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

COMMISSION ON HIV MEETING

January 12, 2017
9:00 AM – 12:50 PM

St. Anne's Conference Center
Foundation Room
155 North Occidental Blvd.
Los Angeles, CA 90046

Los Angeles County Commission on HIV

VISION

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

MISSION

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

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

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GUIDELINES FOR CONDUCT

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

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

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

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

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

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

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2. APPROVAL OF AGENDA:

A Agenda
B Membership Roster
C Committee Assignments
D Geographic Maps
E January – April 2017 Meeting Calendar

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Los Angeles County Commission on HIV
MEETING AGENDA

Thursday, January 12, 2017
9:00am – 12:50pm

St. Anne's Conference Center
Foundation Conference Room
155 North Occidental Boulevard, Los Angeles, CA 90046

All Commission meetings will begin at their appointed times.
Participants should make every effort to be prompt and ready.

All agenda items are subject to action. Public comment will be invited for each item.

All "action" (non-procedural) motions are included on the consent calendar and are approved when the consent calendar is approved.
A motion can be "pulled" from the consent calendar if there are objections to it, or if it is to be presented or discussed later in the meeting.

Members/Visitors: Remember that the agenda order (and the scheduled times for items) can be changed or significantly delayed during and at a meeting.	**Motions**, public comment periods, dates/times/venues of future activities.	**Who** addresses the issue, reports on it, and/or who follows-up after that.	**Agenda Times** are best estimates, but are subject to change at any time.
AGENDA ORDER/AGENDA ITEMS	**MOTIONS/ACTIONS**	**PARTY(IES) RESPONSIBLE**	**SCHEDULED TIMES**
1. Call to Order		**B Land/R Rosales, *Co-Chairs***	9:00 am — 9:03 am
A Roll Call			
2. Approval of Agenda	**MOTION #1**	**Commission**	9:03am — 9:05 am
3. Approval of Meeting Minutes	**MOTION #2**	**Commission**	9:05 am — 9:07 am
4. Executive Director's Report		**C Barrit, MPIA,** Executive Director	9:07am — 9:15am

AGENDA ORDER/AGENDA ITEMS	MOTIONS/ACTIONS, DATES and LOGISTICS	PARTY(IES) RESPONSIBLE	SCHEDULED TIMES
5. Co-Chairs Report		**R Rosales/B Land,** Co-Chairs	9:15am -- 9:20am
A Commissioner Welcome & Service Recognition			
B Committee Co Chairs Elections			
C Meeting Management			
6. County's Health Department Integration Advisory Board (IAB) Report		**A Ballesteros, MBA/B Gordon,** Co-Chairs	9:20am — 9:23am
7. Department of Public Health, Immunization Program Report		**Franklin D Pratt, MD, MPHTM,FACEP** Medical Director,Immunization Program, DPH	9:23am -- 9:27am
8. HOPWA Report		**R Ronquillo** Housing + Community Investment Dept City of Los Angeles	9:27am --- 9:30am
9. Colloquia Series:	**HIV Status and Risk Factors Among Underserved Populations in Los Angeles County**		9:30am — 10:30am
10. Division of HIV/STD Programs (DHSP) Report		**M Peréz, MPH, Director,** DHSP	10:30am — 10:45am
11. California Office of AIDS (OA) Report		**State Office of AIDS**	10:45am -- 11:00am
A California Planning Group (CPG)		**J Rivera,** Commission Representative	
B OA Work/Information		**M Arnold, MS-HAS,** Chief, Care Branch, OA	
12. Break			11:00am — 11:15am
13. Standing Committee Reports			11:15am — 12:15pm
A Planning, Priorities & Allocations (PP&A) Committee		**A Ballesteros, MBA/M Enfield,** Co-Chairs	
(1) Ryan White Program FY 2017 Parts A, B, MAI Allocations	**MOTION #3**		
(2) Community Engagement Work Group		**T Bivens-Davis/E Cockrell,** Co-Chairs	
(a) Tier 2 Listening Sessions Summary Presentation			
B Standards and Best Practices (SBP) Committee		**J Cadden, MD/G Granados, MSW,** Co-Chairs	
(1) Standards of Care Update			
C Public Policy Committee		**A Fox, MPM/W Watts, Esq.,** Co-Chairs	
(1) 2017-18 Legislative Landscape and Impact			
D Operations Committee		**K Stalter/T Winder,** Co-Chairs	

AGENDA ORDER/AGENDA ITEMS	MOTIONS/ACTIONS, DATES and LOGISTICS	PARTY(IES) RESPONSIBLE	SCHEDULED TIMES
14. Caucus Reports			12:15pm -- 12:20pm
A Consumer Caucus		**K Donnelly/J Green/S Samone-Loreca**, Co-Chairs	
B Transgender Caucus		**M Enfield/M Roman**, Co-Chairs	
C Women's Caucus		**B Gordon/Y Salinas**, Co-Chairs	
D Youth Caucus		**G Granados, MSW/E Cockrell**, Co-Chairs	
15. City/Heath District Reports		**City/Health District Representatives**	12:20pm — 12:22pm
16. SPA/District Reports		**SPA/District Representatives**	12:22pm — 12:24pm
17. AIDS Education/Training Centers (AETCs)		**J D. Gates, PhD**, AETC	12:24pm — 12:26pm
18. Public Comment (*Non-Agendized or Follow-Up*)		**Public**	12:26pm — 12:36pm
19. Commission Comment (*Non-Agendized or Follow-Up*)		**Commission Members/Staff**	12:36pm — 12:46pm
20. Announcements		**Commission/Public**	12:46pm — 12:50pm
21. Adjournment			12:50pm
A. In Memory of Matt Redman, Co-Founder of APLA			

PROPOSED MOTION(S)/ACTION(S):

MOTION # 1:	**Adjust, as necessary, and approve the Agenda Order.**
MOTION # 2:	**Approve minutes from the Commission on HIV meetings, as presented or revised.**
MOTION # 3:	**Approve the proposed FY 2017-2018 Ryan White Program Parts A, B and MAI allocations, as presented. Thereafter, forward to the Division of HIV and STD Programs (DHSP) for their application and planning use, with the understanding that these allocations may be revised at a later time as the PP&A Committee completes the FY 2017-18 priority- and allocation-setting process. Moreover, this approval will provide DHSP the authority to make adjustments up to 10% greater or lesser than the approved allocations amount, as expenditure categories dictate, without returning to this body.**

COMMISSION ON HIV MEMBERS

Bradley Land, *Co-Chair*	**Ricky Rosales**, *Co-Chair*	**Majel Arnold, MA-HSA**	**Traci Bivens-Davis**
Al Ballesteros, MBA	**Jason Brown**	**Joseph Cadden, MD**	**Raquel Cataldo**
Edd Cockrell	**Moroni Cortes**	**Kevin Donnelly**	**Michelle Enfield**
Aaron Fox, MPP	**Jerry D. Gates, PhD**	**Joseph Green**	**Terry Goddard, MA**
Bridget Gordon *Patricio Soza (Alternate)*	**Grissel Granados, MSW**	**Lee Kochems, MA** *Eduardo Martinz (Alternate)*	**Abad Lopez**
Eric Paul Leue	**Miguel Martinez, MSW, MPH**	**Anthony Mills, MD**	**José Munoz**
Derek Murray	**Deborah Owens-Collins,** PA, MSPAS, AAHIVS	**John Palomo**	**Raphael Péna**
Mario Peréz, MPH	**Thomas Puckett, Jr.**	**Juan Rivera**	**Maria Roman/** *Juan Preciado (Alternate)*
Rebecca Ronquillo	**Sabel Samone-Loreca/** *Danielle Campbell, MPH (Alternate)*	**Martin Sattah, MD**	**Terry Smith, MPA**
LaShonda Spencer, MD	**Kevin Stalter**	**Yolanda Sumpter**	**Sterling Walker/** *Susan Forrest (Alternate)*
Will Watts, Esq	**Terrell Winder**	**Octavio Vallejo, MD, MPH**	

MEMBERS: 43
QUORUM: 22

for 51 Seats

LEGEND:: **Commissioner/** *Alternate*

NOTES on AGENDA SCHEDULING, TIMING, POSTED and ACTUAL TIMES, TIME ALLOTMENTS and AGENDA ORDER

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

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

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

ADDITIONAL INFORMATION:

Public comment addressing specific agenda items can be made at any time during the meeting. Please complete a request for public comment time and identify the item you would like to address. Otherwise, all other public comment will be delivered during the designated time on the agenda.

Interpretation services for the deaf/hearing impaired or for the non-English-speaking are available free of charge upon request. Please contact Dina Jauregui at (213) 738-2816 (phone), (213) 637-4748 (FAX) at least five working days prior to the meeting date to arrange this service.

Servicios de interpretación para personas con impedimento auditivo y traducción para personas que no hablan Inglés están disponibles sin costo. Para pedir estos servicios, póngase en contacto con Dina Jauregui al (213) 738-2816 (teléfono), o por fax al (213) 637-4748, por lo menos cinco días antes de la junta.

For Commission Audience: All HIV Commission meetings are open to the public. If you wish to address the Commission, please pick up a form at the sign-in table or see staff. For additional information about the Commission, please contact Dina Jauregui at (213) 738-2816.

NOTE: All Commission minutes, tapes and documents are available for review and inspection at the Commission on HIV offices located 3530 Wilshire Boulevard, Suite 1140, Los Angeles, CA 90010. In addition, records from committee meetings are also available at the same location. To make an appointment to review these documents, please call Dina Jauregui at (213) 738-2816.

COMMISSON ON HIV MEMBERSHIP ROSTER

Updated 01/11/2017

MEMBERSHIP SEAT #	MEMBERSHIP SEAT	Commissioners Seated	Committee Assignement	COMMISSIONER	AFFILIATION *(if any)*	TERM BEGINS	TERM ENDS	Alternates Seated	Pending Appointment (Alternates)	ALTERNATE
1)	Medi-Cal representative			***Vacant***		July 1, 2015	June 30, 2017			
2)	City of Pasadena representative	1	OPS	John Palomo	Pasadena Public Health, City of Pasadena	July 1, 2016	June 30, 2018			
3)	City of Long Beach representative	1	TBD	Deborah Owens-Collins, PA, MSPAS, AAHIVS	Dept. of Health and Human Services, City of Long Beach	July 1, 2015	June 30, 2017			
4)	City of Los Angeles representative	1	EXC	Ricky Rosales	AIDS Coordinator's Office, City of Los Angeles	July 1, 2016	June 30, 2018			
5)	City of West Hollywood representative	1	PPA	Derek Murray	City of West Hollywood	July 1, 2015	June 30, 2017			
6)	Director, DHSP	1	PPA	Mario Pérez, MPH	DHSP, LA County Department of Public Health	July 1, 2016	June 30, 2018			
7)	Part B representative	1	PPA	Majel Arnold,MHA	CA Office of AIDS	July 1, 2016	June 30, 2018			
8)	Part C representative	1	PP	Aaron Fox, MPM	Los Angeles Gay and Lesbian Center (LAGLC)	July 1, 2016	June 30, 2018			
9)	Part D representative	1	PPA	LaShonda Spencer, MD	LAC + USC MCA Clinic, LA County Department of Health Services	July 1, 2015	June 30, 2017			
10)	Part F representative	1	PP	Jerry D. Gates, PhD	Keck School of Medicine of USC	July 1, 2016	June 30, 2018			
11)	Provider representative #1	1	SBP	Joe Cadden, MD	Rand Shrader Clinic (SPA1), LA County Department of Health Services	July 1, 2015	June 30, 2017			
12)	Provider representative #2	1	PP	Maria Roman	APAIT Health Center	July 1, 2016	June 30, 2018	1		Juan Preciado
13)	Provider representative #3	1	PPA	Miguel Martinez, MSW, MPH	Children's Hospital Los Angeles	July 1, 2015	June 30, 2017			
14)	Provider representative #4	1	PP	Raquel Cataldo	Tarzana Treatment Center	July 1, 2016	June 30, 2018			
15)	Provider representative #5	1	PP	Terry Goddard, MA	Alliance for Housing and Healing	July 1, 2015	June 30, 2017			
16)	Provider representative #6	1	EXC|OPS	Anthony Mills, MD	Southern CA Men's Medical Group	July 1, 2016	June 30, 2018			
17)	Provider representative #7	1	SBP	Terry Smith, MPA	AIDS Project Los Angeles (APLA), Health and Wellness	July 1, 2015	June 30, 2017			
18)	Provider representative #8	1	PP	Martin Sattah, MD	Rand Shrader Clinic (SPA1), LA County Department of Health Services	July 1, 2016	June 30, 2018			
19)	Unaffiliated consumer, SPA 1			***Michele Daniels***	*unaffiliated consumer/Pending BOS Approval*	July 1, 2015	June 30, 2017			
20)	Unaffiliated consumer, SPA 2	1	PPA	Abad Lopez	*unaffiliated consumer*	July 1, 2016	June 30, 2018			
21)	Unaffiliated consumer, SPA 3	1	PPA	Jason Brown	*unaffiliated consumer*	July 1, 2014	June 30, 2017			
22)	Unaffiliated consumer, SPA 4	1	SBP	Sterling Walker	N/A	July 1, 2016	June 30, 2018	1		Susan Forrest
23)	Unaffiliated consumer, SPA 5	1	PPA	Yolanda Sumpter	*unaffiliated consumer*	July 1, 2015	June 30, 2017	1		
24)	Unaffiliated consumer, SPA 6	1	SBP	Octavio Vallejo	*unaffiliated consumer*	July 1, 2016	June 30, 2018			
25)	Unaffiliated consumer, SPA 7	1	PPA	Raphael Péna	*unaffiliated consumer*	July 1, 2015	June 30, 2017			
26)	Unaffiliated consumer, SPA 8	1	PP	Lee Kochems, MA	*unaffiliated consumer*	July 1, 2016	June 30, 2018	1		Eduardo Martinez
27)	Unaffiliated consumer, Supervisorial District 1	1	PP	Jose Muñoz	*unaffiliated consumer*	July 1, 2015	June 30, 2017			
28)	Unaffiliated consumer, Supervisorial District 2	1	OPS	Moroni Cortes	*unaffiliated consumer*	July 1, 2016	June 30, 2018			
29)	Unaffiliated consumer, Supervisorial District 3	1	EXC|OPS	Juan Rivera	Kroger Speciality Pharmacy	July 1, 2015	June 30, 2017			
30)	Unaffiliated consumer, Supervisorial District 4	1	EXC|OPS	Kevin Donnelly	*unaffiliated consumer*	July 1, 2016	June 30, 2018			
31)	Unaffiliated consumer, Supervisorial District 5	1	SBP	Thomas Puckett, Jr.	*unaffiliated consumer*	July 1, 2015	June 30, 2017			
32)	Unaffiliated consumer, at-large #1	1	PP	Edd Cockrell, Jr.	*unaffiliated consumer*	July 1, 2016	June 30, 2018			
33)	Unaffiliated consumer, at-large #2	1	PP	Joe Green	*unaffiliated consumer*	July 1, 2015	June 30, 2017			
34)	Unaffiliated consumer, at-large #3	1	OPS	Kevin Stalter	The Brotherhood IMPACT Fund	July 1, 2016	June 30, 2018			
35)	Unaffiliated consumer, at-large #4	1	OPS	Bridget Gordon	*unaffiliated consumer*	July 1, 2015	June 30, 2017	1		
36)	Representative, Board Office 1	1	PPA	Al Ballesteros, MBA	JWCH Institute, Inc.	July 1, 2016	June 30, 2018			
37)	Representative, Board Office 2	1	PP	Will Watts, Esq.	Public Counsel	July 1, 2015	June 30, 2017			
38)	Representative, Board Office 3			***Vacant***		July 1, 2016	June 30, 2018			
39)	Representative, Board Office 4			***Vacant***		July 1, 2015	June 30, 2017			
40)	Representative, Board Office 5	1	EXC	Brad Land	*unaffiliated consumer*	July 1, 2016	June 30, 2018			
41)	Representative, HOPWA	1	PP	Rebecca Ronquillo	City of Los Angeles, HOPWA	July 1, 2015	June 30, 2017			
42)	Behavioral/social scientist	1	OPS	Terrell Winder	REACH LA	July 1, 2016	June 30, 2018			
43)	Local health/hospital planning agency representative			***Vacant***		July 1, 2015	June 30, 2017			
44)	HIV stakeholder representative #1	1	SBP	Grissell Granados, MSW	Children's Hospital Los Angeles	July 1, 2016	June 30, 2018			
45)	HIV stakeholder representative #2			***Vacant***		July 1, 2015	June 30, 2017			
46)	HIV stakeholder representative #3			***Vacant***		July 1, 2016	June 30, 2018			
47)	HIV stakeholder representative #4	1	PP	Eric Paul Leue	Free Speech Coaltion	July 1, 2015	June 30, 2017			
48)	HIV stakeholder representative #5			***Danielle Campbell***	*Pending BOS Approval*	July 1, 2016	June 30, 2018			
49)	HIV stakeholder representative #6	1	OPS	Traci Bivens-Davis		July 1, 2015	June 30, 2017			
50)	HIV stakeholder representative #7	1	OPS	Sabel Samone-Loreca	*unaffiliated consumer*	July 1, 2016	June 30, 2018	1		Danielle Campbell, MPH
51)	HIV stakeholder representative #8	1	PPA	Michelle Enfield	AIDS Project Los Angeles (APLA), Health and Wellness	July 1, 2015	June 30, 2017			
	TOTAL	**43**	**0**	**43**				**6**	**0**	

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

LOS ANGELES COUNTY COMMISSION ON HIV

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COMMITTEE ASSIGNMENTS
(Updated 1/11/17)

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

EXECUTIVE COMMITTEE

Regular meeting day: Fourth Monday of the month ***Regular meeting time***: 1:00pm–3:00pm

Number of Voting Members: 14 ***Number of Quorum***: 8

Bradley Land	**Co-Chair, Comm./Exec.***	Commissioner
Ricky Rosales	**Co-Chair, Comm./Exec.***	Commissioner
Kevin Stalter	Co-Chair, Operations	Commissioner
Terrell Winder	Co-Chair, Operations	Commissioner
Al Ballesteros, MBA	Co-Chair, PP&A	Commissioner
Michelle Enfield	Co-Chair, PP&A	Commissioner
Aaron Fox, MPM	Co-Chair, Public Policy	Commissioner
Will Watts, Esq.	Co-Chair, Public Policy	Commissioner
Joseph Cadden, MD	Co-Chair, SBP	Commissioner
Grissel Granados, MSW	Co-Chair, SBP	Commissioner
Kevin Donnelly	At-Large Member*	Commissioner
Anthony Mills, MD	At-Large Member*	Commissioner
Juan Rivera	At-Large Member*	Commissioner
Mario Pérez, MPH	DHSP Director	Commissioner

OPERATIONS COMMITTEE

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

Number of Voting Members: 10 ***Number of Quorum***: 6

Kevin Stalter	**Committee Co-Chair***	Commissioner
Terrell Winder	**Committee Co-Chair***	Commissioner
Traci Bivens-Davis	*	Commissioner
Moroni Cortes	*	Commissioner
Kevin Donnelly	*	Commisisoner
Bridget Gordon	*	Commissioner
Anthony Mills, MD	*	Commissioner
Juan Rivera	*	Commissioner
Sabel Samone-Loreca /Danielle Campbell, MPH	*	Commissioner
John Palomo	*	Commissioner

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

PLANNING, PRIORITIES and ALLOCATIONS (PP&A) COMMITTEE

Regular meeting day: 3rd Tuesday of the month ***Regular meeting time***: 1:00pm-4:00pm

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

Al Ballesteros, MBA	**Committee Co-Chair***	Commissioner
Michelle Enfield	**Committee Co-Chair***	Commissioner
Majel Arnold, MHA	*	Commisioner
Jason Brown	*	Commissioner
Abad Lopez	*	Commissioner
Miguel Martinez, MPH, MSW	*	Commissioner
Derek Murray	*	Commissioner
Raphael Péna	*	Commissioner
LaShonda Spencer, MD	*	Commissioner
Yolanda Sumpter/*Kimler Guiterrez-Cruz*	*	Commissioner
TBD	DHSP staff	DHSP Staff

PUBLIC POLICY COMMITTEE

Regular meeting day: 1st Monday of the month ***Regular meeting time***: 1:00 pm-3:00pm

Number of Voting Members: 14 ***Number of Quorum***: 8

Aaron Fox, MPM	**Committee Co-Chair***	Commissioner
Will Watts, Esq.	**Committee Co-Chair***	Commissioner
Raquel Cataldo	*	Commissioner
Edd Cockrell	*	Commissioner
Jerry Gates, PhD	*	Commissioner
Joe Green	*	Comimssioner
Terry Goddard, MA	*	Commissioner
Lee Kochems, MA	*	Commissioner
Eric Paul Leue	*	Commissioner
José Munoz	*	Commissioner
Maria Roman/Juan Preciado	*	Commissioner
Rebecca Ronquillo	*	Commissioner
Martin Sattah, MD	*	Commissioner
Kyle Baker	DHSP staff	DHSP representative

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

STANDARDS AND BEST PRACTICES (SBP) COMMITTEE

Regular meeting day: 1st Thursday of the month ***Regular meeting time***: 10:00am-12:00pm

Number of Voting Members: 8 ***Number of Quorum***: 5

Grissel Granados, MSW	**Committee Co-Chair***	Commissioner
Joseph Cadden, MD	**Committee Co-Chair***	Commissioner
Angelica Palmeros, MSW	*	Committee member
Thomas Puckett, Jr.	*	Commissioner
Terry Smith, MPA	*	Commissioner
Octavio Vallejo, MD, MPH	*	Commissioner
Sterling Walker	*	Commissioner
Wendy Garland, MPH	DHSP staff	DHSP representative

CONSUMER CAUCUS

Regular meeting day: Following Comm. mtg. ***Regular meeting time***: 1:30pm–3:00pm

Open Membership

Kevin Donnelly	**Co-Chair**	Commissioner
Joseph Green	**Co-Chair**	Commissioner
Sabel Samone-Loreca	**Co-Chair**	Commissioner
Al Ballesteros, MBA	Member	Commissioner
Jason Brown	Member	Commissioner
Edd Cockrell	Member	Commissioner
Moroni Cortes	Member	Commissioner
Grissel Granados, MSW	Member	Commissioner
Bridget Gordon	Member	Commissioner
Lee Kochems, MA	Member	Commissioner
Brad Land	Member	Commissioner
Abad Lopez	Member	Commissioner
Eduardo Martinez	Member	Alternate
Anthony Mills, MD	Member	Commissioner
José Munoz	Member	Commissioner
Raphael Péna	Member	Commissioner
Thomas Puckett	Member	Commissioner
Juan Rivera	Member	Commissioner

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

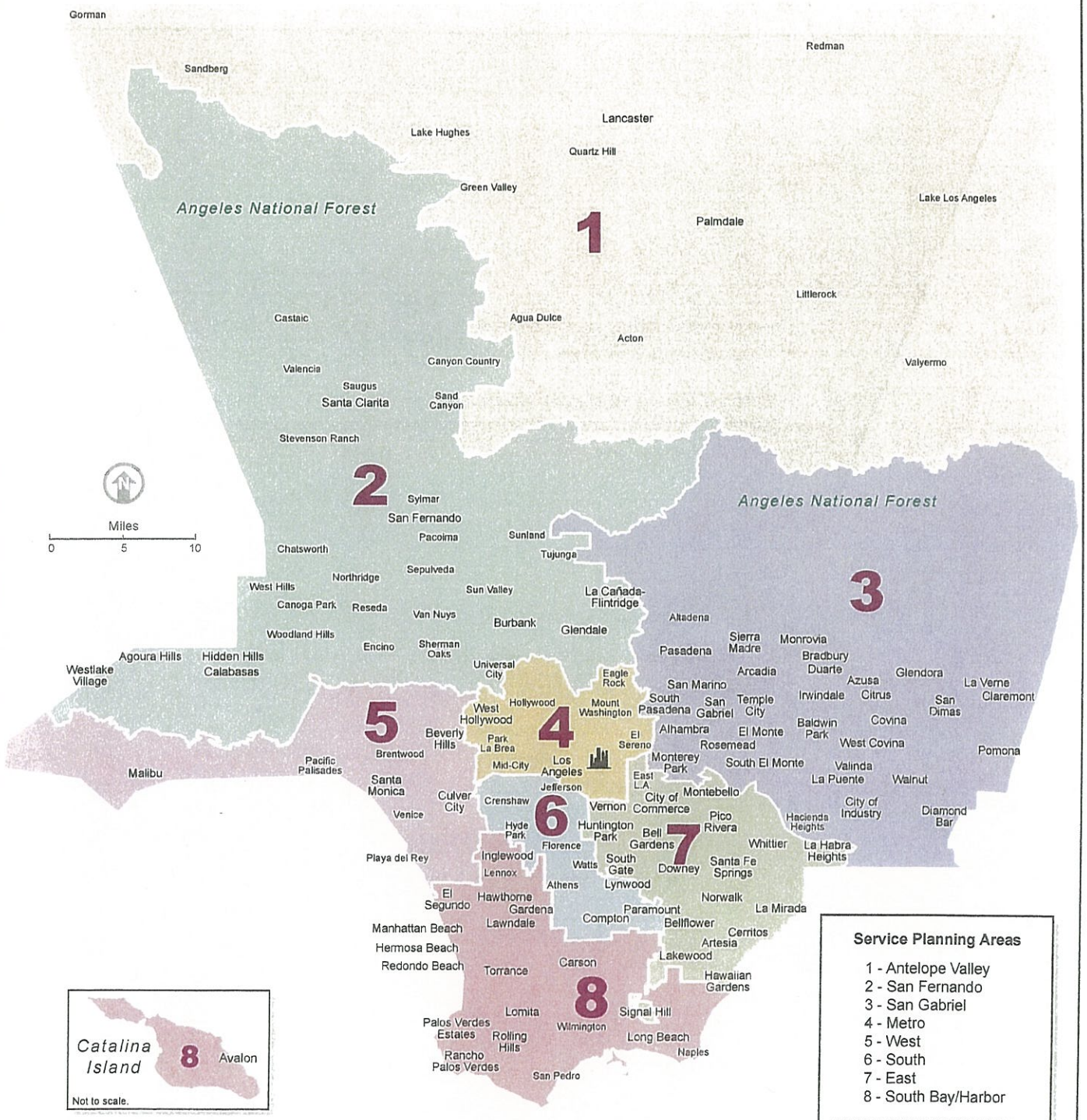
CONSUMER CAUCUS (CONT'D)		
Maria Roman	Member	Commissioner
Terry Smith, MPA	Member	Commissioner
Kevin Stalter	Member	Commissioner
Yolanda Sumpter	Member	Commissioner
Octavio Vallejo, MD, MPH	Member	Commissioner

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

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

YOUTH CAUCUS		
Regular meeting time: TBD		
Open Membership		
Grissel Granados, MSW	**Chair**	Commissioner
Edd Cockrell	Member	Commissioner
Dahlia Ferlito	Member	Community
Eric Paul Leue	Member	Commissioner

Los Angeles County
Service Planning Areas

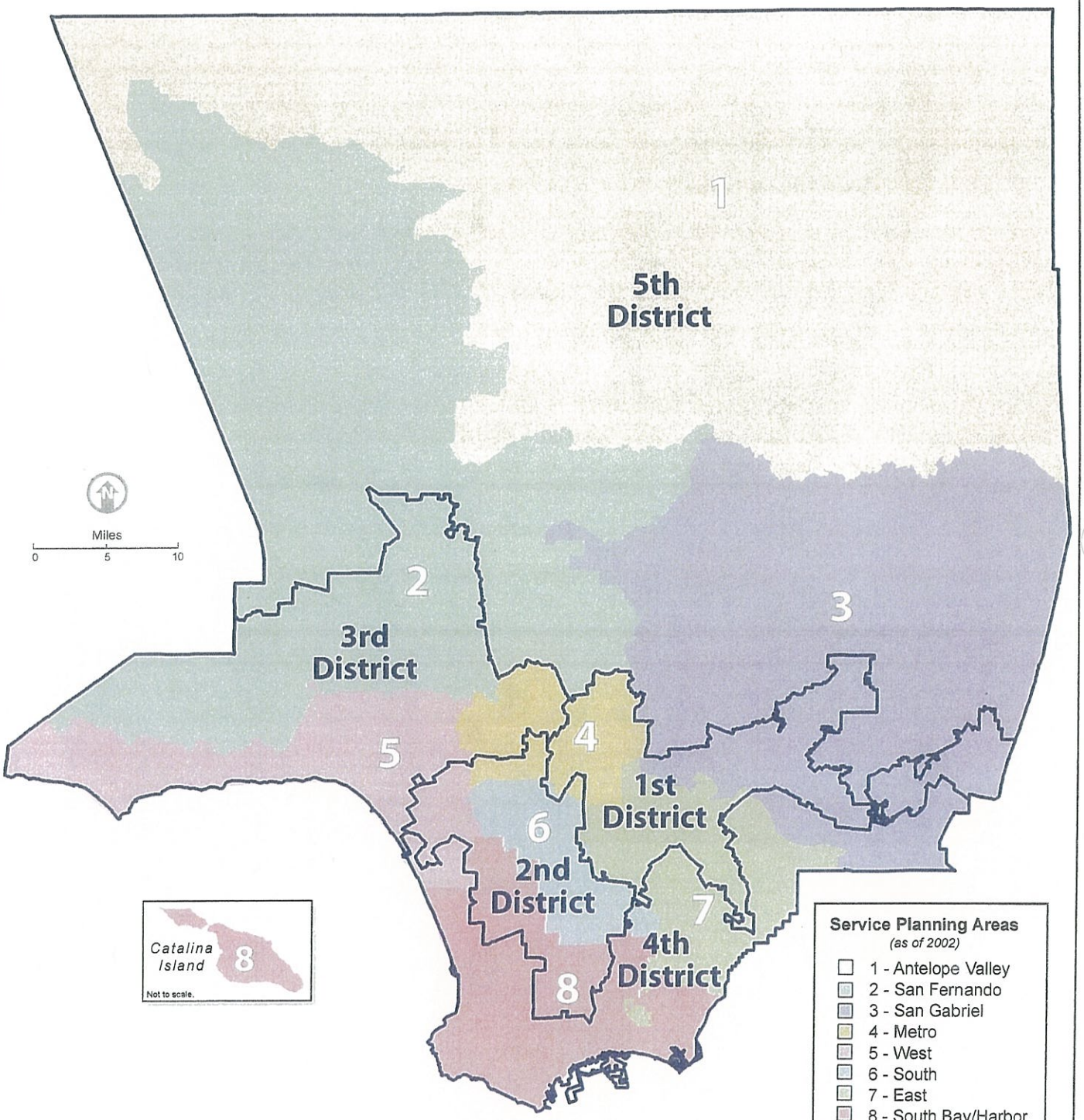


Los Angeles County
Children's Planning Council
Improving Children's Lives

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

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

Los Angeles County Service Planning Areas by Supervisorial District



Service Planning Areas
(as of 2002)

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

American Indian Children's Council covers all SPAs

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

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

HIV Calendar

January 2017

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1 Week 1 New Year's Day	**2** New Year's Day (Observed) - COH Office Closed	**3** 9:30 AM - 1:00 PM Board of Supervisors (BOS) - Meeting Canceled	**4** 9:30 AM - 11:30 AM BOS Agenda Review	**5** 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	**6**	**7**
8 Week 2	**9**	**10** 9:30 AM - 1:00 PM Board of Supervisors (BOS)	**11** 9:30 AM - 11:30 AM BOS Agenda Review	**12** 9:00 AM - 1:00 PM Commission Meeting	**13**	**14**
15 Week 3	**16** Martin Luther King's Day (Observed) - COH Office Closed 10:00 AM - 12:00 PM Transgender Caucus (Canceled) - New Mtg. TBD	**17** 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 4:00 PM Planning, Priorities & Allocations (PP&A)	**18** 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Women's Caucus	**19** 1:00 PM - 3:00 PM Training for Commissioners: Data and Epidemiology Overview	**20**	**21**
22 Week 4	**23** 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	**24** 9:30 AM - 1:00 PM Board of Supervisors (BOS)	**25** 9:30 AM - 11:30 AM BOS Agenda Review	**26**	**27**	**28**
29 Week 5	**30**	**31** 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 3:00 PM Training for Commissioners: Effective Communication and Active Listening	1 9:30 AM - 11:30 AM BOS Agenda Review	2 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	3	4

HIV Calendar

February 2017

Sun	Mon	Tue	Wed	Thu	Fri	Sat
29 Week 5	30	31 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 3:00 PM Training for Commissioners: Effective Communication and Active Listening	1 9:30 AM - 11:30 AM BOS Agenda Review	2 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	3	4
5 Week 6	6 1:00 PM - 3:00 PM Public Policy Committee	7 9:30 AM - 1:00 PM Board of Supervisors (BOS)	8 9:30 AM - 11:30 AM BOS Agenda Review	9 9:00 AM - 1:00 PM Commission Meeting	10	11
12 Week 7	13	14 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 3:00 PM Training for Commissioners: Planning Council Refresher	15 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Women's Caucus	16	17	18
19 Week 8	20 Presidents' Day (Observed) - COH Office Closed 10:00 AM - 12:00 PM Transgender Caucus	21 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 4:00 PM Planning, Priorities & Allocations (PP&A)	22 9:30 AM - 11:30 AM BOS Agenda Review	23	24	25
26 Week 9	27 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	28 9:30 AM - 1:00 PM Board of Supervisors (BOS)	1 9:30 AM - 11:30 AM BOS Agenda Review	2 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	3	4

HIV Calendar

March 2017

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

HIV Calendar

April 2017

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

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

9. COLLOQUIA SERIES

HIV Status and Risk Factors Among Underserved Populations in Los Angeles County

HIV Status & Risk Factors Among Underserved Populations in Los Angeles County

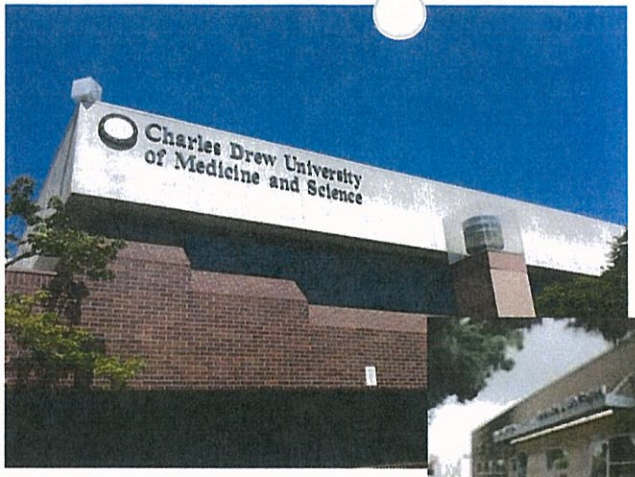
Charles R. Drew University of Medicine and Science

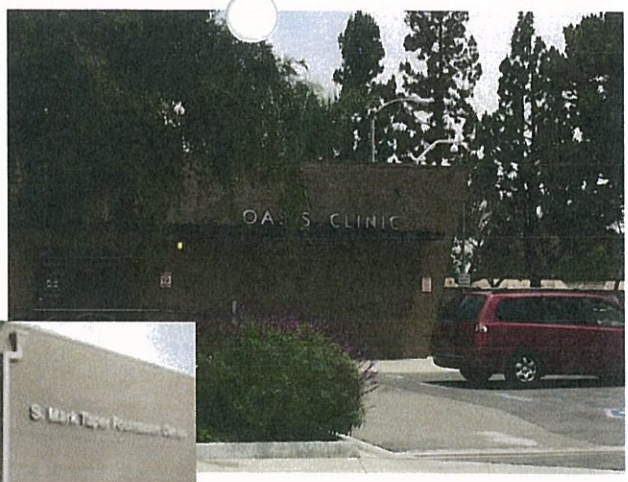
John B. Forbes, BA
HIV Counseling & Testing Program Coordinator
David P. Lee, MSW, MPH
Early Intervention Program Director, PrEP Program Director

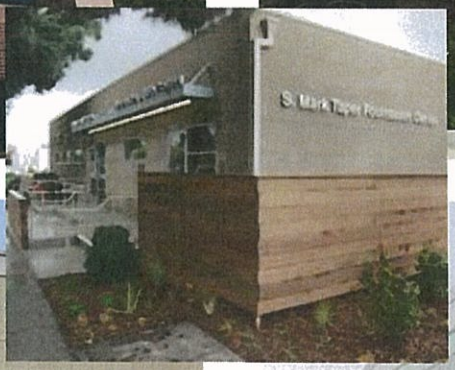
CDU IRB #15-09-2470-01

Learning Objectives

- Provide overview of HIV services at the MLK-OPC/CDU Campus.
- Discuss outreach & referral sources for HIV testing program.
- Outline effective outreach strategies.
- Provide brief overview of epidemiology of HIV in SPA 6.
- Explain HIV testing data study protocol.
- Discuss results of data analyses.
- Explore next steps.

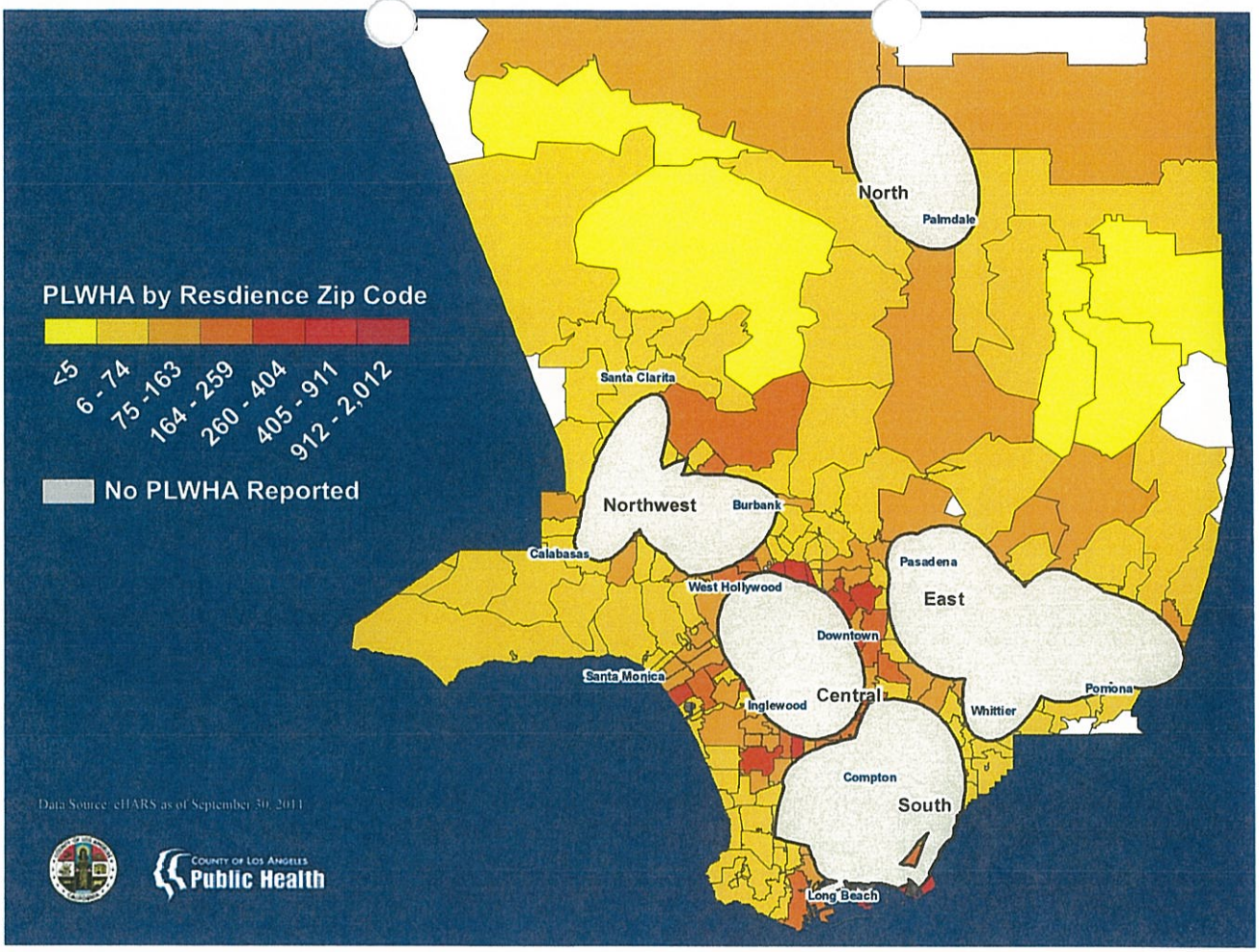






Full Spectrum HIV Services

- Outpatient HIV Medical Care (OASIS Clinic)
- Dental Services (APLA)
- Food Bank (APLA)
- Mental Health Services (CDU)
- PrEP Navigation & Clinical Services (CDU/OASIS Clinic)
- Case Management (OASIS Clinic/CDU)
- Housing Referrals (APLA)
- Therapy Groups (CDU)
- Linkage to Medical Care (CDU)
- HIV Testing & Counseling (CDU)



Community Outreach

What is Outreach?

Definition: *To start where the client is -- outside the office or in the community. Outreach is fostering relationships with individuals and educating them about available programs and services that may benefit them and urging them to access and participate.*

- Outreach workers should be as closely match by race/ethnicity, gender, language, age, and sexual orientation of the population being accessed.

- Outreach messages should be specific to the targeted population.

CDU HIV Testing Programs

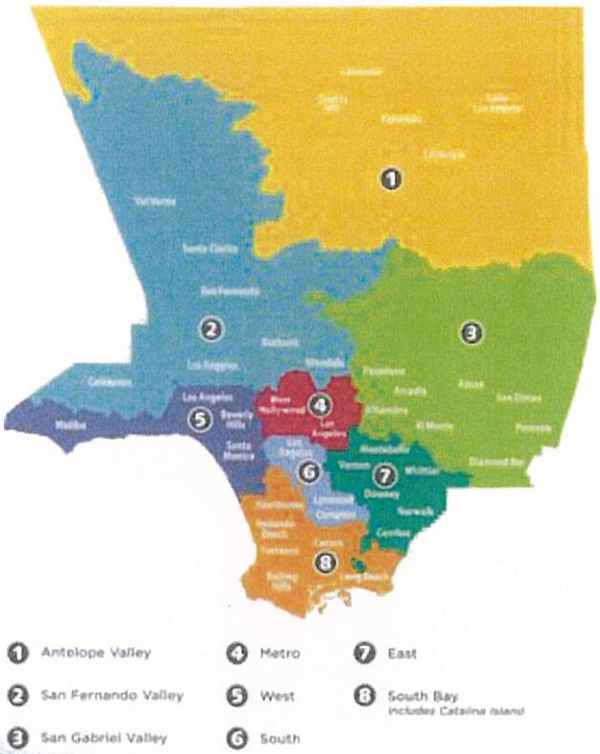
- **Mobile HIV Testing Van**
- **CDU/OASIS Clinic Storefront Program**
  - Walk-ins
  - Community Referrals:
    - Referrals from other agencies
    - Referrals from jail
    - Patient referrals
  - Court mandated
  - Community outreach

Outreach & Educational Target Populations

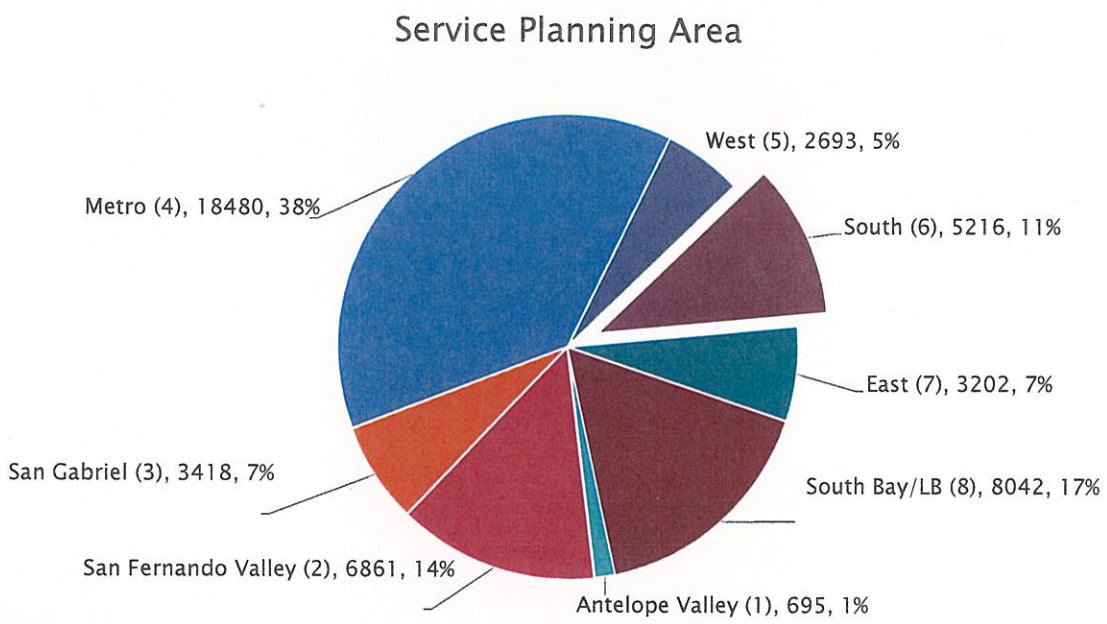
- Providing information about risk behaviors and strategies to eliminate or reduce risk.

- Black & Latino MSM & their partners
- Commercial sex workers
- Pimps
- Swinger Groups
- Community clinics in Watts, Compton, and Willowbrook
- Halfway Houses
- Churches

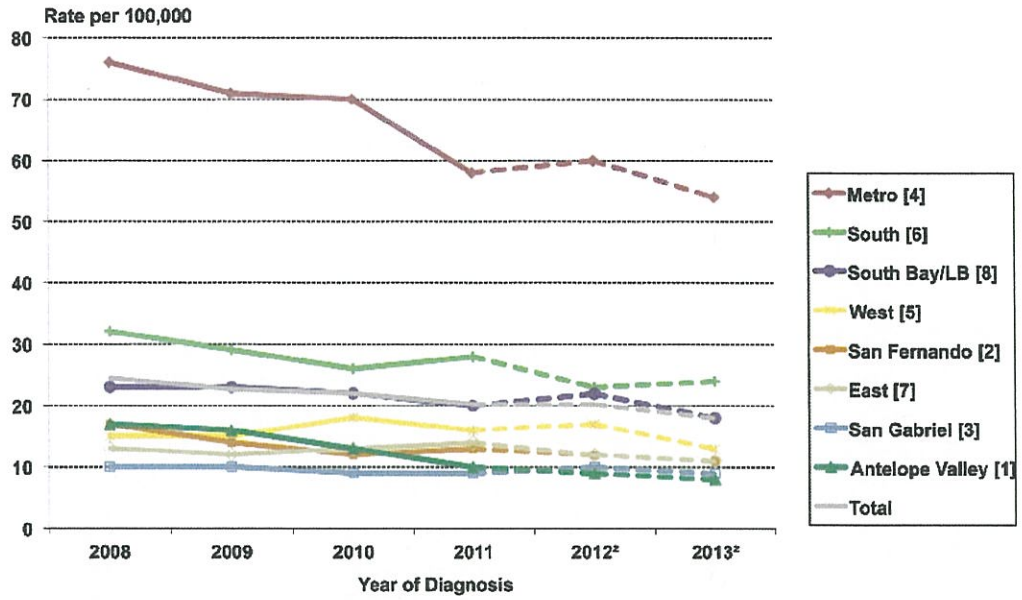
LA County SPAs



HIV Cases as of 2014 by SPA



Rates of HIV Diagnosis by SPA
2008 -2013



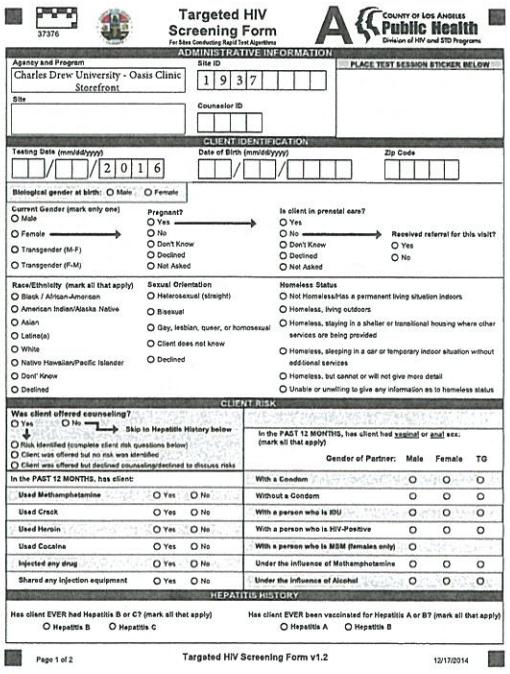
Study Aims

1. To describe the seroprevalence of HIV among individuals tested at the CDU testing site.
2. To describe the demographic characteristics of those testing HIV positive & those testing HIV negative.
3. To describe the risk profile of individuals tested.

Study Design

- Retrospective cohort study design.
- Secondary data analysis of de-identified confidential HIV testing data.
- Data collected collected between January 2013 to September 2015.

Form A



Targeted HIV Screening Form
For Sites Conducting Rapid Test Algorithms
A
County of Los Angeles Public Health
Division of HIV and STD Programs

ADMINISTRATIVE INFORMATION

Agency and Program: Charles Drew University - Oasis Clinic Storefront
Site
Site ID: 1937
Counselor ID
PLACE TEST SESSION STICKER BELOW

CLIENT IDENTIFICATION

Testing Date (mm/dd/yyyy): /2016
Date of Birth (mm/dd/yyyy):
Zip Code
Biological gender at birth: Male Female
Current Gender (mark only one): Male; Female; Transgender (M-F); Transgender (F-M)
Pregnant? Yes; No; Don't Know; Declined; Not Asked
Is client in prenatal care? Yes; No; Don't Know; Declined; Not Asked
Received referral for this visit? Yes; No
Race/Ethnicity (mark all that apply): Black / African-American; American Indian/Alaska Native; Asian; Latino(a); White; Native Hawaiian/Pacific Islander; Don't Know; Declined
Sexual Orientation: Heterosexual (straight); Bisexual; Gay, lesbian, queer, or homosexual; Client does not know; Declined
Homeless Status: Not Homeless/Has a permanent living situation indoors; Homeless, living outdoors; Homeless, staying in a shelter or transitional housing where other services are being provided; Homeless, sleeping in a car or temporary indoor situation without additional services; Homeless, but cannot or will not give more detail; Unable or unwilling to give any information as to homeless status

CLIENT RISK

Was client offered counseling? Yes; No → Skip to Hepatitis History below
Risk identified (complete client risk questions below)
Client was offered but no risk was identified
Client was offered but declined counseling/declined to discuss risks

In the PAST 12 MONTHS, has client:

Used Methamphetamine	Yes	No
Used Crack	Yes	No
Used Heroin	Yes	No
Used Cocaine	Yes	No
Injected any drug	Yes	No
Shared any injection equipment	Yes	No

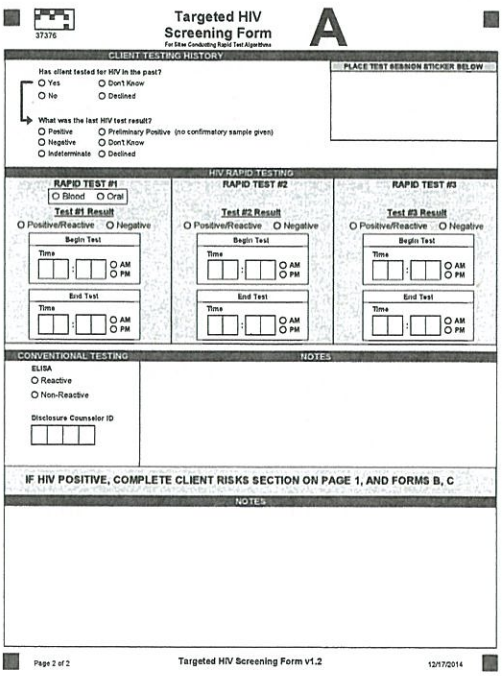
In the PAST 12 MONTHS, has client had vaginal or anal sex: (mark all that apply)

Gender of Partner:	Male	Female	TG
With a Condom			
Without a Condom			
With a person who is HIV			
With a person who is HIV-Positive			
With a person who is MSM (females only)			
Under the influence of Methamphetamine			
Under the influence of Alcohol			

HEPATITIS HISTORY

Has client EVER had Hepatitis B or C? (mark all that apply): Hepatitis B; Hepatitis C
Has client EVER been vaccinated for Hepatitis A or B? (mark all that apply): Hepatitis A; Hepatitis B

Page 1 of 2 — Targeted HIV Screening Form v1.2 — 12/17/2014



Targeted HIV Screening Form
For Sites Conducting Rapid Test Algorithms
A

CLIENT TESTING HISTORY

Has client tested for HIV in the past? Yes; No; Don't Know; Declined
What was the last HIV test result? Positive; Negative; Indeterminate; Preliminary Positive (no confirmatory sample given); Don't Know; Declined
PLACE TEST SESSION STICKER BELOW

HIV RAPID TESTING

RAPID TEST #1	RAPID TEST #2	RAPID TEST #3
Blood Oral		
Test #1 Result: Positive/Reactive Negative	Test #2 Result: Positive/Reactive Negative	Test #3 Result: Positive/Reactive Negative
Begin Test Time : AM PM	Begin Test Time : AM PM	Begin Test Time : AM PM
End Test Time : AM PM	End Test Time : AM PM	End Test Time : AM PM

CONVENTIONAL TESTING

ELISA: Reactive; Non-Reactive
Disclosure Counselor ID

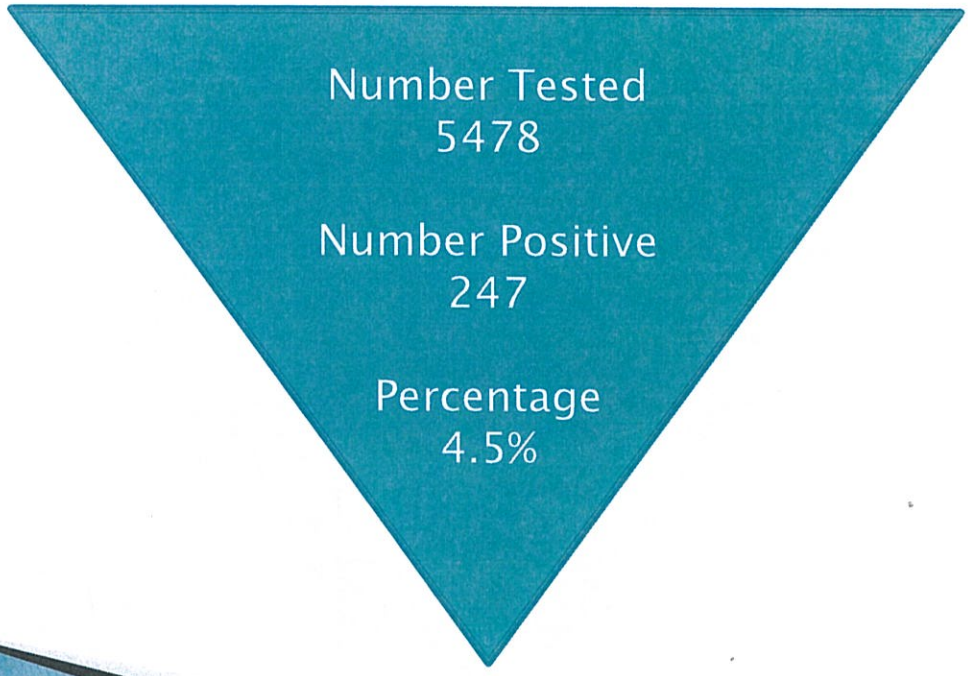
NOTES

IF HIV POSITIVE, COMPLETE CLIENT RISKS SECTION ON PAGE 1, AND FORMS B, C

NOTES

Page 2 of 2 — Targeted HIV Screening Form v1.2 — 12/17/2014

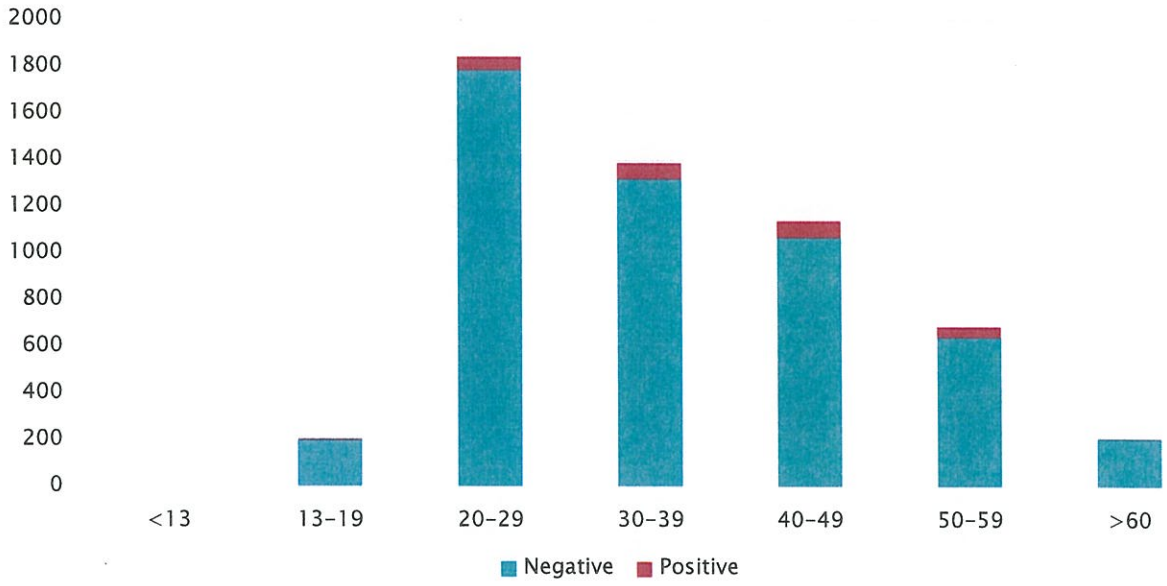
Seropositivity Percentage 1/13 to 9/15



Seropositivity Percentages by Age Group

	Negative	Positive	Total	%	*P*-value
Age Group					
Under 13	3	0	3	0.0%	<0.0001
13–19	202	5	207	2.4%	
20–29	1786	56	1842	3.0%	
30–39	1320	68	1388	4.9%	
40–49	1070	70	1140	6.1%	
50–59	642	46	688	6.6%	
Over 60	208	2	210	1.0%	

Test Results by Age Group



Seropositivity Percentages by Gender

	Negative	Positive	Total	%	*P*-value
Male	3027	204	3231	6.3%	<0.0001
Female	2183	38	2183	1.8%	
Transgender	21	5	26	19.2%	

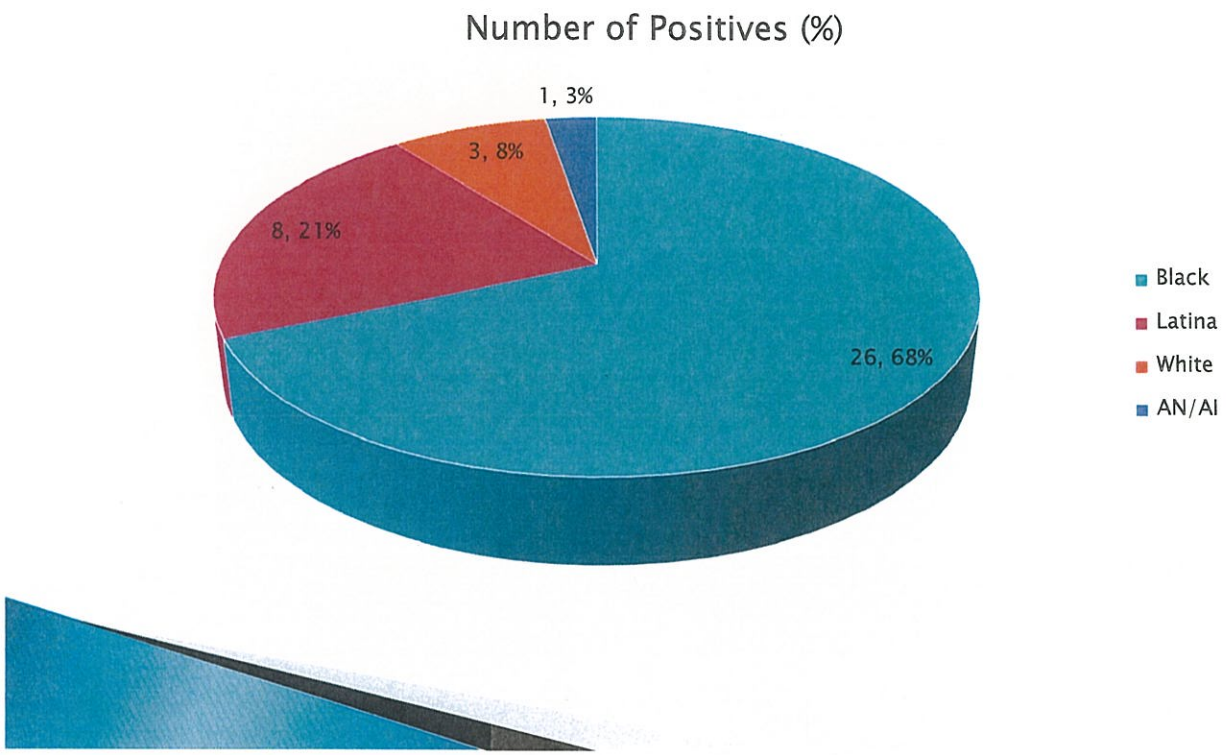
Seropositivity Percentages by Race/Ethnicity

	Negative	Positive	Total	%	*P*-value
White	397	19	416	4.6%	<0.0001
Black	1701	116	1817	6.4%	
Latino	2878	101	2979	3.3%	
Other	217	9	226	4.0%	

HIV+ by Gender & Race/Ethnicity

		White	Black	Latino	Asian	NH/PI	AI/AN	Total
Male	N	15	89	91	6	0	3	204
	%	(7)	(44)	(45)	(3)	(0)	(1)	
Female	N	3	26	8	0	0	1	38
	%	(8)	(68)	(21)	(0)	(0)	(3)	
Transgender	N	1	2	2	0	0	0	5
	%	(20)	(40)	(40)	(0)	(0)	(0)	

HIV+ Women by Race



Seropositivity Percentages by Sexual Orientation

Male/Female	Negative	Positive	Total	%	*P*-value
Heterosexual	3865	105	3970	2.6%	<0.0001
Lesbian/Gay/Bi/ Queer	1307	134	1441	9.3%	

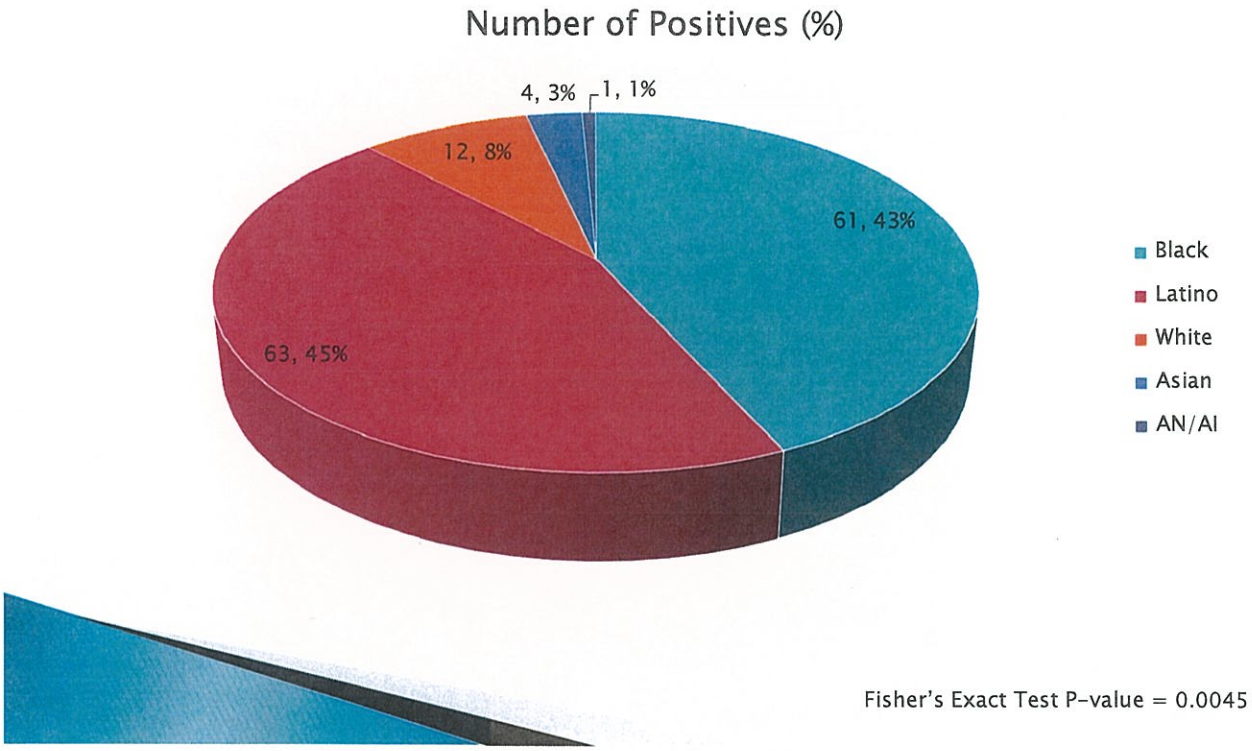
Seropositivity Percentages for MSM

	Negative	Positive	Total	Percentage
MSM	1045	130	1175	11.1%

HIV+ by Sexual Orientation and Race/Ethnicity (M/F)

		White	Black	Latino	Asian	NH/PI	AI/AN	Total
Heterosexual	N	6	55	41	2	0	3	107
	%	(6)	(51)	(38)	(2)	(0)	(3)	
Bisexual	N	3	21	8	0	0	1	33
	%	(9)	(64)	(24)	(0)	(0)	(3)	
Homosexual	N	11	38	52	4	0	2	107
	%	(10)	(36)	(48)	(4)	(0)	(2)	

HIV+ MSM by Race



Fisher's Exact Test P-value = 0.0045

Risk Profiles

Housing Status

	Negative	Positive	Total	%	*P*-value
Permanent Housing	4414	187	4601	4.1%	$P < 0.0002$
No Permanent Housing	711	54	765	7.1%	

Risk Profiles

Drug Use

	Negative	Positive	Total	%	*P*-value
Meth					
Yes	519	39	558	7.0%	$P = 0.0602$
No	3427	183	3610	5.1%	
Crack					
Yes	232	20	252	7.9%	$P = 0.0508$
No	3703	199	3902	5.1%	
Cocaine					
Yes	149	10	159	6.3%	$P = 0.5632$
No	3777	209	3986	5.2%	

Risk Profiles

Drug Use

	Negative	Positive	Total	%	*P*-value
Heroin					
Yes	147	5	152	3.3%	$P = 0.2651$
No	3788	214	4002	5.3%	
Share IDU					
Yes	107	5	112	4.5%	$P = 0.6812$
No	3823	216	4039	5.3%	
IDU					
Yes	178	11	189	5.8%	$P = 0.7420$
No	3756	209	3756	5.6%	

Risk Profiles

Sexual Risk

Did client use a condom while having vaginal/anal sex with a male in the last 12 months?

	Negative	Positive	Total	%	*P*-value
Yes	1417	105	1522	6.9%	*< 0.0011*
No	2564	122	2686	4.5%	

Risk Profiles

Sexual Risk

Did client have vaginal/anal sex with a male injection drug user in the last 12 months?

	Negative	Positive	Total	%	*P*-value
Yes	28	7	35	20.0%	*< 0.0001*
No	3926	215	4141	5.2%	

Risk Profiles

Sexual Risk

Did Client have vaginal/anal sex with an HIV-positive male in the last 12 months?

	Negative	Positive	Total	%	*P*-value
Yes	216	39	255	15.3%	*< 0.0001*
No	3740	185	3925	4.7%	

Risk Profiles

Sexual Risk

Did Client have vaginal/anal sex with an HIV-positive female in the last 12 months?

	Negative	Positive	Total	%	*P*-value
Yes	67	8	75	10.7%	*< 0.04*
No	3887	214	4101	5.2%	

Next Steps

- Explore data on an ongoing basis.
- Explore disease progression in individuals testing positive.
- Do more extensive data analyses, such as odds ratios, to explore presence of HIV in specific groups that test at our site.
- Others?

Summary

- HIV seropositivity percentages are high among men testing at CDU.
- HIV seropositivity percentages are high among MSM testing at CDU.
- HIV seropositivity percentages are high among American Indians/Alaska Natives testing at CDU.
- HIV seropositivity percentages are high among transsexuals testing at CDU.
- Black and Latino represent the highest percentages among men testing positive at CDU.
- Black women represent the highest percentages among women testing positive at CDU.

Acknowledgements

- Wilbert C. Jordan, MD, MPH, Director of Storefront HIV Testing Program
- Magda Shaheen, PhD, Director of Research Design and Biostatistics
- Dulcie Kermah, MPH, Biostatistician

Eric Houston, Gregory Victorianne, and Ryan Kofron

Thank you

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John Forbes, 323-563-5812, johnforbes@cdrewu.edu

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

11. CALIFORNIA OFFICE OF AIDS (OA) REPORT

California Department of Public Health CDPH

OFFICE OF AIDS
California Department of Public Health

California Department of Public Health, Office of AIDS
Report to Los Angeles County Commission on HIV
January 2017

Office of AIDS Division/Cross Branch Issues

The California Department of Public Health (CDPH), Office of AIDS (OA) is pleased to announce that the Governor's Budget proposal, released on January 10, 2017, includes several funding authority shifts and policy changes in alignment with California's *Laying a Foundation for Getting to Zero* Integrated Plan. These include:

- implementing Standards of Care for OA's HIV Care Program,
- enhancing OA's Ryan White Part B Clinical Quality Management Program,
- implementing ADAP Case Management services,
- implementing a new ADAP Pharmacy Quality Incentive Program, and
- expanding ADAP's Medicare Part D Premium Payment Program to pay Medicare Part B premiums and outpatient medical out-of-pocket costs for enrolled individuals in order to achieve parity with OA's Health Insurance Premium Payment Program (OA-HIPP), which pays health insurance premiums and medical out-of-pocket costs for eligible individuals enrolled in ADAP who are not in Medicare.

Additional information about these items and more are available on the OA website (www.cdph.ca.gov/programs/aids/Pages/TOAStateFunding.aspx), including a summary of the OA-specific budget items (www.cdph.ca.gov/programs/aids/Documents/FY%202017-18%20Governor%27s%20Budget%20Office%20of%20AIDS%20Talking%20Points.pdf).

Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention and Care Plan

- On January 5, 2017, the California Conference of Local Health Officers (CCLHO) Board of Directors voted to endorse implementation of California's "Laying a Foundation for Getting to Zero" Plan. Subsequent discussion included encouraging OA to work with Local Health Officers and Local AIDS Directors throughout California to achieve the objectives.

- The California Needs Assessment and Integrated Plan Workgroup reconvenes meeting this month, holding their first meeting of the New Year on January 11th. In January, the Partner Services Brief will be distributed to the co-authors' local planning councils for review; the Mental Health and Substance Use Briefs will

undergo review by subject matter experts. The Housing Brief, which examines both the current housing situation of people living with HIV and the housing services available to them, is now entering a review phase. Input from coauthors pertaining to local re-engagement efforts and services is being collected and will be folded into the Re-engagement Services Brief, also currently in review.

- Leadership from OA met with Covered California and Department of Health Care Services (DHCS) Mental Health and Substance Use Disorders leadership in December to review common goals of the Integrated Plan and discuss collaboration possibilities. OA branches have been meeting and reviewing the strategies and activities of the Integrated Plan to begin to prioritize work plans. Beginning in January, OA staff will reach out to local health jurisdictions to discuss their initial activities to address the goals of the Integrated Plan.

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

- **Staffing Update**
  - OA has started recruitment to fill the ADAP Branch Chief position, formerly filled by Niki Dhillon. In the interim, Majel Arnold, OA's Care Branch Chief and Project Director for OA's Ryan White Part B funding, will temporarily serve as Acting ADAP Branch Chief and work closely with Dr. Karen Mark to address all ADAP priorities and activities.

- **Contractor Update**
  - Since November 29, 2016, the ADAP enrollment portal remains unavailable to ADAP enrollment workers and clients. The portal is only available to ADAP Advisors, A.J. Boggs Customer Support Team (CST), and Magellan call center staff. The portal will be made available to enrollment workers through a new connection via Citrix Access Gateway in late January. OA will contact enrollment workers with more information and instructions on how to access the portal once it becomes available.
  - The Magellan call center is able to provide real-time, 24/7 access to a 30-day supply of medications for existing ADAP clients who experience access issues at the pharmacy. The A.J. Boggs CST also has access to the Magellan system and is able to make real-time eligibility updates.

- **Interim Process**
  - During the portal outage period, enrollment workers have been instructed to fax paper applications for new applicants to A.J. Boggs. Effective December 15, 2016, and until further notice, enrollment workers should not submit an ADAP application or any supplemental application

documentation for medication assistance program annual re-enrollments or six-month re-certifications.

- For OA-Health Insurance Premium Payment (OA-HIPP) clients, health plan documentation must be submitted at the time of re-enrollment or recertification, and anytime there is a change in order to ensure that premium payment is made accurately. Enrollment workers should submit this information to the appropriate OA-HIPP Analyst. Applications for clients that require a binder payment (initial premium payment) must be submitted directly to the appropriate OA-HIPP Analyst via secure/encrypted email.
- **Enrollment workers must continue to meet with their clients to conduct the re-enrollment or recertification process to ensure that clients are still eligible for ADAP. This is a requirement of ADAP's federal funder.** The application and supplemental documentation must be stored in the client's physical file at the enrollment site for audit purposes.
- Effective December 19, 2016, for clients who were due for re-enrollment or recertification in December 2016, January 2017, or February 2017, eligibility has been extended 6 months to their next upcoming re-enrollment or recertification date.
- Effective December 30, 2016, clients whose eligibility had expired on October 31, 2016, and who had taken action on their application in the portal, and clients whose eligibility ended during the month of November 2016, will be extended 6 months to their next upcoming re-enrollment or recertification date.

- **Enrollment Worker Communication**
  - To keep enrollment workers and stakeholders apprised of ADAP updates and enrollment portal status, ADAP has developed a weekly communication plan. Effective December 19, 2016, communication to enrollment workers and stakeholder was disseminated twice a week. Effective January 12, 2017, based on feedback from enrollment workers, communication to enrollment workers and stakeholders is disseminated once a week every Thursday. ADAP Communications are posted on the ADAP webpage of the OA website at www.cdph.ca.gov/programs/aids/Pages/ADAPEWCallSummaries.aspx.

- **ADAP Enrollment Worker Resources**
  - On December 20th and December 21st, ADAP disseminated an enrollment site report to each site that had responded to their ADAP Advisor's email request for their site contact information. The report included a list of the

site's clients' first and last name, date of birth, ADAP ID number, eligibility start date and the client's new, extended eligibility end date.

- The updated 2017 Comprehensive Health Care Coverage client handout has been updated to include health care options for individuals who do not qualify for Covered California Health Coverage. This document has been translated into Spanish and posted on the ADAP website.
  English version:
  www.cdph.ca.gov/programs/aids/Documents/CovCAOverviewbyOA.pdf
  Spanish version:
  www.cdph.ca.gov/programs/aids/Documents/CovCAOverviewbyOASPA.pdf
- Medical out of pocket benefit outreach materials, a provider waiting room poster and client card, have been finalized. These documents will be translated to Spanish and made available to providers and enrollment workers.

RW Part B: HIV Care Program (HCP)

- On January 5, 2017, OA conducted a Fiscal Year 17-18 HCP Contract Kickoff webinar for HCP Contractors. The webinar provided: technical assistance on budget development for 2017/18, technical assistance on budget forms and tracking forms, an overview of changes to Ryan White Service Categories, and a forum for questions and answers.

- On December 1, 2016, Ivo Klemes was promoted to Care Operations Unit Chief. He will continue covering the fiscal desk until a replacement has been hired. Guadalupe Morimune has joined the Care Operations Unit as the newest Care Operations Advisor. She will support Fresno, Madera, Marin, Mariposa, Merced, Sacramento, San Francisco, and Solano Counties.

- The Ryan White Service Report (RSR) is largely unchanged for 2017, although a few minor enhancements have been made to AIDS Regional Information & Evaluation System (ARIES) to make the report more accurate. While the Health Resources and Services Administration, HIV/AIDS Branch's (HAB's) deadline for creating the Provider Report and uploading the Client Report in the RSR Web System is March 7, 2016, Grantees may have a large number of RSRs to review, verify, and submit. They may require an earlier deadline to ensure they can review and validate all their RSRs in a timely manner. HCP providers (Part B) must complete their Provider Report and upload it to the HAB Web Application System by February 15, 2016. More information on the RSR will be available in *The ARIES Advisor* later in the month.

- ARIES Policy Notice E6 was recently posted at www.projectaries.org. The notice defines and documents the data collection requirements for Outreach and Early Intervention Services (EIS) services categories.

AIDS Medi-Cal Waiver Program (MCWP)

- The 2017 – 2021 AIDS Waiver Renewal Application continues to be under Request for Additional Information (RAI) status per the federal Centers for Medicare and Medicaid Services (CMS) pending responses to follow-up questions sent by CMS. DHCS has formally requested a 60-day temporary extension, which was accepted by CMS on December 21st. The extension runs through March 1, 2017. MCWP and DHCS staff continue to respond to the CMS follow-up questions, and anticipate completing the responses by early January.

- The MCWP Project Director (PD) monthly teleconferences will resume on January 11, 2017. In addition to the teleconferences, MCWP anticipates having training sessions for AIDS Waiver agencies regarding the content of the approved 2017 – 2021 Waiver. The MCWP will schedule these trainings as soon as the Waiver application is approved by CMS.

- All Project Directors' Letter 16-03, which was released December 30, 2016, describes changes to the "service hierarchy" in the ARIES. The new MCWP service hierarchy is based directly on the AIDS Waiver Program Billing Code and Rates. This change will better reflect the work performed by MCWP providers, minimize data entry, and allow for more meaningful reports to be created.

HIV Prevention

- Staff from OA attended and participated in the California Syphilis Prevention Summit convened by CDPH Sexually Transmitted Disease Control Branch (STDCB) and the County of Los Angeles Public Health, Division of HIV and STD Programs in Los Angeles, CA from January 9 – 10, 2017. OA staff will collaborate with STDCB on the application of HIV status data on syphilis cases for Linkage-to-Care or Pre-Exposure Prophylaxis (PrEP) referral.

- The Kings County Public Health Department has applied to CPDH to authorize a new syringe exchange program (SEP). The proposed Kings County Needle Exchange will have fixed site locations in Hanford, Lemoore, Corcoran, and Avenal health clinics. The Kings County Board of Supervisors voted to endorse the application.

  The 90-day public comment period for the Kings County SEP certification application was initiated on October 31, 2016, and will close on January 29,

2017. Public comments may be submitted to CDPH SEPCertificationProgram@cdph.ca.gov, and must be submitted no later than 11:59 p.m., January 29, 2017. CDPH will then review the application and issue a decision within 30 business days.

If approved, the new SEP will also be able to participate in the California Syringe Exchange Supply Clearinghouse which now provides a baseline level of supplies to authorized SEPs throughout California. California SEPs have been giving rave reviews of the project, which is a collaboration with the North American Syringe Exchange Supply Network (NASEN.) Several SEPs report being able to add new services, such as patient navigation, wound care, and expanded outreach with the new support from OA and the Supply Clearinghouse.

- OA staff will attend the Bay Area Condom Distribution as a Structural-Level Intervention Regional Institute in Berkley, California from January 23 – 24, 2017. The meeting is being convened by AIDS Project Los Angeles; Asian and Pacific Islander Wellness Center; Cicatelli Associates, Inc.; and the New York Department of Health and Mental Hygiene. Goals for the meeting include: 1) Increase stakeholders' understanding of all aspects of Condom Distribution as a Structural-level Intervention (CDSI); 2) Promote capacity building assistance (CBA) services for health departments, community-based organizations, and community health organizations; and, 3) Increase attendees' capacity to implement CDSI.

California Planning Group (CPG)

OA is in the process of recruiting members for the CPG for the new membership term beginning in March 2017. In order to ensure CPG representation among the communities most affected by the epidemic, OA is doing additional recruitment for At-Large applicants.

While OA is currently reviewing a diverse pool of applicants, OA would like to see stronger CPG representation among these three communities: transgender women of color, young (18-30 years of age) MSM of color, and representatives from the Central Valley. These communities face disproportionate rates of HIV disease as well as HIV-related disparities including stigma, marginalization, and structural inequalities. To address increased access to prevention and care and optimize health outcomes for the people most directly impacted by the epidemic, it is imperative that they be represented in statewide planning efforts.

For those who represent any of the three communities and are interested in applying:

- There is the option of applying for a 3-year or 5-year membership term

- The online application is available on the OA website at www.cdph.ca.gov/programs/aids/Documents/CPG_2017_App_Final.pdf
- Additional information about CPG is available on the OA website at www.cdph.ca.gov/programs/aids/Documents/2017CPG_FunctionStructureWorkProducts_Final.pdf

Applications must be submitted by close of business on **January 20th** by email to cpg@cdph.ca.gov or certified mail to:

California Department of Public Health
MS770, PO Box 997426
Sacramento, CA 95899-7426
Attention: Katrina Gonzalez

For questions regarding this report, please contact: majel.arnold@cdph.ca.gov.

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13. STANDING COMMITTEE REPORTS

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

(1) Ryan White Program FY 2017 Parts A, B, MAI Allocations

(2) Community Engagement Workgroup

(a) Tier 2 Listening Sessions Summary Presentation

(b) Tier 3 Listening Sessions Flyer

Ryan White PY 2017 (March 1, 2017 - February 28, 2018) Allocation Recommendations[A]
(Jan. 11, 2017)

		Year 27 Allocations			
	Category[B]	Part A % (DHSP)	Part B % (DHSP)	MAI % (DHSP)	Priority Ranking
Core Services	Outpatient Medical (AOM/Medical Specialty)	**27%**	0%	0%	4
	Oral Health (General and Endodontics)	**18%**	0%	0%	11
	Mental Health (Psychotherapy and Psychiatric)	**6%**	0%	0%	8
	Medical Case Management (MCC)	**27%**	0%	0%	5
	Home and Community-Based Health Services	**7%**	0%	0%	15
	Medical Nutrition Therapy	0%	0%	0%	20
	Substance Abuse Treatment	0%	0%	0%	13
	AIDS Drug Assistance Program	0%	0%	0%	
	AIDS Pharmaceutical assistance (Local Pharmacy Assistance)	0%	0%	0%	23
	Early Intervention Services	0%	0%	0%	
	Health Insurance Premium and Cost Sharing Assistance	0%	0%	0%	21
	Home Healthcare	0%	0%	0%	16
	Hospice Services	0%	0%	0%	
Support Services					
	Non-Medical Case Management				
	BSS	**4%**	0%	0%	1
	TCM	0%	0%	**21%**	1
	Housing				
	RCFCI & TRCF	0%	**91%**	0%	2
	Other	0%	0%	**53%**	2
	Substance Use Treatment - Residential				
	Residential Detox	0%	**9%**	0%	14
	Residential Rehabilitation, Transitional, and Day Treatment	**7%**	0%	0%	14
	Foodbank/Home-Delivered Meals	**3%**	0%	0%	12
	Transportation	0%	0%	0%	9
	Language Services	0%	0%	0%	17
	Outreach	0%	0%	**26%**	3
	Referral	**1%**	0%	0%	22
	Legal Services	0%	0%	0%	18
	Psychosocial Support Services	0%	0%	0%	7
	Health Education/Risk Reduction	0%	0%	0%	10
	Nutrition Support	0%	0%	0%	12
	Rehabilitation Services	0%	0%	0%	19
	Respite	0%	0%	0%	24
	Direct Services Total[C]	**100%**	**100%**	**100%**	

[A] Los Angeles County has not received the notice of award for PY 2017 as of Jan. 11, 2017

[B] Medical Nutritional Therapy, Transportation, Language, and Legal services will be supported with NCC funds in PY 2017

[C] 10% of the Part A, Part B, and MAI award is for administrative costs
up to 5% of the Part A award must be spent on Quality Management (CQM)

2016
LISTENING SESSIONS HIGHLIGHTS
TIER 2

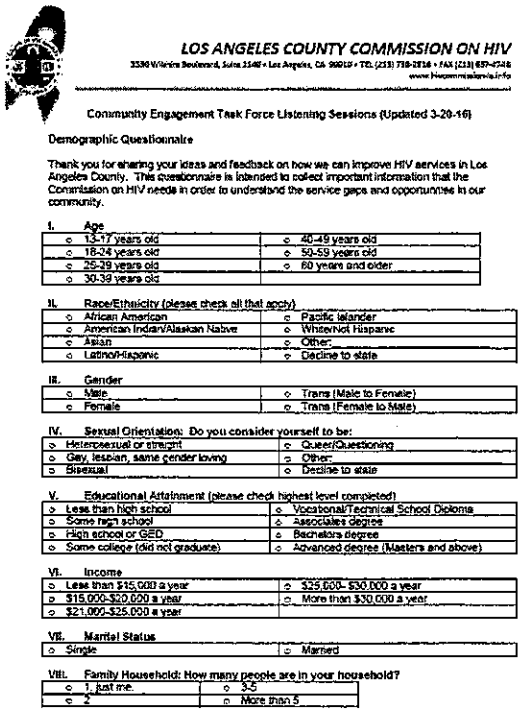
LOS ANGELES COUNTY COMMISSION ON HIV

PROCESS HIGHLIGHTS

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

PROCESS HIGHLIGHTS

- Developed demographic questionnaire and listening sessions discussion questions.
  - English and Spanish
- Secured assistance of neutral and trained facilitators.
- Process is ongoing.



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Community Engagement Task Force Listening Sessions (Updated 3-20-16)

Demographic Questionnaire

Thank you for sharing your ideas and feedback on how we can improve HIV services in Los Angeles County. This questionnaire is intended to collect important information that the Commission on HIV needs in order to understand the service gaps and opportunities in our community.

I. Age

○ 13-17 years old	○ 40-49 years old
○ 18-24 years old	○ 50-59 years old
○ 25-29 years old	○ 60 years and older
○ 30-39 years old	

II. Race/Ethnicity (please check all that apply)

○ African American	○ Pacific Islander
○ American Indian/Alaskan Native	○ White/not Hispanic
○ Asian	○ Other:
○ Latino/Hispanic	○ Decline to state

III. Gender

○ Male	○ Trans (Male to Female)
○ Female	○ Trans (Female to Male)

IV. Sexual Orientation: Do you consider yourself to be:

○ Heterosexual or straight	○ Queer/Questioning
○ Gay, lesbian, same gender loving	○ Other:
○ Bisexual	○ Decline to state

V. Educational Attainment (please check highest level completed)

○ Less than high school	○ Vocational/Technical School Diploma
○ Some high school	○ Associates degree
○ High school or GED	○ Bachelors degree
○ Some college (did not graduate)	○ Advanced degree (Masters and above)

VI. Income

○ Less than $15,000 a year	○ $25,000- $30,000 a year
○ $15,000-$20,000 a year	○ More than $30,000 a year
○ $21,000-$25,000 a year	

VII. Marital Status

○ Single	○ Married

VIII. Family Household: How many people are in your household?

○ 1, just me	○ 3-5
○ 2	○ More than 5

COMMON THEMES

- Need for prevention services
- Importance of culturally responsive services
- Need for follow-through with providers
- Need for improved access to services and housing
- Lack of coordination between health providers
- Need for information being disseminated correctly to clients
- HIV specific treatment centers were seen as highly comprehensive and comfortable for clients
- More proactive approaches to the most in need populations around Los Angeles

SPANISH SPEAKING WOMEN OF COLOR (N=10)

- **Experiences when obtaining HIV services:**
  - Limited time with doctors
  - Limited dental services and clinics
  - Lengthy scheduling process
  - Rude receptionists
  - Sometimes sent to hospitals that are far from place of residence
  - Lack of translation services

SPANISH SPEAKING WOMEN OF COLOR (N=10)

- **Accessing health insurance:**
  - Denial due to missing paper work or lack thereof due to instability in housing and other situations
  - Lack of knowledge about application process
  - Confusion about navigating private insurance (rules and coverage limits)

SPANISH SPEAKING WOMEN OF COLOR (N=10)

- **Services Requested:**
  - Create more educational workshops and support groups
  - Focus on mental health services and access
  - Turnover of psychiatrists make it difficult to get adequate help

SPANISH SPEAKING WOMEN OF COLOR (N=10))

- **Big picture/salient points:**
  - Need more funding for services and clinics
  - Need help with housing services
  - Lack of care coordination
  - Need for cultural competency

TEEN YOUTH (N=3)

- **Experiences when obtaining HIV services:**
  - Lack of information geared towards young people
  - Unsure how to utilize services properly
  - Not sure they would be welcomed due to age
  - Medical clinics appeared to be first line experience in regards to HIV related treatment and prevention
  - Consider different modes of interaction that would reach youth populations (i.e. social media)

TEEN YOUTH (N=3)

- **Accessing health insurance:**
  - Need to go to primary care physician first diminishes convenience
  - Type of insurance determines what type of service they get
  - Not sure they would be welcomed at specialty clinics

TEEN YOUTH (N=3))

- **Services Requested:**
  - More comprehensive STI/HIV education in schools that is offered more frequently
  - Access to resources and groups that help with housing
  - No cost youth services, testing and counseling
  - Ensure privacy and confidentiality from parents

TEEN YOUTH (N=3)

- **Big picture/salient issues brought up:**
  - More opportunities to receive HIV and STI prevention education at various settings easily accessible to youth (i.e., schools, after-school programs, community-based organizations, parks, libraries)

NATIVE AMERICAN (N=17)

- **Experiences when obtaining HIV services:**
  - Takes too much time to get services from specialists
  - Lack of specialty services that target Native American/Alaskan Native populations

NATIVE AMERICAN(N=17)

- **Accessing health insurance:**
  - Disorganization of the health insurance system affects access and ability to navigate the system
  - Miscommunication from private insurers

NATIVE AMERICAN (N=17)

- **Services Requested:**
  - Support groups on mental health
  - More ways to volunteer within the community

NATIVE AMERICAN (N=17)

- **Big picture/salient points:**
  - Need for culturally tailored services for the Native American community
  - Develop services around the unique cultural strengths of the community
  - Harness the influence of leaders in the community to encourage healthy behaviors

NEXT STEPS

- Tier 3 Populations:
  - Asian/Pacific Islander community
  - Trans-masculine individuals
  - Post-incarcerated individuals
  - 25-29 year old individuals
  - HIV workforce (2 sessions)
- Help us recruit
- Flyers are in today's meeting packet.

Los Angeles County Commission on HIV

in collaboration with the

Department of Public Health

Division of HIV and STD Programs

COUNTY OF LOS ANGELES **Public Health**

If you fit any of these targets groups and/or are a consumer of HIV prevention and care services, you are invited to a

COMMUNITY LISTENING SESSION

The listening session (focus group) seeks to understand the needs, gaps, and barriers in accessing HIV prevention and care services within Los Angeles County.
Participants must be 18 years of age or older to participate. Sessions are strictly confidential.

Target Group	Location	Date	Time	RSVP Deadline
Asian/Pacific Islander	APAIT Building 1730 W Olympic Blvd #300	January 25th	6-7:30pm	January 23rd
Trans-Masculine	APAIT Building 1730 W Olympic Blvd #300	January 30th	6-7:30pm	January 27th
Recently Incarcerated	Commission on HIV 3530 Wilshire Blvd Ste. 1140	February 14th	5:30-7pm	February 10th
25-29 Year Olds	Reach LA 1400 E Olympic Blvd # 240	February 16th	3-4:30pm	February 14th
HIV Workforce #1	The California Endowment 1000 North Alameda St.	February 24th	12-1:30pm	February 22nd
HIV Workforce #2	Building Healthy communities Long Beach 920 Atlantic Ave. Suite 102, Long Beach	February 28th	12-1:30pm	February 24th

A maximum of 15 consumer participants per session. Food and gift cards will be made available to those who participate.

Waivers of liability will be required and made available at the Listening Session.

For RSVP and more information please call: (213) 738-2816

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13. STANDING COMMITTEE REPORTS (cont'd)

C. Public Policy Committee:

(1) 2017-18 Legislative Landscape and Impact

ITUP
INSURE THE UNINSURED PROJECT

ACA Watch
Issue 1 – December 6, 2016

Uncertain Future for the ACA

FAQs on Repeal and Replace

About ACA Watch

After six years of vigorous implementation of the federal Affordable Care Act (ACA), California cut the number of uninsured in the state by half and embarked on reforms and system transformations touching all aspects of the state's health care delivery system. In the wake of the 2016 Presidential election, California's reform progress, and progress around the country, is at risk. President-elect Trump, and Republican members of Congress now in the majority in both houses, campaigned on a platform of repealing and replacing the ACA. It is, however, far from clear what comes next.

As the federal repeal and replace debate unfolds, ITUP's **ACA Watch** will periodically highlight emerging federal proposals, Congressional and administrative actions and potential impacts for health care and health reform in California.

While the President-elect committed to "repeal and replace" the ACA during the campaign, he has also recently indicated his desire to retain key ACA provisions, such as the prohibition against insurers excluding or limiting coverage for people with pre-existing health conditions and the requirement allowing dependents up to age 26 to continue coverage under their parent's plan.

In addition, Congressional rules and procedures, as well as disagreements within the Republican Party, make the timing and method for repeal, and the elements of any ACA replacement, uncertain, with new policy and political possibilities unfolding daily.

This set of Frequently Asked Questions (FAQs) outlines key issues and procedural questions controlling the options and strategies federal officials have for moving forward with any ACA repeal.

1. Can the current Congress repeal the ACA in its entirety?

Most likely the ACA will not be completely repealed, though substantial portions of the Act are at risk of repeal through the budget reconciliation process discussed in Question #2 below. Under the current rules of the Senate (which can be altered by a majority vote), it takes two-thirds of the Senate (60 votes) to end debate and proceed to a vote on a bill not created as a part of budget reconciliation. That means in the current Congress at least eight Democrats would be required to support the Republican agenda to reach 60 votes and end any filibuster. In light of the current makeup of the Senate, any significant repeal or amendment of the ACA through the general legislative process would require some Democratic support and compromise. Significantly, many Republicans believe that

moderate Democrats who are running for re-election in 2018 in conservative states may be supportive of Republican efforts to rollback or repeal portions of the ACA.

2. What is the budget reconciliation and what can Congress change or repeal through the budget reconciliation process?

The reconciliation process was created by the Congressional Budget Act of 1974 and allows Congress to change existing laws to conform to the tax, spending and debt levels enacted in the budget. A budget reconciliation bill is not subject to filibuster in the Senate and therefore needs only a majority vote of the Senate (51 votes) to be heard and voted upon. If a reconciliation bill is passed, it is then sent to the President for signature or veto.

3. What parts of the ACA can technically be repealed by Congress as part of budget reconciliation?

Those parts of the ACA that impact spending, revenue or the debt limit, which would include:

- Individual and employer mandates;
- Medicaid expansion;
- Premium subsidies and small business tax credits;
- Cost-sharing reductions;
- Taxes, such as the Health Insurance Tax;
- Limits on the use of Health Savings Accounts, Flexible Spending Accounts (FSAs), and Medical Savings Accounts (MSAs) to purchase over the counter medications; and
- Limits on annual contributions to FSAs.

In 2015, Congressional Republicans sought to repeal these same provisions in budget reconciliation legislation (H.R. 3762), subsequently vetoed by President Obama, which could serve as a model for future ACA repeal legislation. The "Restoring Americans' Healthcare Freedom Reconciliation Act of 2015," did not repeal Obamacare in its entirety. Instead it affected key features of the ACA necessary to make the whole system work. It would have:

- Restricted the federal government from operating health care exchanges;
- Phased out funding for subsidies to help lower and middle-income individuals afford insurance through the health care exchanges;
- Eliminated tax penalties for individuals who do not purchase health insurance and employers with 50 or more employees who do not provide insurance plans;
- Eliminated taxes on medical devices and the so-called "Cadillac tax" on the most expensive health care plans; and
- Phased out the expansion of Medicaid over a two-year period.

4. Are there elements of the ACA that cannot be repealed through the budget reconciliation process?

Yes. Everything that does not involve spending, taxing or the deficit must go through the regular legislative process and is subject to filibuster in the Senate. Provisions of this kind that were not included in the 2015 reconciliation bill include, for example: private market reforms, such as limits on medical-loss ratios, prohibition on pre-existing condition exclusions, and premium rating rules limited to age within specified limits, family size and geography; the requirement that health plans in the individual and small group markets must offer "essential health benefits" at a minimum; and the prohibition on annual and lifetime dollar limits on coverage for essential health benefits.

5. What type of reforms is President-elect Trump contemplating?

It is too early to tell precisely what the President-elect will actually propose related to ACA repeal. His website at one point stated unequivocally that the individual mandate must be eliminated: "No person should be required to buy insurance unless he or she wants to." According to his more detailed **health care plan**,[1] he would replace the ACA with tax-free health savings accounts that would be available to all family members, accumulate over time, and be transferable, tax-free to all heirs. Mr. Trump also seeks to allow insurers to sell policies across state lines and individuals who buy insurance to deduct the premiums on their tax returns. Medicaid would be managed and administered by the individual states via block grants and there would be funding for state high-risk pools for those who fail to maintain coverage and have pre-existing health conditions.

The President-elect's approach is similar to the June 2016 "**Better Way**" white paper[2] on health reform prepared under the leadership of the Speaker of the House Paul Ryan.

As of this writing, many Republicans are supporting a legislative effort early in 2017 to repeal those ACA elements that can be repealed through budget reconciliation as described above, with a delay in the effective date to allow time for development and enactment of a replacement plan. This approach is sometimes referred to as "repeal and delay."

6. What ACA private market reforms did the House Republican Better Way agenda suggest should be retained?

The "Better Way" agenda proposed retaining the following market reforms:

- Pre-existing exclusion prohibition;
- Guaranteed Issue (guaranteed availability);
- Community Rating (though modified);
- Bans on lifetime limits on essential health benefits (but not annual dollar limits); and
- Prohibition against coverage rescissions absent fraud or intentional misrepresentation.

7. What about all the regulations that implemented the ACA? Can Congress repeal those?

Congress lacks authority to repeal regulations absent a statute authorizing it to do so. However, the federal agencies that promulgated the regulations, such as the U.S. Department of Health and Human Services (DHHS), may repeal or revise existing regulations. The nominee to head DHHS, U.S. Representative Tom Price, has been a staunch opponent of the ACA.

Nonetheless, repealing ACA regulations would not be an easy task since federal regulations are subject to the Federal Administrative Procedure Act (APA). The federal APA requires, among other things, that any repeal of regulations be legally supported, after notice to the public and a public comment period.[3] Thus, while attempts may be made to repeal the regulations, absent a Congressional repeal of the federal statutory implementing provisions, an administrative repeal of the regulations may face difficulty passing judicial scrutiny.

8. Assuming Congress does make substantial changes to the ACA, will there be any disruption in coverage that currently exists?

Both the President-elect and Republican leadership have suggested that they wish to avoid disruptions in coverage, though the details on how they would accomplish that goal (other than delaying the effective date of repeal provisions) are yet to emerge.

9. What is the impact of a repeal of the ACA in California?

California has fully embraced the ACA and implemented all of its provisions. California has one of the most successful state-run exchanges in the country, Covered California. In 2016, more than 1.2 million Californians are receiving $4.6 million in premium tax credits to help pay for coverage through Covered California.[4] Since the ACA expansion began, more than 4 million Californians gained coverage under Medi-Cal, California's Medicaid program. The combined total of federal ACA coverage expansion funds in California is estimated at $20 billion annually, approximately $15 billion in Medi-Cal and nearly $5 billion for the insurance subsidies administered by Covered California.

Importantly, many of California's ACA implementing laws are contingent on the validity of federal law and are operative only as long as the federal law is effective, or for a limited period of time after the date of amendment or repeal of federal law. For example, if the federal individual requirement to have coverage is amended or repealed, multiple provisions of California law affecting private insurance coverage would be automatically repealed 12 months later.

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Insure the Uninsured Project (ITUP) is a nonprofit, 501(c)(3) organization, founded in 1996, with offices in Santa Monica and Sacramento, California. ITUP's mission is to advance creative and workable policy solutions that expand health care access and improve the health of Californians. ITUP conducts policy-focused research and convenes broad-based stakeholders on health policy topics, acting as an honest broker among diverse health care leaders in the state. To assist with implementation of health reform in California, ITUP hosts an annual statewide conference in Sacramento and facilitates regional and statewide workgroups on topics affecting health and health care in the state.

FACT SHEET

OUR HEALTH CARE AT RISK

Medicare, Medicaid, and the Affordable Care Act

The election of Donald Trump, along with Republican control of both houses of Congress, threatens health coverage for millions of Americans and the progress we've made in the last half-century with the enactment of Medicaid, Medicare, and the Affordable Care Act (ACA).

Dramatic rollbacks in health care and coverage are at the top of the agenda of both President-elect Trump and Speaker Paul Ryan, who has re-committed to his longstanding plan to cut Medicaid and Medicare. Many of those changes, as well as repeal of many (but not all) elements of the Affordable Care Act, could be passed through budget reconciliation, which only requires 51 votes in the Senate, a majority vote of the House, and the President's signature.

Medicaid Safety-Net Coverage

- **Medicaid (called Medi-Cal in California) provides coverage to nearly 14 million Californians**, over a third of the state, including a majority of our children, 2/3 of nursing home residents, and many other families and individuals living in poverty. Medi-Cal is a lifeline for those who otherwise don't have access to health care and provides a safety-net for any one of us who may suddenly lose a job or income.
- Speaker Ryan's "Better Way" proposal would **undo Medicaid's matching guarantee** to California, and cap the money going to states. States would be forced to choose between taking Medicaid funds either as a block grant or a per-capita cap, neither of which provide sufficient funding to cover California's ongoing needs.
- The GOP Congress also seeks (passing last year in a 51-vote Senate reconciliation bill) to **repeal the Medicaid expansion under the ACA, which provides $16 billion to California** in the 2016-17 budget year.
- Repeal of the Medicaid expansion alone would eliminate coverage to over 3.5 million Californians.
- National estimates forecast the Ryan proposal will cut **Medicaid funding by a third to half in ten years, endangering coverage for millions more Californians**, as well as forcing further funding reductions for hospitals and other health providers.
- Medicaid cuts of this magnitude would endanger the safety net of hospitals and the health providers we all rely on.

Financial Assistance to Buy Private Coverage in Covered California

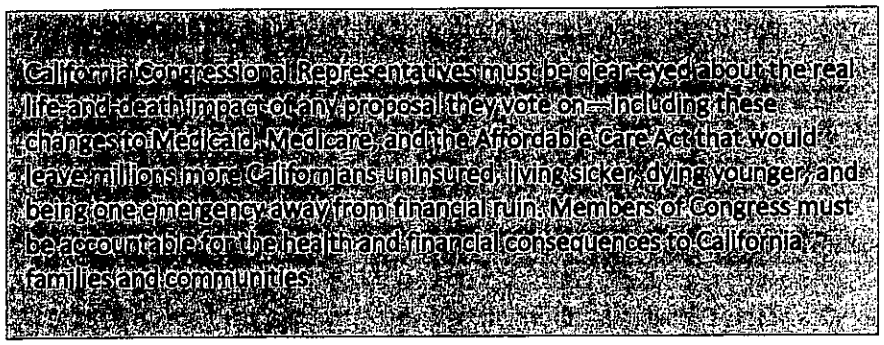
- **Over 90% of the 1.3 million Californians who buy coverage through Covered California get financial assistance** (tax credits) so the health premium is not more than a percentage of their income (on a sliding scale up to 9.5%). Some Covered California enrollees also get subsidies to reduce deductibles and other cost-sharing.
- The nearly $5 billion in financial assistance and subsidies to California families is targeted for repeal—the 51-vote GOP reconciliation bill last year phased them out after two years.
- The loss of tax credits will directly increase the cost of health coverage – by hundreds or thousands of dollars – for a million Californians. The resulting loss of coverage would leave a smaller and sicker risk pool in the individual insurance market, spiking the price of health premiums market-wide.
- One proposed replacement, funding for Health Savings Accounts, would be inadequate to make private coverage affordable, especially for low- and moderate-income Americans. Another proposed replacement, refundable tax credits, would mean consumers pay premiums first and then get tax refunds later, requiring consumers to front thousands of dollars in premiums and copays they cannot afford.

Patient Protections Including No Denials & Rate Hikes for Pre-Existing Conditions

- The Affordable Care Act put in place key consumer protections against insurance company abuses that benefit all patients, most notably by prohibiting health plans from denying (or charging more to) patients with pre-existing conditions. This also includes requirements that insurers cover essential benefits, eliminate annual or lifetime caps, limit out-of-pocket costs, meet actuarial value requirements, not charge women differently than men, and limit differential premiums based on age.
- The GOP Congress has sought to repeal these protections in various 60-vote repeal bills. While these patient protections cannot be repealed under 51-vote budget reconciliation, President-elect Trump could hinder these protections through administrative actions, grant waivers voiding some guidelines, simply not implement or enforce some rules, or allow legal challenges to stand.
- In addition, President-elect Trump has highlighted his proposal to **pre-empt state patient protections** by allowing out-of-state insurers to sell across state lines and avoid California's strong consumer protections. They include coverage of medically necessary care, standards on timely access to care, network adequacy, language access, and the right to appeal denials of care.

The Guarantee of Medicare

- Medicare covers 4 million California seniors and people with disabilities.
- Full repeal of the Affordable Care Act would **roll back the improvements in prescription drug coverage** (which closed the so-called "donut hole") and undo some cost-saving measures that have increased the sustainability of Medicare.
- Speaker Paul Ryan has long advocated to **privatize Medicare into a "premium support" voucher program**, where Medicare beneficiaries would be given a set amount of money to help purchase (but not necessarily fully pay for) private plans. President-elect Trump has made similar references to "modernizing Medicare."



Health Care in Motion

Timely, Substantive Updates on Policy Shifts · Actionable Advocacy to Protect Health Care

January 4. 2017

New Congress Begins; Immediately Attacks the Affordable Care Act and Threatens Domestic Programs Critical to Vulnerable Populations

The 115th Congress began on January 3, 2017. Republican leadership wasted no time in articulating their legislative priorities, particularly with respect to the Affordable Care Act (ACA) and other domestic programs. Notably, Republicans are attempting to initiate a budget reconciliation process to repeal key ACA programs without a replacement proposal in sight. Republicans are also using the House rules process to increase oversight of unauthorized programs and agencies, which could force reauthorization battles over programs like Ryan White with little warning to advocates.

Next Steps for Advocates:

1. **Advocates should be vocal with Republican Senators about the importance of only moving forward with a repeal of the ACA once a fully fleshed out replacement plan has been proposed, to minimize disruption of the health care system and protect our access to care. As such, advocates should ask these Senators to oppose beginning the budget reconciliation process prematurely.**

2. **Advocates should prepare for reauthorization battles within the next two years, even if they were hoping to postpone the process until after mid-term elections.**

The ACA Repeal Process Begins, With No Replacement in Sight

Undoing the ACA has been the legislative priority of the majority of Congressional Republicans for the last several years. The new budget resolution, introduced by Senator Budget Committee Chair Michael Enzi (R-WY) on January 3rd, is Congressional Republicans' opening shot in their latest assault on the ACA. If this budget resolution passes, Congressional Republicans will be able to repeal many key ACA programs without having to propose any replacement. According to the Congressional Budget Office, this could leave as many as 22 million people without health insurance.

It is important to note that the budget resolution is not a bill to directly repeal the ACA. Rather it is a set of instructions to four Congressional Committees, the Ways and Means and the Energy and Commerce Committees in the House and the Finance and the Health, Education, Labor and Pensions Committees in the Senate, to begin the budget reconciliation process. The four authorizing Committees deal with health care legislation, making it clear that this is intended as an attack on the ACA. The budget resolution must be voted upon after fifty hours of debate, which begins on January 4, 2017 and could end as early as **January 11, 2017**.

If the budget resolution passes, the four authorizing Committees must then recommend legislation changing existing laws and programs in order to achieve at least $1 billion each in deficit reductions over fiscal years 2017 through 2026. Republican leaders have indicated that the proposed changes would likely look similar to 2015's H.R. 3762. While ultimately vetoed by President Obama, that bill would have repealed the ACA's insurance subsidies, Medicaid expansion, certain tax increases, and the individual mandate. The budget resolution does allow these Committees to reserve some funds to accommodate future legislation to replace ACA programs, but does not require the Committees to propose such legislation any time soon. Under the terms of this budget resolution, the authorizing Committees would be required to submit their proposed changes to the Senate and the House by January 27, 2017. Debates in the Senate on these changes would be

filibuster proof and require only a simple majority to pass, meaning that Congressional Democrats would not be able to prevent these repeal efforts from going through. For a more detailed explanation of the reconciliation process, please see the Center for Health Law and Policy Innovation's summary of the reconciliation process available here.

The reconciliation process potentially initiated by this budget resolution poses a significant threat to access to care. Congressional Republicans are yet to develop a "replacement" plan for the ACA, so any legislation that comes out of this rapid turn around reconciliation would repeal key ACA programs without any sort of replacement in sight. This would subject millions of Americans, including those living with chronic illnesses and disabilities, to uncertainty and potential disruptions in their health care and treatment and could destabilize our health care system. Further, Congressional Republicans could use a looming health care "cliff" to force Congressional Democrats to accept Republican proposals, regardless of their impact on underserved and vulnerable communities. By contrast, a repeal done with a simultaneous replace strategy allows Congressional Democrats to push for modifications to any health policy proposals, to protect vulnerable populations, while preserving the status quo of the ACA until a replacement plan is debated and improved.

Congressional Democrats, meanwhile, are launching a counterattack aimed at delaying the process and pinning Republicans with responsibility for all negative outcomes. Budget resolutions in the Senate can only be voted upon after all proposed amendments to the resolution have an up or down vote. As there is no limit to the number of amendments that can be proposed, what results is an extensive period of rapid fire voting known as "vote-a-rama." Senate Democrats are planning to use this tactic to delay voting on the budget resolution itself, and to force Republican Senators to take "on-the-record" positions on health care issues, such as the ban on preexisting condition exclusions.

Advocates now face a unique opportunity to insist that any effort to repeal the ACA must also include a specific replacement plan. The budget resolution requires a simple majority to pass in the Senate. **This means that if only three out of the 52 Republican Senators object to opening the door to repeal without replacement, the budget resolution will be stopped.** Several leading Republican Senators, including Lamar Alexander (TN), Bob Corker (TN), and Susan Collins (ME), have expressed concerns about repealing without simultaneously putting forward a replacement. Other potential "swing" Senators include Lisa Murkowski (AK), John McCain (AZ), Chuck Grassley (IA), Dean Heller (NV), Rob Portman (OH), and Shelley Moore Capito (WV). **If you live in a state with a Republican Senator, or know advocates in theses states, it is important to call their offices before January 11, 2017, to let them know that they should oppose any repeal of the ACA without an accompanying replacement plan.** Stable health care is too important to vulnerable patients to allow such uncertainty during the several years it might take to formulate a replacement plan.

House Rules Threaten Programs with Expired Authorizations

At the start of each Congress, the House adopts rules to guide its process. The rules for the 115th Congress are similar to those for the 114th Congress, with a few key exceptions. The House's attempt to undermine the independent Office of Congressional Ethics has received a significant amount of attention. Another rule change, however, should also spark alarm among health policy advocates. The new rules include a requirement that Congressional Committees increase oversight of unauthorized programs and agencies within their jurisdiction. This could draw attention to critical health and nutrition programs and lead to reauthorization battles that would play out in an extremely unfriendly political environment.

Federal programs and agencies are created through authorization legislation but they are funded through appropriation legislation. Generally, authorization legislation can establish, continue, or modify an agency, program, or activity for a fixed or indefinite period of time. Authorization legislation may set forth the duties and functions of an agency or program, its organizational structure, and even suggest funding levels. Programs do not receive funding, however, until an appropriations bill is separately passed allocating funding to the authorized program. While certain programs are authorized indefinitely, most have a specified time limit. Programs whose authorizations expire do not automatically end, rather there are appropriation restrictions that Congress must waive to provide funding to the now unauthorized program. Generally,

unauthorized programs can continue at previously authorized funding levels until reauthorization is passed.

The new rules, however, require that each Committee create a list of unauthorized programs and agencies within their jurisdiction that have received funding in the prior fiscal years as well as recommendations to consolidate or terminate any programs or agencies that are inconsistent with the "appropriate role of the Federal government." The new rules also require recommendations for moving programs or agencies up for reauthorization from mandatory to discretionary funding, which would make these programs more vulnerable to budget cuts.

Many programs that serve vulnerable populations fall into this category of unauthorized programs. For example, the Ryan White Program for people living with HIV and the Healthy and the Hunger-Free Kids Act of 2010, which provides nutritious school lunches for children, are both operating with expired authorization. In the case of some programs, advocates were hoping to postpone reauthorization until mid-term elections at the earliest, in hopes of waiting for a friendlier political environment. **The change in the House rules, however, indicates that advocates should not expect to fly under the radar for key unauthorized programs, and instead should be prepared to fight for these programs at some point during the 115th Congress.**

We recommend that advocates evaluate which key programs do not have active authorization. Each January, the Congressional Budget Office publishes a list of programs funded for the current fiscal year whose authorizations have either expired or are set to expire during that year. The 2017 report has not yet been released, but the 2016 report can be found here. **Advocates should begin to build the case for reauthorizations of these programs by encouraging community members to reach out to their Congressional delegations to discuss the importance of these programs.** They should also begin to work on their messaging around why these programs must be reauthorized and prepare for earlier reauthorization fights than they might otherwise expect.

For further questions or inquiries please contact your Health Care in Motion team:

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California LGBT Health & Human Services Network

LGBTQ Health: What Protections are Safe and What May Go

President-elect Trump repeatedly promised on the campaign trail to repeal the Affordable Care Act (ACA) during his first 100 days in office, as well as repeal all of President Obama's executive orders - including those protecting LGBTQ people from discrimination. A full repeal of all ACA provisions is unlikely to pass due to the 60-vote Senate threshold required for any structural and policy changes to existing federal law. However, the Trump administration could reverse much of the progress we have made in health care. The November presidential election result has left many questions for the thousands of LGBTQ Californians, who benefit from expanded health care access provided by the ACA, Medicaid (Medi-Cal in California), Medicare, and federal non-discrimination protections.

Below is an attempt to clarify how rollbacks of existing federal health care laws will impact LGBTQ Californians.

Will I lose my health coverage?

Not immediately, in all likelihood – but the threat is real. The previous version of the Republican ACA repeal and replace bill included a 2-year delay of the phase-out for funding for Medicaid expansion and health insurance exchanges, also known as marketplaces. This means that over the next few years, coverage could be at risk for the more than 5 million Californians, who gained coverage as a result of the ACA – especially the 3.7 million low-income childless adults, who newly qualified for Medi-Cal and 1.4 million, who purchased insurance through Covered California.[i] If you have employer-based coverage, your coverage is not likely to be threatened, but premium costs will likely increase as a result of overall cost-shifts to that market.

Covered California remains open and is operating business as usual. Coverage for 2017 remains intact, premium rates are locked in, and essential health benefits will be offered. If you need coverage, you are encouraged to apply at www.CoveredCA.com. Additionally, if your income falls between 138% - 400% FPL, then you may be eligible for financial assistance to help pay for your premiums and other healthcare costs.

Federal changes related to the ACA could dramatically disrupt the overall health care system, and more importantly, could cause a dramatic increase in the uninsured.

The repeal of the ACA's Medicaid expansion would eliminate $16 billion in federal funding and coverage for the 3.7 million people that were newly qualified for Medi-Cal.[ii] House Speaker Paul Ryan has also advocated converting federal Medicaid funding matches to block grants and privatizing Medicare. This will jeopardize coverage for nearly 14 million Californians on Medi-Cal currently and an additional 5.6 million California seniors on Medicare. The state will not be able to make up for the loss of nearly $20 billion dollars in federal funding and many people are likely to be without health care, including mental health care, once again.

For more information, see "Our Health Care at Risk" Factsheet.

Will insurance companies or doctors be able to discriminate against LGBTQ patients?

No. California law bans health insurers and providers – both private and public – from discriminating against individuals based on sexual orientation or gender identity. LGBT Californians cannot be denied coverage or care because of their sexual orientation or gender identity.[iii] These protections are based in state law and will stand regardless of what happens at the federal level.

Federal regulations currently protect Americans from denials or limitations on health coverage based on gender identity[iv] and guarantee the rights for patients to designate their visitors at hospitals that receive federal funding regardless of sexual orientation, gender identity, or legal relationship status. [v] Unfortunately, the new administration can re-write existing federal regulation, though this process would take several years and we do not yet know what they will decide to do. We strongly recommend that LGBTQ people and families designate a health proxy and complete an advance health directive to protect their health care decisions – see below.

Will I be able to access transition-related health care?

The biggest question surrounding accessing transition-related health care will likely be related to the expense, if Medi-Cal or Covered California are scaled back. If you have insurance, California regulators require health insurers to provide coverage for all medically necessary health care procedures for transgender people that are otherwise covered for cisgender people.[vi] If you lose insurance, you would likely have to pay out of pocket, which could cost thousands of dollars. If your insurer denies your procedure, you have a right to appeal that decision.

I currently receive services at Planned Parenthood, what will happen?

Planned Parenthood is an important provider of primary and reproductive health care for LGBTQ Californians. The budget reconciliation bill passed by Republicans last year included a provision cutting federal funding to Planned Parenthood health centers. Though the loss of federal funding would be significant, the organization released a statement following the election vowing that its doors will remain open to patients who rely on its services.[vii]

Will my marriage be invalidated? What if I am on my spouse's health insurance?

Legal experts do not believe the Supreme Court would revisit its decision granting same-sex couples the right to marry nation-wide.[viii] Married same-sex couples should continue to receive the same benefits as different-sex married couples, including in health care markets.

I am HIV-positive. Will I lose access to drugs or other healthcare?

Not likely. The Ryan White Program, which is an important safety net to guarantee access to life-saving health care for people living with HIV, enjoys broad bipartisan support. That support will be important to ensure that Congress fully funds the Program as a way to fill in the gaps left by the potential loss of coverage for thousands of people living with HIV who are covered by the ACA.[ix]

What should I do?

- **Enroll in coverage:** The deadline to enroll in coverage is January 30, however, you should apply by December 15 at CoveredCA.com/ for health care coverage that will kick in by the beginning of 2017.
- **Get legal documents in order:** Now is the time to change gender markers on passports, birth certificates and drivers' licenses,[x] make sure that children's documentation accurately includes both parents' legal names, and have an up-to-date advance health directive,[xi] living will, and other documents protecting you and your family's assets.
- **Schedule routine medical care and specialty care:** If you have been putting off getting your physical, wellness exams, HPV vaccination, or transition-related services, now would be a great time to schedule them if you can. Substance use treatment and help quitting smoking are also covered thanks to the Affordable Care Act. Although we expect potions of the ACA to be phased out gradually, you are encouraged to begin any treatments sooner rather than later. If you need coverage, sign up at CoveredCA.com/.
- **Consult an immigration attorney:** You can find answers to some common immigration questions here, however if you have questions about your specific immigration case, it is best to contact an attorney.
- **Share your Health Care Success Story:** Advocates are working hard to protect crucial healthcare programs. You can help by sharing your story about how health reform has helped you and your family. https://www.surveymonkey.com/r/ShareYourACAStory
- **Sign the petition:** http://familiesusa.org/protect-americas-health-coverage
- **Get help if you need it:**
    - If you're experiencing a crisis and need to talk to someone: http://www.thetrevorproject.org/ http://www.glbthotline.org/
    - If you feel you have been discriminated against or need legal help for any reason, you can consult the following experts:
      Lambda Legal - http://www.lambdalegal.org/help
      National Center for Lesbian Rights - http://www.nclrights.org/legal-help/
      Transgender Law Center - http://transgenderlawcenter.org/legalinfo
      American Civil Liberties Union (ACLU) - https://www.aclu.org/about/affiliates?redirect=affiliates

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21. ADJOURNMENT

A. In Memory of Matt Redman, Co-Founder of APLA

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In Memoriam Matt Redman, Co-Founder of AIDS Project Los Angeles

APLA Health mourns the death of Matt Redman, one of the co-founders of AIDS Project Los Angeles. Matt was instrumental in spurring the Los Angeles community to action during the early days of the AIDS epidemic and continuing the fight against HIV over the last 34 years. He was a committed activist, known for his strong personality, biting wit, and passion for details. He passed away on December 27, 2016, at age 66.

In October 1982, Matt and his close friend Nancy Cole Sawaya, along with Ervin Munro and Max Drew, attended an emergency meeting at the Los Angeles Gay and Lesbian Community Services Center. The meeting featured a presentation by a representative from San Francisco's Kaposi's Sarcoma Foundation about Gay Related Immunodeficiency Disease (GRID), one of the early names for AIDS.

Fear about this mysterious new disease was rampant, so the four set up a telephone hotline to answer questions from the community. The hotline was operated from a closet in the Los Angeles Gay and Lesbian Community Services Center, where volunteers answered a single telephone and read information from a one-page fact sheet.

Realizing that funds were needed to educate the community and prevent the spread of the disease, the co-founders enlisted the help of other friends and held

a Christmas benefit. The party raised more than $7,000, which became the seed money for a new organization. Recognizing that AIDS was not just a gay disease, the founders named the organization AIDS Project Los Angeles. The first board of directors was elected on January 14, 1983.

Matt remained deeply involved with APLA after its founding, volunteering and serving as chair of the board of directors from 1987 to 1989. He continued to serve on the board for several years after stepping down as chair, and remained an honorary member after his initial board tenure ended.

In addition, when APLA was a founding member of the Federation of AIDS-Related Organizations—later the AIDS Action Council—Matt was APLA's representative and served on its board for six years. Today, the AIDS Action Council continues as AIDS United, and APLA Health is a leading member. "Matt never lost his interest and enthusiasm for advocacy and policy," APLA Health Director of Government Affairs Phil Curtis notes. "You could always count on him to ask just the right question, to push where the argument needed to go. And with his long institutional memory and very personal experience with HIV, his input was always fierce, heartfelt, and invaluable."

Matt worked as an interior designer for many years, but his commitment to HIV/AIDS causes remained a prominent part of his life. In June 2015, he was honored by the Los Angeles City Council during the fifth annual LGBT Heritage Month, which recognizes LGBT activists, advocates, and pioneers for their work to advance equality.

"Matt was one of the courageous few in Los Angeles who stepped up in the midst of the total devastation of the early days of the AIDS epidemic and demanded that we all do something," APLA Health CEO Craig E. Thompson says. "With his close friend Nancy Cole Sawaya and a handful of others, he founded AIDS Project Los Angeles, changing the lives of countless individuals as a result. He never gave up, never did anything at less than 100%, and he never stepped away. He was a relentless voice on our board of directors for the needs of people living with HIV/AIDS and was literally our conscience for more than 30 years. Only when his strength began to fade as he lost his personal battle with HIV did he pull back. Matt was one of a kind, a dear friend, a tireless advocate, and our champion. To say he'll be missed is an understatement."

To Matt's friends and family, APLA Health extends its deepest condolences on the loss of a tireless champion for people living with HIV/AIDS and the LGBT community. His efforts helped change the course of history and ensured that many lives were made better and saved.