commission.

13. **Multiple Application Requirement**: In accordance with HRSA guidance, there should be multiple candidates for membership seats when possible. All consumer and provider representative seats, along with other seats designated by the Operations Committee, require two or more applications. The Operations Committee may exempt a seat previously designated to require multiple applications from that requirement under the following circumstances:
    a) There has been a vacancy in the seat for six or more months,
    b) The pool of available, possible candidates is limited, and
    c) The Committee is convinced that every effort has been made and exhausted by the appropriate stakeholders to identify additional membership candidates.

14. **"Representation" Requirement**: Ryan White legislation and HRSA guidance require the Part A planning council membership to include specific categories of representation. The Commission's membership seats have been structured to fulfill that requirement. As

specified in the COH bylaws (Policy/Procedure #06.1000), Commission membership shall include individuals from areas with high HIV and STD incidence and prevalence. The Commission endeavors to ensure those categories are always represented by planning council membership.

15. **"Unaffiliated Consumer" Requirement**: Ryan White legislation and HRSA guidance require one-third of the voting membership of the Ryan White Part A planning council to be "unaffiliated" or "non-aligned" consumers. "Unaffiliated" consumers are patients/clients who use Ryan White Part A-funded services and who are not employees or contractors of a Ryan White Part A-funded agency and do not have a decision-making role at any Ryan White Part A-funded agency. Policy/Procedure #08.3107 contains information on Consumer Definitions and Related Rules and Requirements). In addition, the Commission defines "consumer" as someone using Ryan White Part A-funded services within the last year and who is "unaffiliated" or "non-aligned," consistent with Ryan White legislative and HRSA definitions.

    Following the updated ordinance of the Commission as an integrated HIV prevention and care planning body, a "Consumer" is defined as an HIV-positive and/or AIDS-diagnosed individual who uses Ryan White-funded services or is the caretaker of a minor with HIV/AIDS who receives those services, or an HIV-negative prevention services client.

16. **"Reflectiveness" Requirement**: Ryan White legislation and HRSA guidance require both the entire Commission membership and the subset of unaffiliated consumer members to "reflect" the gender and ethnic/racial distribution of the local HIV epidemic. The Commission endeavors to reflect the gender and ethnic/racial demographic distribution of Los Angeles County's HIV epidemic among its membership and consumer members at all times. Furthermore, the CDC HIV Planning Guidance notes that planning bodies place special emphasis on identifying representatives of at-risk, affected, HIV-positive, and socioeconomically marginalized populations.

17. **Committee Nominations**: All factors being equal among two or more applications that meet the requirements of a particular open seat, the Committee will forward the candidate with the highest application score to the Commission for nomination to the Board of Supervisors for appointment to the Commission.

18. **Special Considerations**: There are a number of "special considerations" may preclude the Committee from nominating the candidate with the highest score, resulting in the nomination of a candidate with a lower score to a seat. Those factors may include, but are not limited to:
    a) the necessity of maintaining "reflectiveness",
    b) an adequate proportion of consumer members,
    c) the need to fill certain "representative" categories,
    d) Board of Supervisors interest or feedback,

e) over-representation of a particular stakeholder/constituency, otherwise known as the "two persons per agency" practice.
f) potential appointment challenges.

19. **Conditional Nomination(s)**: The Operations Committee may nominate candidates "conditionally." Conditional nominations require candidates to fulfill certain obligations from the Executive and/or Operations Committee prior to or following the nomination. Conditions are detailed in a "Plan of Corrective Action (PCA)" imposed to correct past Commission performance issues or to enhance certain skills and abilities of the candidate/ member.
    a) The PCA is written with expected timelines and objectives, and must be agreed to and signed by the candidate, the Executive Director and an Executive or Operations Committee co-chair, as appropriate.
    b) The candidate must agree to the PCA by the subsequent regularly scheduled committee meeting following the development of the PCA. A candidate's refusal to accept a PCA may render his/her application ineligible.
    c) If the PCA obligates the candidate to certain conditions prior to nomination, the nomination will not proceed until the candidate has fulfilled those obligations.
    d) If the candidate/member has not fulfilled the conditions of the PCA, he/she will not be eligible for future re-nomination to the Commission.
    e) Terms of the PCA may be modified at any time upon agreement from all three parties (candidate/member, Executive Director, committee).
    f) The Operations Committee is responsible for monitoring a candidate's progress and fulfillment of any PCA obligations and requirements.

20. **Candidate Communication**: At the conclusion of a candidate's evaluation (interview, scoring, qualification and eligibility designation, seat determination, nomination), the Committee shall notify the candidate in written communication of the results of the evaluation and scoring process. The notification will detail one of the three possible results:
    a) The Committee has nominated the candidate for a particular Commission seat;
    b) The Committee has judged that there are no specific seats available concurrent with the candidate's qualifications, but the Committee will keep the candidate's application and evaluation scores for ongoing consideration for up to a year from the date of application submission; or
    c) The candidate's application and/or evaluation has been placed on hold temporarily.

21. **Temporary Hold**: A candidate's application may be held temporarily for up to a year under certain conditions that preclude an otherwise eligible nomination to proceed, including but not limited to:
    a) Multiple candidates have not applied for a seat that requires multiple applications,
    b) Appointment of the candidate to a seat would interfere with the Commission's capacity to meet representation, consumer and/or reflectiveness requirements, and/or

c) The Committee intends to nominate the candidate to a seat that is expected to be vacated in the near future.

The Operations Committee will provide the reason(s) for a temporary hold when it notifies the candidate of his/her application status. Once a candidate's application has been released from the hold, the candidate must agree to the nomination before it proceeds. If the hold is not released within the year, the candidate must submit a new application for Commission membership.

22. **Withdrawal/Declination**: At any time after a candidate has submitted an application up until the appointment is approved by the Board of Supervisors, a candidate is entitled to withdraw his/her application and/or decline a proposed nomination.

23. **Training Requirements**: Commissioners and Alternates are required to fulfill all training requirements, as indicated in the Commission's approved comprehensive training plan, including, but not limited to, the New Member Orientation(s), and Los Angeles County Ethics and Sexual Harassment trainings.

    a) A candidate's nomination will not be forwarded to the Commission until he/she has completed requisite training activities prior to his/her nomination/appointment.
    b) Failure to fulfill training requirements as a Commission member may render the member's subsequent renewal applications ineligible.

24. **Nomination and Approval**: Once the Operations Committee has nominated a candidate for Commission membership, the Committee forwards the nomination(s) to the Commission for approval at its next scheduled meeting. If and when a candidate's nomination has been approved by the Commission, the candidate's Statement of Qualifications shall be forwarded within two weeks to the Executive Office of the Board of Supervisors.
    a) Candidates are advised to attend the Commission meeting at which their nomination will be considered.
    b) Upon Commission approval, the candidate is encouraged to attend all committees to learn how they operate and assess the best fit for a committee assignment.
    c) Upon Commission approval, the candidate is asked to complete a "Committee Preference Form" indicating his/her various committee assignment interests.

25. **Appointment**: The Executive Office of the Board of Supervisors places the nomination on a subsequent Board of Supervisors agenda for appointment. Upon Board of Supervisors approval, the candidate is appointed to the Commission.
    a) Candidates are not required to appear before the Board of Supervisors, although they may attend the designated meeting if so desired.
    b) Candidates will be notified in writing when their nomination will appear before the Board of Supervisors, and following appointment.
    c) A newly appointed Commission member is expected to begin his/her service on the Commission at the next scheduled Commission meeting following Board appointment.

d) Each Commission seat has a pre-designated term of office in which the Commission member will serve until the term expires or he/she resigns from the seat.

~~**26. Performance Evaluations:** As part of the Commission's commitment to developing and maintaining an effective planning body, all Commissioners will complete a performance evaluation at the end of their term. The COH Co-chairs and Executive Director will evaluate members' performance based on member requirements described in the Commission bylaws (Policy/Procedure #06.100) in April of every year. The components of the Commissioner Performance Evaluations (Attachment A) are:~~

~~a) **Attendance:** Commissioners and/or their Alternates are expected to attend all regularly scheduled Commission meetings, priority- and allocation-setting meetings, orientation and training meetings, and the Annual Meeting. Unless on medical leave, members cannot miss three sequential, regularly scheduled Commission or primary assignment committee meetings in a year, or six of either type of meeting in a single year. Such an occurrence can result in a letter of censure or a recommendation for removal from the Commission or Committee.~~

~~b) **Committee Assignments:** Commissioners are required to be a member of at least one standing committee, the member's "primary committee assignment," and adhere to attendance requirements of that committee.~~

~~c) **Code of Conduct:** All Commission members are expected to adhere to the Commission's approved code of conduct at Commission and related meetings and in the private conduct of Commission business.~~

~~d) **Comprehensive Training:** Commissioners and Alternates are required to fulfill all training requirements, as indicated in the Commission's approved comprehensive training plan, including, but not limited to, the New Member Orientation(s), and Los Angeles County Ethics and Sexual Harassment trainings.~~

~~e) **Commissioner and Seat Specific Duty Statements:** Commissioners and/or their Alternates are expected to meet the duties and responsibilities specified in the Commissioner and Seat Specific Duty Statements. All Commissioners must have on file a signed Duty Statement attesting their understanding and acceptance of their roles and responsibilities.~~

~~The Co-Chairs and Executive Director may develop a Plan of Action (PCA; Attachment B) in collaboration with the member, with specific action steps for performance improvements.~~

~~**Attachment A:** Commissioner Performance Evaluation Form~~

~~**Attachment B:** Plan of Corrective Action~~

NOTED AND APPROVED: Cheryl A Barnett **EFFECTIVE DATE:** 5/12/16

Los Angeles County Commission on HIV
Member Recruitment and Retention Strategies (Updated 1/19/18)

Key Documents for Current Commissioners and Interested Applicants

- Commission on HIV (COH) website (membership application, bylaws, meetings, training schedule, duty statements, committees, agendas and materials)
- Comprehensive HIV Plan (CHP)
- Los Angeles County HIV/AIDS Strategy (LACHAS)

Community Outreach

1. Use LACHAS as a call to action and recruitment tool
2. Attend community meetings and events in the Health District
3. Inform community of multiple ways to get involved outside of being a commissioner
4. Promote COH training sessions
5. Continue work of welcoming committee at all COH meetings
6. Implement Annual COH Open House
7. Develop outreach calendar for COH staff at Health District level

Preparation for Application

1. Initial brief overview of COH from COH staff-entails going over application form, process, duty statement, frequency of meetings, committee assignment, documents to review, and role of COH (distinguish from DHSP roles), and attendance requirements
2. Attend at least 2 full COH meetings and 2 committee meetings
3. Encourage speaking to a Current commissioner (preferably a member of the Operations Committee)
4. Inform possible applicant of Committee only membership and other ways to staff engaged with the COH
5. Explain parity, inclusion, and representation principles and requirements
6. Attend training sessions

While Application is Pending or Under Review: Continue steps under "Preparation for Application"

Retention Strategies

1. Develop and send welcome letters to new members from Co-Chairs
2. Assign mentors.
3. Assign Senior Board Specialist (SBS) to check-in with mentor-mentee pairings
4. Develop yearly attendance reports/letters to Commissioners
5. Encourage attendance at training sessions and member orientation
6. End of the year interviews with Commissioners on membership experience and opportunities for improvement (to be led by the SBS)
7. Use Commissioners as ambassadors for HIV Connect, Get PrEP LA, LACHAS and other county-wide efforts to end HIV
8. Implement annual recognition award for outstanding Commissioner of the year (qualifications and selection to be determined by Commissioners; should be tied to efforts to implement LACHAS, address HIV stigma and disparities)

13. STANDING COMMITTEE REPORTS (cont'd):

B. PUBLIC POLICY COMMITTEE:

3. Federal, State and County Legislation/Policy

   a. Proposed 2018 COH Legislative Docket **(MOTION #6)**

LOS ANGELES COUNTY COMMISSION ON HIV

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

The Public Policy (PP) Committee acts in accordance with the role of the Commission on HIV, as dictated by Los Angeles County Code 3.29.090. Consistent with Commission Bylaws Article VI, Section 2, no Ryan White resources are used to support PP Committee activities.

2018 POLICY PRIORITIES

APPROVED by COH 1/8/18

POLICY PRIORITIES

The Public Policy Committee recommends the following policy priorities for the Commission on HIV to focus on in 2018 (*in no particular order*):

- Preserve access to and continuity of care for PLWHA and communities at highest risk for the acquisition and transmission of HIV disease.
  - Preserve federal funding for Medicaid, Medicare, and for HIV/AIDS programs
  - Preserve health insurance coverage for individuals with pre-existing conditions, including HIV and STD programs.

- Protect HIV service access and availability in California's annual budgeting process.

- Maintain and preserve the Ryan White Program (RWP) at current or increased funding levels and, where appropriate and strategically viable, support stronger compatibility and greater effectiveness between the RWP, Medicaid, Medicare, and other health systems.

- Advance and enhance routine HIV testing, expanded linkage to care, and other improvements to the local, state, and national HIV service delivery systems that optimize health outcomes in the HIV Continuum and advance HIV services in LA County consistent with the National HIV AIDS Strategy goals, LA County HIV/AIDS Strategy, and LA County Comprehensive HIV Plan.

- Support policies that use data, without risking personal privacy and health, to improve health outcomes and eliminate health disparities among PLWHA and communities highly impacted by HIV/STDs

- Enhance Federal accountability for deliverables from a heightened and coordinated federal response, particularly in the context of local planning and responsiveness to the NHAS.

- Support proposals and increased funding for the provision of and access to: prevention, care and treatment services; and bio-medical interventions (such as PreP and PEP) for people at risk for acquiring HIV and people living with HIV/AIDS; and comprehensive HIV/STD counseling, testing, education, outreach, research and social marketing programs.

- Support proposals that seek to reduce stigma and address social determinants of health such as poverty, education, violence, substance abuse, and transportation in order to improve health outcomes for people living with HIV/AIDS and special populations at highest risk for contracting HIV.

- Preserve and/or support systems, strategies and proposals that seek to expand affordable housing, as well as prioritize housing opportunities for people living with, affected by, or at risk of contracting, HIV/AIDS.

- Support proposals that eliminate discrimination against or the criminalization of people living with, or at risk of, HIV/AIDS.

- Support proposals that reduce the cost of HIV/AIDS and STD drugs.

- Support proposals that expand the inclusion of HIV biomedical interventions in basic health benefits packages.

- Preserve full funding and accessibility to the AIDS Drug Assistance Program (ADAP).

LOS ANGELES COUNTY
COMMISSION ON HIV

2018-2019 Legislative Docket

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

BILL	TITLE	DESCRIPTION / COMMENTS	POSITION	STATUS
AB 315 (Wood)	Pharmacy benefit management	Requires pharmacy benefit managers to be registered with the Department of Managed Healthcare, disclose conflict of interests to purchasers, drug acquisition costs, rebates from manufacturers, rates with negotiated pharmacies, and prohibits contracts that prohibit providers from recommending alternative medication or certain amounts of medication.	**WATCH**	
AB 587 (Chiu)	State government: pharmaceuticals: procurement: collaborative	Requires various federal departments to assign members to the CA Pharmaceutical Collaborative to address the rising cost of pharmaceuticals and coordinate the best value clinical treatment protocols among members of the collaborative, achieve best value procurement, purchasing, and negotiating with manufacturers for pharmaceutical discounts, and address other pharmaceutical issues.	**SUPPORT**	
AB 595 (Wood)	Health care service plans: mergers and acquisitions	Requires healthcare service plans that intend to merge, purchase, or acquiesce to notify the Director of the Department of Managed Healthcare who will either approve, conditionally approve, or disapprove the transaction/agreement based on assessment of healthcare impact.	**SUPPORT**	
AB 1136 (Eggman)	Health facilities: residential mental or substance use disorder treatment	Requires the State Department of Public Health to solicit a grant that will develop a real-time, Internet-based database to collect, aggregate, and display information about beds in inpatient psychiatric facilities, crisis stabilization units, residential community mental health facilities, and licensed residential substance use disorder treatment facilities.	**SUPPORT**	
AB 1791 (Wiener)	Physicians and surgeons: continuing education	Requires the Medical Board of CA to consider including a continuing education course on PrEP/PEP in primary care settings.	**SUPPORT**	
AB 1971 (Santiago, Chen, Friedman)	Mental health services: involuntary detention: gravely disabled	This bill expands the definition of "gravely disabled" to also include a condition in which a person, as a result of a mental health disorder or chronic alcoholism, is unable to provide for his or her medical treatment. Existing law defines "gravely disabled" to mean either a condition in which a person, as a result of a mental health disorder or chronic alcoholism, is unable to provide for his or her basic personal needs for food, clothing, or shelter, or a condition in which a person has been found mentally incompetent,	**WATCH**	Supported by BOS

BILL	TITLE	DESCRIPTION / COMMENTS	POSITION	STATUS
AB 1985 (Ting)	Hate crimes: law enforcement policies	This bill provides guidance for local law enforcement agencies to update and strengthen their policies on hate crimes, focusing on recognizing hate crimes when they have occurred, engaging in appropriate response given the targeted community and the broader community, and fostering a community environment that prevents future hate crimes and incidents from occurring.	**SUPPORT**	
AB 2119 (Gloria)	Foster care: Gender affirming healthcare and behavioral health services	Minors in foster care have the right to access gender affirming healthcare and behavioral healthcare. Will require the county child welfare agency to ensure the child or non-minor dependent has access to aforementioned care.	**SUPPORT**	
AB 2153 (Thurmond)	Teachers: in-service training: lesbian, gay, bisexual, transgender, queer, and questioning pupil resources	This bill require, within the first six weeks of every school year, each school operated by a school district or county office of education and each charter school to provide in-service training to teachers of pupils in grades 7 to 12 and to all certificated employees at that school, on schoolsite and community resources for the support of lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) pupils as well as strategies to increase support for LGBTQ pupils and thereby improve overall school climate.	**SUPPORT**	
AB 2275 (Arambula)	Medi-Cal managed care: Quality assessment and performance improvement	Establish a quality assessment and performance improvement program for all Medi-Cal managed care plans by tracking measures for specific demographics, reducing disparities, and developing financial incentive program (with stakeholder input) for high performing plans meeting annual targets. Results will be utilized to develop a Quality Rating System for plans.	**SUPPORT**	
AB 2430 (Arambula)	Medi-Cal: Program for aged and disable persons	Existing law requires Medi-Cal eligibility to not exceed an income standard equal to 100% of the applicable federal poverty level (FPL). This bill would require all countable income up to 138% of the FPL to be disregarded for Medi-Cal eligibility.	**SUPPORT**	
AB 2499 (Arambula)	Health care coverage: Medical loss ratios	Increases minimum medical loss ratio percentages applicable to healthcare insurers by 5%, meaning the annual rebate insurers are required to provide to enrollees/insured will increase.	**SUPPORT**	
AB 2601 (Weber)	Pupil instruction: sexual health education: charter schools	This bill would require charter schools to ensure that all pupils in grades 7 to 12, inclusive, receive comprehensive sexual health education and HIV prevention education, as specified. By imposing additional requirements on charter schools, this bill would impose a state-mandated local program.	**SUPPORT**	

BILL	TITLE	DESCRIPTION / COMMENTS	POSITION	STATUS
AB 2639 (Berman)	Pupil suicide prevention policies: evidence-based online training	This bill would require the State Department of Education to identify one or more evidence-based online training programs that a local educational agency can use to train school staff and pupils as part of the local educational agency's policy on pupil suicide prevention.	**SUPPORT**	
AB 2663 (Friedman)	Property taxation: change in ownership: exclusion: local registered domestic partners	This bill would provide retroactive relief to individuals who were registered as domestic partners in municipal jurisdictions and may have had their property taxes increased due to the death of a partner.	**SUPPORT**	
AB 2719 (Irwin)	Aging	This bill would revise the definition of elderly individuals identified as in greatest economic or social need for CA Department of Aging programs to include cultural or social isolation caused by sexual orientation, gender identity, or gender expression.	**SUPPORT**	
AB 2943 (Low)	Unlawful business practices: sexual orientation change efforts	This bill would include, as an unlawful practice prohibited under the Consumer Legal Remedies Act, advertising, offering to engage in, or engaging in sexual orientation change efforts with an individual. Existing law prohibits sexual orientation change efforts with a patient under 18 years of age.	**SUPPORT**	
SB 538 (Monning)	Hospital contracts	Prohibits contracts between hospitals, health care service plans, or health insurers from containing certain provisions that result in higher prices due to hospital consolidations, acquisitions, etc. such as setting payment rates for nonparticipating affiliates of the hospital, keeping the contract's payment rates confidential from any payor, and requiring the contracting agent, plan, or insurer to submit any claims or causes of action that arise to arbitration.	**WATCH**	
SB 790 (McGuire)	Health care providers: gifts and benefits	Prohibits drug manufacturers from providing gifts (fee, payment, subsidy or any other economic benefit) to healthcare providers, including gifts for provider's participation in research.	**SUPPORT**	
SB 827 (Wiener)	Planning & Zoning: Transit rich housing	This bill would authorize a transit-rich housing project (a residential development project that is within a 1/2 mile radius of a major transit stop or a 1/4 mile radius of a high-quality transit corridor with a percentage of very low, low, or moderate-income households) to receive a transit-rich housing bonus.	**WATCH**	4/18/18 Failed passage in committee. Set for hearing 4/25.
SB 910 (Hernandez)	Short-term limited duration health insurance	Existing healthcare coverage market reforms that prohibits insurers from denying coverage for pre-existing conditions does not apply to short term limited duration health insurance. This bill would prohibit health insurers from issuing, selling, renewing, or offering a short-term limited duration health insurance policy for health care coverage.	**SUPPORT**	

BILL	TITLE	DESCRIPTION / COMMENTS	POSITION	STATUS
SB 918 (Wiener)	Homeless Youth Act of 2018	This bill would establish the Office of Homeless Youth in the Department of Housing and Community Development. The bill would set forth the duties of the office, including, but not limited to, setting specific, measurable goals aimed at preventing and ending homelessness among youth in the state. The bill would require a grant proposal to identify how it intends to ensure that participating youth receive services, including, but not limited to, drug abuse education and prevention services, mental and physical health care, and aftercare and follow-up services.	**SUPPORT**	
SB 971 (Nguyen)	~~Criminal procedure: misdemeanors~~ Murder: special circumstances	~~Existing law governs criminal proceedings when a person is arrested for an offense declared to be an infraction or a misdemeanor, including the circumstances under which the person may be brought before a magistrate or the juvenile court, or released upon his or her written promise to appear. Existing law states that these provisions do not apply when a person is arrested for an offense declared to be a felony.~~ Existing law imposes the penalty on a defendant found guilty of murder in the first degree of death or imprisonment in the state prison for life without the possibility of parole, if one or more special circumstances are found to be true. Special circumstances include that the victim was intentionally killed because of his or her race, color, religion, nationality, or country of origin. This bill would additionally include among those special circumstances that the victim was intentionally killed because of his or her sexual orientation or gender.	**WATCH**	4/11/18 Failed passage in committee
SB 974 (Lara)	Medi-Cal: immigration status: adults	This bill would extend eligibility for full-scope Medi-Cal benefits to individuals of all ages (existing law only includes individuals under 19 years of age) who are otherwise eligible for those benefits but for their immigration status.	**SUPPORT**	
SB 1021 (Wiener)	Prescription Drugs	Bill extends existing law (which expires 1/1/20) on requirement: - To cover a single tablet prescription drug regimen for combination ARTs that are medically necessary for the prevention of AIDS/HIV. - To cover any form of cost sharing for a covered outpatient prescription drug shall not exceed $250 for a 30 day supply - That prohibits insurers from discouraging potential enrollees with health conditions from enrolling by reducing generosity of benefits	**SUPPORT**	
SB 1108 (Hernandez)	Medi-Cal: conditions of eligibility or coverage	Prohibits the Department of Health Care Services from seeking or obtaining a Medicaid demonstration project or waiver to require work or community engagement activities as a condition of Medi-Cal eligibility or coverage, to require waiting periods, time limits, or coverage lockouts, or to require any other condition of Medi-Cal eligibility or coverage not authorized by any other provision of state law or federal statute or regulation.	**SUPPORT**	

BILL	TITLE	DESCRIPTION / COMMENTS	POSITION	STATUS
SB 1125 (Atkins)	Federally qualified health center and rural health clinic services	This bill would authorize reimbursement for a maximum of 2 visits taking place on the same day at a single location if after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment, or if the patient has a medical visit and another health visit. Allows FQHCs to bill for a medical and behavioral health visit on the same day.	**SUPPORT**	
SB 1287 (Hernandez)	Health insurance: small employer groups	Expresses the intent of the Legislature to enact legislation that would regulate multiple employer welfare arrangements and other types of association health plans to the extent permitted under federal law, including ensuring that those plans meet minimum financial solvency and reporting requirements.	**SUPPORT**	
HR 1739 (Lee)	REPEAL HIV Discrimination Act of 2017	This bill expresses the sense of Congress that federal and state laws, policies, and regulations regarding people living with human immunodeficiency virus (HIV) should: (1) not place unique or additional burdens on such individuals solely as a result of their HIV status; and (2) demonstrate a public health-oriented, evidence-based, medically accurate, and contemporary understanding of HIV transmission, health implications, treatment, and the impact of punitive HIV-specific laws, policies, regulations, and judicial precedents and decisions on public health and on affected people, families, and communities.	**SUPPORT**	
HR 1882 (Waters)	Stop AIDS in Prison Act of 2017	This bill directs the Bureau of Prisons to develop a comprehensive policy to provide HIV testing, treatment, and prevention for federal inmates in prison and upon reentry. It amends the federal criminal code to require an HIV test for each convicted federal offender sentenced to prison for any length of time regardless of risk factors, unless the individual declines; to make the HIV test part of the routine health screening conducted at intake; and to require a pre-release HIV test, unless the individual declines.	**SUPPORT**	
HR 2119 (Lieu)	Therapeutic Fraud Prevention Act of 2017	This bill prohibits sexual orientation or gender identity conversion therapy from being provided in exchange for monetary compensation. It bars advertisements for such therapy that claim to: (1) change an individual's sexual orientation or gender identity, (2) eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same gender, or (3) be harmless or without risk. Individuals or entities shall not assist or facilitate a conversion therapy if they receive monetary compensation from any source in connection with providing such therapies.	**SUPPORT**	
HR 3602 (Lee)	Real Education for Healthy Youth Act of 2017	This bill requires the Department of Health and Human Services (HHS), in coordination with the Department of Education, to award grants for: (1) comprehensive sex education for adolescents, (2) comprehensive sex education provided by institutions of higher education, and (3) training faculty and staff to teach comprehensive sex education to adolescents. HHS must enter a contract with a nonprofit organization to evaluate and report on these grants. The bill makes appropriations to carry out the bill.	**SUPPORT**	

BILL	TITLE	DESCRIPTION / COMMENTS	POSITION	STATUS
HR 4710 (Peters, Bucshon)	340B Protecting Access for the Underserved and Safety-net Entities Act (PAUSE) Act	To amend the Public Health Service Act to establish a moratorium on the registration of certain new 340B hospitals and associated sites, and for other purposes.	**OPPOSE**	

DRAFT

13. STANDING COMMITTEE REPORTS (cont'd):

D. STANDARDS AND BEST PRACTICES (SBP) COMMITTEE:

2. Legal Assistance Services Standards | **20-Day Public Comment Period (Exp. 5/30)**
3. Quality Improvement Overview & Roles

LOS ANGELES COUNTY
COMMISSION ON HIV

LEGAL SERVICES STANDARDS OF CARE

DRAFT 5/3/18

PUBLIC COMMENT PERIOD: 5/10/18 - 5/30/18

Email comments to: hivcomm@lachiv.org

INTRODUCTION

Service standards outline the elements and expectations a Ryan White service provider follows when implementing a specific service category. The purpose of the service standards are to ensure that all Ryan White service providers offer the same fundamental components of the given service category. The standards establish the minimal level of care that a Ryan White funded agency or provider may offer in Los Angeles County.

The Los Angeles County Commission on HIV has developed the Legal Services Standards of Care to ensure people living with HIV (PLWH) receive accessible, quality care, as well as services and benefits to which they are entitled, regardless of where services are received in the County. The development of the Standards includes review of and alignment with recent Legal Services Request for Proposals from the Los Angeles County Department of Public Health - Division of HIV and STD Program and HOPWA, Health Resources and Services Administration (HRSA) guidelines, Housing Opportunities for Persons with AIDS (HOPWA) RFP, as well as Los Angeles County Commission on HIV – Standards & Best Practices Committee feedback and discussions, and content experts in the legal services arena.

LEGAL SERVICES OVERVIEW

Legal assistance is designed to help mitigate the impact of restrictive social and economic conditions for PLWH by providing relevant legal information, advice, and services. An individual's HIV-positive status may be directly related to a given legal issue. Even where HIV-positive status may not appear to be related, the stress and disruption caused by an unmet legal need may necessitate legal intervention. In a study conducted by The Williams Institute, data has shown that 90% of respondents living with HIV reported they had a legal need. Each individual had an average of 6 distinct legal needs in 4 issue areas.[1]

Increasing access to justice for low-income and low-resources individuals is the purpose of providing HIV legal services. The services are intended to ensure access to and continuity of benefits and services that maintain optimal health and a higher quality of life for PLWH.

Services include consultation, referral, and representation in multiple areas of civil law, such as:

- Public and private benefits
- Advanced planning
- Credit and bankruptcy
- Health and disability insurance
- Housing and eviction prevention
- Discrimination and confidentiality
- Employment
- Gender rights
- Immigration
- Permanency planning for dependent children

Improved health outcomes and increased lifespans resulting from more effective treatment, and evidence based research verifying PLWH with an undetectable viral load have effectively little to no risk

of transmitting HIV, underscores the importance of legal assistance due to increased likelihood of legal issues related to the complex effects of behavioral, psychosocial, and medical implications of HIV. In addition, clients accessing services in Ryan White funded programs, the payer of last resort, often face multiple challenges with regard to the social determinants of health such as housing instability, and poverty.

SERVICE COMPONENTS

All services provided must be in accordance with procedures formulated and adopted by the State Bar of California and in compliance with all applicable federal, State, County, and local laws and regulations and all applicable rules of professional conduct governing the provision of legal services as they currently exist or shall exist at any future time.

All service components shall be delivered in a culturally and linguistically sensitive manner by culturally competent staff.

1. Legal Checkup

According to the CDC, individuals who test positive for HIV should be referred to legal services as soon as possible for counseling on how to prevent discrimination.[2] Clients living with HIV that are new to legal services shall be offered a legal checkup which includes a comprehensive one on one legal evaluation of all significant civil legal issues that may be helped by talking to an attorney. After a legal checkup, the client shall receive education and information on how to access needed legal assistance.

The legal checkup counseling session should review the following: [3]

- Public and private benefits (application and appeals for income and other safety net supports)
- Advanced planning (healthcare directives, financial power of attorney, simple wills)
- Consumer (debtor/creditor, bankruptcy)
- Health coverage and access to healthcare (appealing denials of care/service, disability insurance)
- Housing (eviction, poor conditions, service/support animal rights, requests for reasonable accommodations)
- Discrimination (occurring in healthcare, housing, and employment settings; gender rights)
- Confidentiality (disclosing status, healthcare privacy for minors and those under 26 years of age)
- Immigration (adjustment of status, naturalization)
- Criminal (traffic citations, criminal records expungement)
- Domestic violence (restraining orders, family law)

If a legal need is identified during the legal checkup that cannot be met by the current provider, legal services referral(s) must be provided to the client. Legal service providers will refer to the full compendium of Ryan White service providers to ensure access to and increase utilization of support services for clients.

2. Client Intake

A client intake is required for all PLWH who request or are referred to legal assistance services and should occur at the first meeting with the potential client. The intake records demographic data that includes personally identifiable information such as name, address, and date of birth. Client records for individuals receiving services must be maintained and client confidentiality shall be strictly enforced complying with all relevant legal practice standards of the State Bar of California.

The client intake file should, at minimum, include:

- Contact information
  - Name, home address, mailing address, phone number
- Eligibility Documentation
  - Verification of HIV diagnoses
  - Verification of income
  - Verification of residence in Los Angeles County
- Emergency and/or next of kin contact information
  - Name, home address, phone number
- Release of Information Form
  - Must be updated annually and include what type of information may be released
- Client Rights and Responsibilities Form
- Client Grievance Procedure Form & Limits of Confidentiality

3. Legal Assistance and Representation

Legal service providers will conduct appropriate action on behalf of clients to meet their legal needs. Such action includes offering relevant legal advice and counseling, advocating and negotiating on the client's behalf, providing legal services referrals to other providers/programs, as well as to pro bono attorneys, and representing clients in court and administrative proceedings where appropriate. After a referral is received, a legal services staff member or volunteer will respond within 3 business days to schedule the first legal checkup and client intake with the potential client.

HIV legal assistance service providers will fully inform clients about the nature of services offered, including their rights to engage in the generation and review of any legal goals and/or strategies, confidentiality, and their ability to terminate services at any time. It is the responsibility of the client to inform the legal service representative of any communication with other agencies and adverse parties relevant to the case. Documentation of legal representation efforts shall be maintained in the client record.

4. Referrals

Programs providing HIV legal assistance will provide legal services referrals and information regarding available resources and social services to clients. Documentation of referrals and linkages will be made in the client record.

5. Client Feedback

Legal service providers must allow for a formalized client feedback process to evaluate program effectiveness, customer service, and ensure quality improvement.

6. Case Closures

Legal service providers shall develop client-centered case closure criteria and procedures that ensure clients who have identified legal needs have access to addressing these needs. All attempts to contact the client and notifications regarding missed appointments and/or case closure will be documented in the client file, along with the justification for case closure. Cases will be closed in accordance with the State Bar of California's Rules of Professional Conduct.

Cases may be closed when the client:

- Has become ineligible for the service
- Has had no direct program contact in the past six months
- Is deceased
- No longer needs the service
- Decides to discontinue the service
- Is improperly utilizing the service
- Has not complied with the retainer contract

7. Outreach/Education

Legal service providers will promote, educate, and conduct outreach to HIV service providers, other supportive service organizations, and potential clients regarding the availability of legal assistance for PLWH.

An outreach plan will be developed that demonstrates collaboration with HIV medical outpatient providers and other service providers throughout the 26 Health Districts across Los Angeles County. The plan shall include proactive efforts, via educational forums, to educate and inform HIV service providers on how to access legal services with a specific focus on underserved communities based on socioeconomic status, gender identity, race, sexual orientation and/or nation of origin.

The outreach plan will include (at minimum):

- Written strategy for the provision of legal assistance that links with HIV medical outpatient services and other HIV support services
- Memoranda of Understanding (MOUs) to demonstrate formalized linkages
- Assessment of other available legal and social resources and services
- Required number of educational forums and potential dates and locations
- Timeline for implementing services

- Evaluation plan

8. Staffing Requirements

HIV legal assistance staff and attorneys will have the skills and ability to specialize in the areas of most critical need to PLWH. Staff, attorneys and volunteers will be trained and remain knowledgeable of relevant legal and non-legal HIV/AIDS issues. Staff attorneys, licensed by the state of California and members in good standing with the State Bar of California, will coordinate, supervise and/or provide all services. Note that immigration attorneys practice under the Federal system and do not need to be licensed by the State of California. Licensed volunteer attorneys, law students, law school graduates and other legal professionals, all under the supervision of a qualified staff attorney, may be used to expand program capacity. All legal assistance staff and volunteers onsite will complete an agency-based orientation before providing services.

All HIV legal services attorneys and volunteer attorneys will practice according to the American Bar Association's Model Rules for Professional Conduct (http://www.abanet.org/cpr/mrpc/mrpc_home.html) and the State Bar of California's Rules of Professional Conduct (http://www.calbar.ca.gov/state/calbar/calbar_extend.jsp?cid=10158)

TABLE 1. LEGAL SERVICES STANDARDS

SERVICE COMPONENT	STANDARD	DOCUMENTATION
1. Legal Checkup	Legal service provider will partner with HIV testing agencies and medical providers to recruit potential clients.	MOU outlining referral processes on file at provider agency.
	Comprehensive legal checkup will review the following (at minimum): a. Public and private benefits b. Advanced planning c. Credit and bankruptcy d. Health and disability insurance e. Housing and eviction prevention f. Discrimination and confidentiality g. Employment h. Gender rights i. Immigration j. Permanency planning for dependent children	Client file will include the following (at minimum): a. Intake form (see Standard below) b. Completed legal assessment c. Referrals, interventions, results d. Documentation of all legal assistance and results Referrals to appropriate services as needed.
	Required forms are discussed and completed as appropriate. a. Release of Information	Forms are signed, dated, and kept in client file.

SERVICE COMPONENT	STANDARD	DOCUMENTATION
	b. Client Rights and Responsibility c. Client Grievance Procedure d. Limits of Confidentiality	a. Release of Information Form must be updated annually.
2. Intake	Intake occurs during first contact with client and will collect (at minimum): a. Contact info b. Eligibility documentation c. Emergency and/or next of kin contact info d. Required forms	Completed intake form is included in client file.
3. Legal Assistance and Representation	Legal service provider will respond to potential clients (referrals or outreach efforts) within 3 business days to set up appointment.	Program policy and procedures included in a written document. Provided to staff at orientation.
	Legal service provider will fully inform clients about: a. Nature of services offered b. Right to engage in generation and review of any legal goals/strategies c. Confidentiality d. Ability to terminate services at any time	Program policy and procedures included in a written document. Provided to staff at orientation. Documentation included in client file.
4. Referrals	Programs will provide referrals and information on the full array of Ryan White service providers.	Referral list on file at provider agency. Documentation of referrals in client file.
5. Client Feedback	Legal service provider will seek feedback from clients, at minimum, annually. a. Provider takes necessary steps to address and incorporate feedback into program.	Tool utilized to seek feedback on file (e.g. online survey, evaluation form, client customer service form) a. Documentation of how feedback was addressed and implemented.
6. Case Closure	Legal service provider will follow up with clients who have missed appointments and may be pending case closure.	Number of attempts to contact and mode of communication documented in client file.
	Cases may be closed when the client: a. Has become ineligible for the service b. Has had no direct program contact in the past 6 months c. Is deceased	Justification for case closure documented in client file.

SERVICE COMPONENT	STANDARD	DOCUMENTATION
	d. No longer needs the service e. Is improperly utilizing the service f. Has not complied with the retainer contract	
7. Outreach and Education	Legal service provider will promote services and conduct outreach. Outreach plan will include: a. Written strategy for the provision of legal assistance that links with HIV medical outpatient services and other HIV support services b. Memoranda of Understanding (MOUs) to demonstrate formalized linkages c. Assessment of other available resources and services d. Required number of educational forums and potential dates and locations e. Timeline for implementing services f. Evaluation plan	Outreach plan is kept on file. Site visit will be conducted to verify activities.
	Legal service provider will collaborate with HIV service providers to set up a bi-referral system. HIV service providers include, but are not limited to, primary healthcare, supportive services, etc.	MOUs are kept on file.
8. Staffing Requirements	Attorneys are licensed to practice law in the State of California and are members in good standing of the State Bar of California. Immigration attorneys practice under Federal law and do not need to be licensed by the State of California.	Attorney and staff resumes, and applicable licenses, to be kept on file.
	Attorneys and staff must have the knowledge, skills and ability to specialize in HIV related issues and concerns. a. All staff and volunteers must attend an agency orientation before providing services.	Sign-in sheets and/or certificate of completion for all trainings to be kept on file. Documentation included in staff and volunteer files.

SERVICE COMPONENT	STANDARD	DOCUMENTATION
	b. All staff and volunteers must attend a cultural sensitivity/humility training. c. Staff and volunteers will attend any additional trainings pertaining to HIV related issues and concerns (e.g. DHSP trainings, HIV/STD Prevention trainings)	
	Qualified staff attorneys will coordinate, supervise and/or provide legal services to clients.	Policy and procedures manual and chart review to confirm.
	Qualified staff attorneys will supervise volunteers who may include: a. Licensed volunteer attorneys b. Law students c. Law school graduates d. Other legal professionals	Documentation of supervision on file at provider agency.

REFERENCES

1. Ayako Miyashita, Amira Hasenbush, Bianca D.M. Wilson, Ilan H Meyer, Sheila Nezhad & Brad Sears, The Williams Institute, University of California Los Angeles, School of Law. The Legal Needs of People Living with HIV: Evaluating Access to Justice in Los Angeles (2015). http://williamsinstitute.law.ucla.edu/wp-content/uploads/Legal-Needs-People-Living-with-HIV-Los-Angeles-County-April-2015.
2. Technical Expert Panel Review of CDC HIV Counseling, Testing, and Referral Guidelines. Revised Guidelines for HIV Counseling, Testing, and Referral. February 1999. Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5019a1.htm.
3. The Williams Institute, University of California Los Angeles, School of Law. Whole Person Care – Los Angeles: Expansion to Target People Living with HIV in Los Angeles County (2017).

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Content Expert Reviewers

Sophia Kass — *Positively Trans Program Associate*

Transgender Law Center

Tanya McGary, JD
Supervising Staff Attorney
Homelessness Prevention, Public Counsel

Ayako Miyashita Ochoa, JD
Adjunct Professor, Luskin School of Public Affairs, Department of Social Welfare

Associate Director, UCLA California HIV/AIDS Policy Research Center

Rebecca Watson, JD
Directing Attorney
Inner City Law Center

Standards & Best Practices Committee Members

Ace Robinson, MPH *Co-Chair*
Joseph Cadden, MD *Co-Chair*
Bradley Land
Erika Davies
Kevin Stalter
Wendy Garland, MPH

Clinical Quality Management Policy Clarification Notice

Policy Clarification Notice (PCN) #15-02

Related legislation: Title XXVI of the Public Health Service (PHS) Act §§ 2604(h)(5), 2618(b)(3)(E), 2664(g)(5), and 2671(f)(2)

Scope of Coverage: Ryan White HIV/AIDS Program (RWHAP) Parts A, B, C, and D

Purpose of PCN:

The purpose of this PCN is to clarify the Health Resources and Services Administration (HRSA) RWHAP expectations for clinical quality management (CQM) programs.

Background:

Title XXVI of the Public Health Service Act RWHAP Parts A – D[1] requires the establishment of a clinical quality management (CQM) program to:

- Assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines, (otherwise known as the HHS guidelines) for the treatment of HIV disease and related opportunistic infections; and
- Develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to, and quality of HIV services.

[1] See §§ 2604(h)(5), 2618(b)(3)(E), 2664(g)(5), and 2671(f)(2) of the PHS Act.

The CQM requirement applies directly to Parts A – D recipients; it is the responsibility of the recipient to work directly with their subrecipients to implement, monitor and provide any needed data on the CQM program.

Health care's adaptation of continuous quality improvement and total quality management techniques from manufacturing began nearly 50 years ago with much momentum in the 1980s[2,3,4]. Over the years since, a large body of evidence has emerged suggesting a robust and effective CQM program contribute to overall improvements in healthcare quality delivery. CQM is a major component in the National HIV/AIDS Strategy (NHAS),[5] updated July 2015, for both optimizing health outcomes and ultimately reducing HIV incidence. Coordination of CQM program activities is encouraged across all RWHAP funded recipients and subrecipients within a service area or a service area to support a reduction in data burden and alignment of performance measurement and to maximize the impact of improved health outcomes.

Components of a CQM Program

A CQM program is the coordination of activities aimed at improving patient care, health outcomes, and patient satisfaction. To be effective, a CQM program requires:

- Specific aims based in health outcomes;
- Support by identified leadership;
- Accountability for CQM activities;
- Dedicated resources; and

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[2] Donabedian A. Evaluating quality of medical care. Milbank Q. 1966;44:166–206.
[3] Donabedian A. Exploration of quality assessment and monitoring. Vols 1, 2, 3. Ann Arbor, Michigan: Health Administration Press, 1980.
[4] Berwick DM. Continuous improvement as an ideal in health care. N Engl J Med 1989;320: 53-6. 2
[5] National HIV/AIDS Strategy. The White House. Accessed at https://www.aids.gov/federal-resources/national-hiv-aids-strategy/overview/

- Use of data and measurable outcomes to determine progress and make improvements to achieve the aims cited above.

CQM activities should be continuous and fit within and support the framework of grant administration functions. Recipients are strongly encouraged to use the NHAS to frame CQM activities and goals.

In order to develop a CQM program that improves patient care, health outcomes, and patient satisfaction, certain components are necessary. The three necessary components are infrastructure, performance measurement, and quality improvement, and each of these components have a distinct role in the overall CQM program. All are important to implement a comprehensive CQM program that is able to meet established goals. Recipients may choose to have subcontracts for some or all of the CQM activities. Recipients may also work collaboratively with their stakeholders such as planning councils/planning bodies, governing bodies, and/or board of directors, as appropriate. Whatever mechanism is used, the recipient is ultimately responsible for ensuring that the CQM program meets HRSA's requirements for the RWHAP Parts.

A. Infrastructure

Appropriate and sufficient infrastructure is needed to make the CQM program a successful and sustainable endeavor. Infrastructure is needed to plan, implement, and evaluate CQM program activities. Utilization of RWHAP grant funds to establish an appropriate infrastructure for a CQM program is allowed. An ideal infrastructure consists of:

- Leadership: Leadership to guide, endorse, and champion the CQM program
- Committee: A CQM committee that develops the CQM program and corresponding activities

- Dedicated Staffing: Staff who are responsible for CQM duties and resources, as well as any contractors that may be funded to assist with CQM work
- Dedicated Resources: Resources for building capacity in order to carry out CQM activities (e.g., training on collecting performance measurement data)
- Quality Management Plan: A quality management plan describes all aspects of the CQM program including infrastructure, priorities, performance measures, quality improvement activities, action plan with a timeline and responsible parties, and evaluation of the CQM program
- Consumer Involvement: People living with HIV (PLWH) involvement that reflects the population that is being served and ensures that the needs of PLWH are being addressed by CQM activities
- Stakeholder Involvement: Stakeholder involvement (e.g., subrecipient, other recipients in region, planning body and/or its committees, consumers) that provides input on CQM activities to be undertaken
- Evaluation of CQM Program: Evaluating the effectiveness of the CQM program ensures that the CQM activities are making changes that positively affect outcomes. This evaluation includes assessing whether CQM program activities have been implemented as prescribed by the quality management plan (including the action plan). Recipients should include regular evaluation of their CQM activities in order to maximize the impact of the program. Evaluation provides the opportunity to learn the processes and resources needed in implementing CQM activities through the collection of detailed information. Part of the evaluation should include identifying factors (i.e., staff acceptance of change, improved clinical performance, etc.) that affect the quality improvement activities. Evaluation also identifies effective improvement strategies that can be scaled up or implemented in other facets within a system of care.

Additional elements of an evaluation include effectiveness of the team and its ability to meet timelines and deliverables as described in the action plan in order to determine the success of the planned process.

Although the infrastructure will vary in scope among recipients, the inclusion of all these elements creates a strong foundation for the CQM program.

B. Performance Measurement

Performance measurement is the process of collecting, analyzing, and reporting data regarding patient care, health outcomes on an individual or population level, and patient satisfaction.

In order to appropriately assess outcomes, measurement must occur. Measures should be selected that best assess the services the recipient is funding. A sound performance measure portfolio is reflective of RWHAP funded services, local HIV epidemiology, and identified needs of PLWH. Recipients are strongly encouraged to include HRSA HIV/AIDS Bureau[6] and HHS[7] measures that align with the National HIV/AIDS Strategy (updated July 2015). Recipients should have an identified process to regularly collect and analyze performance measure data which would occur more frequently than data collection for reporting (i.e., the annual Ryan White HIV/AIDS Service Report). It is also important for recipients to collect and analyze performance measure data that allows for inspection and improvement of health disparities across different target populations. In order to optimally support quality improvement activities, data collection for the CQM performance measures should occur quarterly at a minimum[8,9,10] as this

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[6] HIV/AIDS Bureau HIV Performance Measures. 2013. Accessed at http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html

[7] Department of Health and Human Services. Common Indicators for HHS-funded HIV Programs and Services. Accessed at https://www.aids.gov/pdf/hhs-common-hiv-indicators.pdf

[8] Institute for Healthcare Improvement. How to Improve. Accessed at http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementEstablishingMeasures.aspx

affords appropriate reevaluation of the effects of improvements that have been implemented. All funded service categories need to have at least one performance measure. For each highly utilized and highly prioritized RWHAP-funded service category recipients should identify two performance measures and collect the corresponding performance measure data.

C. Quality Improvement

Quality improvement entails the development and implementation of activities to make changes to the program in response to the performance data results. To do this, recipients are required to implement quality improvement activities aimed at improving patient care, health outcomes, and patient satisfaction.[11] Recipients are expected to implement quality improvement activities using a defined approach or methodology (e.g., model for improvement[12], Lean[13], etc.). Quality improvement activities should be implemented in an organized, systematic fashion. As a result, the recipient is able to understand if specific changes or improvements had a positive impact on patient health outcomes or were indicative of further necessary changes in RWHAP funded services. All quality improvement activities should be documented.

Related Activities

Quality Assurance

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[9] Joint Commission. Tools for Performance Measurement in Health Care: a Quick Reference Guide. Access at http://www.jointcommissioninternational.org/assets/1/14/TPMHC200_Sample_Pages.pdf

[10] The timing of data collection for performance measures should be dependent on the availability of the data element. However, the HIV/AIDS Bureau recommends quarterly data collection for quality improvement projects.

[11] See §§ 2604(h)(5), 2618(b)(3)(E), 2664(g)(5), and 2671(f)(2) of the PHS Act.

[12] Institute for Healthcare Improvement. Model for Improvement. Accessed at http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx

[13] Lean Enterprise Institute. What is Lean? Accessed at http://www.lean.org/WhatsLean/

Quality assurance refers to a broad spectrum of activities aimed at ensuring compliance with minimum quality standards. Quality assurance activities include the retrospective process of measuring compliance with standards (e.g., HHS guidelines, professional guidelines, service standards). Site visits and chart reviews are examples of commonly used quality assurance activities. Quality assurance is not the same as quality improvement, although the results of quality assurance activities can be used to develop quality improvement activities.

Quality assurance is part of the larger administrative function of a recipient's program or organization and informs the clinical quality management program, but quality assurance activities by themselves do not constitute a CQM program. Data collected as part of quality assurance processes should feed back into the CQM program to ensure improvement in patient care, health outcomes, and patient satisfaction.

Grant Administration

Grant administration refers to the activities associated with administering a RWHAP grant or cooperative agreement.[14] These include contracting of services, receipt and disbursal of program funds, data collection and submission of reports, monitoring of subrecipients, and compliance with audit requirements. Although these functions are necessary to comply with the terms and conditions of the award, their intent is not on improving health outcomes. Therefore, they are not CQM activities.

See Appendix.

[14] See PCN #15-01 Treatment of Costs Under the 10% Administrative Cap for RWHAP Parts A, B, C, and D available at http://hab.hrsa.gov/affordablecareact/pcn1501.pdf

Applicability to Subrecipients

Recipients are to identify the specific CQM program activities for their service area (Part A and B recipients) or network (Part C and D recipients). Specific CQM program activities include a performance measure portfolio, frequency of performance measure data collection, and identification of quality improvement activities, among other items. Recipients need to ensure that their subrecipients that provide services have the capacity to contribute to the recipient's CQM program, have the resources to conduct CQM activities in their organizations, and implement a CQM program in their organizations, as identified in the written agreements between the recipient and subrecipient. Recipients are expected to provide guidance to subrecipients on prioritizing measures and collecting data. Recipients need to work with subrecipients to identify improvement opportunities and monitor quality improvement activities at the subrecipient locations. Prioritization of CQM activities should be coordinated across RWHAP recipients within service areas and subrecipients funded through the recipient.

Resources

Department of Health and Human Services Guidelines: Each set of Guidelines (see examples below) is developed by Panels or working groups from the National Institutes of Health's Office of AIDS Research and Advisory Council, Centers for Disease Control and Prevention, Health Resources and Services Administration, and other agencies. These guidelines are meant to provide HIV care practitioners with recommendations based on current knowledge. The working group or Panel reviews new evidence and updates recommendations in the Guidelines, when needed.

- Adult and Adolescent Antiretroviral Guidelines

- Adult and Adolescent Opportunistic Infection (OI) Prevention and Treatment Guidelines
- Perinatal Guidelines
- Pediatric Guidelines
- Pediatric OI Prevention and Treatment Guidelines
- HIV Prevention with Adults and Adolescents with HIV in the United States (Prevention With Positives) Recommendations
- Pre-exposure Prophylaxis Guidelines

https://aidsinfo.nih.gov/guidelines

http://www.cdc.gov/hiv/prevention/programs/pwp/index.html

http://www.cdc.gov/hiv/pdf/guidelines/PrEPguidelines2014.pdf

National HIV/AIDS Strategy: First released in 2010 by the White House Office of National AIDS Policy and updated in July 2015, NHAS is a concise plan that will identify a set of priorities and strategic action steps tied to measurable outcomes. The objectives and recommendations of the HIV Care Continuum Initiative have been fully integrated into the updated NHAS.

https://www.aids.gov/federal-resources/national-hiv-aids-strategy/overview/

HIV Care Continuum: (*Included as part of the NHAS as of July 2015*) The HIV care continuum—sometimes also referred to as the HIV treatment cascade—is a model that outlines the sequential steps or stages of HIV medical care that PLWH go through, from initial diagnosis to achieving the goal of viral suppression (a very low level of HIV in the body). The HIV care continuum also shows the proportion of individuals living with HIV who are engaged at each stage.

https://www.aids.gov/federal-resources/policies/care-continuum/

National Quality Center: The HIV/AIDS Bureau funds a cooperative agreement that focuses on providing training and technical assistance to the RWHAP recipients to improve quality of care through an understanding of quality improvement concepts; as well as the use of tools, techniques and various approaches to implement quality management and quality improvement initiatives in their respective programs.

http://nationalqualitycenter.org/

Institute for Healthcare Improvement (IHI): IHI is a recognized innovator, convener, and generous leader, a trustworthy partner, and a place to turn for expertise, help, and encouragement for anyone, anywhere who wants to profoundly change health care for the better.

http://www.ihi.org/

Appendix:

Relationship between Grant Administrative Functions/Administrative Costs/Quality Assurance and CQM:

Grant administration functions/administrative costs are capped pursuant to the RWHAP legislation and include those activities associated with administering a RWHAP grant or cooperative agreement. These include contracting of services, receipt and disbursal of program funds, data collection and submission of reports, monitoring of subrecipients, and compliance with audit requirements. Although these functions are necessary to comply with the terms and conditions of the award, their intent is not on improving health outcomes. Grant administrative activities may include components of quality assurance and may provide important information to the CQM program, but by themselves are not CQM activities nor constitute a CQM program. The chart below demonstrates the overlap between Quality Assurance activities and CQM activities.

The following table illustrates relevant activities under CQM and QA:

Activity	Quality Assurance (Administrative Costs)	Clinical Quality Management
Performance measurement prioritization and alignment with other RWHAP Parts in the service area		X
Development of Service Standards	X	
Data extraction for clinical quality management purposes (collect, aggregate, analyze, and report on measurement data)		X

Chart audits/reviews	X	X
Monitoring site visits	X	If the purpose for the site visit is to assess or monitor the CQM Program
Extracting data for reporting to internal and external stakeholders	X	
Electronic health records interface with other providers; system operations	X	
CQM committee in planning for quality improvement projects		X