LOS ANGELES COUNTY
COMMISSION ON HIV

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RESCHEDULED

EXECUTIVE COMMITTEE

Virtual Meeting

Monday, August 29, 2022
1:00PM - 3:00PM (PST)

*Meeting Agenda + Packet will be available on our website at:
http://hiv.lacounty.gov/Executive-Committee

REGISTER + JOIN VIA WEBEX ON YOUR SMART DEVICE:
https://lacountyboardofsupervisors.webex.com/lacountyboardofsupervisors/onstage/g.php?MTID=e1f9e61e4e85c2e8aa0f634487432ca36

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For a brief tutorial on how to use WebEx, please check out this video:
http://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=9360

**For those using iOS devices - iPhone and iPad - a new version of the WebEx app is now available and is optimized for mobile devices. Visit your Apple App store to download.*

PUBLIC COMMENTS

Public Comment is an opportunity for members of the public to comment on an agenda item, or any item of interest to the public, before or during the Commission's consideration of the item, that is within the subject matter jurisdiction of the Commission.

To submit Public Comment, you may join the virtual meeting via your smart device and post your Public Comment in the Chat box -or- email your Public Comment to hivcomm@lachiv.org -or- submit your Public Comment electronically to https://www.surveymonkey.com/r/PUBLIC_COMMENTS.

All Public Comments will be made part of the official record.

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COMMISSION ON HIV

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AGENDA FOR THE VIRTUAL MEETING OF THE
EXECUTIVE COMMITTEE

Monday, August 29, 2022 @ 1:00 P.M.– 3:00 P.M.

To Join by Computer, please Register at:
https://lacountyboardofsupervisors.webex.com/lacountyboardofsupervisors/onstage/g.php?MTID=e1f9e61e4e85c2e8aa0f634487432ca36
**link is for non-Committee members + members of the public*
To Join by Phone: +1-415-655-0001
Access code: 2597 512 1684 Password: EXECUTIVE

Executive Committee Members:			
Danielle Campbell, MPH, Co-Chair	*Bridget Gordon, Co-Chair*	Al Ballesteros, MBA	Erika Davies
Kevin Donnelly	Luckie Fuller	Lee Kochems, MA	Katja Nelson, MPP
Mario J. Peréz, MPH	Kevin Stalter (LoA)	Justin Valero, MPA	
QUORUM:	**6**		

AGENDA POSTED: August 25, 2022

VIRTUAL MEETINGS: Assembly Bill (AB) 361 amends California's Ralph M. Brown Act Section 54953 to allow virtual board meetings during a state of emergency. Until further notice, all Commission meetings will continue to be held virtually via WebEx. For a schedule of Commission meetings, please click here.

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

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

SUPPORTING DOCUMENTATION can be obtained via the Commission's website at http://hiv.lacounty.gov or at the Commission office located at 510 S. Vermont Ave., 14th Floor, Los Angeles CA 90020. Complimentary parking available at 523 Shatto Place, Los Angeles CA 90020.

Call to Order, Introductions, and Conflict of Interest Statements 1:00 P.M. – 1:10 P.M.

I. ADMINISTRATIVE MATTERS

1. Approval of Agenda **MOTION #1** 1:10 P.M. – 1:13 P.M.
2. Approval of Meeting Minutes **MOTION #2** 1:13 P.M. – 1:15 P.M.

II. PUBLIC COMMENT 1:15 P.M. – 1:20 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 1:20 P.M. – 1:25 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, or where the need to take action arose subsequent to the posting of the agenda.

IV. REPORTS

5. **Executive Director's/Staff Report** 1:25 P.M. – 1:35 P.M.
   A. Commission/County Operational Updates
      (1) Board of Supervisors (BOS) 30-Day Extension of Virtual Brown-Act Meetings
      (2) Program Year (PY) 32 COH Operational Budget
      (3) 2022 Annual Meeting Planning

6. **Co-Chair's Report** 1:35 P.M. – 1:55 P.M.
   A. LA County Department of Health Services (DHS) No Longer Billing Ryan White Program (RWP) | UPDATES
   B. Member Participation & Feedback @ Conferences/Trainings
      (1) Ryan White Conference | August 23-26, 2022
      (2) NMAC United States Conference on HIV/AIDS (USCHA) | October 8-11, 2022
   C. Presential Advisory Council on HIV/AIDS (PACHA) in Los Angeles | September 19-20, 2022
      (1) Cancelled Committee & Working Group Meetings in Support
   D. August 11, 2022 COH Meeting | FOLLOW UP + FEEDBACK
   E. September 8, 2022 COH Meeting Planning/Agenda Development
      (1) 2023 COH Co-Chair Elections
      (2) City of Long Beach Syringe Exchange/Harm Reduction Program Presentation
      (3) CHIPTS EHE Immigrant Latino MSM PrEP Project Presentation (October)
   F. Member Vacancies & Recruitment

7. Division of HIV and STD Programs (DHSP) Report 1:55 P.M. – 2:10 P.M.

A. Fiscal, Programmatic and Procurement Updates
  (1) Ryan White Program (RWP) Parts A & MAI
  (2) Fiscal
  (3) Monkey Pox Debrief | UPDATES

8. Standing Committee Reports 2:10 P.M. – 2:45 P.M.

A. Operations Committee
  (1) Rescheduled Meeting: Thursday, September 1, 2022
B. Planning, Priorities and Allocations (PP&A) Committee
  (1) 2022-2026 Comprehensive HIV Plan (CHP) Development | UPDATES
  (2) Multi-Year Reallocation Contingency Planning
C. Standards and Best Practices (SBP) Committee
  (1) Benefit Specialty Service Standards | **MOTION #3**
  (2) Home-Based Case Management Service Standards | **MOTION #4**
  (3) Oral Health Service Standard: Addendum | UPDATES
  (4) Special Populations Best Practices Project | UPDATES
D. Public Policy Committee (PPC)
  (1) County, State and Federal Policy, Legislation, and Budget
    a. 2022 Legislative Docket | UPDATE
    b. 2022 Policy Priorities | UPDATE
    c. COH Response to the STD Crisis | UPDATES

9. Caucus, Task Force, and Work Group Reports: 2:40 P.M. – 2:50 P.M.

A. Aging Caucus
B. Black Caucus
C. Consumer Caucus
D. Prevention Planning Workgroup
E. Transgender Caucus
F. Women's Caucus

V. NEXT STEPS

10. A. Task/Assignments Recap 2:50 P.M. – 2:55 P.M.
B. Agenda development for the next meeting 2:55 P.M. – 2:55 P.M.
  (1) Presentation: CHIPTS EHE Proposal to Develop Interventions to Support HIV Prevention Activities with Economic Incentives

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

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

VII. ADJOURNMENT 3:00 P.M.

12. A. Adjournment of the August 29, 2022 Executive Committee

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 Benefit Specialty Service Standards, as presented or revised.
MOTION #4:	Approve Home-Based Case Management Service Standards, as presented or revised.

LOS ANGELES COUNTY
COMMISSION ON HIV

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CODE OF CONDUCT

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

All participants and stakeholders should adhere to the following:

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

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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

June 23, 2022

COMMITTEE MEMBERS P = Present | A = Absent			
Bridget Gordon, Co-Chair	P	Katja Nelson, MPP	P
Danielle M. Campbell, MPH, Co-Chair	P	Mario J. Pérez, MPH	P
Erika Davies	P	Kevin Stalter	A
Kevin Donnelly	P	Justin Valero, MA	P
Lee Kochems, MA	P	Gerald Garth	A
Luckie Alexander Fuller	A		
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, MPIA; Dawn McClendon; Catherine Lapointe, MPH; Jose Rangel-Garibay, MPH; and Sonja D. Wright, DACM			
DHSP STAFF – *No additional DHSP staff were in attendance*			

*Some participants may not have been captured electronically. Attendance can be corrected by emailing the Commission.
*Members of the public may confirm their attendance by contacting Commission staff at hivcomm@lachiv.org.
*Meeting minutes may be corrected up to one year from the date of Commission approval.

Meeting agenda and materials can be found on the Commission's website at

https://assets-us-01.kc-usercontent.com/0234f496-d2b7-00b6-17a4-b43e949b70a2/47511df8-49fe-4f7e-81e8-383d0baba17c/Pkt_Exec_062322_Final_Rev.pdf

CALL TO ORDER-INTRODUCTIONS-CONFLICTS OF INTEREST
Bridget Gordon called the meeting to order at approximately 1:07 PM, led introductions, and asked attendees to state conflicts of interest, if any.

I. ADMINISTRATIVE MATTERS

1. APPROVAL OF AGENDA

MOTION #1: *Approve the Agenda Order, as presented or revised* **(✓ Passed by Consensus)**

2. **APPROVAL OF MEETING MINUTES**

MOTION #2: *Approve the May 26, 2022 Executive Committee minutes, as presented or revised* **(✓ Passed by Consensus)**

II. PUBLIC COMMENT

3. **OPPORTUNITY FOR MEMBERS OF THE PUBLIC TO ADDRESS THE COMMISSION ON ITEMS OF INTEREST THAT ARE WITHIN THE JURISDICTION OF THE COMMISSION.** There were no public comments.

III. COMMITTEE NEW BUSINESS ITEMS

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, OR WHERE THE NEED TO TAKE ACTION AROSE SUBSEQUENT TO THE POSTING OF THE AGENDA.** There were no committee new business items.

IV. REPORTS

5. **EXECUTIVE DIRECTOR/STAFF REPORT**

   A. **Commission/County Operational Updates**

   (1) FY 2022-2023/PY 32-33 COH Operational Budget

   - Cheryl Barrit provided a breakdown of the Fiscal Year (FY) 2022-2023/Program Year 32-33 Commission on HIV (COH) Operational Budget. The document can be found in the meeting packet. C. Barrit noted that the current budget is an estimate of anticipated costs and is subject to change.
   - Al Ballesteros asked how many staff positions at the COH are available in the budget. C. Barrit responded that there are a total of seven positions. This includes five current staff members and two vacancies. A detailed description of each staff position and their function within the office was requested for the next meeting.
   - B. Gordon inquired about what happens to the money from the COH budget that is not spent once it is returned to the Division of HIV and STD Programs (DHSP). C. Barrit responded that the COH's primary source of funding is the Ryan White Program (RWP) administrative allocation of the budget, which is 10% of the RWP annual grant. The 10% administration allocation is also shared by DHSP's quality improvement and clinical quality management activities required by the Health Resources and Services Administration (HRSA). Mario J. Peréz, Director, DHSP, provided additional explanation on how the 10%

administrative allocation is used and shared that savings from the COH budget are applied to supplement additional DHSP administrative costs.

(2) Teleconference Meetings Under Assembly Bill 361 and Related Actions

- C. Barrit informed the Executive Committee that on June 14, 2022, the Board of Supervisors (BOS) voted to extend the continuation of virtual meetings for the next 30 days. Hybrid meeting options will be available for all COH meetings once in-person meetings resume.

6. CO-CHAIR'S REPORT

A. Human Relations Commission (HRC) Training Series | FOLLOW UP & NEXT STEPS

- Robert Sowell, Assistant Director, Human Relations Commission (HRC), provided a summary of the "Constructive Candid Conversations" Training Series. The summary can be found in the meeting packet.
- R. Sowell made the following suggestions the COH can take further its efforts to hold constructive candid conversations:
  - Review meeting ground rules and interaction agreements to set the tone for each meeting.
    - The Operations Committee is working on ensuring that commissioner interview questions align with the COH Code of Conduct.
  - Distribute the training series summary to new commissioners and staff members as part of onboarding materials.
  - Incorporate opportunities on meeting agendas to practice constructive candid conversation skills for topics that are non-controversial. Skills include rephrasing and repeating, reflecting emotion, and practicing empathy.
- Lee Kochems supported the suggestions made by R. Sowell and recommended extra steps to build trust among commissioners. He suggested forming small groups within the COH to work as "trust facilitators."
- B. Gordon pointed out issues of a culture that is not welcoming to differences, which leads to difficulties getting work done and suggested that commissioners state "why we are here" at the beginning of meetings to remember the purpose of goals of the COH.
- R. Sowell will work with COH staff and Executive Committee members to discuss plans to address holding constructive candid conversations. L. Kochems, B. Gordon and D. Campbell volunteered to be a part of this discussion.

B. June 9, 2022 COH Meeting | FOLLOW UP + FEEDBACK

- There was no feedback.

C. July 14, 2022 COH Meeting Planning/Agenda Development

- C. Barrit noted that the July meeting will have several motions that will require a vote.
- C. Barrit is working with Dr. Homero E. del Pino and his team to see if they are available to provide their Entré Herman@s presentation at the July COH meeting, and if not available, at the August COH meeting.
- Karl Halfman, MA, Chief, HIV Care Branch, California Office of AIDS, will give a presentation on Project Cornerstone.
- DHSP will present on the Medicaid expansion and its impact on people living with HIV (PLWH) over the age of 50, which was presented at the most Planning, Priorities & Allocations (PP&A) Committee meeting.

D. Executive Committee At-Large Member Recruitment

- B. Gordon expressed concerns with the COH bylaws, which limits two people per organization to be members on the COH. L. Kochems will discuss this issue with the Public Policy Committee to see if anyone is interested in filling the Executive Committee at-large member seat. M. Peréz emphasized the importance of participation from unaffiliated consumers.

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

A. Fiscal, Programmatic and Procurement Updates

(1) Ryan White Program (RWP) Parts A & MAI

- M. Peréz reported that the Los Angeles County Department of Health Services (DHS) has undergone a recent audit that resulted in cost allocation planning, suspending all Memorandum of Understanding (MOU)s related to Ryan White Program (RWP) funding that are currently in place.
- There is an estimated $12 million in services that DHSP supports in the DHS system; about $7 million is used for RWP HIV specialty services. The DHS suspension on MOUs will affect the allocation of these funds.
- Moreover, retroactive to March 1, 2022, DHS will no longer bill DHSP for RWP support services. These services will now be covered under Medicaid and CalAIM instead of RWP. M. Peréz expressed that this decision is a cause for concern because the data is clear that PLWH receiving care from the RWP have far better outcomes, around an 85% viral suppression rate, than those receiving care from publicly funded programs, such as Medicaid.
- The Executive Committee discussed holding a meeting with DHS leaders to discuss concerns with this change. COH staff will work with the Executive Committee to draft a letter to the Dr. Christina Ghaly, Director, DHS, to express the purpose and desired outcomes of the meeting.

8. STANDING COMMITTEE REPORTS

A. Operations Committee

(1) Membership Management

a. 2022 Membership Renewal Slate

MOTION #3: *Approve Membership Applications, as presented or revised, and forward to the July 14, 2022 Commission meeting for recommendation to Board of Supervisors, as follows: Erika Davies (Seat 2); Ricky Rosales (Seat 4); Karl Halfman (Seat 7); LaShonda Spencer (Seat 14); Anthony Mills (Seat 16); Martin Sattah (Seat 18); Kevin Donnelly (Seat 26); Felipe Gonzalez (Seat 34); Al Ballesteros (Seat 36); Katja Nelson (Seat 38); Lee Kochems (Seat 42); William King (Seat 50); Miguel Alvarez (Seat 51)* **(✓Passed by roll call vote. Ayes: J. Valero, K. Nelson, L. Kochems, K. Donnelly, E. Davies, A. Ballesteros, B. Gordon, D. Campbell; No: 0; Abstain: 0).**

b. Seat Vacate | Ernest Walker

MOTION #4: *Approve Seat Vacate for Member Ernest Walker, as presented or revised* **(✓Passed by roll call vote. Ayes: J. Valero, K. Nelson, L. Kochems, K. Donnelly, E. Davies, A. Ballesteros, B. Gordon, D. Campbell; No: 0; Abstain: 0).**

c. Member Resignations/Non-Renewals

- Damone Thomas, Reba Stevens, Isabella Rodriguez, Frankie Darling-Palacios, and Gerald Garth will not be renewing their membership with the COH.

d. Membership Application Process/Interview Questions Workgroup | UPDATES

- There were no updates.

(2) Policies and Procedures

a. Proposed Revision to Policy #09.4205

MOTION #5: *Approve revisions to Policy #09.4205, as presented or revised*

- Motion #5 was removed from the agenda because the Operations Committee has not had a chance to thoroughly discuss a proposed revision to Policy #09.4205.

b. By-Laws | REVIEW

- A more thorough report will be available at the July meeting.

c. Attendance | REVIEW

- A more thorough report will be available at the July meeting.

d. PLANNING CHATT Learning Collaborative Final Project Presentation

- A more thorough report will be available at the July meeting.

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

(1) Revised PY Ryan White Service Category Funding Allocations

MOTION #6: *Approve revised PY 32 Ryan White Service Category Funding Allocations, as presented or revised, 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 by roll call vote. Ayes: K. Nelson, L. Kochems, K. Donnelly, E. Davies, A. Ballesteros, B. Gordon, D. Campbell; No: 0; Abstain: 0).**

(2) 2022-2026 Comprehensive HIV Plan Development

- There was no update.

(3) July 2022 Data Summit Planning

- PP&A co-chairs are working with COH staff to plan for the July data summit. All are invited to participate in the planning process.

C. Standards and Best Practices (SBP) Committee

(1) Benefits Specialty Service Standards | UPDATES

- SBP did not have quorum at their June meeting and was unable to vote on the Benefits Specialty Service Standards. A vote will be held at their July meeting.

(2) Home Based Case Management Service Standards | UPDATES

- SBP did not have quorum at their June meeting and was unable to vote on the Home-Based Case Management Service Standards. A vote will be held at their July meeting.

(3) Oral Health Service Standard: Addendum | UPDATES

- At the June SBP meeting, COH staff led a discussion on the draft addendum to the Oral Health Care Service Standards. COH staff is currently reviewing the feedback and will revise the addendum as needed.

(4) Special Populations Best Practices Project | UPDATES

- SBP will review Transitional Case Management for Incarcerated/Post Release populations at their July meeting.

D. Public Policy Committee (PPC)

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

a. 2022-23 Legislative Docket

MOTION #7: *Approve the 2022-23 Legislative Docket, as presented or revised*
(✓Passed by roll call vote. Ayes: K. Nelson, L. Kochems, K. Donnelly, E. Davies, A. Ballesteros, B. Gordon, D. Campbell; No: 0; Abstain: 0).

b. 2022 Policy Priorities | UPDATE

- PPC will hold a discussion on the 2022 Policy Priorities at their July meeting. A more detailed update will be given at the July Executive Committee meeting.

c. COH Response to the STD Crisis Updates

- M. Perez gave a presentation on the STD Crisis at the most recent Health Deputy meeting. K. Nelson encouraged commissioners to attend Health Deputy meetings, if available.

9. CAUCUS, TASK FORCE, AND WORK GROUP REPORTS

A. Aging Caucus

- The next Aging Caucus meeting will be on July 5, 2022 from 1 to 3 PM.

B. Black Caucus

- The June Black Caucus meeting was cancelled due to unforeseen circumstances. Commission staff is working to schedule a future meeting date.

C. Consumer Caucus

- The next Consumer Caucus meeting will be on July 14, 2022 from 3 to 5 pm. They will be hosting a dedicated conversation on improving housing services for PLWH, led by Chuy Orozco, Housing Opportunities for Persons with AIDS (HOPWA) Program Manager.

D. Prevention Planning Workgroup

- The Prevention Planning Workgroup (PPW) is finalizing a knowledge, attitudes, and beliefs (KAB) survey to assess KAB among commissioners regarding prevention. The PPW also updated their meeting time to 4 to 5:30 pm.

E. Transgender Caucus

- On May 24, 2022, the Transgender Caucus held a sexual health education workshop titled "The Power in Pleasure: Inclusive Sexual Education Through a Youth Lens." They will discuss feedback on the workshop and plan for their next event at their meeting on June 28, 2022.

F. Women's Caucus

- The Women's Caucus June meeting was cancelled due to the Juneteenth holiday. The group is planning for a virtual Lunch and Learn event centered on women living with HIV and sexual empowerment for their July meeting.

V. NEXT STEPS

10. RECAP

A. Task/Assignments Recap

- The Executive Committee and COH staff will work on a letter to DHS to request a meeting to discuss the recent change in RWP services coverage.
- All motions that were approved at the June Executive Committee meeting will move forward for a vote at the July full body COH meeting.
- A small group will be meeting with R. Sowell to discuss concrete, actionable, and meaningful steps the COH can take to sustain work around constructive and candid conversation.

B. Agenda Development for the Next Meeting

- C. Barrit will provide a more detailed listing of COH staff responsibilities as they pertain to the COH operational budget.

VI. ANNOUNCEMENTS

11. OPPORTUNITY FOR MEMBERS OF THE PUBLIC AND THE COMMITTEE TO MAKE ANNOUNCEMENTS

- K. Donnelly announced that Paulina Zamudio, DHSP was presented with an award at the Coping with Hope seminar for her service within the HIV workforce.

VII. ADJOURNMENT

12. ADJOURNMENT OF THE JUNE 23, 2022 EXECUTIVE COMMITTEE MEETING. The meeting adjourned at approximately 3:30 pm.

Commission on HIV Program Year 32 Position Listing

Staff Name	Title	FTE	Tasks Summary
Cheryl Barrit	Executive Director	1	Provides administrative and technical support to the Commission including directing, planning, and coordinating all Commission directives, programs, projects, services and activities. Provides administrative and technical support to the Los Angeles County Commission on HIV including directing, planning, and coordinating all Commission directives, programs, projects, budget, and services and activities. Develop reports and ensure grant deliverables are met; serve as liaison to Executive Office and other partner agencies.
Dawn Mc Clendon	Assistant Director	1	Assist the Executive Director in the day to day administrative, fiscal, and technical operations of the Commission. Leads special projects, Committees and subgroups as assigned. Represents the Executive Director at meetings with stakeholders as needed.
Yeghishe Nazinyan	Research Analyst III	1	Epidemiologist assist in the planning, designing, implementing, evaluating, and managing of health-related surveillance systems, studies and field investigations; and provides consultation to the Commission and on epidemiologic research methodology and design.
Jose Rangel-Garibay	Health Program Analyst I	1	Conducts studies, analyses, and researches on a variety of complex, difficult, and sensitive program areas for the committees within the Commission and makes recommendations for solutions; provides professional and technical guidance to committee members. Lead technical staff for Standards and Best Practices Committee and Public Policy Committee.
Sonja Wright	Senior Board Specialist	1	Coordinates planning council membership applications, renewals, tracks member attendance, provides technical and administrative support to Operations Committee. Supports subgroups as needed.
Catherine Lapointe	Temporary Worker	1	Prepares minutes for committees, subgroups and the general Commission meeting. Coordinates various administrative tasks and projects, including but not limited to social media activities and content management. Provides programmatic support to lead staff, consultants, and special projects.
To be hired	Health Program Analyst I	1	Conducts studies, analyses, and researches on a variety of complex, difficult, and sensitive program areas for the committees within the Commission and makes recommendations for solutions; provides professional and technical guidance to committee members. Slated to be the lead technical staff for Planning, Priorities and Allocations Committee and associated subgroups.
To be Hired	Administrative Analyst II	1	Prepares minutes for committees, subgroups and the general Commission meeting. Coordinates various administrative tasks and projects, including but not limited to social media activities and content management. Provides programmatic support to lead staff, consultants, and special projects.

Join the

74th PACHA Meeting in Los Angeles, CA

Monday, September 19
4:00 P.M. – 10:00 P.M. EST

Tuesday, September 20, 2022
3:30 P.M. – 8:00 P.M. EST

WWW.HHS.GOV/LIVE

#PACHA

LOS ANGELES COUNTY
COMMISSION ON HIV

DUTY STATEMENT

COMMISSION CO-CHAIR

(APPROVED 3-28-17; REVISIONS 3-19-18)

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

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

ORGANIZATIONAL LEADERSHIP:

① Serve as Co-Chair of the **Executive Committee**, and lead those monthly meetings.
② Serve as ex-officio member of all standing Committees:
   - attending at least one of each standing Committee meetings annually or in Committee Co-Chair's absence
③ Meet monthly with the Executive Director, or his/her designee, to prepare the Commission and Executive Committee meeting agendas and course of action,
   - assist Commission staff in the preparation of motions, backup materials and information for meetings, as necessary and appropriate.
④ Lead Executive Committee in decision-making on behalf of Commission, when necessary.
⑤ Act as final Commission-level arbiter of grievances and complaints

MEETING MANAGEMENT:

① Serve as the Presiding Officer at the Commission, Executive Committee and Annual meetings.
② In consultation with the other Co-Chair, the Parliamentarian, the Executive Director, or the senior staff member, lead all Commission, Executive and special meetings, which entail:
   - conducting meeting business in accordance with Commission actions/interests;
   - maintaining an ongoing speakers list;
   - recognizing speakers, stakeholders and the public for comment at the appropriate times;
   - controlling decorum during discussion and debate and at all times in the meeting;
   - imposing meeting rules, requirements and limitations;
   - calling meetings to order, for recesses and adjournment in a timely fashion and according to schedule, or extending meetings as needed;
   - determining consensus, objections, votes, and announcing roll call vote results;
   - ensuring fluid and smooth meeting logistics and progress;
   - finding resolution when other alternatives are not apparent;
   - apply Brown Act, conflict of interest, Ryan White Program (RWP) legislative and other laws, policies, procedures, as required;

- ruling on issues requiring settlement and/or conclusion.

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

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

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

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

MONKEYPOX

Frequently Asked Questions

1. What is monkeypox?

Monkeypox is a contagious disease caused by the monkeypox virus. It was discovered in 1958 when two outbreaks of a pox-like disease arose in colonies of monkeys kept for research. The first human case of monkeypox was recorded in 1970. It was rarely seen in the United States or many other countries until May 2022.

There are 2 types of monkeypox virus. The type that is currently in the US is less severe. The most common symptom is a rash, which may or may not be associated with flu-like symptoms Most people do not need hospital care and recover in 2-4 weeks. Vaccines and antiviral treatment are available for monkeypox.

2. What are the signs and symptoms of monkeypox?

Monkeypox symptoms usually start within 3 weeks of exposure to the virus.

The most common symptom is a rash that may:

- Look like bumps, pimples, blisters, or scabs. It will go through several stages before healing. Generally, the rash starts as red, flat spots, and then becomes bumps. Those bumps can then become filled with fluid which turns to pus. The bumps then crust into a scab.
- Be on or near the genitals (penis, testicles, labia, and vagina), anus (butthole), mouth, or other areas like the hands, feet, chest, and face.
- Spread over the body or it may be limited to one area. There may be just a few bumps or blisters.
- Be painful and/or itchy. Some people have severe pain, especially if the rash is inside their mouth or anus.

People may also develop flu-like symptoms in addition to the rash. These can appear 1-4 days before the rash starts or after the rash starts. They include fever/chills, swollen lymph nodes, exhaustion, muscle aches, and headache.

Most people with monkeypox recover in 2-4 weeks.

3. How does monkeypox spread?

Monkeypox is known to spread by close intimate and/or prolonged contact with someone with monkeypox. These include:

- Direct skin-to-skin contact with monkeypox rash, scabs, or sores during sex and other intimate contact. This can include kissing, massaging, and cuddling.
- Contact with respiratory secretions. This can happen during prolonged, close, face-to-face contact or intimate physical contact, such as kissing, cuddling, and sex with a person with monkeypox.
- Contact with objects and fabrics (such as unwashed clothing and bedding, sharing towels) that have been used by someone with monkeypox and haven't been cleaned.

A person with monkeypox can spread it to others from the time symptoms start until the rash has healed, scabs have fallen off, and there is a new layer of skin. This usually takes 2 to 4 weeks.

A pregnant person with monkeypox can spread the virus to their fetus through the placenta.

Monkeypox is much less contagious than COVID-19. It is NOT spread through casual conversations or by walking by someone who has it.

Scientists are still researching more about how monkeypox is spread, including:

- If the virus can be spread when someone does not have symptoms,
- How often it spreads through respiratory secretions, and
- Any other types of interactions or behaviors that may put people at higher risk.

See ph.lacounty.gov/monkeypox for more details and the latest information.

4. Who is at risk for monkeypox?

In this current outbreak in the U.S., the vast majority of people diagnosed with monkeypox are men who reported having sexual or close intimate contact with other men. But it is important to remember that anyone, regardless of their sexual orientation or gender identity, who has been in close, personal contact with someone who has monkeypox is at risk.

As this is a new outbreak, public health organizations nationally and internationally are still learning about the situations or behaviors that may put people at increased risk. We will continue to share information as we learn more.

5. How is monkeypox treated?

Many people with monkeypox have a mild illness and recover without any antiviral treatment. This usually takes 2 to 4 weeks. There are no FDA approved medicines to specifically treat monkeypox. But an FDA approved antiviral medicine used to treat smallpox called tecovirimat (or TPOXX) can be used to treat people with monkeypox. TPOXX can be given to people with severe monkeypox, including lesions in sensitive areas or pain that is not controlled with over-the-counter remedies. It can also be given to people who are more likely to get severely ill (see question below).

Your doctor can also prescribe non-monkeypox medicines that can help reduce pain and irritation from the rash or sores.

6. What is severe monkeypox?

Most people with monkeypox have a mild illness, but for some people monkeypox can be serious. Signs of severe monkeypox can include:

- Rash or sores on or near the eyes
- Rash that spreads all over the body or blend together
- Pain in the rectum (butt) that makes it hard to go to the bathroom
- Pain in the mouth that makes it hard to eat and drink
- Symptoms that get worse or do not improve over time

Seek medical help right away if you get any of these symptoms or are concerned that you might be getting severe monkeypox.

7. Who might be at higher risk for getting very sick?

Based on what we know from previous monkeypox outbreaks, the following groups are at higher risk for getting severe monkeypox, if infected. We don't yet know the extent of their risk during the current outbreak.

- Children under age 8
- People who are pregnant or breastfeeding
- People who are immunosuppressed (have a weak immune system because of a disease, infection, or treatment)
- People with a history of eczema and other skin conditions

During this outbreak, most people with monkeypox have been adults and have NOT required hospitalization.

8. What should I do if I think I have monkeypox?

Contact your doctor right away if you have a new, unexplained, rash or lesions on any part of your body. This is especially important if you were exposed to someone with monkeypox or suspected to have monkeypox. Cover all parts of the rash with clothing, gloves, and/or bandages and take steps to protect others. These include avoiding skin to skin contact and being physically intimate with others until you have been checked out by a doctor. Be sure to wear a mask when you see a doctor.

Call the Public Health Call Center at 1-833-540-0473 (open daily 8:00 am to 8:30 pm) if you don't have a doctor or health insurance. If you have a rash, you can also access services at Public Health's Sexual Health Clinics (see schedule here).

Until you know you don't have monkeypox, take steps to reduce the risk of spreading the infection by staying away from others. See Isolation Instructions for People with Monkeypox.

9. How do you test for monkeypox?

If you have a rash that might be due to monkeypox, your doctor will evaluate you. Based on their assessment, they may swab your rash for testing. The swabs are sent to a lab, and the test result should be available in a few days. There are no self-tests or home tests for monkeypox at this time.

Until you know you don't have monkeypox, it is important to follow monkeypox isolation instructions.

10. What should I do if I am diagnosed with monkeypox?

If you have been diagnosed with monkeypox, you should isolate to protect others. Follow the Isolation Instructions for People with Monkeypox which are available in several languages at ph.lacounty.gov/monkeypox.

Contact your sex partners and any people you had very close, intimate and/or prolonged contact with since your symptoms started. Do this as soon as possible so they can get vaccinated (if eligible) and can look out for any symptoms of monkeypox.

Please answer calls from Public Health. They will be in touch to ask you about your activities before and after you developed symptoms. This can help to determine how you may have been exposed to monkeypox. It can also help identify any close contacts who may be eligible for post-exposure vaccination to prevent or limit any potential illness.

11. How can monkeypox be prevented?

There are a number of ways to prevent the spread of monkeypox:

- Avoid very close and/or prolonged contact with someone with monkeypox symptoms, especially:
  - Oral, anal, and vaginal sex, or touching the genitals or anus
  - Hugging, cuddling, massaging, kissing
  - Skin-to-skin contact with the rash on their body
  - Sharing towels, clothing, bedding, blankets, or other objects and materials (e.g., toothbrushes, cups, utensils, and sex toys) that have not been cleaned.
  - Talking very closely face to face for a long time (about 3 hours or more).
- Wash your hands often with soap and water or use an alcohol-based hand sanitizer. This is especially important before eating and after you use the bathroom. Avoid touching your face with unwashed hands.
- Wear appropriate protective equipment (mask, gloves, and gown) if you cannot avoid close contact with someone who has monkeypox symptoms.

12. What are other ways to lower the risk of getting monkeypox?

Here are some things that people can do to lower their risk of monkeypox:

- Get vaccinated if eligible.
- Talk to sexual partner(s) about any recent illness and new or unexplained sores or rashes including on the genitals or anus. Avoid sex or skin-to skin contact if either partner has signs of monkeypox or have been diagnosed with monkeypox.
- Don’t share unwashed utensils or cups, towels, bedding, or clothing.
- Cover exposed skin in crowds.
- Use a condom. Condoms alone are likely not enough to prevent monkeypox. But they might reduce the risk, and may help prevent sores in sensitive areas, like the anus, mouth, or genitals.
- Reduce the number of sex partners
- Avoid riskier activities such as anonymous sex and sex parties.
- Avoid going to places where people wear minimal clothing and where there is direct, intimate, skin-to-skin contact such as raves, parties, or clubs. If you do attend these settings or events, cover exposed skin to limit skin-to-skin contact when possible. Events where people are fully clothed and unlikely to have prolonged skin-to-skin contact are safer. But remember that activities like kissing may also spread monkeypox.

For more information see the CDC webpage, Safer Sex, Social Gatherings and Monkeypox.

13. Is there a vaccine for monkeypox?

Yes. A vaccine called JYNNEOS is FDA approved to prevent monkeypox in people ages 18 and over. It is also available under FDA emergency use authorization (EUA) for people under age 18. It is a two-dose vaccine. It takes 14 days after getting the second dose of JYNNEOS to get the best immune response to the vaccine. But even getting one dose can provide some protection. It is important to note, neither one nor two doses of vaccine are 100% effective at preventing infection. It is still important to continue to take other steps to reduce your risk.

If the vaccine is given before a person is exposed to monkeypox, it helps to protect them from getting monkeypox. If it is given after exposure, it may help to prevent the disease or make it less severe. It should be given within 14 days of exposure (ideally in the first 4 days).

If someone already has monkeypox the vaccine is not recommended.

14. How can I get vaccinated?

Vaccine supply is currently limited. The public health priority is to vaccinate as many people who are at higher risk for monkeypox as possible. See the Los Angeles County Monkeypox Vaccine Availability-Eligibility Criteria to see who is currently eligible to get the vaccine in LA County.

Public Health is also doing contact tracing with everyone who has monkeypox. If you are identified as having high- or intermediate-risk contact with someone with monkeypox Public Health will contact you directly to offer the monkeypox vaccine. Public health will also contact you if you were identified as being present at an event/venue where there was a high risk of exposure through skin-to-skin or sexual contact to individual(s) with monkeypox.

15. What should I do if I am exposed to monkeypox?

Track your health. People who develop monkeypox usually get symptoms 7-14 days (and up to 21 days) after being exposed. You can continue your routine daily activities as long as you do not develop symptoms. Be prepared to isolate yourself from others if you develop monkeypox symptoms.

Get vaccinated if Public Health contacts you to offer vaccine or if you are eligible for vaccination. Getting the monkeypox vaccine within 4 days to 14 days after exposure can help prevent you from becoming infected or, if you become infected, it may make your infection less severe.
Because the vaccine supply remains limited, it is being prioritized for people who have a known high-or intermediate-risk exposure to someone with monkeypox or who are at higher risk of exposure. Please answer calls from Public Health.

Follow Guidance for Individuals Who Have Been Exposed to Monkeypox for more information.

16. What kind of cleaning products work against monkeypox?

The U.S. Environmental Protection Agency (EPA) has a list of disinfectant products that are registered for use against the monkeypox virus. The list includes popular products that many businesses and individuals already use. It can be found on the EPA website. The website has a search tool where you can look up disinfectants by different factors such as product name, contact time, and surface type.

- Check that the product is EPA-registered
- Read the manufacturer's directions. Make sure this is the right product for your surface.
- Clean the surface with soap and water if the directions mention pre-cleaning before applying disinfectant or if the surface is visibly dirty. Dirt can keep the disinfectant from working.
- Follow the contact time instructions. The surface should remain wet for the amount of time stated in the instructions to be effective. Reapply if needed.

Regular laundry detergents can be used for cleaning clothes or linens (e.g., bedding and towels) used by someone with monkeypox.

Soiled dishes and eating utensils can be washed in a dishwasher with detergent and hot water or by hand with hot water and dish soap.

See CDC Guidance for Disinfection of the Home and Non-Healthcare Setting for more information and tips about cleaning during and after monkeypox.

17. Can kids get monkeypox?

Yes. Anyone can get monkeypox but the risk of children getting infected during this outbreak is currently very low.

Children are at higher risk of getting monkeypox if they live with someone who has monkeypox, especially if they share a bed or other items with the infected person. If you have monkeypox or suspected monkeypox, take steps to protect everyone in your home. See Isolation Instructions for People with Monkeypox.

Adolescents who are physically intimate/sexually active with others or in situations like parties where they might have skin-to-skin contact are also at higher risk of getting monkeypox. This is especially true if they are in doing these activities with groups where monkeypox is spreading. For more information see the CDC webpage, Safer Sex, Social Gatherings and Monkeypox.

18. How can I protect myself when traveling?

At this time, monkeypox is considered a low threat to the general public. It is much less contagious than COVID-19.

In addition to the prevention steps above, it is recommended that travelers avoid close contact with sick people. If you are traveling on a plane, avoid prolonged skin-to-skin contact. For example, while sharing an armrest. If you are staying in a hotel room or vacation rental, make sure that it was cleaned after the previous people left.

You should also avoid contact with dead or live wild mammals.

If you are traveling to Central and West Africa, avoid contact with animals that can spread monkeypox virus, usually rodents and primates. Also, avoid sick or dead animals, as well as bedding or other materials they have touched. This is because it is possible for people to get monkeypox from infected animals, either by being scratched or bitten by the animal or by preparing or eating meat or using products from an infected animal.

19. Where can I go for more information?

Los Angeles County, Department of Public Health
ph.lacounty.gov/monkeypox

Centers for Disease Control and Prevention
cdc.gov/poxvirus/monkeypox/index.html

California Department of Public Health
cdph.ca.gov/Programs/CID/DCDC/Pages/Monkeypox.aspx

WHAT GAY & BISEXUAL MEN NEED TO KNOW ABOUT MONKEYPOX

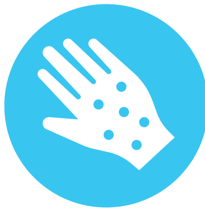
Cases have been detected among gay and bisexual men but **not exclusively**

WHAT IS MONKEYPOX?

Monkeypox is a viral infection transmitted through close personal contact, including kissing, sex, and other skin-to-skin contact. Fatality during the current outbreak is estimated to be very low.

WHAT ARE THE SYMPTOMS?

KEY SYMPTOM



RASH, BUMPS, OR BLISTERS

These may appear anywhere on the body, including the genitals. This may look similar to syphilis, herpes, or other common skin rashes.

OTHER SYMPTOMS

FEVER & HEADACHES

MUSCLE ACHES

SWOLLEN LYMPH NODES

Symptom onset ranges from 5-21 days

WHAT YOU CAN DO

STAY INFORMED

Remain calm. This is a rapidly changing situation. Visit the CDC website for up-to-date guidance.

CONTACT

If you have symptoms, call (do not visit) your health care provider, and ask about testing.

ISOLATE

If you have symptoms, stay at home, wear a mask, and cover lesions to protect others.

Updated: June 2022

ANYONE CAN GET MONKEYPOX

Blaming gay, bisexual, and other men who have sex with men may harm public health efforts and cause providers to miss monkeypox in other communities.

Get the latest updates & downloadable files from
Gay Sexuality & Social Policy Initiative @ UCLA Luskin
gaysexresearch.com

GSSP | gaysexresearch.com

LOS ANGELES LGBT CENTER®

LO QUE LOS HOMBRES GAY Y BISEXUALES NECESITAN SABER SOBRE LA VIRUELA DEL MONO

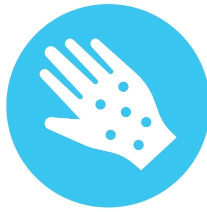
Se han detectado casos entre hombres gay y bisexuales, pero **no exclusivamente.**

¿QUÉ ES LA VIRUELA DEL MONO?

La viruela del mono es una infección viral transmitida a través del contacto personal cercano, que incluyen besos, sexo y otro contacto de piel a piel. Se estima que la mortalidad durante el brote actual es muy baja.

¿CUÁLES SON LOS SÍNTOMAS?

SÍNTOMAS PRINCIPALES



ERUPCIONES, ABULTAMIENTOS O AMPOLLAS

Pueden aparecer en cualquier parte del cuerpo, incluyendo los genitales. Esto puede parecer similar a sífilis, herpes u otras erupciones cutáneas comunes.

OTROS SÍNTOMAS

FIEBRE Y DOLORES DE CABEZA

DOLORES MUSCULARES

GANGLIOS LINFÁTICOS INFLAMADOS

El inicio de los síntomas oscila entre 5-21 días

LO QUE PUEDE HACER

MANTÉNGASE INFORMADO

Mantenga la calma. Esta es una situación que cambia rápidamente. Visite el sitio web de los CDC para obtener orientación actualizada.

CONTACTE

Si tiene síntomas, llame (no visite) a su proveedor de atención médica y pregunte acerca de las pruebas.

AÍSLE

Si tiene síntomas, quédese en casa, use una máscara y cubra las lesiones para proteger a los demás.

Actualizada: junio 2022

CUALQUIER PERSONA PUEDE CONTRAER LA VIRUELA DEL MONO

Al culpar los hombres gay, bisexuales y otros hombres que tienen sexo con hombres puede dañar los esfuerzos de salud pública y causar que los proveedores de atención médica no detecten la viruela del mono en otras comunidades.

Obtenga las últimas actualizaciones y archivos descargables de
Gay Sexuality & Social Policy Initiative @ UCLA Luskin
gaysexresearch.com

GSSPI | gaysexresearch.com

LOS ANGELES LGBT CENTER®

REVISED DRAFT (Version 4; 07.13.22)

LOS ANGELES COUNTY COMMISSION ON HIV
PREVENTION PLANNING WORKGROUP
PREVENTION PLANNING KNOWLEDGE, ATTITUDES, AND BELIEFS SURVEY

Purpose:
To create a baseline for an annual assessment of the knowledge, attitudes, and beliefs (KABs) of members of the Los Angeles Commission on HIV to increase the capacity of members to engage in prevention-focused planning activities.

Audience: Commission members, including committee members only. Secondary focus on anyone in attendance at a Commission meeting within the past 6 months.

Timeline: 3 months. Develop the survey during the months of May and June. Administer survey in July with recommendations developed in August/September.

A. DEMOGRAPHIC INFORMATION

A1. Age
- 13-19
- 20-29
- 30-39
- 20-29
- 30-39
- 40-49
- 50-59
- 60+

A2. Race/Ethnicity *****Please select all that apply*****
- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latinx
- Multi-Race
- Native Hawaiian or Other Pacific Islander
- White or Caucasian
- Other

A3. Gender Identification
- Non-Binary/Gender Non-Conforming
- Transgender: Female to Male
- Transgender: Male to Female
- Female

- o Male
- o If your gender identity is not listed above, please use this space to share how you self-identify:

A4. How long have you served as a Commissioner and/or Alternate on the Los Angeles County Commission on HIV?

- o Less than 1 year
- o Between 1-2 years
- o Between 3-4 years
- o 5 years or more

A5. What is the highest level of education you have completed?

- o High school graduate, diploma or the equivalent (for example: GED)
- o Some college credit, no degree
- o Trade/technical/vocational training
- o Associate degree
- o Bachelor's degree
- o Master's degree
- o Doctorate degree

B. KNOWLEDGE

B1. What do you think are elements of prevention? What are examples of interventions that prevent HIV?

B2. What are the top three barriers to HIV prevention in Los Angeles County?

B3. What is Pre-Exposure Prophylaxis (PrEP)?

- o A pill that individuals can take daily before HIV exposure to prevent HIV acquisition
- o A pill that individuals can take daily after HIV exposure to prevent HIV acquisition
- o An experimental drug that might prevent HIV, research is still being done
- o I don't know.

B4. To your knowledge, how effective is PrEP at preventing HIV transmission when having sex without a condom?

- o Not at all effective
- o Minimally effective
- o Somewhat effective
- o Very/completely effective
- o I don't know

B5. PrEP is currently offered via which route of administration?

- o One (1) oral tablet

- Two (2) oral tablets
- Three (3) oral tablets
- Long-acting injectables

B6. What is the current recommended dose for PrEP to effectively prevent HIV infection?

- Every 12 hours (twice per day)
- Once per day
- Every other day
- Once per week
- Once per month
- Once per six months

B7. Which of the following drugs are current FDA-approved administrations of PrEP? **Select all that apply.**

- Apretude
- Atripla
- Biktarvy
- Descovy
- Triumeq
- Truvada
- I don't know.

B8. What is Post-Exposure Prophylaxis (PEP)?

- A pill that individuals can take daily before HIV exposure to prevent HIV acquisition
- A pill that individuals can take daily after HIV exposure to prevent HIV acquisition
- An experimental drug that might prevent HIV, research is still being done
- I don't know.

B9. HIV treatment (antiretroviral medication) works to:

- Increase HIV viral load and decrease CD4 cells
- Decrease HIV viral load and decrease CD4 cells
- Decrease HIV viral load and increase CD4 cells
- Increase HIV viral load and increase CD4 cells

B10. Bacterial sexually transmitted infections (STIs) (Chlamydia, Gonorrhea, and Syphilis) are curable.

- Yes
- No
- I don't know

B11. A person must start PEP within ______ after a potential HIV exposure.

- 120 hours

- 24 hours
- 48 hours
- 72 hours

B12. What activities can put you at risk for STIs? Check all that apply.
- Having anal, vaginal, or oral sex without a condom
- Having sex with multiple partners, especially anonymous partners
- Having sex while using drugs or alcohol

B13. What STIs can likely lead to HIV? Check all that apply.
- Chlamydia
- Genital herpes
- Gonorrhea
- Human Papillomavirus (HPV)
- Syphilis
- Trichomoniasis

B14. What are 5 ways that STIs can be transmitted?
- Vaginal sex
- Anal sex
- Oral sex
- Skin contact
- Sharing personal items, such as toothbrushes or razors, with someone who has an STI

B15. How can STIs be prevented?
- Practice abstinence
- Use condoms
- Have fewer partners
- Get vaccinated
- Talk with your partner
- Get tested

C. ATTITUDES:

C1. Treatment as prevention means: (Check all that apply).
- Knowing your HIV status
- Being in care if HIV positive
- Being in care if HIV positive and viral load is undetectable

C2. What does serostatus neutral mean?
- knowing your HIV status

- prevention services or interventions targeting persons regardless of HIV status.
- not knowing your HIV status

C3. What are the most important tenets of HIV community planning to you? Please list two.

C4. How comfortable are you with utilizing health districts as the geographic lens for planning efforts? (1 = very uncomfortable, 2 = uncomfortable, 3 = neutral, 4 = comfortable, and 5 = very comfortable).

C5. If you answered 1-3, would you want to have an in-service on the utilization of health districts for planning purposes? (Y/N)

C6. How confident are you in understanding prevention-related data? (1 = Not confident at all, 3 = somewhat confident, 5 = very confident).

C7. If you answered 1-3, would you want to have an in-service on the utilization of prevention-related data for planning purposes? (Y/N)

C8. Which is not part of a sex-positive approach to working with individuals
- Discussing human anatomy
- Using non-judgmental language
- Urging them to be sexually active with other people
- Supporting them in choosing their identity

D. BELIEFS

D1. Please rank the following interventions based on what you think are the most important ways to prevent HIV.
- Barriers (e.g. external condoms)
- Abstinence
- Biomedical approaches (e.g., Post-exposure prophylaxis (PEP) and Pre-exposure prophylaxis (PrEP)
- Structural interventions (e.g., effecting policy or legal changes; enabling environmental changes; shifting harmful social norms; catalyzing social and political change; and empowering communities and groups)
- HIV screening
- Mental health
- Substance use prevention and treatment
- Harm reduction and syringe exchange
- Health education (e.g., individual and group level interventions)
- Navigation and linkage

D2. Please indicate how much you agree or disagree with the following statements. (Strongly disagree; Somewhat disagree; Neither agree nor disagree; Somewhat agree; Strongly agree)

a. Pre-exposure prophylaxis (PrEP) could be effective at reducing new HIV infections in Los Angeles County.
b. Treatment as Prevention (TasP)/Undetectable = Untransmittable (U=U) could reduce new HIV infections in Los Angeles County.
c. Suppressing HIV viral loads to undetectable levels with antiretroviral treatment reduces the risk of transmitting HIV to others.
d. If an agency has the capacity and infrastructure, PrEP and TasP are tools that can drastically reduce new HIV infection rates and community viral loads in my community.
e. I believe the use of PrEP could obstruct existing HIV prevention efforts in any of the following ways: providing a false sense of security, lead to reduced condom use, or lead to other high-risk behaviors.
f. I have the proper knowledge and training to advocate for my community to use PrEP
g. I have the proper knowledge and training to advocate for my community to use TasP to prevent new HIV infections.
h. There are sufficient programs to address access to PrEP in Los Angeles County.
i. I have the proper knowledge and training to advocate for my community to use long-acting Injectables to prevent new HIV infections.
j. I believe that we have the proper knowledge and training to incorporate long-acting antiretrovirals in Los Angeles County.
k. I believe that PLWH who take medication and are virally suppressed (undetectable) cannot transmit HIV.
l. I believe it is an important part of the role of an HIV tester to link people who receive an HIV-negative test result who are at risk for HIV exposure to PrEP and primary care at every test encounter.
m. I believe that most HIV treatment regimens are highly toxic drugs with many side effects.
n. I would trust condoms to protect me against HIV and STIs.
o. I believe it is an important part of the role of an HIV tester to link individuals to HIV treatment if they receive a positive test result.
p. I believe immediate linkage to HIV care and treatment for people who test HIV-positive is important.
q. I believe PrEP causes people to make riskier choices around their sexual practices.
r. I would recommend PrEP to a friend or family member who is at risk for continued HIV exposure.
s. I see HIV testers as a critical part of ending the HIV epidemic.
t. I believe insurance is a barrier to accessing PrEP services, medical visits, labs, and medication.
u. I believe Partner Services is key service to help end the HIV epidemic.
v. I believe outreach to priority populations is key for successful HIV testing programs.

w. I believe PrEP is safe and highly effective.

E. Training Needs

E1. What areas of HIV and STI prevention would you like to learn or gain more knowledge?

E2. What is your preferred way of learning? In what ways would you like to learn? (e.g., reading materials, self-study, workshops, lectures)

E3. Do you have any comments you would like to share?

LOS ANGELES COUNTY
COMMISSION ON HIV

HOME-BASED CASE MANAGEMENT SERVICES SERVICE STANDARDS

SBP COMMITTEE APPROVED 7/5/22

FOR EXECUTIVE COMMITTEE APPROVAL 7/28/22

HOME-BASED CASE MANAGEMENT SERVICES
SERVICE STANDARDS

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

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

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

Service Standards: Ryan White HIV/AIDS Programs

INTRODUCTION

Service standards for the Ryan White HIV/AIDS Part A Program outline the elements and expectations a service provider should follow when implementing a specific service category. The standards are written for providers for guidance on what services may be offered when developing their Ryan White Part A programs. The standards set the minimum level of care Ryan White funded agencies offer to clients, however, providers are encouraged to exceed these standards.

The Los Angeles County Commission on HIV developed the Home-Based Case Management Services standards to establish the minimum standards of care necessary to ensure people living with HIV (PLWH) can receive quality Home-Based Case Management services when attending core medical and/or support services appointments and meetings. The development of the standards includes guidance from service providers, people living with HIV, the Los Angeles County Department of Public Health, Division of HIV and STD Program (DHSP), members of the Los Angeles County Commission on HIV, Standards & Best Practices Committee, Women's Caucus, and the public-at-large.

SERVICE INTRODUCTION

Home-based case management services are client-centered case management and social work activities that focus on care for people living with HIV who are functionally impaired and require intensive home and/or community-based care. Services are conducted by qualified Registered Nurse (RN) case managers and master's [1]degree-level social workers who facilitate optimal health outcomes for functionally impaired people living with HIV through advocacy, liaison, and collaboration.

Home-based case management services may include:

- Assessment
- Service planning
- Attendant care
- Homemaker services
- Medical case management
- Care coordination
- Psychosocial case management
- Mental health therapy

The goals of home-based case management for functionally impaired people living with HIV include:

- Assessing and facilitating in-home services
- Helping clients locate needed health care and supportive services
- Helping service providers coordinate care for clients
- Helping clients understand and manage their medical diagnoses, including comorbidities and other health-related diagnoses that impact HIV care treatment
- Educating clients on reducing risks for HIV infection
- Helping patients adhere to medical regimens and drug therapies
- Helping clients transition appropriately to self-management and care
- Providing appropriate, quality, cost-effective care

All service providers receiving funds to provide Home-based Case Management services are required to adhere to the standards outline in Table 2.

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[1] *Social workers providing home-based case management services will hold an MSW (or related degree) or BA in social work with 1-2 years of experience and practice according to State and Federal guidelines and the Social Work Code of ethics.*

Table 2. HOME-BASED CASE MANAGEMENT SERVICE REQUIREMENTS

SERVICE COMPONENT	STANDARD	DOCUMENTATION
OUTREACH	Home-based case management programs will outreach to potential patients and providers.	Outreach plan on file at provider agency.
INTAKE	Intake process will begin during first contact with client.	Intake tool, completed and in client file, to include (at minimum): • Documentation of HIV status • Proof of LA County residency • Verification of financial eligibility • Date of intake • Client name, home address, mailing address and telephone number • Emergency and/or next of kin contact name, home address and telephone number
	Confidentiality Policy and Release of Information will be discussed and completed.	Release of Information signed and date by client on file and updated annually.
	Consent for Services will be completed.	Signed and dated Consent in client file.
	Client will be informed of Rights and Responsibility and Grievance Procedures.	Signed and dated forms in client file.
ASSESSMENT	Assessments will be completed within 30 days following intake. Updates to the assessment will be done on a continuous basis, but no less than once every 90 days.	Assessment or update on file in client record to include: • Date • Signature and title of staff person • Client's educational needs related to treatment • Assessment of psychological adjustment and coping • Consultation (or documented attempts) with health care and

		related social service providers • Assessment of need for home-health care services • *Assessment of need for housing stability* A client's primary support person should also be assessed for ability to serve as client's primary caretaker.
SERVICE PLAN	Home-based case management service plans will be developed in conjunction with the patient.	Home-based case management service plan on file in client record to include: • Name of client, RN case manager and social worker • Date/signature of RN case manager and/or social worker • Documentation that plan has been discussed with client • Client goals, outcomes, and dates of goal establishment • Steps to be taken to accomplish goals • Timeframe for goals • Number and type of client contacts • Recommendations on how to implement plan • Contingencies for anticipated problems or complications
IMPLEMENTATION AND EVALUATION OF SERVICE PLAN	RN case managers and social workers will: • Provide referrals, advocacy and interventions based on the intake, assessment, and case management plan • *Provide referrals for housing assistance to clients that may need*	Signed, dated progress notes on file to detail (at minimum): • Description of client contacts and actions taken • Date and type of contact • Description of what occurred

	them based on housing stability assessment conducted on intake • Monitor changes in the client's condition • Update/revise the case management plan • Provide interventions and linked referrals • Ensure coordination of care • Conduct monitoring and follow-up • Advocate on behalf of clients • Empower clients to use independent living strategies • Help clients resolve barriers • Follow up on plan goals • Maintain ongoing contact based on need • Be involved during hospitalization or follow-up after discharge from the hospital • Follow up on missed appointments by the end of the next business day • Ensuring that State guidelines regarding ongoing eligibility are followed	• Changes in the client's condition or circumstances • Progress made toward plan goals • Barriers to plan and actions taken to resolve them • Linked referrals and interventions and current status/results of same • Barriers to referrals and interventions/actions taken • Time spent • RN case manager's or social worker's signature and title
ATTENDANT CARE	Attendant care will be provided under supervision of a licensed nurse, as necessary.	Record of attendant care on file in client chart.
	When possible, programs will subcontract with at least Home Care Organizations (HCO) or Home Health Agencies (HHA).	Contracts on file at provider agency.
HOMEMAKER SERVICES	Homemaker services will be provided under the supervision of a licensed nurse, as necessary.	Record of homemaker services on file in client record.

	Homemaker services will be monitored at least once every 6 months.	Record of monitoring on file in the client record.
	When possible, programs will subcontract with at least HCOs or HHAs.	Contracts on file at provider agency.
HIV PREVENTION, EDUCATION AND COUNSELING	RN case manager and social worker will provide prevention and risk management education and counseling to all clients, partners, and social affiliates.	Record of services on file in client medical record.
	RN case managers and social workers will: • Screen for risk behaviors • Communicate prevention messages • Discuss sexual practices and drug use • Reinforce safer behavior • Refer for substance abuse treatment • Facilitate partner notification, counseling, and testing • Identify and treat sexually transmitted *diseases including Hepatitis C* *Consider expanding the clinical scope of RN case managers to include home-based testing for communicable infections such as Sexually Transmitted Infections (STIs), Hepatitis C, COVID-19, blood pressure and blood glucose, and urinalysis.*	Record of prevention services on file in client record.
	When indicated, clients will be referred to appropriately credentialed/licensed professionals for prevention education and counseling.	Record of linked referral on file in client record.

<table>
<tr><td rowspan="3">REFERRAL AND COORDINATION OF CARE</td><td>Home-based case management programs will maintain a comprehensive list of providers for full spectrum HIV-related services referrals.</td><td>Referral list on file at provider agency.</td></tr>
<tr><td>Home-based case management programs will collaborate with other agencies and providers to provide effective, appropriate referrals.</td><td>Memoranda of Understanding detailing collaborations on file at provider agency.</td></tr>
<tr><td>Home-based case management programs will develop procedures and protocols for referrals.</td><td>Written procedures and protocols on file at provider agency that includes process for tracking and monitoring referrals.</td></tr>
<tr><td>CASE CONFERENCE</td><td>Case conferences held by RN case managers and social workers, at minimum, will review and revise services plans at least every 60 days. Client or representative feedback will be sought.</td><td>Documentation of case conferences on file in client record to include names and titles of those participating in the review and client or representative input.</td></tr>
<tr><td rowspan="2">PATIENT RETENTION</td><td>Programs will develop a broken appointment policy to ensure continuity of service and retention of clients.</td><td>Written policy on file at provider agency.</td></tr>
<tr><td>Programs will provide regular follow-up procedures to encourage and help maintain a client in home-based case management.</td><td>Documentation of attempts to contact in signed, dated progress notes. Follow-up may include:
• Telephone calls
• Written correspondence
• Direct contact</td></tr>
<tr><td rowspan="2">CASE CLOSURE</td><td>Clients will be formally notified of pending case closure.</td><td>Contact attempts and notification about case closure on file in client record</td></tr>
<tr><td>Home-based case management cases may be closed when the client:
• Has achieved their home-based case management service plan goals
• Relocates out of the service area</td><td>Case closure summary on file in client chart to include:
• Date and signature of RN case manager and/or social worker
• Date of case closure
• Service plan status
• Statue of primary health care and service utilization</td></tr>
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<table>
<tr><td></td><td>• Has had no direct program contact in the past six months
• Is ineligible for the service
• No longer needs the service
• Discontinues the service
• Is incarcerated long term
• Uses the service improperly or has not complied with the client services agreement
• Has died</td><td>• Referrals provided
• Reason for closure
• Criteria for re-entry into services</td></tr>
<tr><td>POLICIES, PROCEDURES AND PROTOCOLS</td><td>Home-based case management programs will have written policies procedures and protocols, including eligibility criteria.</td><td>Policies, procedures, and protocols on file at provider agency.</td></tr>
<tr><td rowspan="2">STAFFING REQUIREMENTS AND QUALIFICATIONS</td><td>RNs providing home-based case management services will:
• Hold a license in good standing form the California State Board of Registered Nursing
• Have graduated from an accredited nursing program with a BSN or two-year nursing associate degree
• Have two year’s post-degree experience and one year’s community or public health nursing experience
• Practice within the scope defined in the California Business & Professional Code, Section 2725</td><td>Resumes on file at provider agency to verify experience. Program review and monitoring to confirm.</td></tr>
<tr><td>Social workers providing home-based case management services will hold an MSW (or related degree) or BA in social work with 1-2 years of experience and practice</td><td>Resumes on file at provider agency to verify experience. Program review and monitoring to confirm.</td></tr>
</table>

	according to State and Federal guidelines and the Social Work Code of ethics	
	RN case managers and social workers will attend an annual training/briefing on public/private benefits.	Documentation of attendance in employee files.
	Staff will maintain licenses by completing continuing education requirements of their respective professional boards.	Record of continuing education in employee files at provider agency.

DEFINITIONS AND DESCRIPTIONS

Assessment is a comprehensive evaluation of each client's physical, psychological, social, environmental, and financial status to determine the type and level of service needs. Assessments will be performed in accordance with guidelines set forth by the California Department of Public Health (CDPH) Case Management Program (CMP).

Attendant Care includes the provision of non-medical personal care by a home health aide or nurse assistant certified by the CDPH. Services are provided under the direct supervision of a licensed nurse.

Home Care Organization (HCO) is an entity that provides attendant care and/or homemaker services only. HCOs are not licensed by the CDPH and are not subject to State-issued service standards or criteria.

Home Health Agency (HHA) is a public or private entity that provides skilled nursing and other therapeutic services to clients in their place of residence under a treatment plan prescribed by an attending physician. HHAs must be qualified and licensed by the CDPH as a home health agency.

Homemaker Services include general household activities performed when the client is unable to manage home care for himself or herself at home. Services are provided under the direct supervision of a licensed nurse.

Registered Nurse (RN) Case Management Services include the provision of comprehensive medical case management for people living with HIV who require intensive home and/or community-based services.

Service Plan is a written document identifying a client's problems and needs, intended interventions, and expected results, including short- and long-range goals written in measurable terms.

Social Work Case Management Services include the provision of comprehensive social work case management services including, but not limited to, psychosocial, financial, housing, and related concerns for people living with HIV who require intensive home- and/or community-based services.

Social Workers, as defined in this standard, are individuals who hold a master's degree in social work (or related field) *or BA in social work with 1-2 years of experience from an accredited program.*

Service Standards for

BENEFITS SPECIALTY SERVICES

SBP Committee Approved 7/5/22

For Executive Committee Approval 7/28/22

BENEFITS SPECIALTY SERVICES
service standards

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

Ryan White HIV/AIDS Services: Determining Client Eligibility and Payor of Last Resort Program Clarification Notice (PCN) #21-02

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

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

INTRODUCTION

Service standards for the Ryan White HIV/AIDS Part A Program outline the elements and expectations a service provider should follow when implementing a specific service category. The standards are written for providers for guidance on what services may be offered when developing their Ryan White Part A programs. The standards set the minimum level of care Ryan White funded agencies offer to clients, however, providers are encouraged to exceed these standards.

The Los Angeles County Commission on HIV developed the Benefits Specialty Services standards to establish the minimum standards of care necessary to ensure people living with HIV (PLWH) can receive quality Benefits Specialty Services when attending core medical and/or support services appointments and meetings. The development of the standards includes guidance from service providers, people living with HIV, the Los Angeles County Department of Public Health, Division of HIV and STD Program (DHSP), members of the Los Angeles County Commission on HIV, Standards & Best Practices Committee, and the public-at-large.

BENEFITS SPECIALTY SERVICES (BSS): OVERVIEW

Benefits Specialty Services are client-centered activities that facilitate a client’s access to public/private maintenance of health, social services, and disability benefits and programs. Benefits Specialty Services work to maximize public funding by helping clients identify all available health, social services, and disability benefits supported by funding streams in addition to Ryan White Part A funds. These services are designed to assist a client navigate care and social services systems outside of the service delivery network funded by the Ryan White Program, educate people living with HIV about public and private benefit programs, and aid in accessing and securing these benefits.

Benefits Specialty Services are unlicensed. All HIV Benefits Specialty Services will be provided in accordance with Commission on HIV guidelines and procedures, and local laws and regulations and will respect the inherent dignity of each person living with HIV they serve. In addition, BSS contractors must adhere to contractual requirements stipulated by DHSP.

Benefits Specialists will assist clients directly or through referral in obtaining the following (at minimum):

Table 1. BENEFIT SPECIALTY SERVICES LIST

Health Care	• AIDS Drug Assistance Program (ADAP)* • Patient Assistance Programs (Pharmaceutical Companies)
Insurance	• State Office of AIDS Health Insurance Premium Payment (OA-HIPP) • Covered California/Health Insurance Marketplace • Medicaid/Medi-Cal/MyHealthLA • Medicare • Medicare Buy-in Programs • Private Insurance
Food and Nutrition	• CalFresh • DHSP-funded nutrition programs (food banks or home delivery services)
Disability	• Social Security Disability Insurance (SSDI) • State Disability Insurance • In-Home Supportive Services (IHSS)
Unemployment/Financial Assistance	• Unemployment Insurance (UI) • Worker's Compensation • Ability to Pay Program (ATP) • Supplemental Security Income (SSI) • State Supplementary Payments (SSP) • Cal-WORKS (TANF) • General Relief/General Relief Opportunities to Work (GROW)
Housing	• Section 8, Housing Opportunities for People with AIDS (HOPWA) and other housing programs • Rent and Mortgage Relief programs
Other	• Women, Infants and Children (WIC) • Childcare • Entitlement programs • Other public/private benefits programs • DHSP-funded services

All contractors must meet the Universal Standards of Care in addition to the following Benefits Specialty Services service standards. Universal Standards of Care can be access at: http://hiv.lacounty.gov/Projects

Table 2. BENEFITS SPECIALTY SERVICES REQUIREMENTS

SERVICE COMPONENT	STANDARD	DOCUMENTATION
Outreach	Benefits specialty programs will outreach to potential clients/families and providers.	Outreach plan on file at provider agency.
	Benefits specialty programs will collaborate with primary health care and supportive services providers.	Memoranda of Understanding on file at the provider agency.
Intake	The intake process will begin during first contact with client.	Intake tool in client file to include (at minimum): • Documentation of HIV status • Proof of LA County residency or Affidavit of Homelessness • Verification of financial eligibility • Date of intake • Client name, home address, mailing address and telephone number • Emergency and/or next of kin contact name, home address and telephone number
	Confidentiality policy and Release of Information will be discussed and completed.	Release of Information signed and dated by client on file and updated annually.
	Consent for services will be completed.	Signed and dated Consent in client file.
	Client will be informed of Rights and Responsibility and Grievance Procedures.	Signed and dated forms in client file.
	When indicated, the client will provide Disclosure of Duty Statement.	Signed and date Disclosure of Duty Statement in client file.

	Client will be informed of limitations of benefits specialty services through Disclaimer form.	Signed and date Disclaimer in client file.
Benefits Assessment	Benefits assessments will be completed during first appointment.	Benefits assessment in client chart on file to include: • Date of assessment • Signature and title of staff person • Completed Assessment/Information form • Functional barriers • Notation of relevant benefits and entitlements and record of forms provided • Benefits service plans
Benefits Management	Benefits management services will be provided to clients who are enrolled in benefits programs and require advocacy to maintain their benefits.	Benefits assessment on file in client chart to include: • Date • Signature and title of staff person • Notation of relevant benefits and presenting issues(s) • Benefits service plan to address identifies benefits issue(s)
Benefits Service Plan (BSPs)	BSPs will be developed in conjunction with the client at the completion of the benefits assessment.	BSP on file in client chart that includes: • Name, date and signature of client and case manager • Benefits/entitlements for which to be applied • Functional barriers status and next steps • Disposition for each benefit/entitlement and/or referral
Appeals Counseling and Facilitation	As necessary, specialists will assist clients with appeals counseling and facilitation. Cases that require further	Signed, date progress notes on file that detail (at minimum): • Brief description of counseling provided

	legal assistance will be referred to Ryan White Program-funded or other legal service provider.	• Time spent with, or on behalf of, the client • Legal referrals (as indicated)
	Specialists will attempt to follow up missed appointments within one business day.	Progress notes on file in client chart detailing follow-up attempt.
Client Retention	Programs will develop a broken appointment policy to ensure continuity of service and retention of clients.	Written policy on file at provider agency.
	Programs will provider regular follow-up procedures to encourage and help maintain a client in benefits specialist services.	Documentation of attempts to contact tin signed, date progress notes. Follow-up may include: • Telephone calls • Written correspondence • Direct contact
	Programs will develop and implement a client contact policy and procedure for homeless clients and those with no contact information.	Contact policy on file at provider agency. Program review and monitoring to conform.
Case Closure	Clients will be formally notified of pending case closure.	Contact attempts and notification about case closure on file in client chart.
	Benefits cases may be closed when the client: • Successfully completes benefits and entitlement applications • Seeks legal representation for benefits • Relocates out of the service area • Has had no direct program contact in the past six months • Is ineligible for the service • No longer needs the service • Discontinues the service • Is incarcerated long term	Case closure summary on file in client chart to include: • Date and signature of benefits specialist • Date of case closure • Status of the BSP • Reasons for case closure

	• Uses the service improperly of has not complied with the client services agreement • Has died	
Staffing Development and Enhancement Activities	Benefits specialty programs will hire staff that have the ability to provide linguistically and culturally appropriate care to clients living with HIV. Staff meet the minimum qualifications for their job position and have the knowledge, skills, and ability to effectively fulfill their role. Employment is an essential part of leading an independent, self-directed life for all people, including those living with HIV/AIDS. Agencies should develop policies that strive to hire people living with HIV in all facets of service delivery, whenever appropriate.	Hiring policy and staff resumes on file.
	All staff will be given orientation prior to providing services.	Record of orientation in employee file at provider agency.
	Benefits specialists will complete DHSP's certification training within three months of being hired and become ADAP and Ryan White/OA-HIPP certified in six months.	Documentation of Certification completion maintained in employee file.
	Staff will complete benefits specialty recertification training annually and will seek other training opportunities as available.	Documentation of training maintained in employee files to include: • Date, time, and location of training • Title of training • Staff members attending • Training provider • Training outline • Meeting agenda and/or minutes

	Benefits specialists will practice according to generally accepted ethical standards.	Program review and monitoring to confirm.
	Benefits specialists will receive a minimum of four hours of supervision per month.	Record of supervision on file at provider agency.

APPENDIX A: DEFINITIONS AND DESCRIPTIONS

Benefits Assessment is a cooperative and interactive face-to-face interview process during which the client's knowledge about and access to public and private benefits are identified and evaluated.

Benefits Management refers to benefits specialty services provided to individuals who are enrolled in various health and disability programs. The goal of benefits management is to provider advocacy that helps the individual maintain his or her benefits.

Case Closure is a systematic process of disenrolling clients form active benefits specialty services.

Client Intake is a process that determines a person's eligibility for benefits specialty services.

Entitlement Program are benefits that require financial contribution into the program prior to collecting from the program (e.g., State Disability Insurance (SDI) and Social Security Disability Insurance (SSDI)).

Legal Representation defines a process through which a consumer is represented by an attorney, paralegal and/or licensed/certified insurance adjustor. (Please see Legal Assistance Standard of Care.)

Outreach promotes the availability of and access to benefits specialty services to potential clients and services providers.

Public Benefits describe all financial and medical assistance programs funded by governmental sources.