LOS ANGELES COUNTY
COMMISSION ON HIV

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

EXECUTIVE COMMITTEE Virtual Meeting

Thursday, September 24, 2020

1:00PM-3:00PM (PST)

Agenda + Meeting Packet will be available on the Commission's website at:
http://hiv.lacounty.gov/Executive-Committee

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PUBLIC COMMENTS

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AGENDA FOR THE **VIRTUAL** MEETING OF THE
LOS ANGELES COUNTY COMMISSION ON HIV (COH)
EXECUTIVE COMMITTEE

Thursday, September 24, 1:00 P.M.–3:00 P.M.

To Join by Computer, Please Register at:
https://tinyurl.com/y3jxnbzu
**link is for non-Committee members + members of the public only*

To Join by Phone: +1-415-655-0001
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Executive Committee Members:			
Al Ballesteros, MBA, Co-Chair	*Bridget Gordon, Co-Chair*	Raquel Cataldo	Michele Daniels (Exec At-Large)
Erika Davies	Joseph Green	Lee Kochems, MA	Katja Nelson, MPP
Mario Perez, MPH	Juan Preciado	Kevin Stalter	
QUORUM*:	**6**		

Due to COVID-19, quorum requirements suspended for teleconference meetings per Governor Newsom's Executive Order N-25-20

AGENDA POSTED: September 18, 2020

ATTENTION: Any person who seeks support or endorsement from the Commission or Committee 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 72 hours' notice before the meeting date. To arrange for these services, please contact the Commission office at (213) 738-2816 or via email at hivcomm@lachiv.org.

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 la oficina de la Comisión al (213) 738-2816 (teléfono), o por correo electrónico á hivcomm@lachiv.org, por lo menos 72 horas 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 a 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 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, Introductions, and Conflict of Interest Statements 1:00 P.M. – 1:03 P.M.

I. ADMINISTRATIVE MATTERS

1. Approval of Agenda **MOTION # 1** 1:03 P.M. – 1:05 P.M.
2. Approval of Meeting Minutes **MOTION # 2** 1:05 P.M. – 1:07 P.M.

II. PUBLIC COMMENT 1:07 P.M. – 1:10 P.M.

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

III. COMMITTEE NEW BUSINESS ITEMS 1:10 P.M. – 1:13 P.M.

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

IV. REPORTS

5. Executive Director's/Staff Report 1:13 P.M. – 1:30 P.M.
A. Commission/County Operational Updates
B. 2020 Commission Training Schedule | REMINDER
C. 2020 Presidential Election Assistance
D. Unaffiliated Consumer Member Stipends
E. Ending the HIV Epidemic and Commission Activities
F. Annual Meeting Preparation

6. Co-Chair's Report 1:30 P.M. – 1:50 P.M.
A. September 10, 2020 COH Meeting Feedback
B. October 10, 2020 Commission Meeting Agenda
C. Board Letter Regarding Contractual Process | UPDATE
D. 2021 Co-Chair Open Nomination + Elections | Elections: 10.8.20
E. At Large Executive Committee Member Open Nominations | REMINDER+ONGOING

7. Division of HIV and STD Programs (DHSP) Report 1:50 P.M. – 2:05 P.M.
A. Fiscal, Programmatic and Procurement Updates
B. Ending the HIV Epidemic (EHE) Activities + Updates

8. **Standing Committee Reports:** 2:05 P.M. – 2:45 P.M.

A. Operations Committee
   (1) Assessment of the Administrative Mechanism (AAM) Supplemental Report
   (2) Membership Management
      i. New Member Application: Everardo Alvizo | City of Long Beach Representative Seat **MOTION #3**
   (3) Mentorship Program Implementation
   (4) 2020 Training Schedule

B. Planning, Priorities and Allocations (PP&A) Committee
   (1) Program Directives for Maximizing Ryan White Part A and MAI Funds for Program Years 30, 31, 32 **MOTION #4**

C. Standards and Best Practices (SBP) Committee
   (1) Child Care Standards of Care | UPDATE
   (2) Universal Standards of Care | UPDATE

D. Public Policy Committee
   (1) 2020-2021 Legislative Docket | UPDATE
   (2) Ballot Initiatives
   (3) FY 2020-21 Measure H and Homeless Housing, Assistance and Prevention (HHAP) Funding Recommendations
   (4) STD Epidemic Update
   (5) Housing Saves Lives: HUD Rule Change serving Transgender Persons

9. **Caucus, Task Force, and Work Group Reports:** 2:45 P.M. – 2:50 P.M.

A. Aging Task Force | September 28, 2020 @ 10am-12pm
B. Black/African-American Community (BAAC) Task Force | September 28, 2020 @ 1pm-3pm
C. Consumer Caucus | October 10, 2020 @ 3pm-5pm
D. Women's Caucus | October 19 @ 2pm-4pm
E. Transgender Caucus | October 27, 2020 @ 10am-12pm

V. NEXT STEPS

10. Task/Assignments Recap 2:50 P.M. – 2:53 P.M.

11. Agenda development for the next meeting 2:53 P.M. – 2:55 P.M.

VI. ANNOUNCEMENTS 2:55 P.M. – 3:00 P.M.

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

VII. ADJOURNMENT

13. Adjournment for the meeting of September 24, 2020. 3:00 P.M.

PROPOSED MOTION(s)/ACTION(s):	
MOTION #1:	Approve the Agenda Order, as presented or revised.
MOTION #2:	Approve the Executive Committee minutes, as presented or revised.
MOTION #3:	Approve New Member Applicant, Everardo Alvizo, for the City of Long Beach representative seat and elevate to October 10, 2020 COH meeting for approval, as presented or revised.
MOTION #4	Approve Program Directives for Maximizing Ryan White Part A and MAI Funds for Program Years 30, 31, 32, as presented or revised.

LOS ANGELES COUNTY
COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-6748
HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov

CODE OF CONDUCT

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

All participants and stakeholders should adhere to the following:

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

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

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TO END HIV, WE MUST END RACISM

On the behalf of the Los Angeles County Commission on HIV, the Black/African American Community (BAAC) Task Force recognizes that these are extremely difficult, disturbing and painful times for us and our communities. We remain steadfast in solidarity with our Black/African American communities and vehemently condemn the pervasive, systemic racism that continues to plague our communities. “Without reckoning with our history of racial injustice and violence we will continue to be haunted by its ugly and painful legacy.” (Equal Justice Initiative [EJI].)

Racism IS a public health emergency and impacts us all. Racism impacts access to and the quality of health care and it dictates when, how and by whom health care is given or withheld. Medical mistrust by our Black/African American communities and implicit biases of the health care system are rooted in historical, institutional and socialized racism. It is without question we cannot end the HIV epidemic without dismantling these systems that continue to perpetuate the injustices that result in disproportionately poorer outcomes in our Black/African American communities. Our HIV community must remain diligent and committed to actively engaging in policy and action that promote health equity, eliminate barriers and address social determinants of health such as: implicit bias; access to care; education; social stigma, i.e. homophobia, transphobia and misogyny; housing; mental health; substance abuse; and income/wealth gaps.

As HIV advocates, we cannot sit idly by and allow these inequities to continue. We must act now by centering ALL of our work and conversations around the intersection of racism and the unequal burden of HIV on our Black/African American communities. The Commission is committed to taking action.

We stand in memoriam of Breonna Taylor, George Floyd, Tony Mc Dade, Ahmaud Arbery, and all those who have lost their lives to senseless acts of violence, police brutality and HIV/AIDS. We stand with you, we hurt with you, and we will take action to address these inequities and heal with you.

In Solidarity,

Los Angeles County Commission on HIV
Black/African American Community (BAAC) Task Force

#EndBlackHIV #KnowYourStatus #EndingtheEpidemic #VOTE

“Injustice anywhere is a threat to justice everywhere. We are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly, affects all indirectly.” - Martin Luther King, Jr.

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HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov ORG • *VIRTUAL WEBEX MEETING*

Presence at virtual meetings is recorded based on the attendance roll call. Only members of the Commission on HIV are accorded voting privileges and must verbally acknowledge their attendance in order to vote.
Approved meeting minutes are available on the Commission's website; meeting recordings are available upon request.

EXECUTIVE COMMITTEE MEETING MINUTES

August 27, 2020

MEMBERS PRESENT	MEMBERS PRESENT *(cont.)*	PUBLIC	COMM STAFF/ CONSULTANTS
Al Ballesteros, MBA, *Co-Chair*	Juan Preciado	Alasdair Burton	Cheryl Barrit, MPIA
Bridget Gordon, *Co-Chair*		Leopoldo Cabral	Carolyn Echols-Watson, MPA
Raquel Cataldo	**MEMBERS ABSENT**	Geneviéve Clavreul, RN, PhD	Dawn McClendon
Erika Davies	Michele Daniels	Kevin Donnelly	Jane Nachazel
Joseph Green	Kevin Stalter	Aaron Fox, MPM	
Lee Kochems, MA		Carlos Moreno	**DHSP STAFF**
Katja Nelson, MPP			Pamela Ogata, MPH
Mario Pérez, MPH			Julie Tolentino, MPH

*Some participants may not have been captured electronically. Attendance can be corrected by emailing the Commission.

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1) **Cover Page**: Executive Committee Virtual Meeting, *8/27/2020*
2) **Agenda**: Executive Committee Meeting Agenda, *8/27/2020*
3) **Minutes**: Executive Committee Meeting Minutes, *7/23/2020*
4) **Table**: Commission Member "Conflicts of Interest," *Updated 7/1/2020*
5) **Table**: Virtual Training Schedule for Commissioners and Community Members, *8/2020*
6) **Table**: Service Category, YR 29 (2019) Allocations, YR 29 (2019) Final Expenditures, *8/2020*
7) **Graphic**: Ending the HIV Epidemic in Los Angeles County, *July 2020*
8) **Roles/Responsibilities**: Ending the HIV Epidemic, Steering Committee and Commission on HIV, Roles and Responsibilities, *July 2020*
9) **Curriculum Vitae**: Paul Nash, PhD, CPsychol, AFBPsS FHEA, *February 2020*
10) **Curriculum Vitae**: Stephanie Cipres, MPH, *2020*
11) **Table**: Planning, Priorities and Allocations Committee, Service Category Rankings PY 30, 31, 32 Recommendations for Executive Committee Approval on 8/27/2020, *8/18/2020*
12) **Table**: Planning, Priorities and Allocations Committee, Allocation Percentages for PY 30, 31, 32 Recommendations for Executive Committee Approval on 8/27/2020, *8/18/2020*
13) **Standards of Care**: Psychosocial Support Standards of Care, Final for Executive Committee Approval, *8/27/2020*
14) **Standards of Care**: Child Care Services Standards of Care, Draft for Subject Matter Expert Review, *Updated 8/11/2020*

CALL TO ORDER-INTRODUCTIONS-CONFLICTS OF INTEREST: Ms. Gordon called the meeting to order at 1:08 pm.

I. ADMINISTRATIVE MATTERS

1. APPROVAL OF AGENDA
MOTION #1: Approve the Agenda Order, as presented ***(Passed by Consensus)***.

2. APPROVAL OF MEETING MINUTES
MOTION #2: Approve the 7/23/2020 Executive Committee Meeting Minutes, as presented ***(Passed by Consensus)***.

II. PUBLIC COMMENT

3. OPPORTUNITY FOR PUBLIC TO ADDRESS COMMISSION ON ITEMS OF INTEREST WITHIN COMMISSION JURISDICTION: There were no comments.

III. COMMITTEE NEW BUSINESS ITEMS

4. OPPORTUNITY FOR COMMISSIONERS TO RECOMMEND ITEMS FOR FUTTURE AGENDAS, OR ITEMS REQUIRING IMMEDIATE ACTION DUE TO AN EMERGENCY, OR IF NEED FOR ACTION AROSE AFTER POSTING AGENDA:

- Ms. Gordon raised the issue of meeting accessibility for both Commissioners and members of the community. Not everyone has the technology to access these virtual meetings or they may lack internet services.
- ➲ Agendize addressing the means to ensure technological access to meetings of the Commission and its subsidiary bodies.

IV. REPORTS

5. EXECUTIVE DIRECTOR/STAFF REPORT

A. 2020 Commission Training Schedule

- Ms. Barrit reported the Operations Committee Co-Chairs and staff have worked to develop the annual training schedule. The virtual meetings will launch 9/2/2020 and will be posted on the Commission website afterwards.
- Both Commissioners and interested parties are welcome with Commissioners encouraged to bring a consumer guest.

6. CO-CHAIR REPORT

A. Los Angeles LGBT Center Statement Regarding Brutal Attack on 3 Transgender Women

- Ms. Gordon said she saw on 8/26/2020 that the three attackers were released. Concern was expressed during the Operations Committee Meeting that morning that the issue would not be properly addressed.
- Mr. Fox reported the Center's first statement of 8/19/2020 was followed on 8/25/2020 by a second on the current process, the need for transparency, and the need for accountability for this law enforcement and prosecutorial process as well as overall law enforcement and prosecutorial activity around LGBTQ and hate crimes.
- Mr. Pérez asked at the 8/20/2020 Commission Meeting to add this agenda item today to consider if the Commission should offer support in writing to the Center's appeal. In light of this crisis of violence against transgender women, especially those of color and, in particular, Black transgender women, he felt it important to signal unequivocal support for justice as a Los Angeles County (LAC) Commission. He asked about the Center's initial appeal and if appeals were planned to the LAC Sheriff's Department or LAC District Attorney as well as the Los Angeles Police Department (LAPD).
- Mr. Fox reported mainly working on the last week of the legislative session in Sacramento so was unfamiliar with all the details, but he can have legal services department staff follow-up. The Center crafted its statements to represent its own agency rather than garner sign-ons so he suggested the Commission develop its own statement, as desired.
- He added a new phone number, much like 911, to report hate crimes would launch soon. Ongoing LAPD LGBTQ Working Group Meetings mainly offer LAPD personnel the opportunity to hear LGBTQ community member concerns. Meetings have become more heated in recent months. Information on them is posted on the LAPD website.
- ➲ Mr. Fox will forward Center statements to staff for distribution and have legal services department staff follow-up.
- ➲ Agreed to develop statement after gathering information on statements by the Center and others, the case, and charges, in particular, relative to hate crimes. The statement should be directed at partners who can make decisions about the case. That is unlikely to include the Board of Supervisors (Board) but, rather, LAC prosecutorial departments.

B. 8/20/2020 Commission Meeting Feedback

- Ms. Barrit reported there was written feedback from the Consumer Caucus that they found all the presentations helpful and, in particular, appreciated the Surveillance Report presentation.
- Mr. Green was concerned that only one consumer voted at the last Planning, Priorities and Allocations (PP&A) Committee. It is important to increase diverse consumer participation at such meetings.
- Ms. Barrit said consumer feedback on Priority Setting and Resource Allocation (PSRA) found it a very technical process with a lot of information from many sources. They felt a separate meeting would help coach them and explain PP&A's

process and thinking behind allocations. Mr. Ballesteros, Ms. Cataldo, and Ms. Barrit will host a meeting on 8/28/2020. Mr. Kochems will also come. He said all were required to attend in the past, but many did not understand the process.

- Mr. Pérez was glad the discussion was being held and strongly subscribed to the Parity, Inclusion, and Representation (PIR) community planning principles. It is important for Parity to ensure everyone at the table has the skills and resources to make informed contributions to the planning process. He did urge clarifying the conversation's timing as it relates to creating a foundation of learning and understanding to inform future PP&A and Commission PSRA processes versus the PSRA for PY 31 that will be part of the application that DHSP needs to submit in September 2020.

➲ Mr. Pérez will identify DHSP staff to participate in the 8/28/2020 meeting to help inform the PSRA conversation.

C. Board Letter Regarding Contractual Process - UPDATE

- Ms. Gordon noted this letter to the Board advised that LAC was under an expectation to expedite the use of funds.
- Ms. Barrit and the Commission Co-Chairs engaged in a call on the topic with Barbara Ferrer, PhD, MPH, MEd, Director, and Jeffrey Gunzenhauser, MD, MPH, Chief Medical Officer/Medical Director and Director, Disease Control Bureau, Department of Public Health (DPH). Dr. Gunzenhauser committed to weekly calls to ensure there are no delays.
- Her recall of the discussion includes that HIV and the LAC response is as important as COVID-19 and, consequently, HIV dollars should be distributed quickly to fund services and maintain trust with the community. The Co-Chairs stressed this is a long-standing issue, especially critical as Ending the HIV Epidemic (EHE) and the Centers for Disease Control and Prevention (CDC) COVID-19 funds are time sensitive. Consumers and clients should not have to wait for services due to contracting delays. Contracts should be expedited including DHSP approval to use atypical mechanisms like sole source.
- Mr. Ballesteros said STDs were not specifically discussed, but both EHE and CDC grants noted they overlap with HIV. He related that Dr. Ferrer supported disbursing funds to services as quickly as possible. Ms. Gordon added that the Co-Chairs reviewed Commission responsibilities under the Bylaws and asked for an expedited - three- to five-month - timeline. She felt they had not understood the urgency of disbursing funds quickly.
- Mr. Ballesteros noted the weekly meetings with Dr. Gunzenhauser will offer opportunities to address other issues.

D. At Large Executive Committee Member Open Nominations - REMINDER + ONGOING

- There are three At Large seats. Ms. Daniels was elected to one, but has not attended recently. Ordinarily, candidates for the one-year terms would already be seated so nominations and elections will be ongoing until seats are filled.

➲ Ms. Barrit will contact Frankie Darling-Palacios and Felipe Gonzalez, both nominated by Mr. Green, to ask if they will accept nomination.

7. DIVISION OF HIV AND STD PROGRAMS (DHSP) REPORT

A. Fiscal, Programmatic, and Procurement Updates

- Mr. Pérez reported roughly 80% of the DHSP work force, some 200 staff, continues to be deployed to COVID-19 assignments. DHSP was trying to maintain programmatic responsiveness as well as possible, but delays may occur.
- DPH did poll its divisions for a list of staff to meet critical needs and DHSP submitted its appeal. DHSP has met with DPH and they shared that, due to the changing nature of COVID-19, they cannot honor the request to have staff return at this time. About 15 staff who do public health investigations have been allowed to help with HIV and syphilis cases three days a week if they work on COVID-19 on Saturdays and Sundays. Improvement was not expected until 2021.
- He reviewed the three new funding resources: HRSA 078 EHE, multi-year grant in response to the administration's EHE Initiative in America; Coronavirus Aid, Relief, and Economic Security (CARES) Act, HRSA funding allocation, $1 million awarded to benefit PLWH; CDC EHE, multi-year grant. DPH has not yet released guidance on whether DHSP will be allowed to spend HRSA 078 EHE and/or CDC EHE funding.
- In response, arguably, to the Commission's meeting with DPH the prior week, DHSP received support to spend the $1 million in CARES Act funds pending confirmation from DPH they have not been used for other purposes including COVID-19. Mr. Pérez has not yet received that confirmation, but contracts were already amended before DHSP was advised the funds may have been invested elsewhere. If they were, other funding sources will need to be identified for the Personal Protective Equipment (PPE), food, and home equipment purchased with the grant.
- Separately, DHSP learned a couple of days ago that, in response to a DPH request directly to the Department of Health and Human Services (HHS), the CDC has approved the use of funds tied to five CDC grants to DHSP to be used for COVID-19 related expenses of salary and related benefits. DHSP is working to understand the impact of the decision, particularly in two areas. The first pertains to any staff re-assigned from an HIV initiative to COVID-19 work.

- DHSP was seeking clarification and reconciliation of various messages, some relayed directly to Commission leadership and some to DHSP. DHSP was trying to schedule a follow-up meeting to the Commission's Co-Chairs' meeting with DPH that includes those people making decisions about these funds so that everyone has the same information.
- Finally, Mr. Pérez provided input on debate at the 8/20/2020 Commission Meeting regarding a recommendation to use Ryan White (RW) Part A funds to support Emergency Financial Assistance (EFA) as part of the prospective RW Program Years (PYs). When that recommendation was made, LAC had not yet received notice that additional funds would be made available including HRSA 078 EHE funds. DHSP was able to increase the EFA allocation from $1 million in RW Part A funds to $1.5 million in HRSA 078 EHE funds while relieving pressure on Part A from increases in other categories.
- Regarding the CDC grant that began 8/1/2020, the biggest part is community engagement and mobilization. That was in motion. DHSP will present more details on all the grants at the 9/10/2020 Commission Meeting.
- Mr. Ballesteros was concerned, first, that DPH delay in approving DHSP access to the designated funds might impede utilization within the PY. If so, funds may be lost or, even carried over, service implementation or enhancement would be postponed. Community trust would be undermined in either case. In the worst case scenario, funds that were meant to address HIV could be absorbed into the general DPH budget. That is not acceptable. DPH leadership needs to be aware that the Commission Co-Chairs must sign annual letters of concurrence with allocation and utilization of RW funds. While not specific to other funds, other funds including Net County Cost (NCC) do impact utilization of RW funds.
- Ms. Cataldo noted DHSP was not unique. Funds across LAC were being diverted to COVID-19 without accountability.
- Dr. Clavreul recommended demanding DPH communication on where funds were being spent.
- ➲ Mr. Pérez committed to a DHSP report at the 9/10/2020 Commission Meeting on: the HRSA 078 EHE spending plan; the CDC EHE spending plan; and confirming availability of the CARES Act funds for investment as already started.
- ➲ Agreed to develop a memorandum on behalf of the Executive Committee to DPH leadership requesting information on the contracting process, and HRSA EHE and CDC EHE funding plans.

B. Ending the HIV Epidemic (EHE) Activities + Updates

(1) Review Health Resources and Services Administration (HRSA) and Centers for Disease Control and Prevention (CDC) EHE Workplans + Roles for Commission

- Ms. Tolentino presented on the Workplan in the packet based on the four EHE pillars: Diagnose, Prevent, Treat, Respond. This was developed on the initial submission. Due to COVID-19, DHSP was working to address goals as creatively as possible in partnership with providers to move forward with the minimal staff available.
- Foci for the first three pillars were: Diagnose - testing, especially home test kits, and re-screening; Prevent - PrEP, and Syringe Service Programs (SSPs) including partnership with Substance Abuse Prevention and Control (SAPC) on landscape analysis and linkage to HIV prevention services; Treat - facilitation of Rapid Antiretroviral Therapy (ART), expand Partner Services, increase knowledge of and access to HIV services, assess mental health landscape, and addressing other factors related to health and wellbeing that impact adherence.
- The Los Angeles County HIV/AIDS Strategy (LACHAS) focused on Diagnose, Prevent, and Treat. DHSP looked forward to new EHE funding to support Respond by enhancing its surveillance infrastructure. Andrea Kim, PhD, MPH, Chief, HIV and STD Surveillance was to lead that effort, but has been diverted to COVID-19. It is hoped that Dr. Kim will be able to return to EHE work in year two of the effort.
- As noted earlier, the CDC EHE focus is community engagement. Ms. Tolentino was working to move the solicitation through as quickly as possible to work with different communities whether or not they have been involved with HIV previously. Two-fold goals are to increase education and awareness, but also actions that effect change.
- DHSP was hosting an EHE Town Hall on 9/16/2020 to provide an overview of the December CDC submission.
- With current COVID-19 circumstances, DHSP needs to further enhance its partnerships to advance the work. The Commission can be especially helpful in providing additional opportunities to increase promotion of RW services, e.g., the Lunch and Learn series can help increase community knowledge about available services.
- Mr. Green asked about Steering Committee development and ensuring it does not duplicate Commission work. Ms. Tolentino noted the review team, including Ms. Barrit, has finished review of the 83 applications. A key criterion was drawing in new voices not well represented on the Commission or in DHSP. The goal for the body is to focus on specific activities not duplicative of Commission work while partnering with other bodies as well such as Consumer Advisory Boards (CABs) and provider networks.

8. STANDING COMMITTEE REPORTS

A. Operations Committee

(1) Membership Management:

- Mr. Green reported half of the membership slate has been appointed. The Board of Supervisors (Board) is only addressing emergency measures this month so the other half has been put on hold until next month.
- Kevin Donnelly's application will go before the full Commission for approval at its next meeting.
- Operations heard a Youth/Young Adult panel at today's meeting to initiate a deeper discussion on engagement.

(i) New Member Applications

1. *Paul Nash, PhD, CPsychol, AFBPsS FHEA* A professor of gerontology at the University of Southern California (USC), he has been involved with both the Los Angeles LGBT Center and AIDS Project Los Angeles (APLA).

MOTION #3: Approve New Member Applicant, Paul Nash, PhD, CPsychol, AFBPsS FHEA, for HIV Stakeholder seat and elevate to the full Commission on 9/10/2020 for approval, as presented ***(Passed by Consensus)***.

2. *Stephanie Cipres, MPH* This candidate would replace LaShonda Spencer, MD as the Part D Representative.

MOTION #4: Approve New Member Applicant, Stephanie Cipres, MPH, for Part D Representative Seat and elevate to the full Commission on 9/10/2020 for approval, as presented ***(Passed by Consensus)***.

(ii) Seat Change - LaShonda Spencer, MD: This change follows Dr. Spencer's move to the Charles R. Drew University.

(2) Mentorship Program Implementation

- Mr. Green reported Operations presented the Mentorship Program to the Youth/Young adult panel. Per the panel's recommendation, Operations will forward it for additional review to Youth/Young Adult CABs.
- There was also discussion on renaming it a Collaborative Partnership rather than the Mentorship Program. That language has been found to feel more inclusive, especially by Youth/Young Adults.

B. Planning, Priorities, and Allocations (PP&A) Committee: Members reviewed and affirmed their Conflicts of Interest.

(1) Ryan White Program Years (PYs) 30, 31, and 32 Service Category Prioritization

- Ms. Barrit presented the service category prioritizations. No changes have been made since their last review.
- Mr. Kochems noted this motion forwards priorities to the full Commission for approval. The Consumer Caucus will also review the priorities on 8/28/2020 and bring any additional recommendations to the Commission.

MOTION #5: Approve Ryan White Program Years (PYs) 30, 31, and 32 Service Category Prioritization, as presented ***(Passed: Yes -*** Cataldo, Green, Kochems, Nelson, Pérez, Preciado, Gordon, Ballesteros***; No -*** none***; Abstentions -*** none***)***.

(2) Ryan White PYs 30, 31, and 32 Allocation Percentages

- Mr. Ballesteros noted some slight modifications to PY 30, the current year, due to how the year was progressing. The Commission normatively provides DHSP the option to shift allocations up to 10% to respond to situations in which some categories may expend less than anticipated while others expend more.
- A category may expend less funds than expected for a variety of reasons such as provider inability to hire or replace staff, or expanded access to other services, e.g., Oral Health expenses declined when Medi-Cal Dental Care was refunded and has recently declined due to COVID-19 restrictions and consumer concerns.
- PY 31 begins 3/1/2021. Most allocations are similar to PY 30. An allocation of 1% was added for Child Care in anticipation of the SOC under development. DHSP has no current provider, but solicitation will be prioritized once the SOC is complete. The 1% was taken from Oral Health based on the current expenditure decline.
- These PY 31 priorities and allocations will be submitted with the PY 31 HRSA application. It is understood that they will be revised as new data develops from what is understandably an atypical year and once the award is received.
- PY 32 was currently the same as PY 31 and functions simply as a starting point for deliberations.
- Mr. Green asked about linguistics. Mr. Pérez replied the workforce is increasingly multilingual so the need was less. DHSP has a language services contract to supplement what is available through the workforce, but the vendor has not provided services at a level that meets DHSP expectations. DHSP was reviewing the category and will re-solicit the service to contract a new language and translation provider. Meanwhile, NCC was funding any needs.

MOTION #6: Approve Ryan White PYs 30, 31, and 32 Allocation Percentages, as presented, and provide DHSP the authority to make adjustments of 10% greater or lesser than the approved allocations amount, as expenditure categories dictate, without returning to this body ***(Passed: Yes -*** Cataldo, Green, Kochems, Nelson, Pérez, Preciado, Gordon, Ballesteros***; No -*** none***; Abstentions -*** none***)***.

C. Standards and Best Practices (SBP) Committee

- SBP initiated review of the Universal SOC at its last meeting. Work will continue including incorporation of telehealth.

- The next meeting will be 9/1/2020, 10:00 am to 12:00 noon. All are welcome.

(1) Psychosocial Support Standards of Care (SOC)

- Ms. Davies reported SBP had several robust conversations on this SOC. Peer services have been highlighted and staff requirements and qualifications revised, as noted starting on page 4.
- Peer support staff will participate in trainings to increase their capacity for fulfilling their responsibilities with several trainings suggested including: motivational interviewing, trauma informed care, mental health overview, and HIV/AIDS service providers and resources available to clients.
- Under Peer Support, page 6, the SOC incorporates peer navigation, educators, or other peer delivered programs.

MOTION #7: Approve the Psychosocial Support Standards of Care (SOC), as presented ***(Passed by Consensus)***.

(2) Child Care SOC: SBP will continue review of this SOC at its next meeting.

D. Public Policy Committee

- Ms. Nelson said the Senate developed a slimmed down COVID-19 aid package, but nothing has passed as yet.
- The deadline for California bills to pass the Legislature will be 8/31/2020. Governor Gavin Newsom has until 9/30/2020 to sign or veto the bills. If he does neither, the bill becomes law.
- Governor Newsom indicated legislation to permanently support telehealth has been postponed to next year. Coverage continues as an emergency declaration. The 90-day declaration expires in October, but was expected to be renewed.
- The eviction moratorium was set to expire in September, but extension was also expected for that.
- Mr. Kochem reported he and Ms. Nelson had a conversation with Richard Zaldivar, Founder and Executive Director, The Wall Las Memorias Project, regarding prioritizing methamphetamine as a Substance Use (SU) problem for LAC. The conversation will move to the Public Policy Committee with the expectation of developing a countywide awareness effort. It is an issue that layers across the overlapping epidemics of HIV, COVID-19, racism, STDs, and homelessness.
- Ms. Nelson said Public Policy will do a deep review of the Black/African American Community (BAAC) Task Force recommendations at its 9/14/2020 meeting with a view towards developing actions. All are welcome to attend. Mr. Kochems added the Public Policy and BAAC Task Force Co-Chairs will be meeting to further an ongoing partnership in addressing structural and institutionalized racism in Public Policy and the Commission as a whole.
- Ms. Nelson noted a follow-up letter to the Board on addressing STDs remains on the Committee's agenda to ensure the issue remains top of mind. Development of the proposed letter was on hold due to diversion of Board attention to COVID-19. Per the May 2018 Board Motion, a quarterly report of about ten pages on the current state of STD services and funding in LAC was posted on the Board correspondence website a couple of weeks ago.
- ➲ Add to Public Policy agenda review of bill on independent contracts impacting Uber and Lyft. Transgender Caucus members were concerned about the loss of transportation services due to the companies' threat to leave the state.

9. CAUCUS, TASK FORCE, AND WORK GROUP REPORTS

A. Aging Task Force - 9/28/2020, 10:00 am - 12:00 noon

- ➲ Mr. Kochems will forward information from a New York State Town Hall that includes an aging services instrument. Another town hall on this was planned to include Anthony Fauci, MD. Mr. Kochems will send any available information.

B. Black/African American Community (BAAC) Task Force - 9/28/2020, 1:00 - 3:00 pm

- The Task Force will discuss its restructuring. It will also address requests for guidance in implementing the BAAC Task Force recommendations from the various Committees.

C. Consumer Caucus - 8/28/2020, 10:00 - 12:00 (Special Meeting on PSRA) and 9/10/2020, 3:00 - 5:00 pm

- Mr. Moreno said the last meeting heard a presentation regarding pharmacy services. Consumers are urged to attend.

D. Women's Caucus - 9/21/2020, 2:00 - 4:00 pm (new date)

- Ms. McClendon reminded everyone about the four-part Lunch and Learn Women's series. The next segment will be 8/31/2020, 1:00 to 2:30 pm, and will address mental health and women living with HIV with a prevention and care lens. The guest speaker will be Neva Chaupette, PsyD with facilitators Shary Alonzo and Dr. Spencer.
- ➲ Ms. McClendon will distribute the flyer.

E. Transgender Caucus - 9/22/2020, 10:00 am - 12:00 noon

- Frankie Darling-Palacios is the Chair. There is a call for more community members to participate.
- At its last meeting, the Caucus reviewed the COVID-19 communitywide survey used by PP&A to inform this year's PSRA.

- Tracking the impact of COVID-19 on the transgender community is a standing item. They also discussed the most recent attack on members of the transgender community.

V. NEXT STEPS

10. **TASK/ASSIGNMENTS RECAP**: There were no additional items.

11. **AGENDA DEVELOPMENT FOR NEXT MEETING**:
    - Add Co-Chair Report standing item: Update on spending plans and DHSP leadership on expediting contracts.
    - Increase time for Public Policy to address bills, especially that regarding independent contractors for, e.g., Uber and Lyft.
    - Add Operations Committee standing item: Training.
    - Updated draft of Child Care SOC from SBP.

VI. ANNOUNCEMENTS

12. **OPPORTUNITY FOR PUBLIC AND COMMITTEE TO MAKE ANNOUNCEMENTS**: There were no announcements.

VII. ADJOURNMENT

13. **ADJOURNMENT**: The meeting adjourned at 3:45 pm.

LOS ANGELES COUNTY
COMMISSION ON HIV

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Get in touch: hivcomm@lachiv.org

Virtual Training Schedule for Commissioners and Community Members

These trainings are **highly recommended.** The Ryan White HIV/AIDS Program Part A Manual stipulates the provision of a thorough orientation to new and returning planning council members and ongoing formal training to attain skills necessary to perform their duties.

September 2 @ 2pm to 3:30pm REGISTER HERE: https://tinyurl.com/y4rdbl6u	**Commission on HIV (COH) Overview** | Learn about the purpose of the COH, its ordinance and bylaws, and structure. Learn about integrated HIV prevention and care community planning.
September 14 @ 10am to 11:30am REGISTER HERE: https://tinyurl.com/yxnnleq5	**Ryan White CARE Act Legislation Overview** | Learn about the landmark law that establishes lifesaving care for people living with HIV in the United States.
October 1 @ 10am to 11:30am REGISTER HERE: https://tinyurl.com/yyl8gu9r	**Membership Structure and Responsibilities |** Learn about the duties of a Commissioner, the 51 seats on the body, and the functions of the Operations Committee. Learn how different member perspectives help facilitate a sound integrated HIV/STD prevention and care planning process. Understand the concepts of Parity, Inclusion, Reflectiveness, and Representation.
October 29 @ 10am to 11:30am REGISTER HERE: https://tinyurl.com/yyhgv8sb	**Priority Setting and Resource Allocation (PSRA) Process |** Ryan White HIV/AIDS Program resources are limited and need is severe. Learn about the responsibility of planning councils to use sound information and a rational decision-making process when deciding which services and other program categories are priorities (priority setting) and how much to fund them (resource allocation).
November 5 @ 10am to 11:30am REGISTER HERE: https://tinyurl.com/y3c7f632	**Service Standards Development Process** | Learn why the COH develops service standards for HIV services, the functions of the Standards and Best Practices Committee, and how community members help shape standards of care in Los Angeles County.
November 19 @ 10am to 11:30am REGISTER HERE: https://tinyurl.com/yyh64om6	**Policy Priorities and Legislative Docket Development Process** | Learn about the functions of the Public Policy Committee and how the COH's policy priorities and legislative positions are developed. Learn about the Board of Supervisors guidance for Commissions on taking positions on legislative bills.

LOS ANGELES COUNTY
COMMISSION ON HIV

POLICY/PROCEDURE #09.7201	Compensation for Unaffiliated Consumer Commission Members	Page 1 of 6

ADOPTED 4/12/12
Draft Updates 9/15/20

SUBJECT: **Payment of compensation and reimbursements to the Commission's unaffiliated consumer members.**

PURPOSE: **To stipulate the requirements, processes and procedures for providing stipends and reimbursements to the Commission's unaffiliated consumer members.**

BACKGROUND:

- Active, full and engaged membership on the Commission requires a commitment of time, energy and resources. Ryan White legislation requires that no fewer than 33% of the members of a Ryan White Part A planning council (the Commission is Los Angeles County's Ryan White Part A planning council) must be "unaligned (unaffiliated) consumers."

- Both Ryan White legislation and guidance from the Health Resources and Services Administration (HRSA) acknowledge that planning council membership can be particularly challenging for unaffiliated consumers: "One of the greatest obstacles to PLWHA involvement in planning councils is the financial cost of participation. Costs of attending planning council meetings may involve transportation, child or partner care, and meals. Additional expenses may include sending and receiving faxes, making telephone calls, preparing materials, and accessing the Internet. These expenses can present a problem for PLWHA on disability or with very limited incomes, and for PLWHA who do not have jobs that provide them access to office equipment and supplies." (*Ryan White HIV/AIDS Program Part A Manual, VI. Planning Council Operations, 4. PLWHA/Consumer Participation, C. Ensuring PLWHA Participation, Maintenance of PLWHA Involvement, Financial Support*)

- HRSA guidance indicates that "Financial support for PLWHA involvement needs to be addressed with respect to several different categories of issues:
  - ⇨ What kinds of Ryan White or other funds are available for use in providing financial support for activities related to PLWHA involvement?
  - ⇨ What kinds of expenses can be covered for PLWHA within legislative requirements regarding 'reasonable costs?' and
  - ⇨ What allowable expenses need to be covered in order to ensure strong PLWHA participation in the planning council?" (*Ibid.*)

- HRSA guidance further stipulates that "Under Part A grants, funds are available not only for administrative costs but also for Planning Council Support. Ryan White funds can be used to cover actual expenses for PLWHA such as child care, transportation, or other meeting-related costs. Ryan White funds cannot be used to provide cash payments such as stipends or honoraria." (*Ibid.*)

- Los Angeles County Code 3.29.080 (Compensation) includes the following provisions: "Corresponding with Ryan White legislation and HRSA guidelines, members of the Commission may also be reimburse for local travel and mileage, meals associated with Commission business, child care during Commission activities, and computer-related expenses if those costs were incurred in the performance of commission-related duties. The Commission may, rather than reimburse for those expenses, make arrangements to provide services directly to members or obtain alternate funding for member stipends. . . . The Commission and the executive director will establish and implement procedures for eligibility and utilization of the foregoing described requirements."

- Section 5 (Commission Member Compensation) in Article VI (Resources) of the Commission's Bylaws (*Policy/Procedure #06.1000: Bylaws of the Los Angeles County Commission on HIV*) states "In accordance with Los Angeles County Code 3.29.080 (Compensation), Ryan White Part A planning council requirements, and/or other relevant grant restrictions, Commission members may be compensated for travel or other allowable expenses contingent upon the development policies and procedures governing Commission member compensation practices."

POLICY:

1) **Compensation**: Commission member compensation comes in two forms—stipends and reimbursements. Stipends are intended to compensate eligible members for the work they do as a member of the Los Angeles County Commission on HIV and to defray intangible costs incurred in the performance of that role. Reimbursements are intended to re-pay members for expenses they have incurred fulfilling their responsibilities as members of the Commission on HIV.

2) **Stipends**: Payment of stipends is limited to "unaffiliated" consumer members who are serving as the Commission's 17 designated unaffiliated consumer members, and their alternates, or for unaffiliated consumer members who are serving as Commission members/alternates in other membership seats/capacities by consent of the Co-Chairs and the Executive Director.
   a. Community members of the Commission are not entitled to stipends, nor are
   b. other Commission members who are not unaffiliated consumers.

3) **Stipend Requirements**: Eligible stipend recipients must meet attendance requirements, as detailed in Procedures #4 and #5, and must fulfill training requirements and member expectations, as detailed in Procedure #6. Eligible stipend recipients must complete a monthly "Stipend Claim Form," which must be subsequently approved by the Executive Director. Stipend payments are made quarterly.

4) **Reimbursements**: In accordance with Policy/Procedure #08.3303 (*Reimbursable Commission Expenses*), reimbursements are allowable re-payment of personal funds that Commission members have expended in the course of performing or fulfilling Commission responsibilities. The Commission's unaffiliated consumer members are entitled to claim all types of allowable reimbursements.

5) **Payment Sources**: Stipends and certain reimbursements are funded by Los Angeles County Net County Costs (NCC) or other non-Ryan White funds, as appropriate. Ryan White funds can be used for most reimbursements, unless not allowable by Ryan White legislation or HRSA guidance.

PROCEDURE(S):

1. **Monthly Stipends**: Eligible recipients of stipends may receive them monthly if they fulfill the respective stipend requirements as outlined in Procedures #4 - #6. Eligible stipend recipients may decline their stipends at any time for any period.

2. **Stipend Eligibility**: Commissioners and alternates who are unaffiliated consumer members are eligible to receive stipends. Commissioners and alternates who are not unaffiliated consumers and community members of the Commission are not eligible for stipends.
   a) Commissioners and alternates in the 17 designated unaffiliated consumer seats are automatically entitled to earn stipends.
   b) The Co-Chairs and the Executive Director must approve the payment of stipends to unaffiliated consumers who serve as Commission members in other membership seats that are not designated for unaffiliated consumers.

3. **Stipend Rates**: Eligible Commissioners may earn a $150.00 stipend every month that they fulfill their respective stipend requirements. Eligible Alternates may earn a $100.00 monthly stipend if they fulfill the stipend requirements. Alternates who fill a Commissioner's role and meet the requirements for any month in which the Commissioner is incapacitated, or for a seat in a month in which there is no sitting Commissioner, may earn a $150.00 monthly stipend.
   a) Prorated amounts based on partial fulfillment of stipend requirements are not permitted.

4. **Commissioner Stipend Requirements**: In order to qualify for a monthly stipend, a Commissioner must attend 70% of the regularly scheduled meetings in which they are responsible for participating, including the Commission meeting, any committees to which they have been assigned, and the Consumer Caucus. Attendance for more than 75% of the meeting is necessary to qualify it as attendance.

5. **Alternate Stipend Requirements**: In order to qualify for a monthly stipend, an Alternate must attend 70% of the regularly scheduled meetings in which they are responsible for participating, including any committees in which the Alternate has taken a secondary assignment, the Consumer Caucus and any Commission/committee meetings that the Commissioner for whom they are serving as an Alternate cannot attendance. Attendance for more than 75% of the meeting is necessary to qualify it as attendance.

6. **Additional Stipend Requirements**: In addition to the attendance requirements outlined in Procedures #4 and #5, Commissioners and Alternates must fulfill all respective training requirements, and must fulfill their duties as outlined in Policies/Procedures #07.3002, #07.3003, #07.1002 (*Duty Statements for the unaffiliated seats and Alternate*) or any other respective duty statement. Commissioners and Alternates must also comply with membership requirements, as outlined in relevant Policies/Procedures #08.3000 (*Membership*).

7. **Stipend Claim Form**: All stipend recipients must complete the "Stipend Claim Form" (Attachment A) for each month in which the recipient expects to earn a stipend. Stipend Claim Forms submitted more than three months after the month(s) for which they are claimed will not be approved, unless previously authorized by the Executive Director.

8. **Executive Director Approval**: All Stipend Claim Forms must be approved by the Executive Director before the payment of the stipend. The Executive Director determines the resolution of any discrepancies between the recipient's claim and the stipend requirements.
   a) The Committee Assignment List included in the monthly Commission meeting materials is the final determinant of committee assignments, unless changes have been made and noted in the interim between Commission meetings.
   b) If a submitted Stipend Claim Form is not approved by the Executive Director, the Executive Director must indicate in writing on the form why it has not been approved, and a copy of the form is returned to the Commission member.
   c) If a form is not approved by the Executive Director for non-attendance reasons, those issues will be forwarded to the Operations Committee for follow-up review and action.

9. **Stipend Payments**: Stipends will be paid to eligible Commissioners/Alternates in aggregate quarterly amounts on calendar quarters. Stipends are paid in accordance with relevant Los Angeles County rules, requirements and procedures.
   a) Stipends can be paid in the form of currency or store vouchers, at the choice of the recipient.

10. **Reimbursements**: Reimbursements are allowable re-payment of funds expended in the course of performing or fulfilling duties as a member of the Commission. In accordance with Policy/Procedure #08.3303 (*Reimbursable Commission Expenses*), the Commission's unaffiliated consumer members are eligible for all available reimbursements.
    a) Unaffiliated consumers are eligible for all types of reimbursements without prior consent from the Executive Director, unless the procedure specifically requires prior authorization from the Executive Director.
    b) Reimbursement claims are still subject to the Executive Director's approval to ensure they were incurred in the conduct of Commission business, are necessary and are reasonable.
11. **Payment Sources**: As detailed in Policy/Procedure #08.3303 (*Reimbursable Commission Expenses*), Ryan White funds can be used for reimbursement for some allowable expenditures, but cannot be used for stipends (*"Ryan White funds cannot be used to provide cash payments such as stipends..."*). Stipends and reimbursements that are not allowed by the Ryan White Program are funded by Los Angeles County Net County Costs (NCC) or other non-Ryan White funds, as appropriate.

DEFINITIONS:

- **Approve/Approval**: in the context of this policy/procedure, when the Executive Director agrees to the payment of a reimbursement.

- **Authorize/Authorization**: in the context of this policy/procedure, the Executive Director's prior consent that an expenditure is eligible for reimbursement, provided it complies with the conditions as outlined in the foregoing procedures.

- **Bylaws:** Policy/Procedure #06.1000 (*Bylaws of the Los Angeles County Commission on HIV*), the Commission's governing operational procedures and practices.

- **Commission Members**: The term used to refer to all stakeholders formally affiliated with the Commission: Commissioners, Alternates, community representatives, approved representatives and staff. In the context of this policy, "Commission members" does not refer to staff.

- "**Eligible"**: in the context of this policy/procedure, when a Commission member qualifies for a particular type of reimbursement, or when an expenditure can be claimed for reimbursement.

- **Executive Director:** The Commission's lead staff member, who manages Commission staff and operations.

- **Health Resources and Services Administration (HRSA)**: Health Resources and Services Administration, the federal agency that administers and governs the Ryan White Program nationally.

- **Los Angeles County Code (3.29)**: the legal provisions establishing the Commission and governing its operations.
- **Net County Costs (NCC)**: Los Angeles County general funds, not federally supported.
- **Planning Council**: In Ryan White Part A-funded jurisdictions, the planning council is responsible for various planning and evaluation functions of the local Ryan White Part A system of care; the Commission on HIV is the local Ryan White Part A planning council for Los Angeles County.
- **"PLWHA"**: People Living with HIV/AIDS.
- **Unaffiliated Consumers**: same as "unaligned consumer"; see below.
- **Unaligned Consumers**: by HRSA definition and consistent with Commission Policy/Procedure #08.3107 (*Consumer Definitions and Related Rules and Requirements*), a Commission member is unaligned if he/she receives services from a Part A-funded provider and is not affiliated as an "officer, employee or consultant" of any Part A-funded agency.

NOTED AND APPROVED:  **EFFECTIVE DATE:** April 12, 2012

Original Approval: 4/12/2012 *Revision(s): Updated 9/15/20*

LOS ANGELES COUNTY
COMMISSION ON HIV

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Possible Commission on HIV Ending the HIV Epidemic Activities and 2020 Annual Meeting Ideas

FOR EXECUTIVE COMMITTEE DISCUSSION ONLY
DRAFT

Below are some ideas for discussion on what specific EHE activities the Commission may undertake for Years 1 and 2. The support and involvement of Commissioners is critical.

Year 1

- Conduct a thorough review of the draft EHE Plan; collect feedback from Commissioners and submit comments to DHSP. Encourage Commissioners, in particular, consumers, to also submit comments as community members. Review workplans and refine based on feedback from the community and environmental realities due to COVID-19

- Promote community participation in the DHSP EHE Townhall and public review period, with a special focus on consumers and highly impacted populations (i.e., young Black gay and bisexual men, Latinx communities, women of color, transgender communities, youth, people of color)

- Agendize EHE feedback at all Commission committees, caucuses, and task forces. Convene additional meetings if needed.

- Agendize EHE plan review and discussion at October 8 Commission meeting.

- Increase community awareness of EHE, HIV prevention, treatment, and local services through Commission meetings, Virtual Lunch and Learn events; HIV Connect resource website; Social media; virtual and in-person (pending DPH guidance) health and resource fairs (these may be ongoing activities)

- Hire a community engagement consultant to conduct EHE focused strategic planning sessions for the Commission; strategic planning sessions may lead to the development of a roadmap for the Commission on its roles and specific goals to end the HIV epidemic in LA County in 10 years; do deeper analysis of EHE plan and operationalize relevant activities for Commission; determine how to best support and supplement the work of the DHSP EHE Steering Committee; assist staff in developing "EHE Community Engagement and HIV Service Promotion Speaker's Tool Kit" for Commissioners to use in the community.

- Commission Co-Chairs and Executive Director to attend DHSP EHE Steering Committee meetings to learn and understand how to best support and supplement each other's work. Create a synergistic approach to EHE in Los Angeles County.

- (Ongoing) Facilitate county wide attention and collaborations to end HIV.

Year 2: Secure funding from DHSP to develop and implement leadership training for consumers of HIV prevention and care services in Los Angeles County; program aims to broaden leadership capacity of consumers in the community and Commission; program must have meaningful stipend amounts to incentivize participation. Assess how to take advantage of leadership programs from NMAC for Commissioners and community at large.

Annual Meeting Ideas (November 12)

Some Factors to Consider/Discuss:

- Optimal length of annual meeting for a virtual format
- Community participation and engagement
- Commissioner time and commitment

Theme: Ending the HIV Epidemic: A Countywide Call to Action

1. Welcome and Recap from Last Year's EHE Kick-Off Meeting (Co-Chairs and Commission Staff)

2. DHSP Presentation (topic to be determined based on pressing issue and feedback from Co-Chairs and Commissioners)

3. Trifecta of Health: Are We Closer to a Truly Integrated Health Services? (DMH, DPH, DHS Directors)

4. Creating Spaces for Meaningful Intergenerational Conversations in the HIV Movement

5. Los Angeles County's Anti-Racism Initiative: Elevating HIV in Countywide Anti-Racist Policies (CEO, or Human Relations Commission, or Health Deputies Panel)

Supplement to the Assessment of the Administrative Mechanism

Report prepared for the Los Angeles County Commission on HIV

Next-Level Consulting, Inc.

February 2020

Supplement to the Assessment of the Administrative Mechanism

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I. Introduction and Purpose of Report

As a Ryan White Part A planning council, the Los Angeles County Commission on HIV ("the Commission") is required by Health Resources and Services Administration (HRSA) to conduct a regular "Assessment of the Administrative Mechanism" (AAM). The AAM is meant to evaluate the speed and efficiency with which Ryan White Program funding is allocated and disbursed for HIV services in Los Angeles County. The last AAM in Los Angeles County was conducted in 2018. Upon review of the findings of the last AAM, and recommendations therein, the Commission identified key areas to assess further. In 2019, the Commission engaged the services of Next-Level Consulting, Inc. to implement a survey with all Commissioners and to conduct key informant interviews with ten randomly sampled providers contracted by DHSP to implement HIV-related services.

The purpose of this report is to present the findings of this supplemental assessment. Outlined in the sections below is the assessment methodology, and findings.

II. Assessment Methodology

As a supplement to the 2018 AAM, the Commission choose to conduct a survey of the entire Commission on HIV membership (including Commissioners and Alternates), and key informant interviews of ten randomly sampled provider agencies that were funded by DHSP to implement HIV-related services with federal funds.

The consultant, in partnership with Commission staff and members of the Operations Committee, adapted the original assessment methodology used in the AAM for the supplemental assessment. Specifically, an online survey tool and a semi-structured interview tool were created (see attached).

Online Survey of Commissioners:

The Commission provided a list of all Commissioners, including Alternates, and their contact information. The consultant emailed each to invite them to participate in the online survey. The consultant also invited each participant to enter into a raffle for a $50 gift card after they completed the survey. Several follow-up emails were sent to ensure a high response rate. Forty-seven people were invited to participate in the survey and thirty responses were recorded at close of survey for a response rate of 64%.

Key Informant Interviews of Contracted Providers:

Key informants were selected for the assessment by the consultant after receiving a list of providers from the Commission that excluded providers who had been interviewed for the AAM. The list also included the type and number of contracts that each provider had entered into with DHSP.

Representative potential respondents were identified based on an anonymized sampling across the dimensions of service type and size of contract. Each agency contacted was informed about the nature of the assessment and corresponding questions, and was asked to identify the staff who would be most appropriate to participate in the interview. Once identified, each participant was interviewed either in-person or over the phone (per their preference) utilizing a semi-structured interview tool. Given that some agencies chose to have more than one person participate in the interview, in total there were thirteen people interviewed, representing ten different agencies.

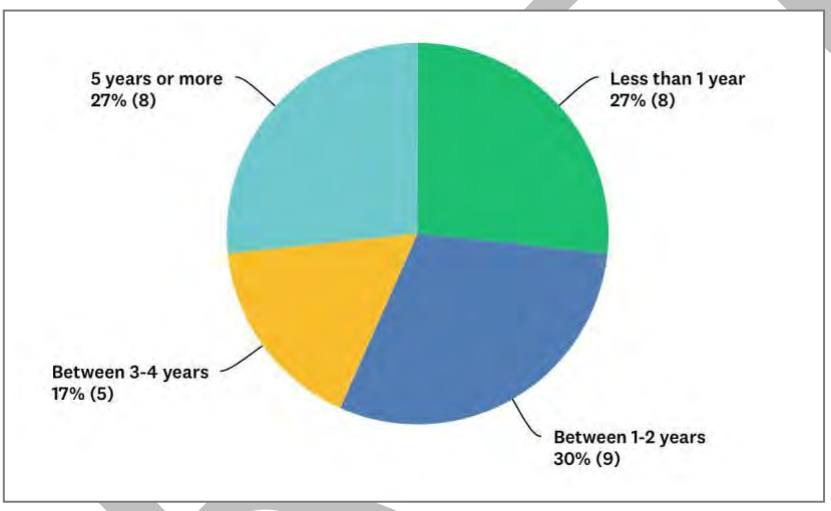
The data generated through these assessment activities were then analyzed to identify common themes.

III. Assessment Findings

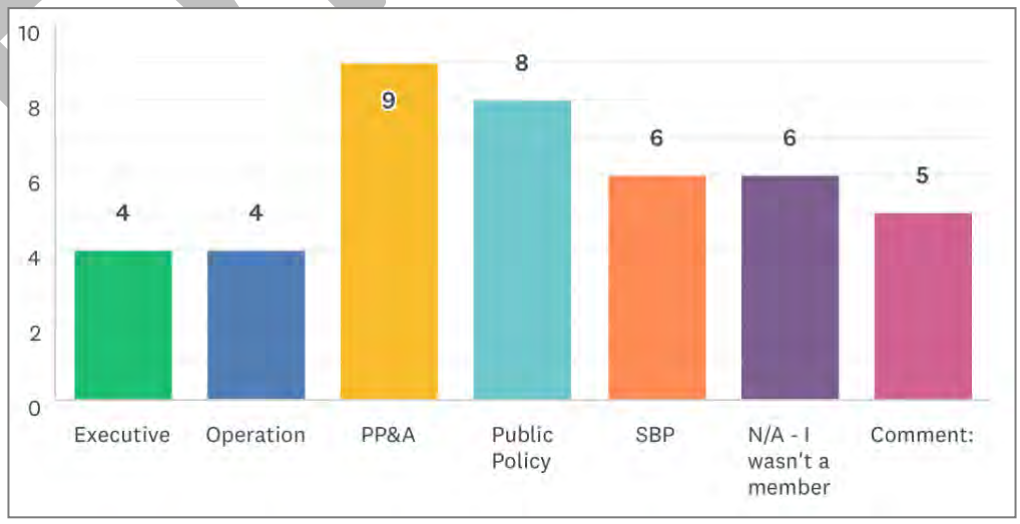
Findings from the data generated via assessment activities, including the survey of Commissioners and key informant interviews with contractors, are outlined below.

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

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

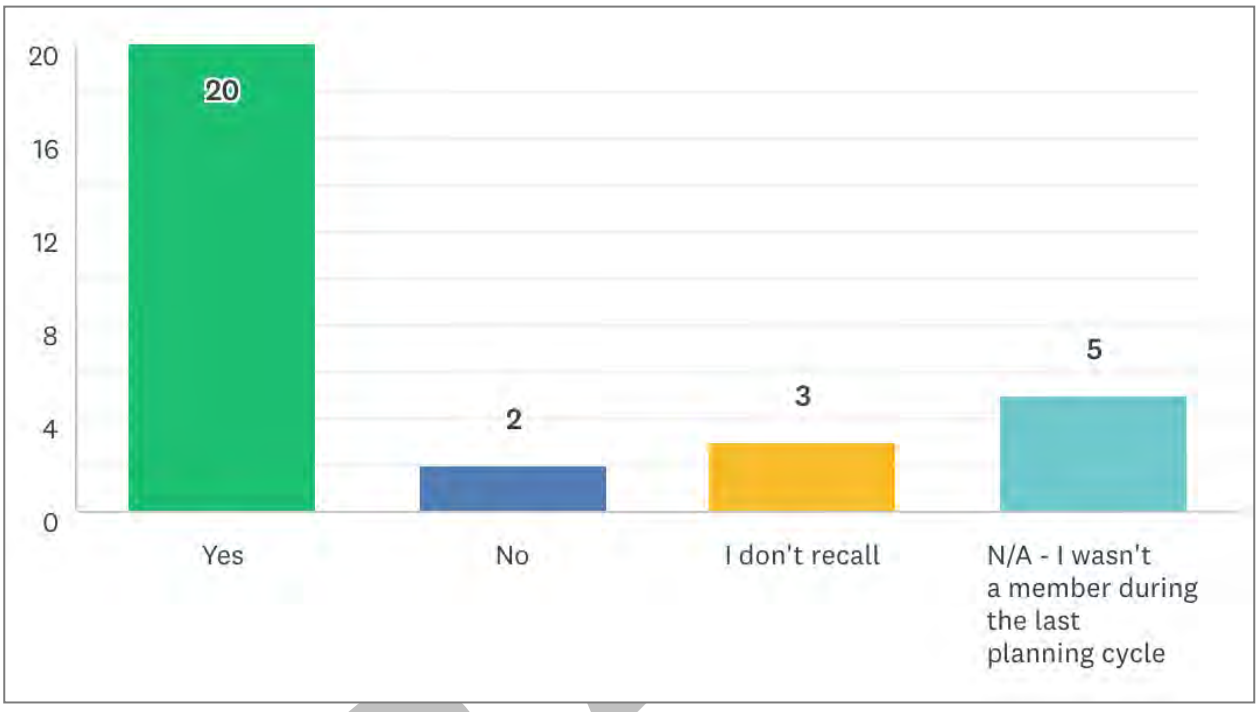


2. During the 2018 planning, priority setting and resource allocation process, which committee(s) were you a member of?



1 n=30

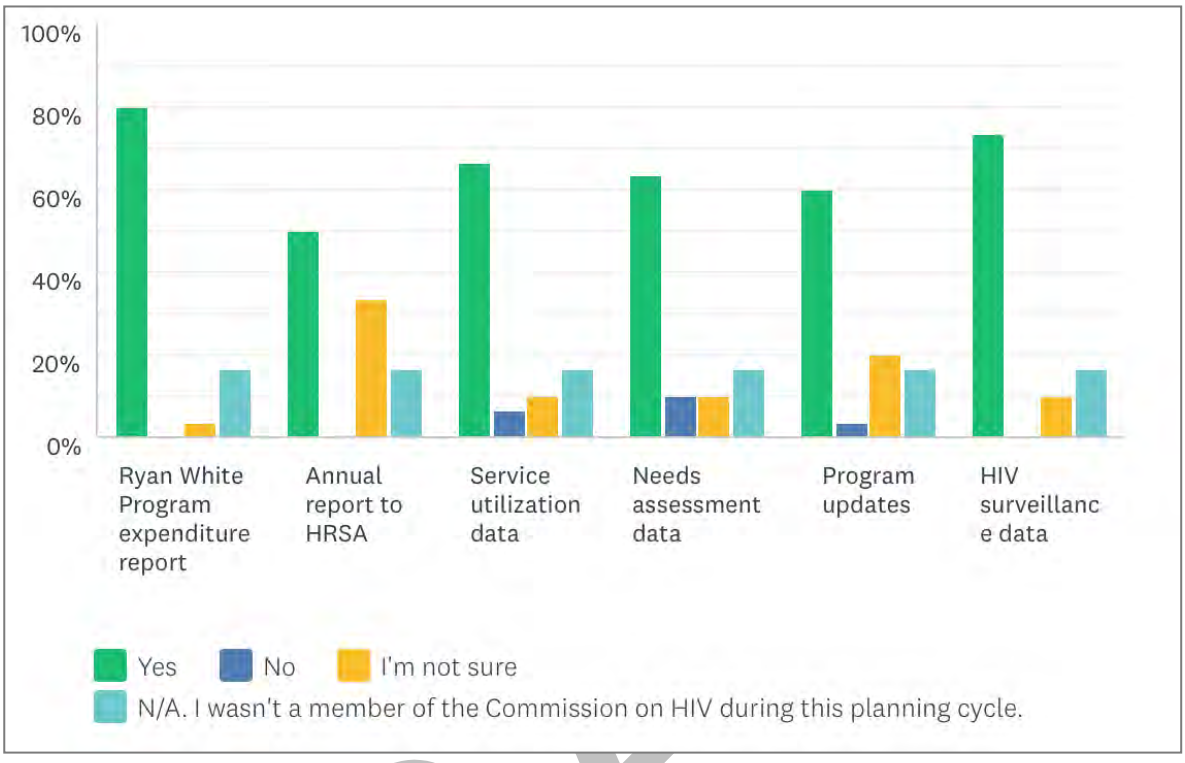
3. During the 2018 priority setting and resource allocation planning cycle, did the Commission on HIV assess an appropriate amount and type of data on an ongoing basis in order to determine community needs?



Comments:

- I don't think everyone understands the data.
- Better AND MORE data and PLANNING for aging HIV POPULATION
- But we are finally moving in the right direction. There was a great improvement in getting appropriate data this year. We are still limited in the needs assessment for all key population groups. We received utilization data for some categories, but housing, mental health services, subs abuse were not complete. Also spa/health district utilization and need would be very helpful in relationship to HIV incidence. It needs to be clear that the resources are going to those with highest need and that key populations are being addressed. We also probably need more time to process the data- having it ahead of the meeting to review.
- I feel as though the commission does the most with what's available to them... some of the data is from 2017, but that's what's available for that particular situation. I feel as though it's a systems issue- but improvements are coming with the new system (if I heard correctly at one of the most recent meetings...)

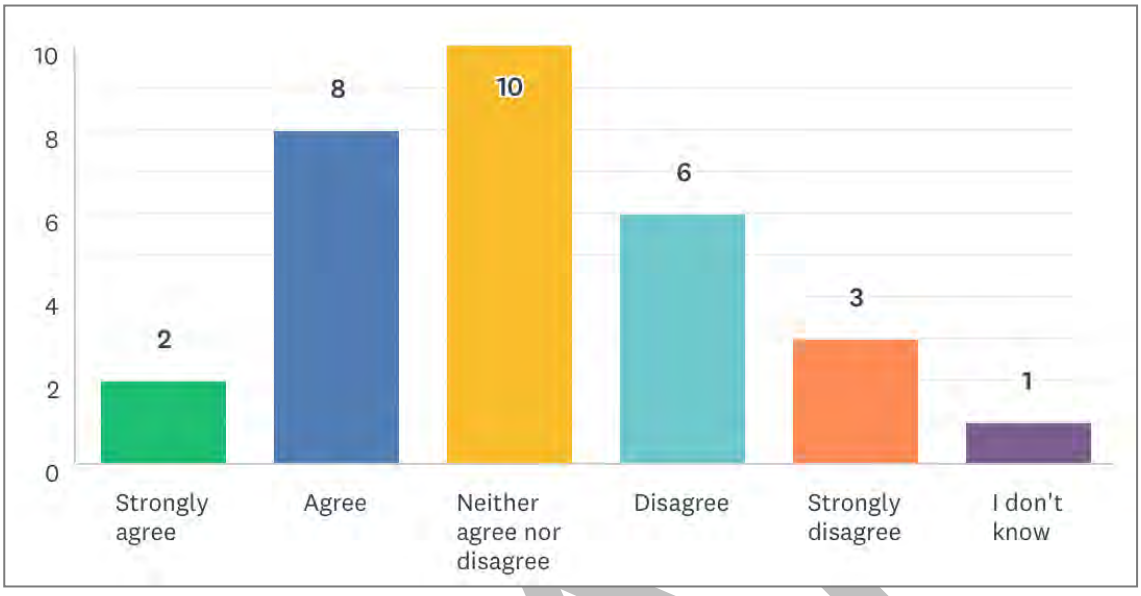
4. During the 2018 planning cycle, do you recall any of the following DHSP reports being provided as a part of the priority setting and resource allocation process?



Comments:

- The needs assessment presented was not current. Utilization data was presented this year- don't recall seeing any table like that last year.
- I'm not totally sure of the specifics- however, if I'm thinking of the correct meeting there was a lot of information to review allowing for us/the commission to make informed decisions.

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



Comments:

- The problem is awareness of the commission to quality candidates.
- There are not adequate consumer participants/representation, specially at The Consumer Caucus meeting.
- I would like to see the consumer caucus present their concerns and ideas either bimonthly or quarterly.
- 1). Agencies and partners should be required to bring consumers not working in HIV services. 2.) Such consumers could be paid for their time. 3.) Actual recruitment by fieldworkers targeting engagement and paid recruitment of consumers and or potential consumers in specific service/cultural/situational categories could be utilized to empower consumers. 4.) Above strategy could also be used to reach "not-yet reached" members of "emerging infected and affected populations. 5.) A De-Professionalization CULTURE AND STANDARDS of HIV CARE, TX AND PREVENTION (as well as promoted in a more universal medical systems) should be developed and promoted that explicitly remains focused on ELIMINATING a disease not just TREATING for longer survival with illness OR BIOMEDICALLY PREVENTING illness which more than likely, if viewed long range and/or historically, probably ensures future Dis-Ease burden on social, medical, and individuals' "health" systems. Youth and senior populations of consumers AND providers should be engaging in a DIDACTIC DIALOGUE BRIDGING GENERATIONAL GAPS OF EXPERIENCE OF

THE CHANGING EPIDEMIC To achieve numbers 4 And 5 above. This must include A wider range of professionals and researchers engaged in this discourse along with the recruited non experienced and/or “naive (of services or perhaps personal needs)” affected populations.

- Put more resources towards community engagement and invite more organizations to participate and contribute.

- Hard to say – I know some folks have difficulties coming to the table but I think the Commission staff also do a lot of outreach. As I am not a consumer it is not my place to say.

- There are consumers that attend the meetings but there are always could be more.

- A small demographic of consumers participates in PP&A, it tends to skew older, white and cis-male. There is little to no representation of younger, Black or Latinx, transgender consumers.

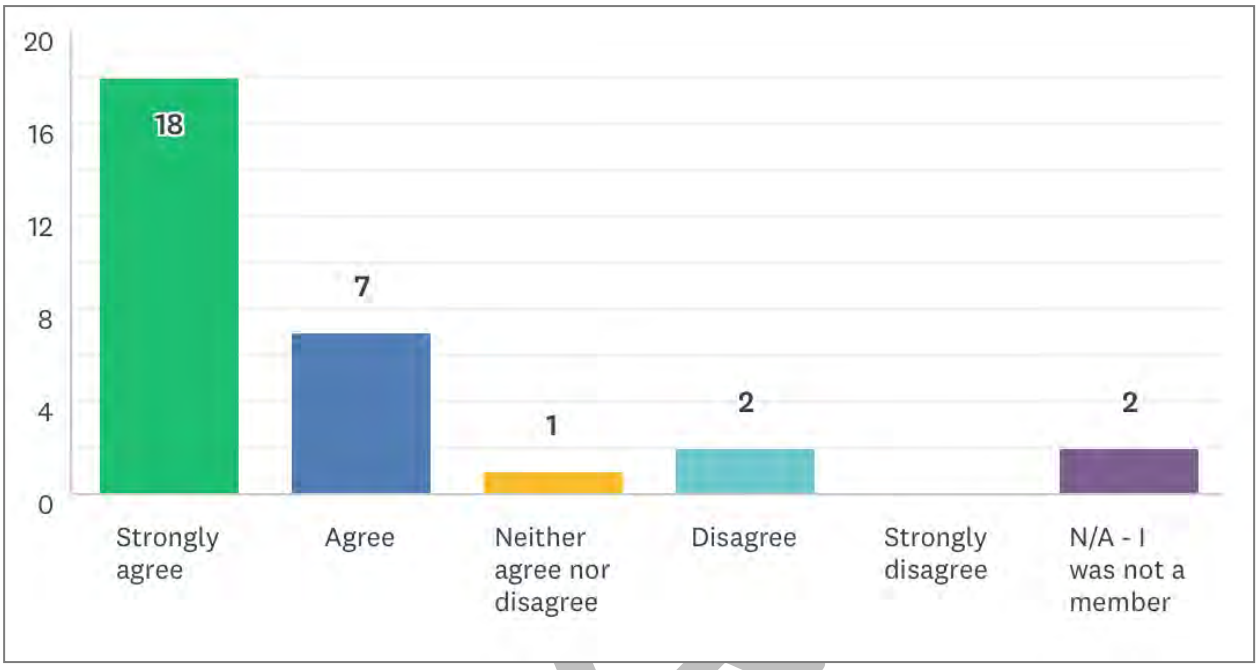
- APPOINT more unaffiliated consumers to committee

- There is a lack of consumer participation at PP&A meetings.

- I think there could be more public involvement. There should be.

- I agree, though I do feel there is always room for improvement! I know the commission staff and the commissioners are always actively accepting applications and are very supportive and open to feedback when I speak to a certain item. I definitely feel heard at the table when I share what my experience has been.

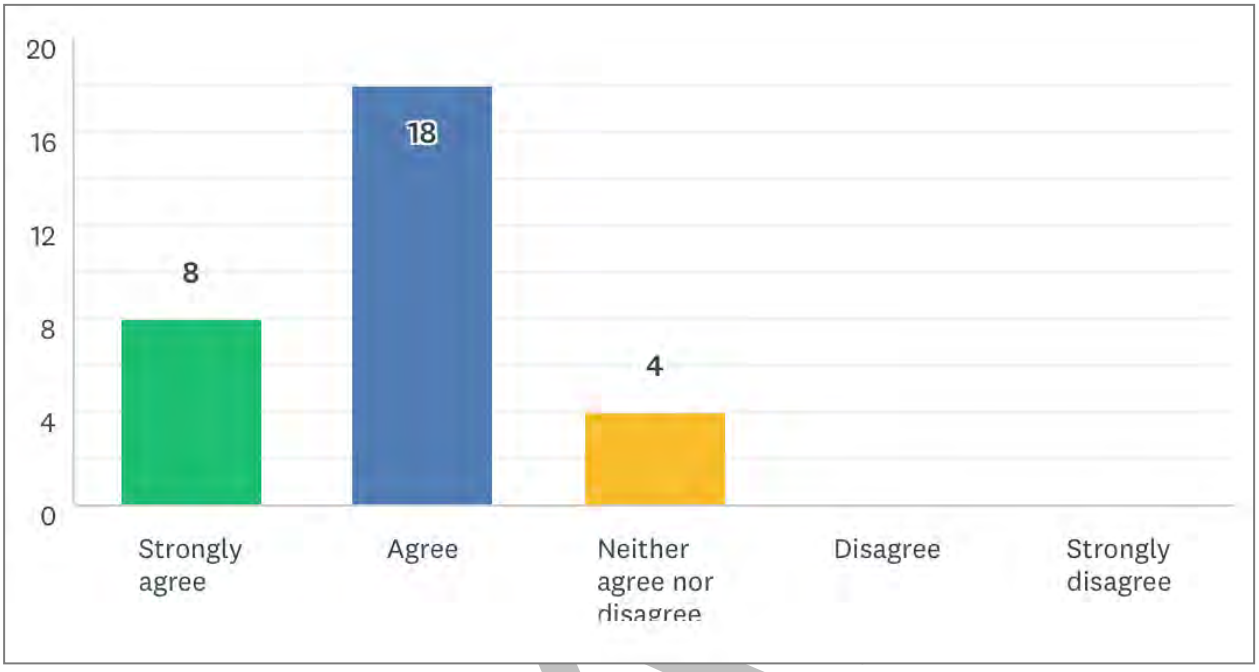
6. **Please indicate the degree to which you agree with the following statement:** ***During the last planning cycle, I was adequately notified of planning, priority setting and resource allocation activities and meetings.***



Comments:

- The commission staff are very communicative with meetings and time changes if there are any- also, are very quick to respond to emails.
- Staff are well on top of things to the best of my knowledge.

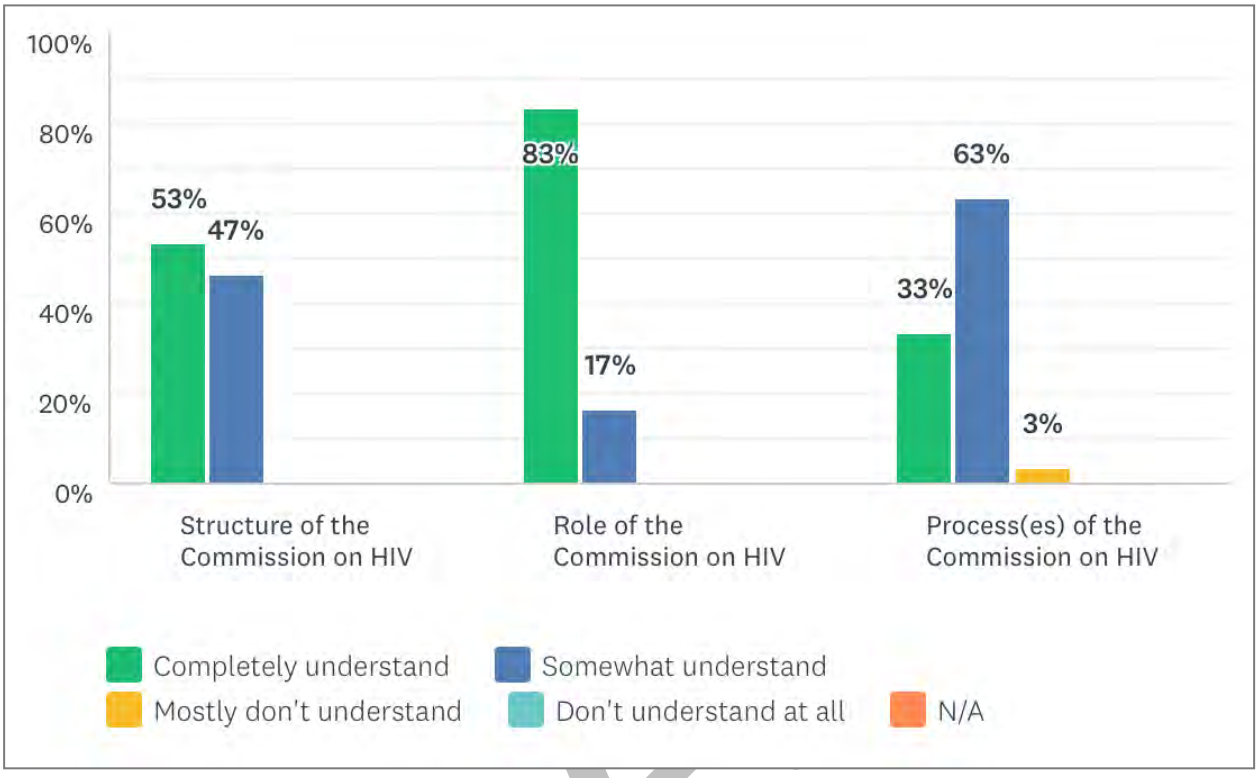
7.* Please indicate the degree to which you agree with the following statement: *In terms of structure and process, the Commission on HIV is effective as a planning body.



Comments:

- Things are improving. Earnest effort at seeking consensus.
- Cheryl and the other commission staff, as well as the chairs and co-chairs and commissioners do a stellar job.
- I do think the Commission is doing well in its intensions to improve and move matters forward. There are Hiccups that I have witnessed, but overall the Commission is effective.

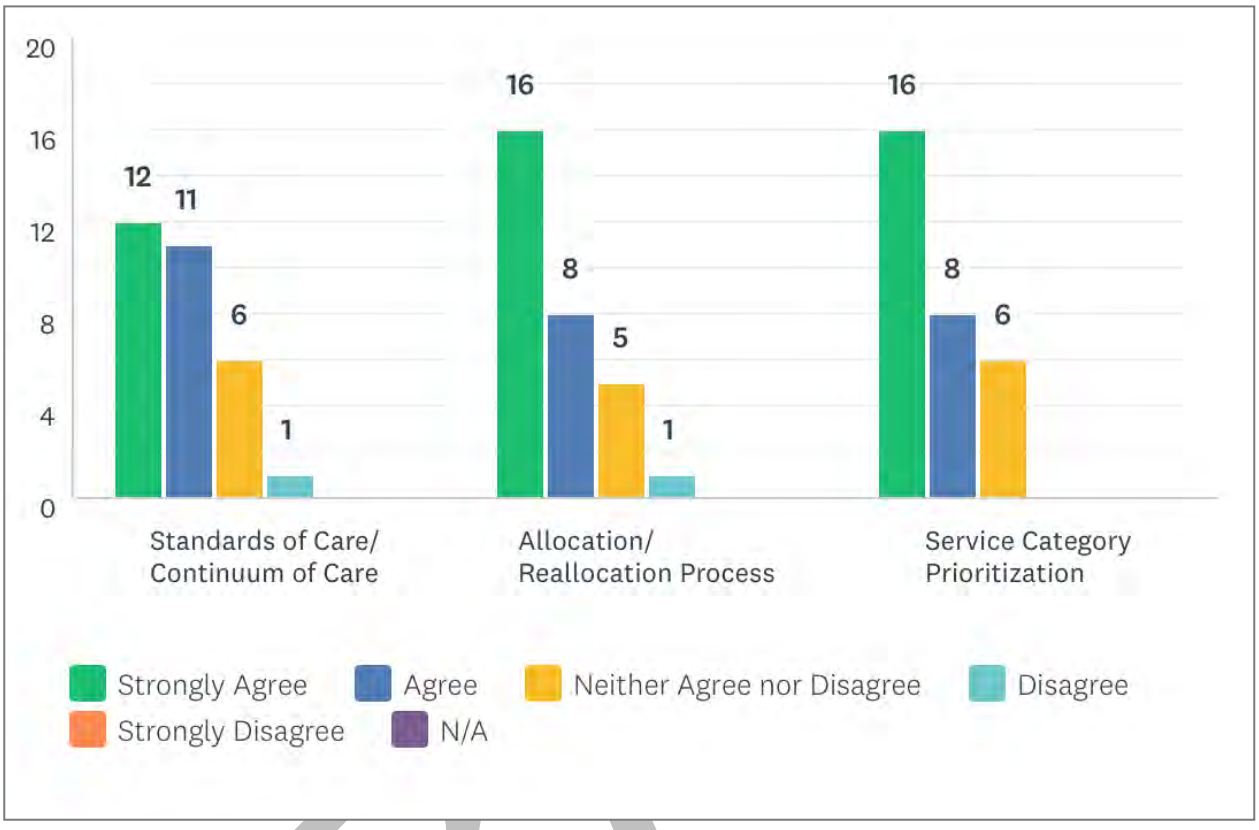
8. Please indicate the degree to which you understand the following:



Comments:

- I understand it now. However, after being first elected, it took a while to grasp the structure, roles of the commission. Coming from working with a CPG in another state, it was somewhat difficult at first. But after engagement with others, it became clear.
- I've been a commissioner since August 2019, and frequented meetings prior to that- needless to say I'm still learning and there is always room for improvement! But, everyone is always helpful when I have questions and have never treated me as anything less then an essential member at the table and in the conversations.
- Over the course of the last few months a complete, and better understanding has been provided via very helpful trainings. Although, I do not feel completely competent in all aspects of structure, role, process, etc. I do feel much more empowered.
- I am new to this body, and need some time to learn specifics of issues being addressed, but I have a basic understanding of the process and structure.

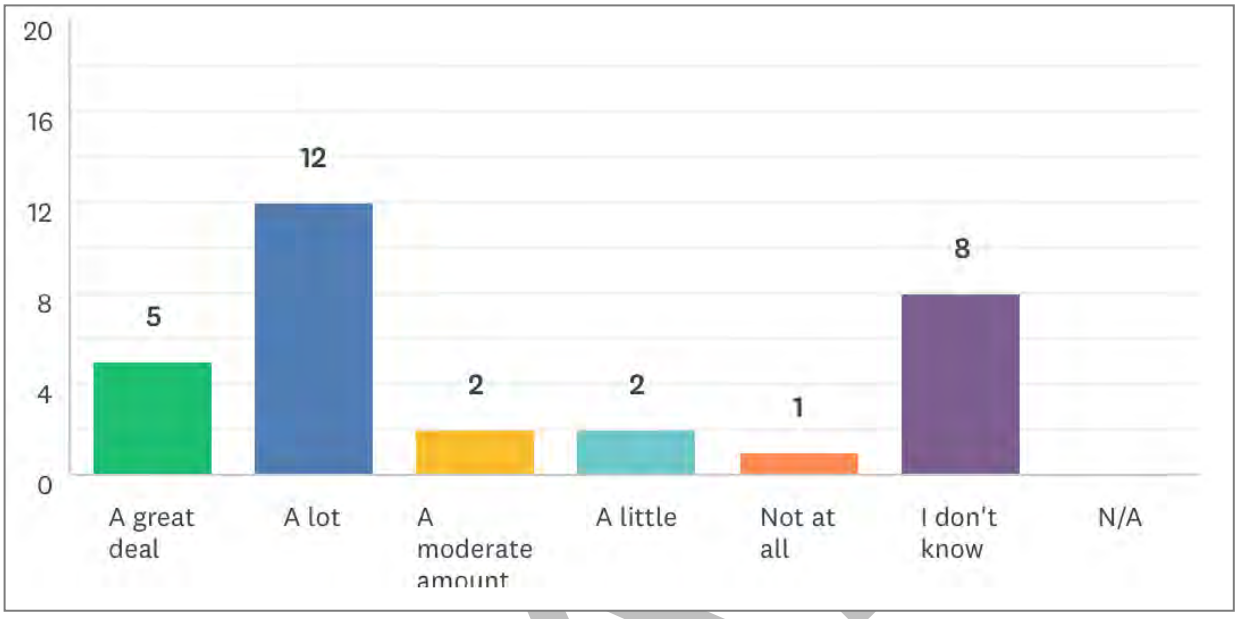
9.* Please indicate the degree to which you agree with the following statements: *The Commission on HIV has prepared me to make decisions related to:



Comments:

- I would say that I have gained more of my preparation to make appropriate decisions from my attendance at the PP&A meetings than from the rest of the CoH training ... with that said, the two combined have strongly helped to make me much better prepared ...
- Because I have participated in SBP and PP&A
- Though I'm on Standards and Best Practices... at those meetings and others I attend that I'm not actually assigned to I always feel like there is information to make the best informed decisions possible and thankfully whenever there is more information needed or requested- those situations have always been honored. The commission staff are very supportive and are always willing to have representatives come and speak or provide more information.
- Like I say, I am new and need to learn more specifics of issues at hand. The Commission is preparing me to achieve those goals.

10. Please indicate the degree to which you believe the priorities and allocations established by the Commission on HIV in 2018 were followed by DHSP.



Comments:

- I have no clue because I wasn't there in 2018. I'm sure it has been done, but has been stated as we are doing XYZ, I'm not sure.
- We are not able to make changes based on the time frame DHSP needs to get out RFPs.
- I feel they have and do – but there is always room for improvement.
- I would like to see a link between priority/allocations- expenditures- HIV continuum for key populations and what funding/services is available to these key populations along the continuum. Prior to this year, we have been doing the same allocations, etc. and expecting different results in our HIV continuum. Despite recognizing the need to address disparities in key populations and writing about it in reports, it's not clear that the funding and resources were getting to those key populations. This year was an improvement in really trying to understand the data and the utilization. We will need to see what DHSP does with the information gathered this year to address the disparities and gaps.
- Being my first year, I am reluctant to judge on this question. It appears to me that DHSP has followed through, but I am still keeping my ear to the ground to understand better the situation on the ground.
- Problem is that my perception which has not been challenged by the data is that resource allocation does not necessarily in alignment with disease burden.

B. Key Informant Interviews with Contracted Providers[2]

Major Themes:

Gratitude: Many participants acknowledged that despite challenges, certain staff and systems at DHSP are supportive and useful.

- I have an excellent relationship with my program person. They are tenured and knowledgeable. They get back to be within 24 hours and they really have our agency's best interests at heart. To me it's about the processes at DHSP, not the person. I just want the process to be streamlined.

- DHSP has been very supportive of us and our programs.

- In the past, staff were not very receptive. Now staff are trying to work with us within the restraints they have. They're trying to help us meet our goals – and it's very helpful.

- I've enjoyed working with DHSP. They are a huge champion re: HIV prevention and now STDs.

Inconsistency: Many participants commented that there were major inconsistencies between DHSP program managers over time (i.e. previous program managers compared to current program manager) and across programs (i.e. different contracts).

- There's a high level of inconsistency on behalf of DHSP staff. Some know how to prepare us for an upcoming audit and others confuse us about expectations, length of time feedback will take, how many charts they might review, what they might need, etc.

- When they don't know the answer to a question, one program manager will say, "I don't know, let me check and get back to you." The other one gives you the answer to a question you didn't even ask.

Sluggishness: There were many comments that things seem to take a very long time at DHSP, including responses to questions, receiving feedback, the RPF process, and the budget modification process.

- We get guidance but it takes forever.

[2] n=12 providers representing 10 agencies

- Response is slow sometimes and we can miss a deadline as a result.

- There seem to be too many hands: the program manager, the fiscal analyst, and the person who approves everything. That's why things take so long.

Concern about smaller organizations not getting funded: While overall, participants felt the system was mostly fair with respect to funding decisions, there were concerns raised about smaller agencies that do good work, but can't seem to compete.

- The small organizations have lost their voice because of the "big 3" organizations. They always get the funding.
- Savvy organizations can manage with the inconsistencies and other challenges, but the newer ones can't.

- The system may be fair, but I don't know if it's equitable. Some agencies reach certain populations (e.g. small CBO) but don't qualify because they don't have certain documentation that the larger clinics have.

- More consideration should be given to CBOs that have the capacity to engage the people as well as established CBOs that have the financial capacity.

Turnover of staff at DHSP: Many commented about the high turnover rate and how they perceive this to be a major driver of these inconsistencies.

- My main concern about DHSP is that with all the turn-over there's been a significant loss of historical knowledge and experience that the agency has yet to address.

- There's a lot of turnover there. They were very helpful on budget modifications until about 3-4 years ago.

Understanding of Context: Participants acknowledged that the larger context within which DHSP operates may be contributing to some of these challenges.

- It seems like DHSP's hands are tied since they are part of the broader county mechanism.

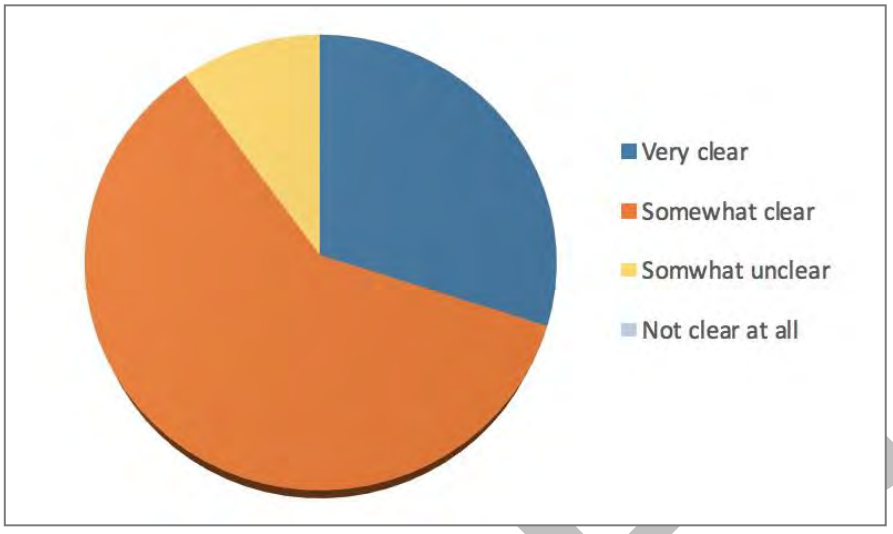
- With the structural changes at the county level, it seems like DHSP is trying to operate in an environment that is not very supportive of them.

Responses to Specific Questions:

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

- I'd give it a 6.2 out of a 10-point scale. Some programs and some staff provide great guidance and feedback. Other contracts and other staff, not so much.
- We don't get a lot of guidance, but we've been doing this for a while so we're okay.
- If you need a budget modification, it's so slow it becomes useless.
- They have such high turnover there – there is limited historical knowledge on program budgets – I think it's gotten a lot worse.
- The finance people don't seem to understand the programs now that Dave Young is not there.
- It's frustrating. My budget is based on a budget from 14 years ago – there's no adjustment for inflation.
- There are changes at the county that we find out about too late (e.g. mileage reimbursement).
- More flexibility would be nice re: over/under spending in broad categories (personnel)
- I get okay guidance. It's a confusing process – no real clear guidelines about how this is done.
- We struggle with not getting enough guidance and information. Institutional memory seems to be lost with turn-over.
- County budget and budget modification process makes it very difficult because the categories are so restrictive – everything has to be spent exactly. HRSA is a lot easier.
- Sometimes they will insist that we have to do a budget modification on something, but I know that we don't.
- On the positive side: They provide a lot of tools on their website and the program manager helps us too. They are also very receptive to feedback. On the negative side, *specific* guidance is not available.
- We avoid budget modifications because it's a headache.
- There's no consistency. Some say "such and such is fine;" others say "no, it's not."
- No guidance except "uniform guidance." Instructions are basic – not very specific. If we have questions we're supposed to contact the program manager, but they don't have good grasp of budget. I'm more of an expert than they are.

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



- We were clear for many years but it's gotten worse recently.
- Each time they come out – they spring something new on you.
- The program managers don't get the people. The program is too dogmatic– there's no flexibility with respect to how we can count things. They're working with old data and evidence.
- It's pretty consistent and they are generally very organized: they send out a letter and list what they need to review, but it can be vague on 1-2 items. Sometimes we get thrown a curve ball or it's inconsistent between program managers one year to the next.
- We didn't know exactly what they were going to do at our site visit. It seems to vary by project officer and contract.
- Supervision of the program managers matters - It could be why the program managers are so inconsistent.
- We had questions about our site visit and one program manager responded quickly, but the other didn't.
- Very clear – I always know what's expected.
- Our program manager is good.
- High turnover means gaps with respect to information. The program manager takes information with them when they leave.
- Yes – the expectations are clear what they want and we know in advance.

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

- Maybe once a year – around audit time – but not enough. It's too late to fix what we need to fix. We'd like feedback to be at least every 6 months. It feels more punitive than supportive. If there is a corrective action requested, should be with guidance and discussion, but now, it's just "fix this."
- No, but it depends on the program manager. Even when they do, some have no background in planning or health and very limited knowledge on evaluation and implementation.
- We want them to be proactive. We don't want to be surprised.
- Feedback should not be a "gotcha." They should catch me doing something right and share it with others.
- Yes, after the annual review which is fine.
- Not outside of scheduled feedback. It would be helpful to get regular feedback. TA would be useful too since it's in both of our interests to succeed. We need more timely feedback and TA as needed to respond to a particular challenge.
- Depends on the program – Sometimes program managers don't know how to respond. Seems like complex questions can't be answered by them – they always have to go to the top and that takes time. There's no one in the middle.
- No, not regularly. Rare to hear from our program manager – only if it's wrong.
- They don't read reports at all.
- Don't really want feedback – just give me my money.
- Yes. Because of my relationship with our program manager. We always know where we are numbers – wise. When they do the audit we know what to expect and are prepared.
- Used to but last two years not as much. We don't get any positive qualitative feedback, just quantitative.
- We don't feel heard. When we get feedback it's always helpful but it needs to be in advance of rather than after the fact.

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

- It depends on the contract. Some will provide it within 14 days. It gives me the sense that some read reports and some don't.
- We get feedback too late. They are less organized – they ask for the same thing multiple times even when we give it to them.
- Yes, we do. It took a long time to get, but it was very helpful.
- We always list things but never get feedback.
- No. They don't really know what they're doing. When we push back, they go to their supervisor.
- We get engagement but no feedback.
- Yes – all around helpful.
- No, we don't get any but we do want some. It would be nice just to get positive comments for the team every now and then. That would help boost morale.
- Not usually. Do they even read the report? Often they'll question us without even reading our report.
- We did have TA and it was very good.
- RW quarterly meetings that we are required to attend are not helpful. DHSP sends a different person to lead the meeting every time so there is no consistency. Some are line item staff that don't seem committed. I know that capacity building is important, but we all have very different needs.

5. With respect to the development of your DHSP contract, how would you describe the level of technical assistance and support provided by your assigned program manager and fiscal representative?

- Pretty good guidance and feedback on finance. Very little on program guidance. Seems to be a disconnect between program and finance. During negotiations, we had a good back and forth with finance – program people don't do that.

- Paulina is really good on contract side – has helped with program side. We had one program manager who was very punitive/judgmental. Their predecessor was much better.
- Overall, fiscal representative is good and very responsive.

- Depends on the program manager. Sometimes they're very slow. Too long to get feedback on objectives. Sometimes there is a bottleneck because the program manager is not authorized to do anything. DHSP should fix this – maybe hire more directors?

- Slooow. Is there a standard format? We have award notices but no controls – not good for smaller agencies.

- Mostly fine.

- Now that Dave Young is no longer there it seems that fiscal guidance takes a lot longer.

- Contracts are clear. There's not a lot of negotiating. They tell you how many people you need to reach and at what level.

- Good. But depends on who. Last program manager was better – they were from the field. The current on is fine, but this is not their background.

6. Do the RPFs provide clear instructions, directions, and/or guidance? If yes, how so? If no, in what ways are they unclear?

- So far, yes. Pretty clear deadlines. Guidance/process for questions pretty clear – have improved from 7-8 years ago.
- Yes, but it takes too long.
- Generally, yes, but not always. Objectives need to be clearer so agencies know what the expected deliverables are.
- No – some have been confusing. Each agency is different and they don't allow for that (clinic vs. CBO). Not clear about alternative documents needed.
- Yes. Especially this last round of RFPs– they seem to have been better structured.
- They ask for a lot of administrative information, but I guess they have to.
- I'm concerned that the number of attachments is way too much for some agencies. It seems unfair.
- We do great work and deserve more attention but get overlooked because RFPs always reset. It would be great if DHSP could work differently with already funded organizations with respect to the application process.

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

- Yes. They've always been responsive when I've asked questions about funding outcomes.
- Yes. It seems like they get held up because they are being sued, but yes.
- I think that they favor biomedical too much.
- Only "four walls" for HIV testing – doesn't seem fair. I disagree with their argument about why they can't fund mobile testing.
- Yes, it feels fair to me, but maybe that's because we get funded.
- Historically, yes, but more recently some decisions have seemed odd.
- Yes, and no. My community is concerned about who keeps getting funded. The truth is that there are not a lot of minority-based CBOs that do this work – we're not there anymore. When you're not at the table, you're not going to get the funding. That leads to disparities.
- More consideration should be given to CBOs that have the capacity to engage the people as well as established CBOs that have the financial capacity.
- I think so. Compared to 10 years ago – there are a lot of agencies that get funding now that didn't then.
- In general yes.

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

LOS ANGELES COUNTY COMMISSION ON HIV

2020 MEMBERSHIP ROSTER| UPDATED 8/24/20

SEAT NO.	MEMBERSHIP SEAT	Commissioners Seated	Committee Assignment	COMMISSIONER	AFFILIATION (IF ANY)	TERM BEGIN	TERM ENDS	ALTERNATE
1	Medi-Cal representative			***Vacant***		July 1, 2019	June 30, 2021	
2	City of Pasadena representative	1	SBP	Erika Davies	City of Pasadena Department of Public Health	July 1, 2018	June 30, 2022	
3	City of Long Beach representative			***Vacant***		July 1, 2019	June 30, 2021	
4	City of Los Angeles representative	1	PP	Ricky Rosales	AIDS Coordinator's Office, City of Los Angeles	July 1, 2018	June 30, 2022	
5	City of West Hollywood representative	1	PP&A	Derek Murray	City of West Hollywood	July 1, 2019	June 30, 2021	
6	Director, DHSP	1	EXC|PP&A	Mario Pérez, MPH	DHSP, LA County Department of Public Health	July 1, 2018	June 30, 2022	
7	Part B representative	1	PP&A	Karl Halfman, MA	California Department of Public Health	July 1, 2018	June 30, 2022	
8	Part C representative	1	EXC|PP	Aaron Fox, MPM	Los Angeles LGBT Center	July 1, 2018	June 30, 2022	
9	Part D representative	1	PP&A	LaShonda Spencer, MD	Charles Drew University	July 1, 2019	June 30, 2021	
10	Part F representative	1	PP	Jerry D. Gates, PhD	Keck School of Medicine of USC	July 1, 2018	June 30, 2022	
11	Provider representative #1	1	OPS	Carlos Moreno	Children's Hospital Los Angeles	July 1, 2019	June 30, 2021	
12	Provider representative #2	1	SBP	David Lee, MPH, LCSW	Charles Drew University	July 1, 2018	June 30, 2022	
13	Provider representative #3	1	SBP	Harold Glenn San Agustin	JWCH Institute, Inc.	July 1, 2019	June 30, 2021	
14	Provider representative #4			***Vacant***		July 1, 2018	June 30, 2022	
15	Provider representative #5			***Vacant***		July 1, 2019	June 30, 2021	
16	Provider representative #6	1	PP&A	Anthony Mills, MD	Southern CA Men's Medical Group	July 1, 2018	June 30, 2022	
17	Provider representative #7	1	PP&A	Frankie Darling-Palacios	Los Angeles LGBT Center	July 1, 2019	June 30, 2021	
18	Provider representative #8	1	PP	Martin Sattah, MD	Rand Shrader Clinic, LA County Department of Health Services	July 1, 2018	June 30, 2022	
19	Unaffiliated consumer, SPA 1	1	EXC/OPS	Michele Daniels	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	
20	Unaffiliated consumer, SPA 2			***Vacant***		July 1, 2018	June 30, 2022	
21	Unaffiliated consumer, SPA 3			***Vacant***	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	
22	Unaffiliated consumer, SPA 4	1	EXC|SBP	Kevin Stalter	*Unaffiliated Consumer*	July 1, 2018	June 30, 2022	
23	Unaffiliated consumer, SPA 5			***Vacant***		July 1, 2019	June 30, 2021	
24	Unaffiliated consumer, SPA 6	1	PP	Pamela Coffey	*Unaffiliated Consumer*	July 1, 2018	June 30, 2022	Alasdair Burton (PP)
25	Unaffiliated consumer, SPA 7			***Vacant***		July 1, 2019	June 30, 2021	Thomas Green (SBP)
26	Unaffiliated consumer, SPA 8			***Vacant***		July 1, 2018	June 30, 2022	
27	Unaffiliated consumer, Supervisorial District 1			***Vacant***		July 1, 2019	June 30, 2021	
28	Unaffiliated consumer, Supervisorial District 2			***Vacant***		July 1, 2018	June 30, 2022	Nestor Rogel (PP)
29	Unaffiliated consumer, Supervisorial District 3	1	SBP	Joshua Ray	*Unaffilated Consumer*	July 1, 2019	June 30, 2021	Eduardo Martinez (SBP/PP)
30	Unaffiliated consumer, Supervisorial District 4			***Vacant***		July 1, 2018	June 30, 2022	
31	Unaffiliated consumer, Supervisorial District 5	1	PP&A	Diamante Johnson	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	Kayla Walker-Heltzel (PP&A/OPS)
32	Unaffiliated consumer, at-large #1			***Vacant***		July 1, 2018	June 30, 2022	Tony Spears
33	Unaffiliated consumer, at-large #2	1	OPS	Joseph Green	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	
34	Unaffiliated consumer, at-large #3	1	SBP	Felipe Gonzalez	*Unaffiliated Consumer*	July 1, 2018	June 30, 2022	
35	Unaffiliated consumer, at-large #4	1	EXC	Bridget Gordon	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	
36	Representative, Board Office 1	1	EXC|PP&A	Al Ballesteros, MBA	JWCH Institute, Inc.	July 1, 2018	June 30, 2022	
37	Representative, Board Office 2			***Vacant***		July 1, 2019	June 30, 2021	
38	Representative, Board Office 3	1	EXC|PP|SBP	Katja Nelson, MPP	APLA	July 1, 2018	June 30, 2022	
39	Representative, Board Office 4	1	SBP	Justin Valero, MA	Unaffilated Consumer	July 1, 2019	June 30, 2021	
40	Representative, Board Office 5	1	PP&A|EXC	Raquel Cataldo	Tarzana Treatment Center	July 1, 2018	June 30, 2022	
41	Representative, HOPWA	1	PP&A	Maribel Ulloa	City of Los Angeles, HOPWA	July 1, 2019	June 30, 2021	
42	Behavioral/social scientist	1	PP	Lee Kochems	*Unaffiliated Consumer*	July 1, 2018	June 30, 2022	
43	Local health/hospital planning agency representative			***Vacant***		July 1, 2019	June 30, 2021	
44	HIV stakeholder representative #1	1	EXC	Grissel Granados, MSW	Children's Hospital Los Angeles	July 1, 2018	June 30, 2022	
45	HIV stakeholder representative #2			***Vacant***		July 1, 2019	June 30, 2021	
46	HIV stakeholder representative #3	1	EXC|OPS	Juan Preciado	Northeast Valley Health Corporation	July 1, 2018	June 30, 2022	
47	HIV stakeholder representative #4			***Vacant***		July 1, 2019	June 30, 2021	
48	HIV stakeholder representative #5	1	OPS	Danielle Campbell, MPH	UCLA/MLKCH	July 1, 2018	June 30, 2022	
49	HIV stakeholder representative #6	1	SBP	Amiya Wilson	Unaffiliated Consumer	July 1, 2019	June 30, 2021	
50	HIV stakeholder representative #7	1	PP&A	William D. King, MD, JD, AAHIVS	W. King Health Care Group	July 1, 2018	June 30, 2022	
51	HIV stakeholder representative #8			***Vacant***		July 1, 2018	June 30, 2022	Miguel Alvarez (OPS/SBP)
	TOTAL:	**33**						

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

LOA: Leave of Absence

Planning Council/Planning Body Reflectiveness (Updated 9.16.20)

Race/Ethnicity	Living with HIV/AIDS in EMA/TGA*		Total Members of the PC/PB		Non- Aligned Consumers on PC/PB	
	Number	Percentage**	Number	Percentage**	Number	Percentage**
White, not Hispanic	13,965	27.50%	10	24.39%	3	25.00%
Black, not Hispanic	10,155	20.00%	12	29.27%	5	41.67%
Hispanic	22,766	44.84%	16	39.02%	3	25.00%
Asian/Pacific Islander	1,886	3.71%	3	7.32%	0	0.00%
American Indian/Alaska Native	300	0.59%	0	0.00%	0	0.00%
Multi-Race	1,705	3.36%	0	0.00%	1	8.33%
Other/Not Specified	0	0.00%	0	0.00%	0	0.00%
Total	50,777	100%	41	100%	12	100%
Gender	Number	Percentage**	Number	Percentage**	Number	Percentage**
Male	44,292	87.23%	28	68.29%	9	75.00%
Female	5,631	11.09%	12	29.27%	3	25.00%
Transgender	854	1.68%	1	2.44%	0	0.00%
Unknown	0	0.00%	0	0.00%	0	0.00%
Total	50,777	100%	41	100%	12	100%
Age	Number	Percentage**	Number	Percentage**	Number	Percentage**
13-19 years	122	0.24%	0	0.00%	0	0.00%
20-29 years	4,415	8.69%	1	2.44%	1	8.33%
30-39 years	9,943	19.58%	17	41.46%	4	33.33%
40-49 years	11,723	23.09%	9	21.95%	2	16.67%
50-59 years	15,601	30.72%	8	19.51%	4	33.33%
60+ years	8,973	17.67%	6	14.63%	1	8.33%
Other	0	0.00%	0	0.00%	0	0.00%
Total	50,777	99.99%	41	99.99%	12	99.99%

*** data includes persons diagnosed with an HIV infection through 2018 and living in LAC at year-end 2019, based on the most recent residence**

**** Percentages may not equal 100% due to rounding**

and it can be mailed, e-mailed or picked up at the office. Similarly, the application and is available online from the Commission's website at http://hiv.lacounty.gov. Submit your application by mailing it to or dropping it off at: 3530 Wilshire Blvd, Suite 1140, Los Angeles, CA 90010.
Applications may be emailed to hivcomm@lachiv.org. Staff will verify receipt of all applications via email. After receiving the application, staff will review it for accuracy and completeness, and contact the applicant if there are any possible errors, sections needing clarification, and/or if there are any questions that emerge from the application. Once the application has been deemed to be "complete" (either after revisions have been made, if necessary, or none are needed), staff will contact the applicants to schedule an interview with members of the Operations Committee. If you have questions or need assistance with the application, please contact the Commission office at (213) 738-2816.

PART II: MEMBERSHIP APPLICATION FORM
Section 1: Contact Information

1. Name: Everardo Alvizo
   (Please print name as you would like it to appear in communications)
2. Organization: (if applicable) Long Beach Health and Human Services
3. Job Title: HIV/STD Strategic Implementation Specialist
4. Mailing Address: 2525 Grand Ave. #115
5. City: Long Beach State: CA Zip Code: 90815
6. Provide address of office and where services are provided (if different from above):
   Mailing Address:
   City: State: Zip Code:

7. Tel.: (562) 570-4435 Fax: (562) 570-4106
8. Email: Everardo.Alvizo@longbeach.gov
   (Most Commission communications are conducted through email)
9. Mobile Phone #: (optional):

My signature below indicates that I will make every effort to attend all of the meetings and activities of the Commission, the committee to which I am assigned and related caucuses, task forces and working groups that I have joined voluntarily or that I have been asked to support. I will comply with the Commission's expectations, rules and regulations, conflict of interest guidelines and its code of conduct, consistent with all relevant policies and procedures. As the undersigned, I understand that governing legislation and/or guidance may be altered in the future, necessitating revision, modification, or elimination of specific Commission processes or practices—necessitating change with which I will be expected to comply as well. I further understand that sections of this application will be distributed publicly, as required by the Commission's Open Nominations Process and consistent with California's Ralph M. Brown Act. I affirm that the information herein is accurate to the best of my knowledge.

09/04/2020
Date

Signature:

Everardo Alvizo
Print Name

Section 2: Demographic Information

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

2. **In which Supervisorial District and SPA do you work?** Check all that apply.

District 1 ❑	SPA 1 ❑	SPA 5 ❑
District 2 ❑	SPA 2 ❑	SPA 6 ❑
District 3 ❑	SPA 3 ❑	SPA 7 ❑
District 4 ■	SPA 4 ❑	SPA 8 ■
District 5 ❑		

3. **In which Supervisorial District and SPA do you live?**

District 1 ❑	SPA 1 ❑	SPA 5 ❑
District 2 ❑	SPA 2 ❑	SPA 6 ❑
District 3 ❑	SPA 3 ❑	SPA 7 ❑
District 4 ■	SPA 4 ❑	SPA 8 ■
District 5 ❑		

4. **In which Supervisorial District and SPA do you receive HIV (care or prevention) services?** Check all that apply.

District 1 ❑	SPA 1 ❑	SPA 5 ❑
District 2 ❑	SPA 2 ❑	SPA 6 ❑
District 3 ❑	SPA 3 ❑	SPA 7 ❑
District 4 ❑	SPA 4 ❑	SPA 8 ❑
District 5 ❑		

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

5a. **Gender:** ■ Male ❑ Female ❑ Trans (Male to Female) ❑ Trans (Female to Male) ❑ Unknown

5b. **Race/Ethnicity:** (Check all that apply)

❑ African- American/Black,not Hispanic	❑ Hispanic
❑ American Indian/Alaska Native	❑ Multi-Race
■ Anglo/White, not Hispanic	❑ Other :_____
❑ Asian/ Pacific Islander	❑ Decline to State/Not Specified

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

6. **FOR APPLICANTS LIVING WITH HIV:**

6a. **Are you willing to publicly disclose your HIV status?** ❑ Yes* ❑ No
***DO NOT CHECK YES HERE if you do not want your HIV status known publicly. There is NO requirement that someone with HIV must disclose his/her status to the Commission or publicly.**

6b. **Age:**

❑ 13 – 19 years old	■ 20 – 29 years old	
❑ 30 – 39 years old	❑ 40 – 49 years old	❑ 50-59 years old
❑ 60+ years old	❑ Unknown	

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

6d. **Are you "affiliated" with a Ryan White Part A-funded agency?** ■ Yes ❑ No

By indicating "affiliated," you are a: ❑ board member, ■ employee, or ❑ consultant at the agency. A volunteer at an agency is considered an unaffiliated consumer.

Section 3: Experience/Knowledge

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

7a. **What organization/Who, if any/anyone, recommended you to the Commission?**

Long Beach Health and Human Services Department

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

City of Long Beach Representative

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

1 ❑ I am willing to publicly disclose that I have Hepatitis B or C.
2 ■ I am an HIV-negative user of HIV prevention services and who is a member of an identified high-risk, special or highly impacted population.
3 ❑ I am a member of a federally-recognized American Indian tribe or Native Alaskan village.
4 ❑ I am a behavioral or social scientist who is active in research from my respective field.
5 ❑ I am involved in HIV-related research in the following capacity(ies) (Check all that apply):
❑ scientist, lead researcher or PI, ❑ staff member, ❑ study participant, or ❑ IRB member.
6 ■ A health or hospital planning agency has recommended that I fill that seat on the Commission.
7 ❑ I am an HIV specialty physician or an Infectious Disease (ID) doctor with HIV- positive patients.
8 ❑ The agency where I am employed provides mental health services.
9 ❑ The agency where I am employed provides substance abuse services.
10 ■ The agency where I am employed is a provider of HIV care/treatment services.
11 ■ The agency where I am employed is a provider of HIV prevention services.
12 ■ The agency where I am employed is provider of ❑ housing and/or ■ homeless services.
13 ❑ The agency where I am employed has HIV programs funded by Federal sources (other than Ryan White).
14 ❑ I work for or am otherwise affiliated with a health care provider that is a Federally Qualified Health Center (FQHC) or a Community Health Clinic (CHC).
15 ❑ As someone who is employed as an advocate for incarcerated PWLH and/or as a PWLH who has been incarcerated in the past three years, I can represent the interests of incarcerated PWLH.
16 ❑ I am able to represent the interests of Ryan White Part C grantees.
17 ❑ I am able to represent the interests of Ryan White Part D grantees.
18 ❑ I am able to represent the interests of Ryan White Part F grantees given my affiliation with:
❑ one of LA County's AETC grantees/sub-grantees ❑ a HRSA SPNS grantee
❑ Part F dental reimbursement provider ❑ HRSA-contracted TA vendor
19 ❑ As an HIV community stakeholder, I have experience and knowledge given my affiliation with: (Check all that apply)

❑ union or labor interests
❑ provider of employment or training services
❑ faith-based entity providing HIV services
❑ organization providing harm reduction services
❑ an organization engaged in HIV-related research
❑ the business community
❑ local elementary-/secondary-level education agency
❑ youth-serving agency, or as a youth.

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

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

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

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

Section 4: Biographical Information

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

As the City of Long Beach Representative, I seek to ensure that the voices of the Long Beach community are represented and hope to identify opportunities to collaborate on County-wide efforts to reduce HIV/STD infections, ensure and expand access to care and preventative interventions such as PrEP and PEP.

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

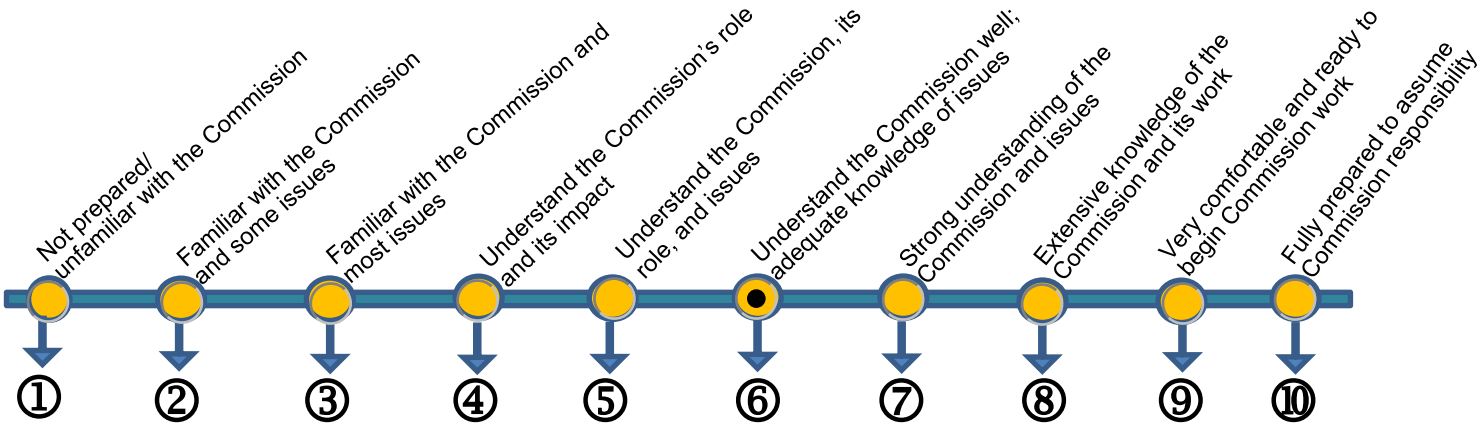
Everardo Alvizo is the HIV/STD Strategic Implementation Specialist for the City of Long Beach, tasked with overseeing the implementation of Mayor Robert Garcia's HIV/STD Strategy 2019-2022. Prior to this role, Alvizo provided psychotherapy at school and community sites in South Los Angeles and the South Bay working with children, youth, adults and families. Alvizo's career has also focused on macro social work, including grant writing/implementation/evaluation, non-profit management, and public policy advocacy for various high-risk groups, including those at-risk of HIV/AIDS, living with HIV/AIDS, having co-morbidities (mental illness/substance use/abuse) and/or experiencing life stressors such as homelessness/undocumented status. Alvizo implemented a SAMHSA grant that integrated HIV/AIDS prevention/medical care, mental health and substance use services targeting MSM and trans women (many seeking asylum from Mexico and Central America) in Koreatown/Los

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

N/A

Section 5: New Member Applicant (Only to be completed by new member applicant)

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



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

My experience as a Project Coordinator for Special Service for Groups / Health Integration for At-Risk Racial Ethnic Communities (SSG/HIARC) program, a SAMHSA grant, has given me the professional experience to help prepare me for the issues that will come to the attention and are of importance to the Commission. SSG/HIARC integrated HIV/AIDS prevention/medical care, mental health and substance use services targeting MSM and trans women (many seeking asylum from Mexico and Central America) in Koreatown/Los Angeles. As Project Coordinator, I worked with and gained a thorough understanding of impacted community members and service providers in the HIV/AIDS field. My goal was and continues to be to provide culturally and linguistically competent services.

I'm also a graduate of Liberty Hill Foundation's Commissions Training Program for Grassroots Leaders, a program that trains community leaders to become advocates within local government structures and readies them to serve on city and county boards and commissions.

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

I believe getting to know all the other potential 50 members of the Commission will be challenging, just given the number. I also think that staying abreast of the inevitable diverse issues that the Commission will address will also be a challenge.

After participating in the Virtual Training on the Commission on HIV (COV) Overview, I have a better understanding of how the Commission is actively attempting to ensure that all voices are heard and are actively participating through Caucus participation. I appreciate hearing that the current Commissioners are open to new ideas of facilitation as well. I hope to bring my experiences/knowledge in group facilitation to help achieve consensus whenever possible.

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

As a representative of the City of Long Beach within my role as HIV/STD Strategic Implementation Specialist, LA County residents living with or at high risk of HIV/STDs will benefit from my ability to bring forward a collaborative effort in promoting effective prevention and treatment strategies being used by community providers and stakeholders in the city of Long Beach. I will also bring my professional experience as a clinical social worker to ensure that issues that impact a person's level of risk, such as mental health, substance use/abuse, homelessness, immigration status, language, and gender identity are adequately addressed in the decision making process.

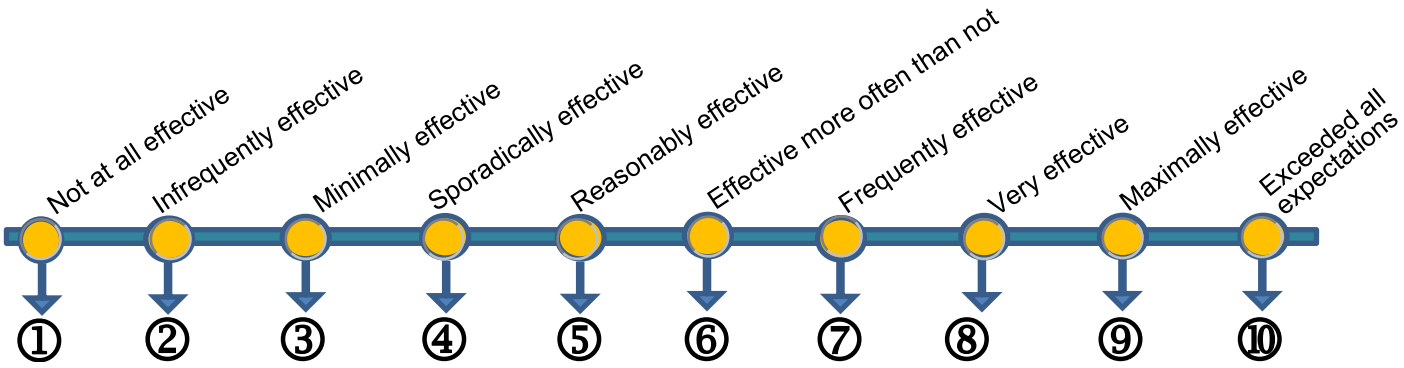
17. **Which of your strengths do you feel will enhance your Commission performance? What skills will you need to develop further for optimal Commission performance? Continue on an additional page if necessary.**

As a clinical social worker, my strengths in facilitating difficult conversations and ability to build trust/rapport with others may enhance my Commission performance. I have experience working with a diverse community providing individual and family therapy in different areas of Los Angeles County (South LA, Koreatown, South Bay). I hope to continue improving my ability to receive critical feedback and utilize it to in my personal and professional growth.

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

Section 6: Renewal Applicant (Only to be completed by renewal applicant)

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



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

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

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

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

24. **Candidates are also nominated to fill Alternate seats as well: if you were nominated for an Alternate seat, would you be willing to serve in that capacity?**

CLICK HERE TO PRINT FORM

CLICK HERE TO CLEAR FORM

APPROVED PP&A COMMITTEE MEETING 09-15-2020
For Executive Committee Approval 9/24/20

LOS ANGELES COUNTY COMMISSION ON HIV

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

PROPOSED PROGRAM DIRECTIVES FOR RYAN WHITE PROGRAM YEARS 30, 31, AND 32

September 24, 2020

To: Mario J. Perez, Director of HIV and STD Programs (DHSP), Department of Public Health

From: Alvaro Ballesteros and Bridget Gordon, Co-Chairs, Commission on HIV

Re: Program Directives for Maximizing Ryan White Part A and MAI Funds for Program Years 30, 31, 32

In keeping with the Commission on HIV's commitment to engage in multi-year priority setting and resource allocation planning for the next three years, the PP&A Committee has developed a set of program directives for program years (PY) 30, 31, and 32. The multi-year service rankings and allocations aim to assist DHSP in your programmatic planning and initiating the solicitations process so that services are in place by the start of the upcoming Ryan White program years.

Part A Planning Councils are required to "establish priorities for the allocation of funds within the eligible area, including how best to meet each such priority and additional factors that a Recipient should consider in allocating funds under a grant based on numerous factors including: "size and demographics of the population of individuals with HIV disease;" "priorities of the communities with HIV disease;" and "capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities."

Along with service priorities, the Planning Council (i.e., Commission on HIV) gives the Recipient (i.e., Division of HIV and STD Programs) directives for how to best meet the priorities. Directives are instructions that the Recipient must follow in developing requirements for providers for use in procurement and contracting. While the Planning Council has no involvement in the procurement process, it is responsible for providing guidance on service models or strategies, population priorities, and methods for overcoming barriers to care. (Mosaica for the HRSA/HAB TAC – 2007 – TARGET Center – http://careacttarget.org)

This document is a comprehensive list of program directives for the Division of HIV and STD Programs (DHSP) aimed at informing the design and implementation of HIV/STD program and service delivery in Los Angeles County (LAC). The Commission on HIV will review the document at least annually to ensure alignment with funding, priorities, service needs and opportunities to advance the goals of ending the HIV epidemic in Los Angeles County.

Based on epidemiological data, the disproportionately impacted populations in Los Angeles County are **young MSM (YMSM), African American MSM, Latino MSM, and transgender persons**. Given the physiologic role that sexually transmitted diseases (STDs) play in HIV transmission, it is recognized that maximizing HIV prevention will require significant reduction in syphilis and gonorrhea cases, among these aforementioned groups and **women of color** (LACHAS, pg. 14).

The 2019 HIV Surveillance Report notes following areas of disparities:

- Largest gaps in awareness of HIV-positive status existed for persons aged <35 years, where over 50% of HIV-infected persons aged 13-24 years and one third of HIV-infected persons aged 25-34 years were unaware of their infection. Disparities also existed for persons who inject drugs (PWID), with over one-third of HIV-infected PWID unaware of their HIV-positive status and only 55% having been tested for HIV in the past 12 months.

- There are continued disparities in HIV diagnosis by population and geographic location. Rates of new HIV diagnosis are higher among men than women. Across age groups, young men aged 20-29 years and women aged 30- 39 years had highest HIV diagnosis rates. Black men and women had higher rates of HIV diagnosis compared with other race/ethnicity groups. Among men the highest rates of diagnoses were seen in the Central, South, and Hollywood-Wilshire Health Districts, and the highest rates for women were seen in the Central, South, and Southeast Health Districts.

- Populations with lowest achievements in linkage to care were females, Blacks, adolescents, persons aged ≥ 60 years, and persons with injection drug use (IDU) or heterosexual transmission risk. Health Districts with greatest need for interventions to improve linkage to HIV care services were Antelope Valley, El Monte, and South Health Districts where linkage rates were ≤ 70%.

- Approximately 9 in 10 people living with diagnosed HIV were on HIV treatment. Of those, 8 in 10 had adhered to their drugs in the past 3 days. Treatment coverage was lowest for Black populations and persons aged < 40 years, while adherence was lowest for younger persons aged <30 years and the Latinx population.

- Greatest disparities in viral suppression were among Black populations, females, persons aged 30-49 years, and persons whose transmission risk included injection drug use. Geographically, unsuppressed viral load was highest in the Central Health District, followed by South, Southeast, Hollywood-Wilshire, and West Health Districts.

With the unprecedented opportunity and infusion of additional resources to end the HIV epidemic in the next 10 years, we recommend that Ryan White funded services be expanded to address the unacceptable disparities in HIV health outcomes (both prevention and care) that

continue to persist for African Americans, Latinos, transgender individuals and youth. Furthermore, funds released under the HRSA NOFO 20-078, should be used to overcome income and service standards restrictions set forth under the Ryan White Part A requirements. Given the more flexible nature of the HRSA Ending the HIV Epidemic dollars, every effort should be made to fund previously prohibited items that would help achieve optimal health for PLWH. These items include but are not limited to, refrigerators for food, ability for providers to procure dental chairs, computers, and other equipment necessary to expand access to services.

It is important to note that during the Committee's service ranking deliberations, the consumers, ranked housing as their number one service need for PY 31 and 32. This speaks to the need for keeping PLWH stably housed to support their retention to care, viral suppression and overall health. Medical/outpatient care also remains a top priority for consumers.

The program directives below expand on the directives sent to DHSP on April 23, 2019:

1. Across all funding sources, prioritize investments in populations most disproportionately affected and in health districts with the highest disease burden and prevalence, where service gaps and needs are most severe.

2. Implement the recommendations developed by the Black/African Community (BAAC) Task Force (TF) which set a progressive and inclusive agenda to eliminate the disproportionate impact of HIV/AIDS/STDs in all subsets of the African American/Black diaspora. PP&A is calling special attention to the following recommendations from the BAAC TF as key priorities for RFP development, funding, and service implementation starting in 2020:

    - Require contracted agencies to complete training for staff on cultural competency and sensitivity, implicit bias, medical mistrust and cultural humility. DHSP should work with the Black/African American community as subject matter experts in developing training materials and curriculum.
    - In collaboration with the Black/African American community, conduct a comprehensive needs assessment specific to all subsets of the Black/African American population with a larger sample size. Subgroups include MSM, transgender masculine and feminine communities, and women.
    - Assess available resources by health districts by order of high prevalence areas.
    - Conduct a study to identify out of care individuals, and populations who do not access local services and why they do not.
    - Fund mental health services for Black/African American women that are responsive to their needs and strengths.
    - Ear mark funds for peer support and psychosocial services for Black gay and bisexual men.
    - It is recommended that DHSP collaborate with SBP to convene subject matter experts from the African American community to ensure that mental health and psychosocial support services are culturally tailored to the needs of the community.

3. Provide Non-Medical Case Management services in non-traditional and traditional locations to support improved service referrals and access points to Ryan White services for identified priority populations, such as young men who have sex with men (YMSM), African American men and women, Latinx communities, transgender individuals, and older adults.[1]

4. Continue to enhance Foodbank and Home Delivered Meals services to include dietary guidance, better quality foods (specifically more high quality nutrient rich fruits, vegetables and lean proteins), and increase the amount of food available for clients based on their individual needs or by gaps observed or reported by agencies and clients; cover essential non-food items such as personal hygiene products (to include feminine hygiene items), household cleaning supplies, and personal protective equipment (PPE). Permit contracted agencies to provide grocery, gas, and transportation support (e.g., Metro Tap cards, ride share services) to clients to facilitate expanded access to food.

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

6. Continue to support the expansion of medical transportation services.

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

8. Augment contracts to permit agencies to have an operational line item budget for childcare and transportation to facilitate consistent engagement in care and support services. This strategy would avoid releasing a stand-alone RFP for childcare and transportation and give service providers the flexibility to provide these services to all clients with children.

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

9. Fund mobile care teams or clinics that provide holistic care for women. Mobile teams should be available for all agencies and link women to services where they reside, congregate, or prefer to be engaged.

10. Fund psychosocial services and support groups for women. Psychosocial support services must

[1] The Aging Task Force will provide further guidance on the age parameters for "older adults."

include peer support in order to build a stronger sense of community, empowerment and resilience among women living with HIV.

In order to inform the Commission's planning efforts around HIV/STD prevention and care services, we direct DHSP to provide written fiscal reports and status updates on these directives to the PP&A Committee and full Commission on a regular basis.

In support of the recommendations from the PP&A Committee, Standards and Best Practices (SBP) will continue updating and/or developing service standards for the following service categories. These service categories were prioritized by the PP&A Committee as recommended by DHSP and because of the feasibility of releasing solicitations in 2020-2022. Status updates on the development of service standards are noted below.

1. **Universal Service Standards -**Completed; updated and approved on 9/12/19
2. **Non-Medical Case Management –** Completed; updated and approved on December 12, 2019
3. **Psychosocial Support -**in progress and on the 9/10/20 Commission agenda for approval
4. **Emergency Financial Assistance –** Completed; approved by the Commission on 6/11/20
5. **Childcare** - in progress; public comment period 9/11-9/23; target month for Commission approval is October/November

The Commission is committed to ongoing collaborations with DHSP and we seek your feedback on how we can work together to implement these directives. We thank DHSP for ongoing regular progress reports on implementing directives and efforts to maximize Ryan White funds and activities to end the HIV epidemic. Furthermore, we appreciate feedback from DHSP in updating service standards. Thank you, we appreciate the ongoing partnership and support from you and your staff.

cc: Raquel Cataldo, PP&A Co-Chair
Kevin Stalter and Erika Davies, SBP Committee Co-Chairs
Miguel Martinez and Jason Brown, 2019 PP&A Committee Co-Chairs

ATTACHMENT: Black/African American Task Force Recommendations

(REVISED) Black/African American Community (BAAC) Task Force Recommendations

October 10, 2019

Introduction

The BAAC Task Force was formed in response to the Commission on HIV's (COH) February 14, 2019 National Black HIV/AIDS Awareness Day (NBHAAD) Panel discussion in an effort to address the disproportionate impact of HIV/AIDS in the Black/African American (AA) communities of Los Angeles County.

The BAAC Task Force convened on April 30, 2019 to develop a progressive and inclusive agenda to address and provide recommendations to the COH on how to reduce and ultimately eliminate the disproportionate impact of HIV/AIDS and STIs in all subsets of the Black/AA community utilizing a community-wide mobilization effort.

Healthcare Disparities in the Black/AA Community

The United States Census Bureau estimates Black/AA living in Los Angeles County (LAC) at 9% or approximately 909,500 as of 2018.(1) In 2017, there were 51,438 persons living with diagnosed HIV (PLWH) in LAC. **Twenty percent (20%) were Black/AA.**(2)

In 2016, **the highest overall rate of HIV diagnoses was among African Americans (56 per 100,000)**, followed by Latinos (19 per 100,000), whites (12 per 100,000), and Asians (6 per 100,000). These differences in rates were also observed by sex, most notably among **African American females (17 per 100,000) where the rate of HIV diagnoses** was 8 times higher than that of white females (2 per 100,000) and 5 times higher than the rate for Latinas (3 per 100,000). Among **males**, the rate of HIV diagnoses among **African Americans (101 per 100,000)** was 5 times higher than among whites (22 per 100,000) and 3 times higher than the rate for Latinos (34 per 100,000).(2)

The highest rate of stage 3 diagnoses (Acquired Immunodeficiency Syndrome) (AIDS) **was among African Americans (18 per 100,000).** The rate of stage 3 diagnoses for **African American females (6 per 100,000)** was 9 times higher than the rate for white females (<1 per 100,000) and 3 times higher than the rate for Latinas (2 per 100,000). Among **males**, the rate of stage 3 diagnoses for **African Americans (32 per 100,000)** was 4 times higher than the rate for whites (9 per 100,000) and 3 times higher than the rate for Latinos (13 per 100,000).(2)

Black/AA Care Continuum as of 2016[3]

Demographic Characteristics	Diagnosed/Living with HIV	Linked to Care ≤30 days	Engaged in Care	Retained in Care	New Unmet Need (Not Retained)	Virally Suppressed
Race/Ethnicity						
African American	**9,962**	**54.2%**	**65.9%**	**49.7%**	**50.3%**	**53.0%**
Latino	21,095	65.4%	68.3%	55.7%	44.3%	59.7%
Asian/Pacific Islander	1,710	80.5%	74.6%	60.5%	39.5%	68.5%
American Indian/Alaskan Native	294	75.0%	70.1%	54.10%	45.9%	52.4%
White	14,778	75.2%	71.6%	54.5%	45.5%	64.9%

The Ryan White (RW) program in LAC served 15,747 individuals between March 1, 2018 and February 28, 2019. Three-thousand three-hundred sixty (3,360) were Black/AA during the same period.[4]

Objectives:

- **Identify** strategies on how the COH can support Black/AA leaders and community stakeholders in an effort to end HIV in the Black/AA community
- **Identify** HIV prevention, care and treatment best practices in the Black/AA community
- **Identify** specific strategies to reduce HIV stigma in the Black/AA community

General/Overall Recommendations:

1. Provide on-site cultural sensitivity and education training – to include addressing implicit bias and medical mistrust within the Black/AA community – for all County-contracted providers and adopt cultural humility into the local HIV provider framework. *Decision makers must realize their own power, privilege and prejudices and be willing to accept that acquired education and credentials alone are insufficient to address the HIV epidemic in the Black/AA community.*

2. Revise messaging County-wide around HIV to be more inclusive, i.e., "If you engage in sexual activity . . . you're at risk of HIV" in an effort to reduce stigma.

3. Incorporate universal marketing strategies for HIV prevention that appeal to all subsets of the Black/AA community in an effort to reduce stigma and increase awareness.

4. Provide resources to Community-Based Organizations (CBOs) to develop, implement and evaluate primary prevention interventions which are culturally appropriate and relevant.

5. Support young people's right to the provision of confidential sexual health care services.

6. Increase Pre-exposure Prophylaxis (PrEP) advertising within the Black/AA community to increase awareness. Marketing materials must depict the very community it is attempting to reach - specifically, Black/AA youth, women, transgender individuals, and gender nonconforming populations.

7. Initiate or partner in culturally informed research that aims to address the needs of the Black/AA communities. Researchers, whenever possible, must mirror the affected community it purports to study. Community reflectiveness in academic and CBO partnerships should include training in instrument development, data interpretation, presentations and publications.

8. Increase use of local statistics regarding new infections and disparities to educate and plan for the community; request Department of Public Health data be organized by Health Districts and zip codes to better target and identify communities in need.

9. Provide technical assistance to aid Black/AA agencies in obtaining funds for culturally sensitive services.

10. Proactively reach out to engage CBOs that are connected to the local Black/AA community.

11. End the practice of releasing Request for Proposals (RFPs) that have narrowly defined "Proposer's Minimum Mandatory Requirements." *This discriminatory practice purposely disqualifies existing relevant CBOs and other agencies that provide intersection health and human services.* When issuing RFAs, RFPs, or RFSQs, establish a demonstration/data pilot by creating a 15% funding carve-out for CBO's/ASO's, whose qualifications are below the "Minimum Mandatory Requirements", but at an agreed upon standard, to identify the proven and effective grassroots/community empowerment efforts that reach specified Black/AA audiences. This will allow DHSP in collaboration with the Commission to determine the efficacy of methodologies for outreach, linkages to care, retention in care, and other sensitive treatment and prevention interventions that are effective in reducing new HIV cases.

12. Continue to evaluate for effectiveness and increase the investment in Vulnerable Populations Grants that target subset populations of the Black/AA community (i.e. Trans men/women, women & girls, MSM) to address barriers and social determinates of health.

13. Engage agencies already funded as well as those not currently funded to focus on a Countywide PrEP Education and Outreach mini-grant process that will target all various subset populations of the Black/AA community, i.e. Trans community, women & girls, MSM.

14. Increase mobilization of community efforts to include:
    a. Increase community awareness fairs and social media campaigns intended to promote health and wellness in the Black/AA community, with concentration in high incidence areas;
    b. Condom distribution in spaces where adults congregate;
    c. HIV education and access to prevention tools in schools, spiritual communities, social clubs, neighborhood associations, etc.;
    d. Fund one social marketing campaign that addresses stigma and internalized homophobia as it relates to health and wellness around HIV;
    e. Support efforts that will ensure additional research and evaluation support be made available to agencies that provide services to the Black/AA community and to increase their capacity to link and collaborate with research institutions; and
    f. Provide training and incentives for CBOs within high incidence areas to prescribe PreP and nPep.

Population-Specific Recommendations:

Black/African American Trans Men:

The Ryan White (RW) program in LAC served 96 Black/AA Transgender persons during the period of March 1, 2018 to February 28, 2019. This was approximately .6% of the total PLWH/A in LAC.(4)

1. Conduct a Countywide needs assessment of the Trans masculine community that focuses on sexual risk behaviors.
2. Use Williams Institutes' research/data using Sexual Orientation Gender identity (SOGI) (method agencies use to collect patient/client data on sexual orientation and gender identity) to develop Trans male-specific programming.
3. Include Trans men in program decision making.
4. Develop a Trans masculine-specific PrEP campaign which will resonate with and reach Trans men in such a way that the message is not convoluted and therefore lost within the overall PrEP messaging. Messaging should include language around safety and gender affirmation - a campaign that says "Trans masculine individuals . . . this is for YOU." Perhaps include a myth buster around the notion that all Trans men are straight and only date and are sexually involved with cis men; a message that says we know sexual appetites are fluid for Trans men and that is why PrEP is important.
5. Educate/train medical and mental health providers to be more inclusive of Trans masculine bodies and its many different nuances.

6. Create a pilot/demonstration project using the information obtained from the various data sources listed above.

Black/African American Trans Women:

The Ryan White (RW) program in LAC served 96 Black/AA Transgender persons during the period of March 1, 2018 to February 28, 2019. This was approximately .6% of the total PLWH/A in LAC.(4)

1. Conduct a Countywide needs assessment of the Trans women community to address barriers and social determinants of health to better provide more targeted programming.
2. Increase efforts in collecting epidemiological data through surveillance on Trans women for purposes of planning more targeted programming.
3. Use William's Institutes' research/data using SOGI (method agencies use to collect patient/client data on sexual orientation and gender identity) to develop Trans women-specific programming.
4. Include and prioritize Trans women in program decision making.
5. Address stigma and the increasing violence against Trans women.

Black/African American Women and Girls: *(DHSP defined Black/AA women and girls as either childbearing women between the ages of 15-44 and those 50 Years and Older)*

The Ryan White (RW) program in LAC served 501 Black/AA women during the period of March 1, 2018 to February 28, 2019. This is approximately 31.82% of those receiving RW services.(4)

1. Evaluate existing PrEP and prevention access and messaging for impact on intervention groups and community health; assess dissemination methodologies and refine outreach and engagement strategies.
2. Allocate resources to create a PrEP Center for Excellence targeting women and their families, sexual and social networks.
3. Conduct an inventory of County-wide HIV/STD interventions and initiatives that target African American women at risk of and living with HIV that focus on education, employment services, empowerment, co-infections, treatment as prevention (TAsP), sexual reproductive health, intimate partner violence, and mental health.
4. Obtain data for all populations of women, especially those who are pregnant or such age groups affected by the high rates of STIs; include women-specific data in summits, reports, and community forums.

5. Reorganize and adopt educational approaches to care and prevention that incorporate information and knowledge on how preventative methods can benefit the woman within the context of her life. Such approaches include but should not be limited to:
   a. Integrate train-the-trainer models for community health outreach workers and testing staff that use motivational and empowerment strategies as a tool for risk reduction. Generating collective approaches and solutions that promote honesty and integrity within self and relationships with others is paramount. Hold agencies accountable to host honest adult conversations and have the courage to meet people where they are and build on what they know.
   b. Generate collective approaches and solutions that promote honesty and integrity of self and relationships with others is paramount; and
   c. Train community health outreach workers in all HIV Testing Sites to have conversations that validate the experience and power dynamics women confront within their relationships. Most often partners are missing from engagement, enrollment, and retention strategies. Include sexual and social networks in education, outreach, testing and other interventions that support family sustainability as a method of retention.

6. Allocate money to partner with institutions to support three demonstration projects at $250,000 each led and facilitated by and for Black women:
   a. Ensure agencies have tools available to demonstrate accountability and cultural competence. Staff should be linguistically and culturally representatives of the community and any intervention include a navigation component to address barriers to recruitment, uptake and retention of prevention and care based programming.
   b. All protocols should explicitly embrace the experience of women who have sex with men of known or unknown status as well as those diagnosed with HIV/AIDS. Further, qualitative interviews or Audio Computer-Assisted Self-Interview (ACASI) instruments should include an assessment of historical care and prevention participation as well as barriers to continuous engagement and participation.

7. Strategically reflect the needs of women in the jurisdictional stigma reduction efforts by funding projects that reduce stigma and increase access to female controlled HIV preventive tools such as Pre-Exposure Prophylaxis (PrEP), Post Exposure Prophylaxis (PEP), and the Female Condom 2 (FC2). Support agencies to integrate comprehensive opportunities for education, research and a complement to other strategies that give women the power to take control of their lives and situations in which have historically had little to no influence.

8. Expand the availability of community-based mental health services as a part of a continuous effort to treat women holistically: HIV and mental health education and awareness should accompany a range of holistic services that recognize that a woman may have multiple traumas that inform her choices. Increased collaborations between community and the private sector which is necessary to build awareness and reduce cultural and social based stigmas associated with mental health care. Increased education and training of non-HIV/AIDS service providers in hopes of offering a full circle of multidisciplinary services to those in need.

9. Develop a standard requiring all contracted organizations offer living wages as an incentive to hiring persons with lived experience. Initiating programming for Black women enables organizations to invest in their peers. Further, increased access to professional development opportunities and resources (ex. Income) enables them to self-sustain and decrease the impact that social correlates of health such as poverty have on informed sexual decision making.

<u>Black/African American Men Who Have Sex with Men (MSM):</u>

The Ryan White (RW) program in LAC served 2,093 Black/AA MSM during the period of March 1, 2018 to February 28, 2019. This was approximately 13.3% of those receiving RW services. (4)

1. Continue to increase the investment in innovative layered interventions that target young MSM and address barriers and social determinates of health like the Vulnerable Populations Grant.

2. Develop and release of Request for Application/Request for Proposal (RFA/RFP) that focuses on HIV positive MSM of all ages who are sexually active and at risk of co-infections.

3. Increase funding and resources in treatment as prevention, social support efforts, housing and mental health services.

4. Address Chemsex within the Black/AA MSM community through CBO led group sessions, evidence-based medicine directed intervention and medication assisted treatment.

Conclusion

Only by genuinely addressing the recommendations as provided above can the Los Angeles County HIV/AID Strategy (LACHAS) goals be met. Many of the recommendations provided are in alignment with the LACHAS and the County's Comprehensive HIV Plan (CHP), however, there must be very intentional and targeted efforts made to address social determinants, primarily stigma and racism, in the Black/AA communities. It is not enough to implore the same strategies of old; we must modernize methodologies in our marketing strategies to reach subpopulations within the Black/AA communities who do not identify according to current messaging. Messaging must be *truly* inclusive – "if you are sexually active, you are at risk".

The adage is true – "to reach them, you have to meet them where they are" - HIV and sexual health education along with HIV prevention interventions must be accessible in schools, jails, churches, barber/beauty shops, and social venues where Black/AA communities gather; while providers must be trained and educated to understand the various cultural nuances that can either stigmatize and subsequently discourage or create a culturally welcoming environment for Black/AA communities to access HIV prevention, care and treatment services.

On behalf of the BAAC Task Force, we thank the Executive Committee for its consideration of the above recommendations and look forward to its plan of action in response.

Special thanks to the following BAAC Task Force members and community stakeholders who volunteered their time and contributed to the development of recommendations: Greg Wilson (COH), Traci Bivens-Davis (COH), Bridget Gordon (COH), Dr. LaShonda Spencer (COH), Danielle Campbell (COH), Yolanda Sumpter (COH), Dr. William King (COH), Cynthia Davis (AHF), Luckie Fuller (COH), Jeffrey King (ITMT), Louis Smith III, Stevie Cole, Ivan Daniel III, Carl Highshaw (AMAAD Institute), Charles McWells (LACADA), Dr. Derrick Butler (THE Clinic), David Lee (CDU), Rev Russell Thornhill (MAPP), Terry Smith (APLA), Doris Reed (COH), Carolyn Echols-Watson (COH) and Dawn Mc Clendon (COH).

Endnotes

1. Census.gov/quickfacts/fact/table/losangelescountycalifornia; RH1225218
2. 2017 Annual HIV Surveillance Report; Ryan White program Clients Living with HIV YR 28 (03/01/2018 – 02/28/19)[i]
3. Los Angeles County HIV/AIDS Strategy (LACHAS) – P26; Table 5
4. Ryan White Program Clients YR 28 (3/1/18-2/28/19) Los Angeles County; Utilization by Service Category among Ryan White Priority Populations in Year 28

LOS ANGELES COUNTY
COMMISSION ON HIV

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PUBLIC POLICY COMMITTEE
PUBLIC COMMENTSUBMITTED TO HOUSING SAVES LIVES REGARDING PROPOSED RULE CHANGE BY HUD AND DENYING ACCESS TO HOUSING FOR TRANSGENDER INDIVIDUALS

HUD must maintain protections for transgender people under the Equal Access Rule in order to support your own administration's priority to end HIV by 2030 (https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview).

For people living with HIV/AIDS (PLWHA) and those at a high-risk of contracting HIV, stable housing is the most effective health intervention, over time having a bigger impact on preventing transmission and retaining PLWHA in medical care than demographics, health status, insurance coverage, mental illness and substance abuse, or other supportive services. Nationally, transgender individuals make up .06% of the population, but HOPWA grantees report that 3% of their client populations identify as transgender. Moreover, transgender women of color have an almost 1 in 2 chance of becoming HIV-infected during their lifetime. In Los Angeles County, transgender individuals shoulder a disproportionate burden of HIV, with poorer health outcomes across the HIV continuum.

HUD has documented this link between housing instability and both delayed HIV diagnosis and increased risk of acquiring and transmitting HIV infection. Homelessness and unstable housing are strongly associated with inadequate access to healthcare and poor health outcomes. It is important to note that as an infectious disease without a cure, HIV/AIDS continues to be a critical public health issue, and there is a disproportionate risk of transmission and lack of healthcare among the homeless and unstably housed. Stable housing supports more frequent HIV testing and is linked to fewer new transmissions. The three-pronged benefit of stable housing for PLWHA, increased testing, and fewer transmissions will help bring LA County and the Nation one step closer to realizing the federal initiative to end HIV by 2030.

END THE EPIDEMICS

It's time to end the HIV, HCV & STD epidemics in California.

End the Epidemics Racial Justice Working Group Condemns Policy Brutality and White Supremacist Violence September 22, 2020

The End the Epidemics Racial Justice Working Group condemns the ongoing police brutality and violence perpetrated against Black, Indigenous and People of Color (BIPOC) in California and across the United States. Racism is a public health crisis and we will not end the HIV, HCV, and STD epidemics until we address the systemic racism that is embedded in nearly every facet of our society.

Fear is a dangerous thing and the ongoing cycle of brutal violence, beatings, modern day lynchings, and murders at the hands of police and those empowered by a broken system are all due to an escalating cycle of fear and unwillingness to allow BIPOC to simply exist with liberty and justice for all, just as it says in the Pledge of Allegiance. Racism, the need to dominate others, a false sense of entitlement, and hatred are all based in fear. These are the elements that prompt young white people to march down the street with guns, white supremacists to attack and kill protestors, and voting rights to be manipulated. Fear infects our society, creating division, and making us all weak. We do not abide by a society that gives some of its members false privilege and allows them to turn a blind eye, yet is based on the claim that "all men are created equal under the law."

To those who would say "shut up and dribble" we say: We do not recognize you who try to claim power to control us. You do not have the power to push us down, to make us invisible, and to cancel out our rights. Promoting the buy back of guns in BIPOC neighborhoods to "save our streets," while encouraging white people to arm themselves is against humanity. This promotion unfortunately lends itself toward a call to arms for white people as a way to protect the status quo and a culture dominated by white supremacist thinking. For those who attempt to arm themselves against us, your right to bear arms does not cancel out our right to bear them, in addition to our rights to free speech, freedom of assembly, and justice under the law.

And to those who preferentially allow only police and white citizens permission to perpetrate violence against others with no regard for their culpability under the law we say: THAT TIME HAS PASSED! We must do more than work to address disparities in health outcomes, we have to act to dismantle the systems that perpetuate oppression and inequities. It is time for

intervention, education, training in civility, humility, and demilitarization of the police. So often we are silent in the shadows observing, working to "stay in our lane," but not anymore! Life, liberty, and justice for all is everyone's right and there are no longer lanes to stay in! WE STAND IN SOLIDARITY FOR WHAT IS RIGHT! WE WILL BE SILENT NO MORE!

For more information, contact Dr. Demisha Burns, End the Epidemics Racial Justice Co-Chair, clarystrategies@gmail.com.

End the Epidemics is committed to ending the syndemic of HIV, hepatitis C (HCV) and sexually transmitted diseases (STDs) in California, with a focus on advocating for anti-racist policies and funding priorities to eliminate health inequities among people of African descent/African Americans/Black, Latino/a/x, Indigenous populations and all people of color (POC).

AGING TASK FORCE

Monday, August 3, 2020 | 10:0am to 12:00pm

VIRTUAL MEETING SUMMARY

In attendance:

Al Ballesteros (Co-Chair)	Michael Buitron	Dawn Mc Clendon (COH Staff)
Dr. Paul Nash	Brian Riesling	Carolyn Echols-Watson (COH Staff)
Joseph Green	Katja Nelson	
Lee Kochems	Alasdair Burton	
Mark McGrath	Lt. CDR Jose Ortiz	
Craig Pulsipher	Patrick Piper	
Yuisa Gimeno	Chery Barrit (COH Staff)	

1. **Welcome & Introductions**
   - Cheryl Barrit, Executive Director, welcomed all to the first task force meeting since its last meeting in January 2020 and since COVID.
   - Ms. Barrit introduced guest speaker Dr. Paul Nash, CPsychol, AFBPsS, FHEA, Instructional Associate Professor of Gerontology, USC Leonard Davis School of Gerontology, to lead a discussion on the aging and HIV.
2. **2020 Work Plan, Goals and Objectives Review:**
   - Ms. Barrit provided a brief refresher of where the task force left off in requesting utilization data from DHSP. However, due to COVID, priorities shifted and DHSP's workforce has largely been reassigned to COVID-related assignments; data is still pending.
   - At its last meeting, the Task Force requested that Dr. Paul Nash be invited to its next meeting to assist the group in planning and developing activities to meet the needs of the aging population living with HIV.
3. **Presentation & Discussion: Aging with HIV: COVID, Intersectionality and Discrimination**
   - Dr. Paul Nash presented on Ageing with HIV: COVID, Intersectionality and Discrimination. *See PPT presentation (attached).*
   - Dr. Nash's presentation addressed:
     - The picture of HIV
     - Development of ageism and stereotypes
     - Intersectionality
     - Care continuum
     - COVID, HIV & older adults
     - Challenges for minority populations
     - Collaborative research direction

- Key data points discussed included:
    - 70% of individuals living with HIV are 50+ years old as of 2020
    - 72% of new HIV infection in 2017 were among individuals 40+ years of age; 17% were 60+
    - 42% of Blacks/African Americans account for new HIV diagnoses yet only make up 13% of the population
    - 27% of Latino/Hispanics account for new HIV diagnoses yet only make up 18% of the population
    - Women account for almost 25% of older adults living with HIV
    - While 80% of COVID-related deaths occurred in individuals 65+ years old; COVID-related hospitalization occurred age range 18-40.
- Older adults living with HIV experience "triple stigmas" associated with ageism, misconceptions about HIV/AIDS and anti-gay prejudice.
- Internalized ageist stereo types can be drivers of increased HIV acquisition rates among the ageing community
- Loneliness/social isolation is the biggest challenge the aging population experiences; more damaging than smoking and obesity.
- Long term care support for older adults living with HIV is challenging due to peer re-closeting, reduced access to preventive health care, reduced access to testing services, inadequate housing options, and inadequately educated and trained staff
- Older adults living with HIV also experience multiple barriers (i.e. food and housing insecurities) which produce multiple negative health outcomes.
- Older adults are experiencing the digital divide as a result of COVID as 50% of individuals 65+ do not have internet at home.
- To help challenge ageist stereotypes, intergenerational contact should be fostered and encouraged.
- Recommendations provided to better meet the needs of older adults living with HIV included:
    - Increase education targeting specific populations
    - Increase the availability of effective treatments
    - Increase/maintain funding
    - Promote safer sex but don't stigmatize
    - Promote medication adherence via ART and PrEP
    - Conduct research to study the experiences of older adults living with HIV
    - Reframe aging services
    - Include ageing activism to challenge misconceptions about ageing
    - Support health departments and community-based organizations to help deliver effective prevention interventions

- The Task Force shared the following comments and suggestions in reaction to Dr. Nash's presentation:
    - Invite Dr. Nash to the full Commission meeting to educate the community on older adults living with HIV
    - Be more intentional in the Commission's planning activities to include the ageing community as a priority population.
    - Utilize the suggested recommendations as the Task Force's baseline to develop its own recommendations to submit to the Commission to help better plan for aging individuals living with HIV.
    - Conduct continuing education activities focused on older adults living with HIV
    - Include youth in future conversations regarding ageing and HIV to help bridge the intergenerational gap.
    - Include in future discussions the benefit of pets and service animals to help older adults cope with social isolation
    - Invite Dr. Nash to apply for Commission member and/or attend and participate in Commission/Committee meetings (Dr. Nash graciously accepted and indicated that he is available to the Commission).

4. **Determine Next Meeting Dates and Times**
    - The Task Force will continue to meet the first Monday of each month, however, the next meeting date of September 7, 2020 falls on a County holiday and therefore the meeting will be rescheduled to a date TBD; the Committee will be notified.
5. **Next Steps/Agenda Development**
    - The Task Force will begin development of recommendations at its next meeting.
6. **Announcements**
    - APLA will host an upcoming virtual conference on ageing in September; details to be forthcoming.
7. **Adjournment.**

LOS ANGELES COUNTY
COMMISSION ON HIV

BLACK AFRICAN AMERICAN COMMUNITY (BAAC) TASK FORCE

Monday, August 10, 2020 | 10:0am to 12:00pm

VIRTUAL MEETING SUMMARY

In attendance:

Danielle Campbell (Co-Chair)	**Greg Wilson (Co-Chair)**
Angela Boger	Carolyn Echols-Watson (COH Staff)
Jeffrey King	Dawn Mc Clendon (COH Staff)
Dr. William King	Cheryl Barrit (COH Staff)
JaVontae Wilson	

1. **Welcome + Introductions + Check In**
   - Co-Chairs Danielle Campbell and Greg Wilson welcomed the task force members and led introductions.

2. **Co-Chair Report**
   - Co-Chairs lauded the Task Force's efforts in developing a Statement of Solidarity in the wake of the George Floyd, Jr. murder and anti-Black racism and acknowledged the traction, awareness and positive response it's received.

3. **June 29, 2020 Special BAAC Task Force Meeting Recap + Follow Up**

   A. Q&A
   - Concerns were shared from the last meeting specifically relating to:
     - engagement with the Commission and community
     - autonomy
     - accountability and reporting process to Commission
     - member standing, interest and recruitment
     - 10-point list of concerns provided by In the MeanTime (ITMT)
   - Staff referenced the January 24, 2020 meeting summary as a refresher of the discussion and decisions made regarding structure, autonomy, reporting process and membership. (See January 24, 2020 meeting summary.)

   ➢ Task Force suggested developing a formal membership application process (i.e. interest form or member application) to assess interest, confirm membership and/or monitor accountability

   B. 10-point Recommendation by Jeffrey King

   ➢ Task Force voted to postpone this item for a future meeting where more time (45 min – 1hr) can be allocated to a fuller discussion. This discussion will also address the concerns noted above.

4. **Development of a Coordinated Statement**
   - At the recommendation of consultant/facilitator, Diane Burbie, at the June 29, 2020 special meeting, the Task Force discussed developing and issuing a "coordinated statement" as a demonstration of a cohesive unified voice, reinforcing the goals and objectives of the Task Force in response to recent conflicts.
   - It was determined that the coordinated statement can also be used as a recruitment tool as more community members reflecting the Black/ African American diaspora are needed.
   - Dr. King and Danielle Campbell volunteered to assist in drafting the statement for task force review.
   - ➢ Additional members who wish to assist in the development of the coordinated statement were asked to express their interest within the next 7 days.

5. **BAAC Task Force Recommendations Update + Follow Up**

A. January 24, 2020 Meeting Summary Refresher

B. February 24, 2020 Task List Review
   - Task Force discussed a pending task that was interrupted by COVID – as requested by Priorities, Planning and Allocation (PP&A) Committee on behalf of DHSP, to recommend Black/African American women-centered and MSM/bi-sexual men-centered RFP language regarding mental health and psychosocial services.
     - o Jeffrey King, in collaboration with community partners, submitted recommendations to staff pertaining to the MSM/bi-sexual men-centered language.
     - o Staff noted receipt of Dr. Spencer's recommendations pertaining to women.
     - ➢ Danielle Campbell indicated that additional language would be submitted by the end of the month.

C. Guidance Request by Commission Committees & Caucuses
   - Staff shared an ongoing request by the Commission's working groups for the task force's guidance on and/or a more detailed presentation of its recommendations. Specifically, Operations, Public Policy and the Consumer Caucus are requesting guidance on how to best incorporate the recommendations into its planning activities.
   - ➢ Task Force agreed at its next meeting to review the role, responsibility and scope of the Commission, its committees and working groups and DHSP to determine fit and expectations, and potentially assign recommendations appropriately.

D. Prosper LA
   - Staff provided a brief description of the County's new initiative – Prosper LA – as a mechanism to rebuild its economy in light of the fiscal impact COVID has had by soliciting creative and innovative ideas from the community, specifically in the area of streamlining business services, services, processes, or contracting with the County.
   - The Task Force was asked to consider submission as an opportunity to address its recommendations specific to procurement and contracting of services.
   - Task Force was asked to review ahead of its next meeting to determine whether to participate.

6. **Meeting Recap and Agenda Development for Next Meeting**
   - Next meeting scheduled for September 28, 2020 at 1-3pm **Time was revised post-meeting in light of scheduling conflict.*
   - Follow up and agenda items for next meeting noted in red.

7. **Public Comment + Announcements.** Jeffrey King announced that he is resigning as a member of the task force but will be available as a community member, as needed.

8. **Adjournment**

VIRTUAL LUNCH & LEARN SERIES:

SHARE, LEARN, AND SUSTAIN OUR HIV MOVEMENT

WOMEN+ HIV
A Special 4-Part Conversation

Spanish interpretation will be provided. See second page for instructions.

Please join the **Los Angeles County Commission on HIV Women's Caucus** for a special 4-part conversation as we center our movement around women and HIV in addressing four key social determinants of health that disproportionately impact women affected by HIV/AIDS and STDs in Los Angeles County.

Let's continue to work together as we rebuild our HIV movement amid the COVID pandemic by promoting and advancing the health and wellness of women and families impacted by HIV and STDs.

October 14, 2020 | 12-1:30pm
WOMEN+HIV: ADDRESSING ECONOMIC + HOUSING INSECURITY
Elizabeth Lee, LCSW, Director of Housing, Women's Downtown Center
Register Now: https://tinyurl.com/yxa5xjfn

November 10, 2020 | 12-1:30pm
WOMEN+HIV: THE IMPACT OF TRAUMA
Susie Baldwin, MD, MPH & Nicolle Perras, LCSW, Office of Women's Health
Los Angeles County Department of Public Health
Register Now: https://tinyurl.com/y2mkvum9

October 14, 2020
12:00-1:30pm

WOMEN+HIV:
ADDRESSING ECONOMIC + HOUSING INSECURITY

GUEST SPEAKER:
Elizabeth Lee, LSCW
Director of Housing
Women's Downtown Center

FACILITATORS:
Shary Alonzo &
Dr. LaShonda Spencer
Women's Caucus Co-Chairs

REGISTER NOW:
https://tinyurl.com/yxa5xjfn

TO JOIN BY PHONE:
+1-415-655-0001
Access code: 145 481 3594

GRAB YOUR LUNCH, INVITE A FRIEND AND LET'S SHARE, LEARN & BREAK BREAD TOGETHER
#STRONGERTOGETHER

LOS ANGELES COUNTY COMMISSION ON HIV
3530 Wilshire Blvd., Suite 1140 Los Angeles, CA 90010

http://hiv.lacounty.gov

Tel: 213.738.2816
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LOS ANGELES COUNTY COMMISSION ON HIV

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SE PROPORCIONARÁ TRADUCCIÓN SIMULTÁNEA DURANTE EL EVENTO.

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