LOS ANGELES COUNTY COMMISSION ON HIV
3530 Wilshire Boulevard, Suite 1140, Los Angeles, CA 90010 · TEL. (213) 7382816 · FAX (213) 637-4748
Website: http://hiv.lacounty.gov Email: hivcomm@lachiv.org

COMMISSION ON HIV MEETING

Thursday, October 12, 2017
9:00 AM - 1:00 PM

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

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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1. APPROVAL OF THE AGENDA:

A. Agenda
B. Membership Roster
C. Committee Assignments
D. Commission Member Conflict of Interest
E. Geographic Maps
F. November 2017 - February 2018 Meeting Calendars

AGENDA FOR THE REGULAR MEETING OF THE
LOS ANGELES COUNTY COMMISSION ON HIV
(213) 738-2816 / FAX (213) 637-4748
hivcomm@lachiv.org http://hiv.lacounty.gov

THURSDAY, OCTOBER 12, 2017, 9:00 A.M. – 1:00 P.M.

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

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

AGENDA POSTED: October 6, 2017

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

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

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

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

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

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

External stakeholders who would like to participate in the deliberation of discussion of an a posted agenda item, but who may only be able to attend for a short time during a limited window of opportunity,

may call the Commission's Executive Director in advance of the meeting to see if the scheduled agenda order can be adjusted accordingly. Commission leadership and staff will make every effort to accommodate reasonable scheduling and timing requests—from members or other stakeholders—within the limitations and requirements of other possible constraints.

	Call to Order and Roll Call		9:00 A.M. - 9:03 A.M.
	I. ADMINISTRATIVE MATTERS		
1.	Approval of Agenda	MOTION #1	9:03 A.M. - 9:04 A.M.
2.	Approval of Meeting Minutes	MOTION #2	9:04 A.M. - 9:06 A.M.
3.	Consent Calendar	MOTION #3	9:06 A.M. - 9:07 A.M.
	II. REPORTS		
4.	Executive Director's Report		9:07 A.M. - 9:15 A.M.
5.	Co-Chair's Report		9:15 A.M. - 9:25 A.M.
6.	County's Health Agency Integration Advisory Board Report		9:25 A.M. - 9:27 A.M.
7.	Housing Opportunities for People Living With HIV/AIDS (HOPWA) Report		9:27 A.M. - 9:32 A.M.
	III. COLLOQUIA SERIES		**9:32 A.M. - 10:32 A.M.**
8.	**Keeping Patients with Immigration Concerns in HIV Care and Services** Tom Donohoe, Alonso Bautista, Ayako Miyashita UCLA Center for HIV Identification, Prevention and Treatment Services (CHIPTS) & AltaMed Services		
9.	Immunization Program Report Department of Public Health		10:32 A.M. - 10:40 A.M.
10.	Division of HIV/STD Programs (DHSP) Report Department of Public Health		10:40 A.M. - 11:10 A.M.
11.	California Office of AIDS (OA) Report		11:10 A.M. - 11:20 A.M.
12.	**IV. STANDING COMMITTEE REPORTS:**		11:20 A.M. - 12:10 P.M.
	A. Planning, Priorities and Allocations (PP&A) Committee		
	B. Standards and Best Practices (SBP) Committee		

C. Operations Committee

1. Membership Management:
   a. Membership Application(s):
      1. Lee Kochems: Behavioral/Social Scientist Seat — MOTION #4
      2. Diana Oliva: Provider Representative #2 — MOTION #5
      3. William King, MD: HIV Stakeholder #7 — MOTION #6
      4. Andrew Lopez: Alternate, UC Supervisorial District #2 — MOTION #7
      5. Marcos Garcilazo: Alternate, UC Supervisorial District #1 — MOTION #8
      6. Monica Sor: UC, Service Planning Area #8 — MOTION #9
      7. David Cunningham: Alternate, UC Supervisorial District #4 — MOTION #10

D. Public Policy Committee

13. Caucus, Task Force and Work Group Reports — 12:10 P.M. – 12:15 P.M.

14. City/Health District Reports — 12:15 P.M. – 12:30 P.M.
City of Long Beach: Program Overview

15. SPA/District Reports — 12:30 P.M. – 12:35 P.M.

V. PUBLIC COMMENT — 12:35 P.M. – 12:45 P.M.

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

VI. COMMISSION COMMENT

17. Non-Agendized or Follow-Up

VII. ANNOUNCEMENTS — 12:45 P.M. – 12:50 P.M.

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

VIII. ADJOURNMENT AND ROLL CALL — 12: 50 P.M .- 1:00 P.M.

19. Adjournment for the meeting of October 12, 2017.

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

CONSENT CALENDAR:	
MOTION #4:	Approve recommendation for Lee Kochems, MA, appointment to Behavioral/Social Scientist seat, as presented.
MOTION #5:	Approve recommendation for Diana Oliva, MSW, appointment to Provider Representative #2 seat, as presented.
MOTION #6:	Approve recommendation for William King, MD, JD, appointment to HIV Stakeholder #7 seat, as presented.
MOTION #7:	Approve recommendation for Andrew Lopez: Alternate, UC Supervisorial District #2 seat, as presented.
MOTION #8:	Approve recommendation for Marcos Garcilazo, Alternate UC Supervisorial District #1 seat, as presented.
MOTION #9:	Approve recommendation for Monica Sor, UC, Service Planning Area #8 seat, as presented.
MOTION #10:	Approve recommendation for David Cunningham, Alternate, UC Supervisorial District #4 seat, as presented.

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

Commission on HIV Members:			
Bradley Land, Co-Chair	Ricky Rosales, Co-Chair	Majel Arnold, MA-HSA	Traci Bivens-Davis
Al Ballesteros, MBA	Jason Brown	Joseph Cadden, MD	Danielle Campbell, MPH
Raquel Cataldo	Deborah Owens Collins, PA, MSPAS, AAHIVS	Michele Daniels	Kevin Donnelly
Matthew Emons, MD	Susan Forrest (Alternate)	Aaron Fox, MPP	Jerry D. Gates, PhD
Joseph Green	Terry Goddard, MA	Bridget Gordon	Grissel Granados, MSW
Lee Kochems, MA	David P. Lee (Alternate)	Eric Paul Leue	Abad Lopez
Eduardo Martinez (Alternate)	Miguel Martinez, MSW, MPH	Anthony Mills, MD	José Munoz
Derek Murray	Frankie Darling-Palacios	John Palomo	Raphael Péna
Mario Peréz, MPH	Juan Preciado	Thomas Puckett, Jr.	Ace Robinson, MPH
Rebecca Ronquillo	Martin Sattah, MD	LaShonda Spencer, MD	Kevin Stalter
Yolanda Sumpter	Greg Wilson	Russell Ybarra	
MEMBERS:	**43**		
QUORUM:	**22**		

COMMISSION ON HIV MEMBERSHIP SLATE

APPROVED BY COH ON 07/13/2017 (With Proposed Members for COH Approval 10/12/17)

MEMBERSHIP SEAT #	MEMBERSHIP SEAT	Commissioners Seated	Committee Assignment	COMMISSIONER	AFFILIATION *(if any)*	TERM BEGINS	TERM ENDS	ALTERNATE
1	Medi-Cal representative			***Vacant***		July 1, 2017	June 30, 2019	
2	City of Pasadena representative	1	OPS	John Palomo	Pasadena Public Health, City of Pasadena	July 1, 2016	June 30, 2018	
3	City of Long Beach representative	1	PP&A	Deborah Owens Collins, PA, MSPAS, AAHIVS	Dept. of Health and Human Services, City of Long Beach	July 1, 2017	June 30, 2019	
4	City of Los Angeles representative	1	EXC	Ricky Rosales	AIDS Coordinator's Office, City of Los Angeles	July 1, 2016	June 30, 2018	
5	City of West Hollywood representative	1	PP&A	Derek Murray	City of West Hollywood	July 1, 2017	June 30, 2019	
6	Director, DHSP	1	PP&A	Mario Pérez, MPH	DHSP, LA County Department of Public Health	July 1, 2016	June 30, 2018	
7	Part B representative	1	PP&A	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	PP&A	LaShonda Spencer, MD	LAC + USC MCA Clinic, LA County Department of Health Services	July 1, 2017	June 30, 2019	
10	Part F representative	1	PP	Jerry D. Gates, PhD	Keck School of Medicine of USC	July 1, 2016	June 30, 2018	
11	Provider representative #1	1	SBP	Joseph Cadden, MD	Rand Shrader Clinic (SPA1), LA County Department of Health Services	July 1, 2017	June 30, 2019	
12	Provider representative #2	1		***Vacant (Proposed: Diana Oliva)***	St. John's Well Child and Family Center	July 1, 2016	June 30, 2018	
13	Provider representative #3	1	PP&A	Miguel Martinez, MSW, MPH	Children's Hospital Los Angeles	July 1, 2017	June 30, 2019	
14	Provider representative #4	1	EXC|OPS	Raquel Cataldo	Tarzana Treatment Center	July 1, 2016	June 30, 2018	
15	Provider representative #5	1	PP	Terry Goddard, MA	Alliance for Housing and Healing	July 1, 2017	June 30, 2019	
16	Provider representative #6	1	PP&A	Anthony Mills, MD	Southern CA Men's Medical Group	July 1, 2016	June 30, 2018	
17	Provider representative #7	1	PP&A	Frankie Darling-Palacios	Los Angeles Gay and Lesbian Center (LAGLC)	July 1, 2017	June 30, 2019	
18	Provider representative #8	1	PP	Martin Sattah, MD	Rand Shrader Clinic (SPA1), LA County Department of Health Services	July 1, 2016	June 30, 2018	
19	Unaffiliated consumer, SPA 1	1	OPS	Michele Daniels	*unaffiliated consumer*	July 1, 2017	June 30, 2019	
20	Unaffiliated consumer, SPA 2	1	PP&A	Abad Lopez	*unaffiliated consumer*	July 1, 2016	June 30, 2018	
21	Unaffiliated consumer, SPA 3	1	PP&A	Jason Brown	*unaffiliated consumer*	July 1, 2017	June 30, 2019	
22	Unaffiliated consumer, SPA 4			***Vacant***	*unaffiliated consumer*	July 1, 2016	June 30, 2018	Susan Forrest
23	Unaffiliated consumer, SPA 5	1	PP&A	Yolanda Sumpter	*unaffiliated consumer*	July 1, 2017	June 30, 2019	
24	Unaffiliated consumer, SPA 6			***Vacant***	*unaffiliated consumer*	July 1, 2016	June 30, 2018	David Lee, MPH, LCSW
25	Unaffiliated consumer, SPA 7	1	PP&A	Raphael Péna	*unaffiliated consumer*	July 1, 2017	June 30, 2019	
26	Unaffiliated consumer, SPA 8	1	PP	***Vacant (Proposed: Monica Sor)***	*unaffiliated consumer*	July 1, 2016	June 30, 2018	
27	Unaffiliated consumer, Supervisorial District 1	1	PP	Jose Muñoz	*unaffiliated consumer*	July 1, 2017	June 30, 2019	***Proposed: Marcos Garcilazo***
28	Unaffiliated consumer, Supervisorial District 2			***Vacant***	*unaffiliated consumer*	July 1, 2016	June 30, 2018	***Proposed: Andrew Lopez***
29	Unaffiliated consumer, Supervisorial District 3			***Vacant***	unaffiliated consumer	July 1, 2017	June 30, 2019	Eduardo Martinez
30	Unaffiliated consumer, Supervisorial District 4	1	EXC|OPS	Kevin Donnelly	*unaffiliated consumer*	July 1, 2016	June 30, 2018	***Proposed: D. Cunningham***
31	Unaffiliated consumer, Supervisorial District 5	1	SBP	Thomas Puckett, Jr.	*unaffiliated consumer*	July 1, 2017	June 30, 2019	
32	Unaffiliated consumer, at-large #1	1	PP&A	Russell Ybarra	*unaffiliated consumer*	July 1, 2016	June 30, 2018	
33	Unaffiliated consumer, at-large #2	1	EXC|OPS	Joseph Green	*unaffiliated consumer*	July 1, 2017	June 30, 2019	
34	Unaffiliated consumer, at-large #3	1	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, 2017	June 30, 2019	
36	Representative, Board Office 1	1	PP&A	Al Ballesteros, MBA	JWCH Institute, Inc.	July 1, 2016	June 30, 2018	
37	Representative, Board Office 2			***Vacant***		July 1, 2017	June 30, 2019	
38	Representative, Board Office 3			***Vacant***		July 1, 2016	June 30, 2018	
39	Representative, Board Office 4	1	SBP	Ace Robinson, MPH	No Affiliations	July 1, 2017	June 30, 2019	
40	Representative, Board Office 5	1	EXC	Bradley Land	*unaffiliated consumer*	July 1, 2016	June 30, 2018	
41	Representative, HOPWA	1	PP	Rebecca Ronquillo	City of Los Angeles, HOPWA	July 1, 2017	June 30, 2019	
42	Behavioral/social scientist	1		***Vacant (Proposed: Lee Kochems)***		July 1, 2016	June 30, 2018	
43	Local health/hospital planning agency representative	1	SBP	Matthew Emons, MD, MBA	LA Care	July 1, 2017	June 30, 2019	
44	HIV stakeholder representative #1	1	SBP	Grissel Granados, MSW	Children's Hospital Los Angeles	July 1, 2016	June 30, 2018	
45	HIV stakeholder representative #2	1	SBP	Greg Wilson	In the Meantime Men's Group	July 1, 2017	June 30, 2019	
46	HIV stakeholder representative #3	1	OPS	Juan Preciado	Northeast Valley Health Corporation	July 1, 2016	June 30, 2018	
47	HIV stakeholder representative #4	1	PP	Eric Paul Leue	Free Speech Coaltion	July 1, 2017	June 30, 2019	
48	HIV stakeholder representative #5	1	OPS	Danielle Campbell, MPH	UCLA/MLKCH	July 1, 2016	June 30, 2018	
49	HIV stakeholder representative #6	1	OPS	Traci Bivens-Davis	N/A	July 1, 2017	June 30, 2019	
50	HIV stakeholder representative #7	1		***Vacant (Proposed: William King, MD)***		July 1, 2016	June 30, 2018	
51	HIV stakeholder representative #8			***Vacant***		July 1, 2015	June 30, 2017	
	TOTAL:	43						

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

= Vacant

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

COMMITTEE ASSIGNMENTS
(Updated 10/02/17)

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

EXECUTIVE COMMITTEE		
Regular meeting day: 4th Thursday of the month	***Regular meeting time***:	1:00pm–3:00pm
Number of Voting Members: **14**	***Number of Quorum***: **8**	
Bradley Land	**Co-Chair, Comm./Exec.***	Commissioner
Ricky Rosales	**Co-Chair, Comm./Exec.***	Commissioner
Al Ballesteros, MBA	Co-Chair, PP&A	Commissioner
Traci Bivens-Davis	Co-Chair, Operations	Commissioner
Jason Brown	Co-Chair, PP&A	Commissioner
Joseph Cadden, MD	Co-Chair, SBP	Commissioner
Raquel Cataldo	At-Large Member*	Commissioner
Kevin Donnelly	At-Large Member*	Commissioner
Aaron Fox, MPM	Co-Chair, Public Policy	Commissioner
Grissel Granados, MSW	Co-Chair, SBP	Commissioner
Joseph Green	At-Large Member*	Commissioner
Eric Paul Leue	Co-Chair, Public Policy	Commissioner
Mario Pérez, MPH	DHSP Director	Commissioner
Kevin Stalter	Co-Chair, Operations	Commissioner

OPERATIONS COMMITTEE		
Regular meeting day: 4th Thursday of the month	***Regular meeting time***:	10:00am-12:00pm
Number of Voting Members: **10**	***Number of Quorum***: **6**	
Traci Bivens-Davis	**Committee Co-Chair***	Commissioner
Kevin Stalter	**Committee Co-Chair***	Commissioner
Danielle Campbell, MPH	*	Commissioner
Raquel Cataldo	*	Commissioner
Michele Daniels	*	Commissioner
Kevin Donnelly	*	Commissioner
Bridget Gordon	*	Commissioner
Joseph Green	*	Commissioner
John Palomo	*	Commissioner
Juan Preciado	*	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: **14**	***Number of Quorum***: **8**	
Al Ballesteros, MBA	**Committee Co-Chair***	Commissioner
Jason Brown	**Committee Co-Chair***	Commissioner
Susan Forrest	*	Commissioner
Abad Lopez	*	Commissioner
Miguel Martinez, MPH, MSW	*	Commissioner
Anthony Mills, MD	*	Commissioner
Derek Murray	*	Commissioner
Deborah Owens Collins, MPA, MSPAS, AAHIVS	*	Commissioner
Frankie Darling Palacios	*	Commissioner
Raphael Péna	*	Commissioner
LaShonda Spencer, MD	*	Commissioner
Yolanda Sumpter	*	Commissioner
Russell Ybarra	*	Commissioner
TBD	DHSP staff	DHSP Staff

PUBLIC POLICY COMMITTEE		
Regular meeting day: 1st Monday of the month	***Regular meeting time***:	1:00 pm-3:00pm
Number of Voting Members: **10**	***Number of Quorum***: **6**	
Aaron Fox, MPM	**Committee Co-Chair***	Commissioner
Eric Paul Leue	**Committee Co-Chair***	Commissioner
Jerry Gates, PhD	*	Commissioner
Terry Goddard, MA	*	Commissioner
Lee Kochems, MA	*	Commissioner
Eduardo Martinez	*	Alternate
José Munoz	*	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
Matthew Emons, MD, MPH	*	Commissioner
Angelica Palmeros, MSW	*	Committee member
Thomas Puckett, Jr.	*	Commissioner
Wendy Garland, MPH	DHSP staff	DHSP representative
Ace Robinson, MPH	*	Commissioner
Wilson, Greg	*	Commissioner

CONSUMER CAUCUS		
Regular meeting day: Following Comm. mtg.	***Regular meeting time***:	1:30pm–3:00pm
Open Membership		
Joseph Green	**Co-Chair**	Commissioner
Yolanda Sumpter	**Co-Chair**	Commissioner
Raphael Péna	**Co-Chair**	Commissioner
Al Ballesteros, MBA	Member	Commissioner
Jason Brown	Member	Commissioner
Michele Daniels	Member	Commissioner
Kevin Donnelly	Member	Commissioner
Grissel Granados, MSW	Member	Commissioner
Bridget Gordon	Member	Commissioner
Lee Kochems, MA	Member	Commissioner
Brad Land	Member	Commissioner
Abad Lopez	Member	Commissioner
Eduardo Martinez	Member	Alternate
Anthony Mills, MD	Member	Commissioner
José Munoz	Member	Commissioner
Thomas Puckett	Member	Commissioner
Kevin Stalter	Member	Commissioner

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

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

TRANSGENDER TASK FORCE		
Time/Date: TBD		
Open Membership		
Destin Cortez	**Co-Chair**	Community Member
Maria Roman	**Co-Chair**	Commissioner
Michelle Enfield	Member	Commissioner
Susan Forrest	Member	Commissioner
Jaden Fields	Member	Community
Kimberly Kisler, PhD	Member	Community

LOS ANGELES COUNTY COMMISSION ON HIV
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http://hiv.lacounty.gov

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

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

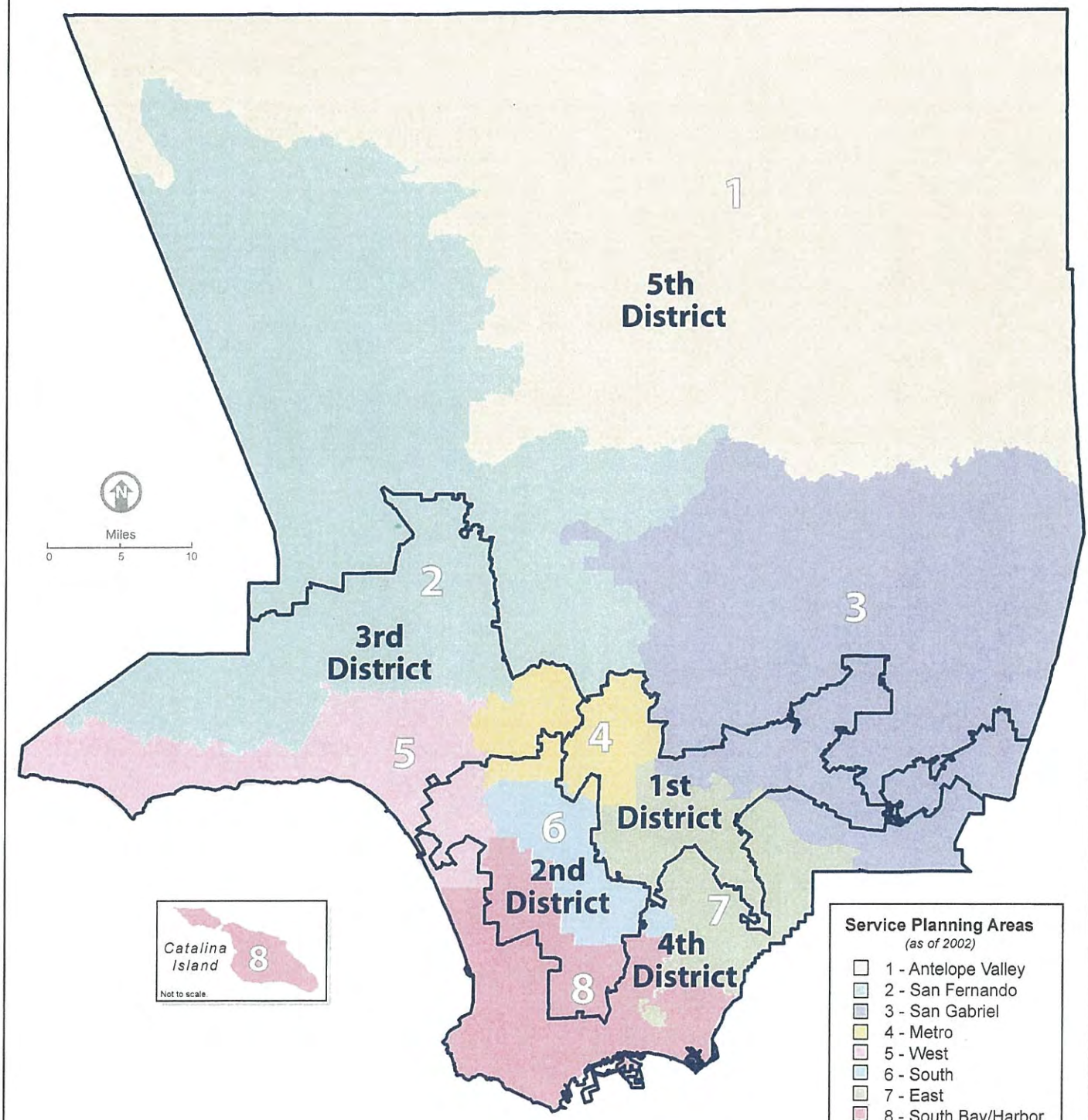
COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ARNOLD	**Majel**	California State Office of AIDS	No Ryan White or prevention contracts
BROWN	**Jason**	Unaffiliated consumer	No Ryan White or prevention contracts
BALLESTEROS	**Al**	JWCH, INC.	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty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

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

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

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

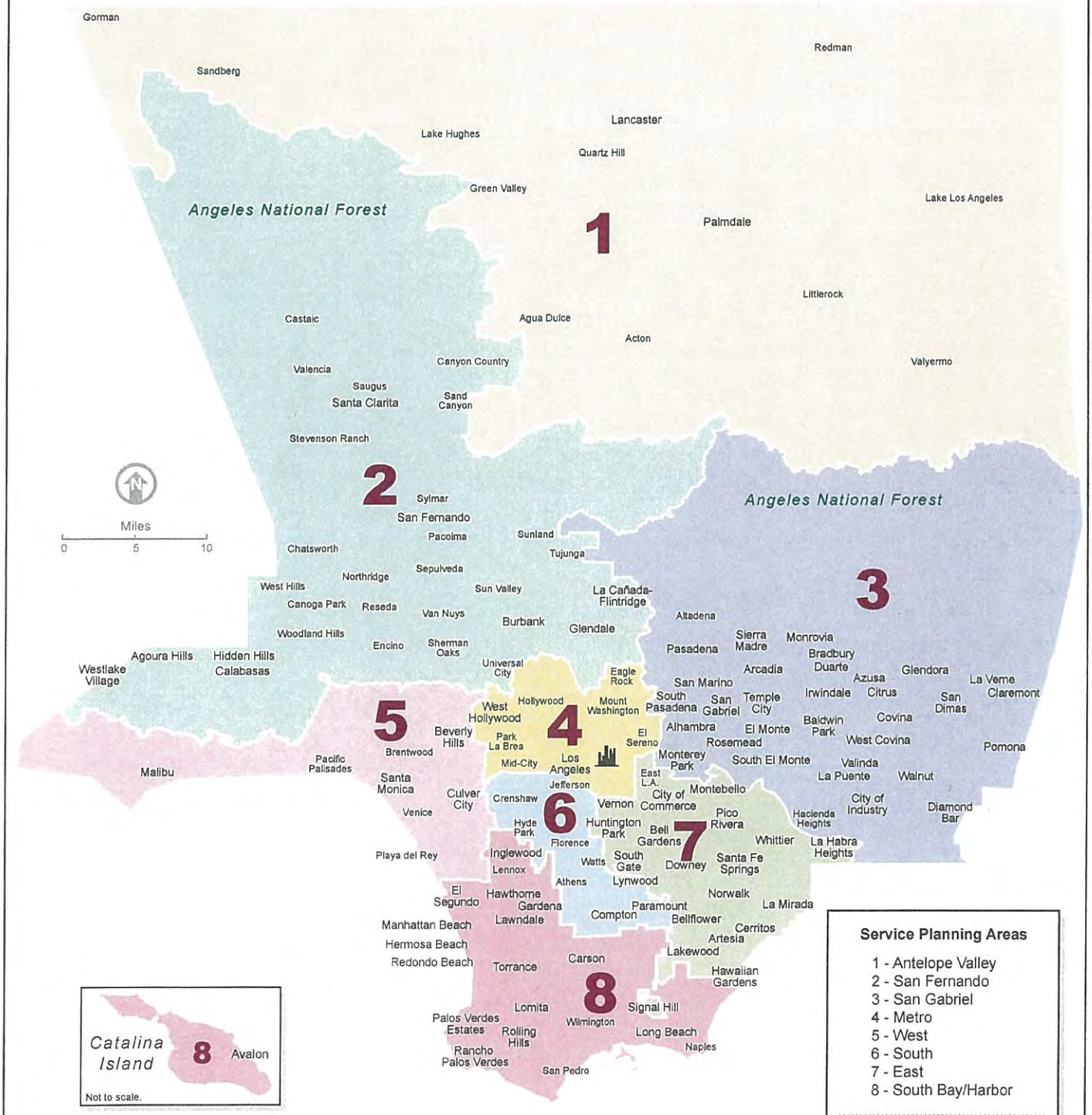
Los Angeles County Service Planning Areas by Supervisorial District



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

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

Los Angeles County
Service Planning Areas



Service Planning Areas

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

American Indian Children's Council covers all SPAs

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

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

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

HIV Calendar

November 2017

Sun	Mon	Tue	Wed	Thu	Fri	Sat
29 Week 44	30	31 9:30 AM Board of Supervisors (BOS)	1 9:30 AM BOS Agenda Review	2 10:00 AM Standards & Best Practices (SBP)	3	4
5 Week 45	6 1:00 PM Public Policy Committee	7 9:30 AM Board of Supervisors (BOS)	8 9:30 AM BOS Agenda Review	9 9:00 AM Annual Commission Meeting at the Dorothy Chandler Pavillion Salons A&B,5th Floor	10	11
12 Week 46	13	14 9:30 AM Board of Supervisors (BOS)	15 9:30 AM BOS Agenda Review	16	17	18
19 Week 47	20	21 9:30 AM Board of Supervisors (BOS) 1:00 PM Planning, Priorities & Allocations (PP&A)	22 9:30 AM BOS Agenda Review 10:00 AM Housing Taskforce	23 Thanksgiving Holiday - COH Office Closed 10:00 AM [CANCELED] Operations Committee Meeting 1:00 PM [CANCELED] Executive Committee Meeting	24 Thanksgiving Holiday - COH Office Closed	25
26 Week 48	27	28 9:30 AM Board of Supervisors (BOS)	29 9:30 AM BOS Agenda Review	30	1 World AIDS Day	2

HIV Calendar

December 2017

Sun	Mon	Tue	Wed	Thu	Fri	Sat
26 Week 48	27	28 9:30 AM Board of Supervisors (BOS)	29 9:30 AM BOS Agenda Review	30	1 World AIDS Day	2
3 Week 49	4 1:00 PM Public Policy Committee	5 9:30 AM Board of Supervisors (BOS)	6 9:30 AM BOS Agenda Review	7 10:00 AM Standards & Best Practices (SBP)	8	9
10 Week 50	11	12 9:30 AM Board of Supervisors (BOS)	13 9:30 AM BOS Agenda Review	14	15	16
17 Week 51	18	19 9:30 AM Board of Supervisors (BOS) 1:00 PM Planning, Priorities & Allocations (PP&A)	20 9:30 AM BOS Agenda Review	21	22	23
24 Week 52	25 8:00 AM Christmas Holiday - COH Office Closed	26 9:30 AM Board of Supervisors (BOS)	27 9:30 AM BOS Agenda Review 10:00 AM Housing Taskforce	28 10:00 AM Operations Committee Meeting 1:00 PM Executive Committee Meeting	29	30
31 Week 1	1 1:00 PM Public Policy Committee	2 9:30 AM Board of Supervisors (BOS)	3 9:30 AM BOS Agenda Review	4 10:00 AM Standards & Best Practices (SBP)	5	6

HIV Calendar

January 2018

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

HIV Calendar

February 2018

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

LOS ANGELES COUNTY COMMISSION ON HIV
3530 Wilshire Boulevard, Suite 1140, Los Angeles, CA 90010 · TEL. (213) 7382816 · FAX (213) 637-4748
Website: http://hiv.lacounty.gov Email: hivcomm@lachiv.org

7. HOUSING OPPORTUNITIES FOR PEOPLE LIVING WITH HIV/AIDS (HOPWA) REPORT

A. City of Los Angeles Consolidated Plan Community Meetings

City of Los Angeles Consolidated Plan Community Meetings

Each year the City of Los Angeles has an opportunity to develop an annual plan to decide how to best allocate funds received directly from the federal government. These funds are directed to assist businesses to create jobs, to build affordable housing (including fair housing and housing for people with HIV and AIDS), to alleviate homelessness, to provide services and shelter for domestic violence victims, to improve neighborhoods and to provide social services for low and moderate income residents. The annual plan generally follows a longer term five year vision. It is time to develop a new five year plan beginning in 2018 and going forward to 2023.

One of the requirements for the funds and the plan is the involvement of community residents particularly those living in communities most in need of the services. The City has two approaches to seeking community input. The first is direct communication at a series of community meetings. The second is through a survey of community needs (https://www.research.net/r/losangelescityconplan2017).

Please join us at one or all of the following meetings to make your needs known.

DATES FOR CONSOLIDATED PLAN COMMUNITY MEETINGS:

All meetings held 5:30 p.m. -7:30 p.m.		
TUESDAY, OCTOBER 17, 2017 El Nido FamilySource Center 11243 Glenoaks Blvd. Pacoima, CA 91331	**WEDNESDAY, OCTOBER 18, 2017** El Centro de Ayuda Boyle Heights City Hall 2130 E. First Street Los Angeles, CA 90033	**THURSDAY, OCTOBER 26, 2017** South Los Angeles Senior Center (SLASC) 7020 S. Figueroa Street, Los Angeles, CA 90003

Community Consultation with the Los Angeles County Commission on HIV Planning, Priorities and Allocations Committee Meeting

Tuesday, October 17, 2017
1 pm to 4 pm
3530 Wilshire Blvd, Suite 1140
Los Angeles, CA 90010

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8. COLLOQUIA SERIES

A. Colloquia Flyer

B. Keeping Patients with Immigration Concerns in HIV Care and Services

HIV Research & Community Colloquia Series 2017

The Los Angeles County Commission on HIV and the UCLA Center for HIV Identification, Prevention, and Treatment Services (CHIPTS) invite you to attend

Keeping Patients with Immigration Concerns in HIV Care and Services

Tom Donohoe, MBA
UCLA & LA PAETC

Alonso Bautista, MA, MFTI
AltaMed Services

Ayako Miyashita, JD
UCLA & LAHLPP

Thursday, October 12, 2017
9:30am to 10:30am*

St. Anne's Maternity Home
155 N. Occidental Blvd
Los Angeles, CA 90026

Currently, many Latino patients may have concerns and misinformation that put them at risk of falling out of care. What can providers do to ensure patients remain in care? This presentation will discuss ways in which providers can help reduce anxiety among their patients and be informed of their rights as providers and the rights of their patients.

About the Presenters

Tom Donohoe, MBA, is Adjunct Professor in the Department of Family Medicine at the UCLA David Geffen School of Medicine. He is Principal Investigator and Director of the Los Angeles Region Pacific AIDS Education Training Center (PAETC). The LA Region PAETC collaborates with other regional AETCs to provide trainings to providers serving HIV-infected patients in United States/Mexico border communities.

Alonso Bautista, MA, MFTI serves as a Supervisor/Mental Health Clinician at AltaMed Health Services. In his role, he provides administrative oversight to mental health clinicians in HIV/Infectious Disease Division at AltaMed. He provides staff development and training on LGBT sensitivity and cultural competence. He has over two decades of experience working with monolingual Spanish speaking adults who are living with or who are affected by HIV/AIDS.

Ayako Miyashita, JD, is the Associate Director of the UCLA California HIV/AIDS Policy Research Center. She also serves as the Director of the Los Angeles HIV Law and Policy Project under the Clinical and Experiential Department at UCLA School of Law. Previously, Ayako served as the Sears Law Teaching Fellow at the Williams Institute, a research institute focused on LGBT issues at UCLA School of Law. Her past practice includes providing legal assistance to primarily low-income people living with HIV in Los Angeles and the San Francisco Bay Area.

LOS ANGELES COUNTY COMMISSION ON HIV

CHIPTS
Center for HIV Identification, Prevention and Treatment Services

*as part of the Commission on HIV meeting agenda. No registration required.

KEEPING PATIENTS WITH IMMIGRATION CONCERNS IN HIV CARE AND SERVICES

Thursday, October 12, 2017

9:30 am – 10:30 am

Presenters

- **Tom Donohoe, MBA**

Professor of Family Medicine & Director, LA Region PAETC

David Geffen School of Medicine at UCLA

- **Alonso Bautista, MA, MFTI**

Supervisor/Mental Health

AltaMed Health Services Corporation

- **Ayako Miyashita, JD**

Director, Los Angeles HIV Law and Policy Project

UCLA School of Law

Objectives

At the end of the session, participants will be able to:

- Discuss how to make a HIV clinic a safer space
- Ensure clients remain in HIV care
- Reduce anxieties of impacted client populations
- Review key laws (and misperceptions) about healthcare rights
- Utilize fact sheets and other referral resources to empower clients to know their rights, and stay in care

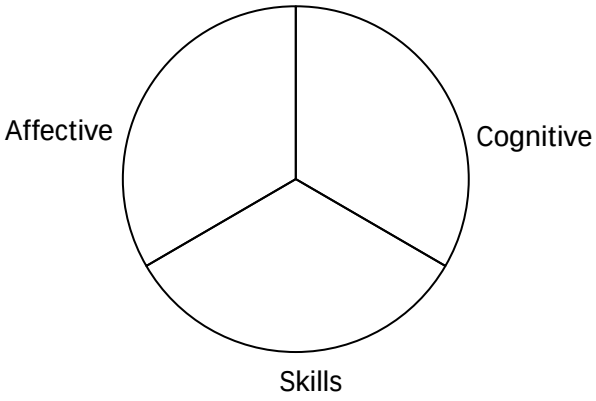
PATIENTS WITH IMMIGRATION CONCERNS & THE HIV CARE CONTINUUM

Tom Donohoe
Professor of Family Medicine
Director, Los Angeles Region Pacific AIDS Education and Training Center
Associate Director, UCLA Center for Health Promotion and Disease Prevention
David Geffen School of Medicine at UCLA
Tdonohoe@mednet.ucla.edu
(310) 794-8276

I have worked in HIV for ____ years.

0%	A.	0-1
0%	B.	1-3
0%	C.	3-5
0%	D.	5-10
0%	E.	10-15
0%	F.	15-20
0%	G.	20+

Learning and Teaching Domains



HRSA Continuum of Engagement

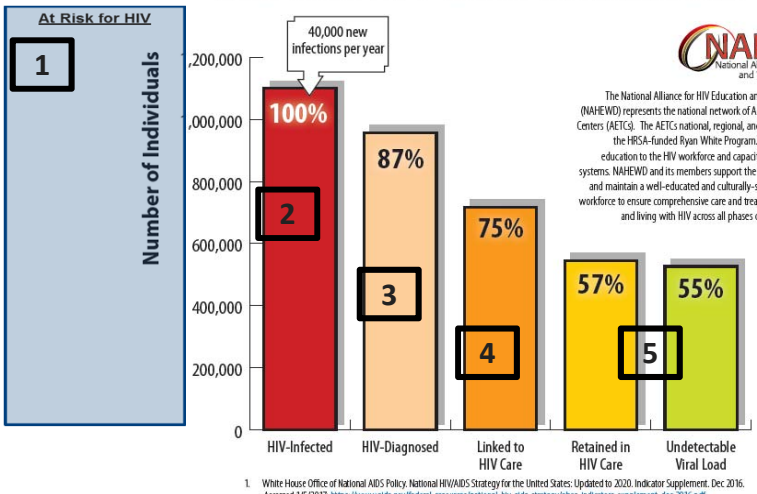
Not in Care ⟷ **Fully engaged**

Unaware of HIV status	Aware of HIV status	May be receiving other medical care but <u>not</u> HIV care	Entered HIV medical care but dropped out	In and out of HIV care or infrequent user	Fully engaged in HIV medical care

What about patients/clients worried about immigration status?

Source: Cheever. Clin Infect Dis 2007;44:1500-1502

The U.S. HIV Care Continuum[1]



1. White House Office of National AIDS Policy. National HIV/AIDS Strategy for the United States: Updated to 2020. Indicator Supplement. Dec 2016. Accessed 1/5/2017: https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-indicators-supplement-dec-2016.pdf

NAHEWD National Alliance for HIV Education and Workforce Development

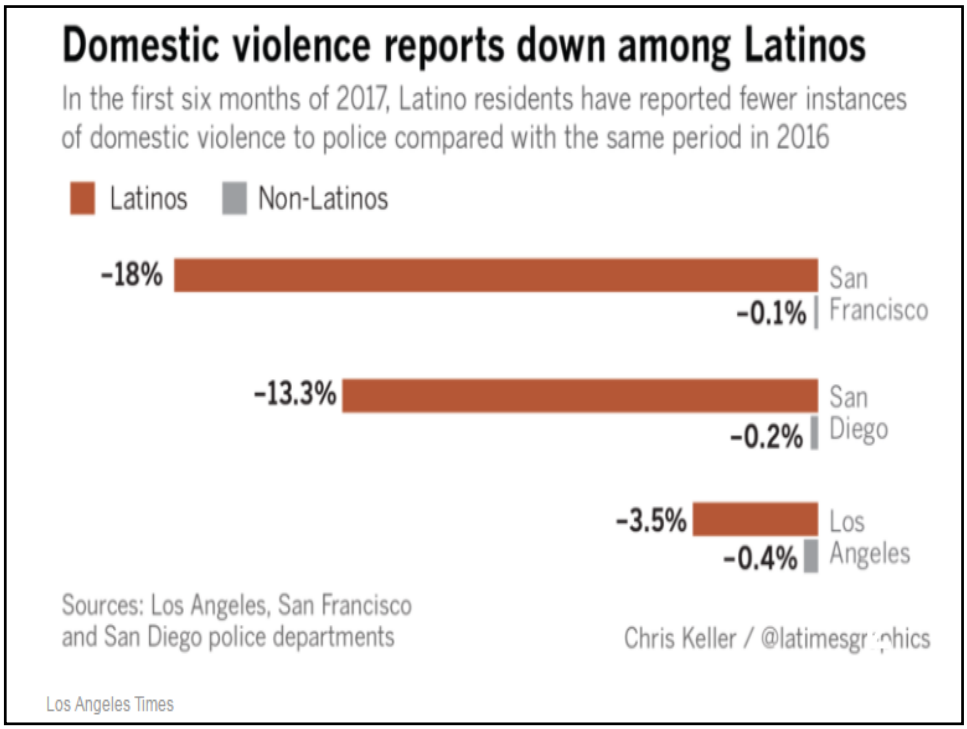
The National Alliance for HIV Education and Workforce Development (NAHEWD) represents the national network of AIDS Education and Training Centers (AETCs). The AETCs national, regional, and local centers are a part of the HRSA-funded Ryan White Program. The AETCs provide clinical education to the HIV workforce and capacity-building support to care systems. NAHEWD and its members support the work of the AETCs to build and maintain a well-educated and culturally-sensitive health professions workforce to ensure comprehensive care and treatment to people at-risk for and living with HIV across all phases of the HIV Care Continuum.

Rev 1-11-17

SPNS LATINO ACCESS INITIATIVE ETAC

Where do you think immigration concerns most impact the HIV Continuum?

0%	1)	Prevention
0%	2)	Testing & diagnosis
0%	3)	Linkage to care
0%	4)	Retention in care
0%	5)	Treatment

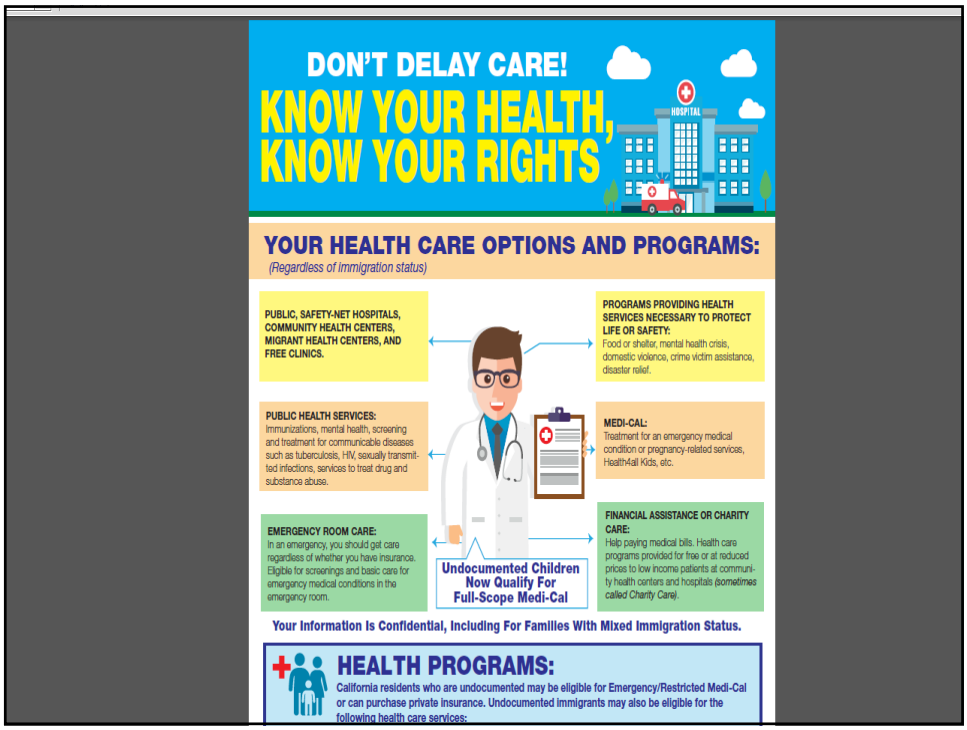


Over the past 2 years, I have worked with ___ HIV positive patients who have shared with me immigration concerns.

0%	A.	Zero
0%	B.	1-2
0%	C.	3-5
0%	D.	More than 5

I believe our HIV clinic/program is perceived to be a "Safe Place" for patients with immigration concerns.

0%	A.	Yes, 100% sure
0%	B.	Yes, 50-99% sure
0%	C.	I'm not sure
0%	D.	No



¡NO DEMORE EL CUIDADO!

CONOZCA SU SALUD, CONOZCA SUS DERECHOS

Guia

PROGRAMAS Y OPCIONES DE ATENCIÓN MÉDICA:

(Independientemente de su estatus migratorio)

HOSPITALES PÚBLICOS, CENTROS DE SALUD DE LA COMUNIDAD, CENTROS DE SALUD PARA MIGRANTES Y CLÍNICAS GRATUITAS.

PROGRAMAS DE SERVICIOS DE SALUD NECESARIO PARA PROTEGER LA VIDA O LA SEGURIDAD: Alimentos o refugio, crisis de salud mental, violencia, asistencia a victimas de crimenes, socorro en casos de desastre.

SERVICIOS DE SALUD PÚBLICA: Inmunizaciones, salud mental, la detección y el tratamiento, las enfermedades transmisibles como la tuberculosis, VIH, las infecciones de transmisión sexual, tratamiento del el abuso de drogas y sustancias.

MEDI-CAL: Tratamiento para una emergencia médica, condición o servicios relacionados con el embarazo al igual que otros programas.

SALA DE EMERGENCIA: En una emergencia, usted debe recibir atención independientemente de si tiene seguro. Elegible para exámenes y atención básica para condiciones médicas de emergencia en la sala de emergencia.

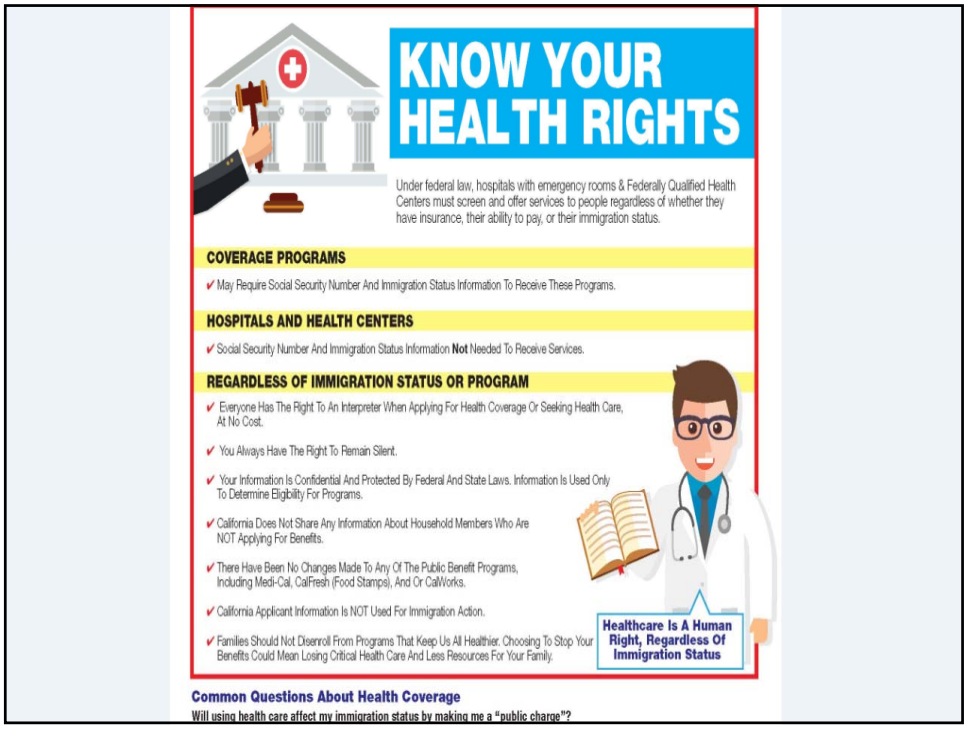
LOS NIÑOS INDOCUMENTADOS AHORA SON ELEGIBLES PARA EL MEDI-CAL COMPLETO

ASISTENCIA FINANCIERA O DE CARIDAD: Ayuda para pagar las facturas médicas, programas de atención médica de forma gratuita o precios reducidos en centros de salud comunitarios y hospitales *(a veces llamado Charity Care)*.

Su Información Es Confidencial, Incluyendo Para Familias Con Diferentes Estatus Migratorios.

PROGRAMAS DE SALUD:

Los residentes de California que son indocumentados pueden ser elegibles para Medi-Cal de Emergencia / Restringido o pueden comprar un seguro privado. Los inmigrantes indocumentados también pueden ser elegibles para los siguientes servicios de atención médica:



KNOW YOUR HEALTH RIGHTS

Under federal law, hospitals with emergency rooms & Federally Qualified Health Centers must screen and offer services to people regardless of whether they have insurance, their ability to pay, or their immigration status.

COVERAGE PROGRAMS

✔ May Require Social Security Number And Immigration Status Information To Receive These Programs.

HOSPITALS AND HEALTH CENTERS

✔ Social Security Number And Immigration Status Information **Not** Needed To Receive Services.

REGARDLESS OF IMMIGRATION STATUS OR PROGRAM

✔ Everyone Has The Right To An Interpreter When Applying For Health Coverage Or Seeking Health Care, At No Cost.

✔ You Always Have The Right To Remain Silent.

✔ Your Information Is Confidential And Protected By Federal And State Laws. Information Is Used Only To Determine Eligibility For Programs.

✔ California Does Not Share Any Information About Household Members Who Are NOT Applying For Benefits.

✔ There Have Been No Changes Made To Any Of The Public Benefit Programs, Including Medi-Cal, CalFresh (Food Stamps), And Or CalWorks.

✔ California Applicant Information Is NOT Used For Immigration Action.

✔ Families Should Not Disenroll From Programs That Keep Us All Healthier. Choosing To Stop Your Benefits Could Mean Losing Critical Health Care And Less Resources For Your Family.

Healthcare Is A Human Right, Regardless Of Immigration Status

Common Questions About Health Coverage

Will using health care affect my immigration status by making me a "public charge"?


CONOZCA SU SALUD,
CONOZCA SUS DERECHOS
Guia
HOSPITAL
PROGRAMAS Y OPCIONES DE ATENCIÓN MÉDICA:
(Independientemente de su estatus migratorio)
HOSPITALES PÚBLICOS, CENTROS DE SALUD DE LA COMUNIDAD, CENTROS DE SALUD PARA MIGRANTES Y CLÍNICAS GRATUITAS.
PROGRAMAS DE SERVICIOS DE SALUD NECESARIO PARA PROTEGER LA VIDA O LA SEGURIDAD: Alimentos o refugio, crisis de salud mental, violencia, asistencia a víctimas de crímenes, socorro en casos de desastre.
SERVICIOS DE SALUD PÚBLICA: Inmunizaciones, salud mental, la detección y el tratamiento, las enfermedades transmisibles como la tuberculosis, VIH, las infecciones de transmisión sexual, tratamiento del el abuso de drogas y sustancias.
MEDI-CAL: Tratamiento para una emergencia médica, condición o servicios relacionados con el embarazo al igual que otros programas.
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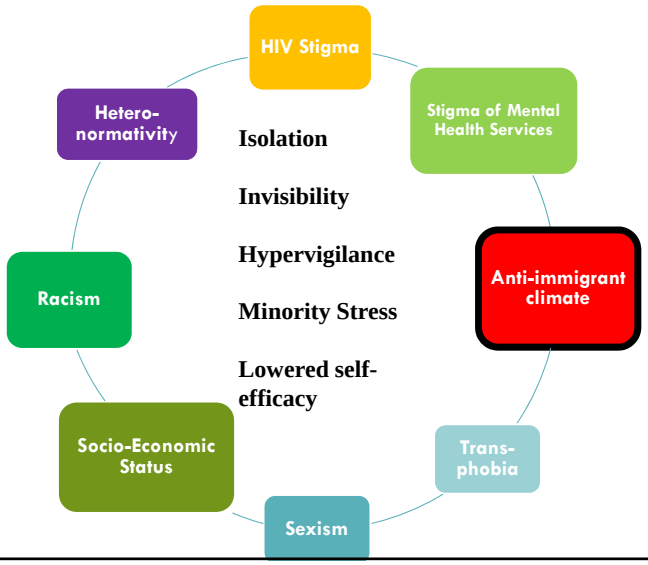
Los residentes de California que son indocumentados pueden ser elegibles para Medi-Cal de Emergencia / Restringido o pueden comprar un seguro privado. Los inmigrantes indocumentados también pueden ser elegibles para los siguientes servicios de atención médica:
• Capacidad de Pago (ATP) 1-800-378-9919
• Programa de Tratamiento del Cáncer de Seno y de la Cerviz (BCCTP) Medi-Cal 1-800-824-0088
• Programa de Salud Infantil Kaiser Permanente 1-800-464-4000
• MEDI-CAL- SALUD PARA TODOS LOS NIÑOS
Medi-Cal para niños de bajos ingresos menores de 19 años,


Albergue
Las Memorias
Remedios

PSYCHOSOCIAL STRESSORS AND BUILDING INTERNAL RESILIENCIES AMONG IMMIGRANT COMMUNITIES LIVING WITH AND IMPACTED BY HIV

Alonso D. Bautista, MA, MFTI
Marriage and Family Therapist Registered Intern, #IMF 91449
Supervisor, Mental Health Services
AltaMed Health Services Corporation
abautista@la.altamed.org
323-869-5408

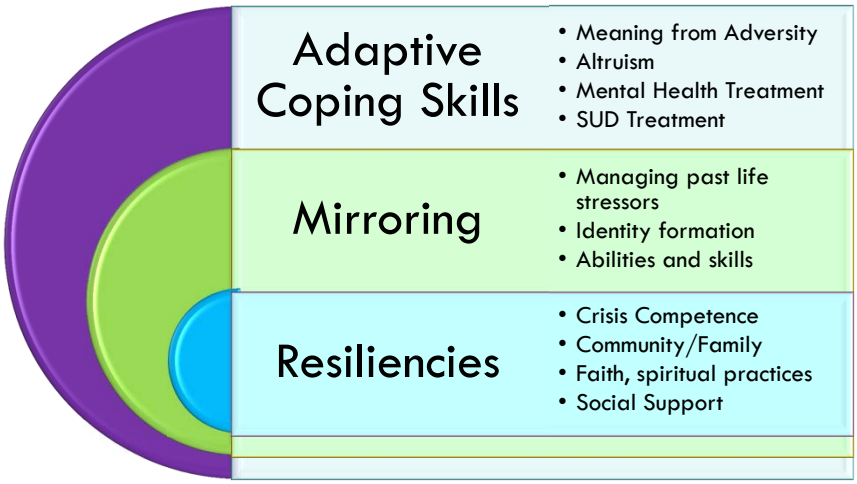
Psychosocial Stressors of Latinos Living with HIV



I have worked with patients/clients living with HIV whose mental health has recently been negatively impacted by immigration concerns.

0%	A.	Yes
0%	B.	No
0%	C.	Don't know

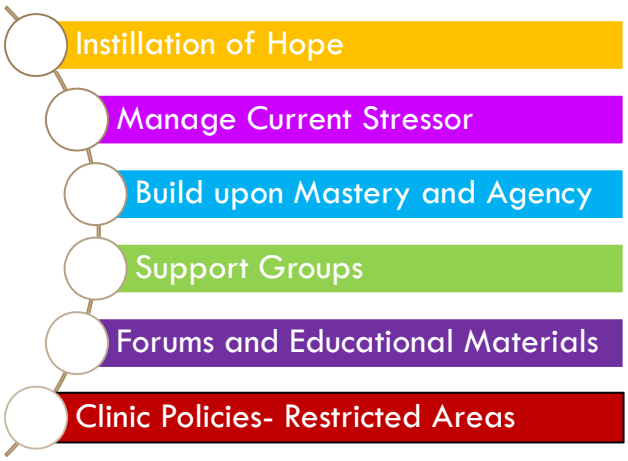
Strength-based, Resiliency Model



Building Internal Resilience

- Build on the client's belief that they can cope with stress (Self-worth)
- Assess client's inner-dialogue and reflect back or provide alternative affirming messages
- Assess the client's perceived sphere of influence regarding societal messages (Activism)

Creating an Environment of Safety



Maintain a Stance of CULTURAL HUMILITY

IMMIGRATION ENFORCEMENT:

DEVELOPING A PROFESSIONAL RESPONSE

Ayako Miyashita
Director, L.A. HIV Law and Policy Project
Associate Director, California HIV/AIDS Policy Research Center
(310) 206-9088
miyashita@law.ucla.edu
Visit us at www.thelahlpp.org and www.chprc.org

Objectives

- Identify constitutional rights and understand how they can be deployed for protection during interactions with immigration enforcement bodies.
- Develop the foundational capacity necessary for sharing this information with clients/patients.
- Demonstrate the difference between immigration law and policy.
- Consider the role of providers (individual and/or organizational) in the context of current conditions.

Disclaimer

All materials have been prepared for general information purposes only to permit you to learn some basic information. The information presented is not legal advice, is not to be acted on as such, may not be current and is subject to change without notice.

How frequently do you serve immigrants?

0%	A. Never
0%	B. Somewhat
0%	C. Frequently
0%	D. Always

Does your agency serve undocumented individuals?

0%	A. Yes
0%	B. No
0%	C. I don't know

In the past several months, have HIV-positive immigrant clients/patients expressed concerns with regard to their immigration status?

0%	A.	Never
0%	B.	Somewhat
0%	C.	Frequently
0%	D.	Always

In the past several months, has your agency specifically discussed current immigration policies and impacts on the HIV-positive immigrant client/patient population?

0%	A.	Yes
0%	B.	No

If yes, has your agency taken to address this issue (ex. sharing information, establishing a policy)?

0%	A.	Yes
0%	B.	No

Do you and/or your agency need more resources to address these issues?

0%	A.	Yes, client/patient education
0%	B.	Yes, client/patient support groups
0%	C.	Yes, legal assistance
0%	D.	Yes, provider education
0%	E.	No

At Risk of Removal

- "Visa abuser" – a visa holder who violates the terms/conditions of their visa
- Non-citizens with criminal convictions
  - Felonies
  - Misdemeanors
  - Other violations
- Undocumented immigrants

U.S. Constitution

Reasonable Expectation of Privacy

- At home
- At work
- Grocery store
- School
- Parking lot
- Waiting room
- Patient examination room

Immigration Enforcement: In Public

ALWAYS carry these documents, if you have them:

- Valid temporary visa or LPR/Green Card
- Copy of your DACA Work Permit
- CA Driver's License or ID Card
- Proof of physical presence in the US for at least the last 2 years:
  - Taxes
  - School records
  - Utility bills
  - Bank statements

Immigration Enforcement: In Public

NEVER carry these documents:

- Fake LPR/Green card
- Fake social security card
- Fake passport
- Birth certificate
- Home country ID cards
- Home country passport

Immigration Enforcement: Health Settings

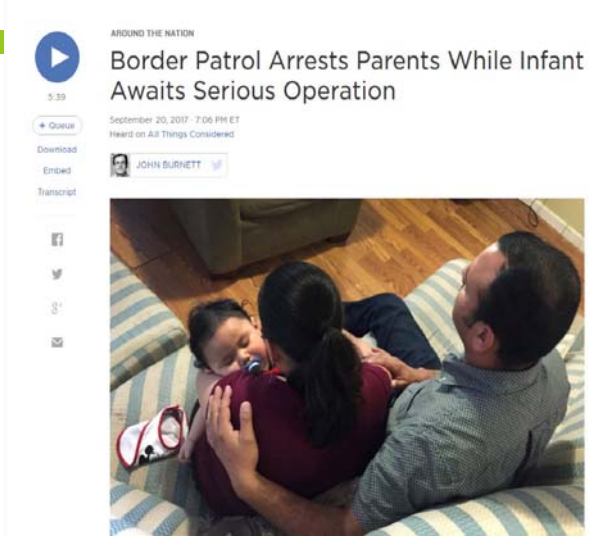
- Immigration Law
- Constitutional Law
- Use of Discretion
- Law vs. Guidance
- Collateral Consequences

Sensitive Locations

As of March 1, 2017, Guidance still intact

- Enforcement should not be occurring at healthcare facilities unless:
  - Agents are there with preapproval
  - Agents are led there via another enforcement action; or
  - Unless exigent circumstances exist

Sensitive Locations



Sensitive Locations

Problems for Healthcare Settings

- When Guidance is not law
- When there is no reasonable expectation of privacy
  - Subjectively believes they have an expectation
  - That expectation is reasonable
- When a warrant requirement can be waived
  - Eroding expectation of privacy
  - "Knowingly exposing to the public"

Developing Protocol and Procedures

- Require a designated staff member who is the only person authorized to review a warrant to "sign off"
  - Consider adding legal counsel to the review process
  - Maintain privacy consistently in the spaces you deem private

Rules of Engagement

- Do file a complaint with the appropriate enforcement organization
- Do give clients and patients information about their rights
- Do <u>not</u> do the following:
  - Hide a patient
  - Fail to cooperate or impede law enforcement efforts
  - Rely on Guidance

Questions?

Thank You!!!!

Uncertain Times: HIV and Immigration

Answers to Questions from Migrants Living with HIV and Their Providers

August 2017

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DISCLAIMER

The information contained in this guide is not legal advice that you should rely upon. The information contained in this guide may be outdated. It was last revised on September 5, 2017. If you have a legal question you should speak with a licensed attorney as soon as possible in order to preserve any claims or options you may have.

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I. ICE ENFORCEMENT

1. Can ICE enter my home?

ICE officers cannot enter your home without a valid warrant and without your permission. A warrant is valid only if: (1) it is signed by a judge; (2) identifies the person or thing being searched for; and (3) lists the exact address, including unit number, of the location to be searched. However, any adult residing in the home has the power to waive these requirements if they consent to the search by inviting ICE in. Therefore, families are urged to instruct everyone in the household to never open the door for ICE officers and to always check for a valid warrant before allowing an ICE officer to come inside. If ICE enters your home without a valid warrant and without consent, contact the ICE Office of Diversity and Civil Rights (ODCR) to make a complaint by calling (202) 732-0192. ODCR complaints must be filed within 45 days of any improper action.

For more information, see: Maryland v. Dyson, 527 U.S. 465, 466 (1999); https://www.aclusocal.org/en/know-your-rights/what-do-if-immigration-agents-come-your-door; https://www.ice.gov/contact; https://www.ilrc.org/sites/default/files/resources/family_preparedness_plan.pdf

2. Where can I go if ICE enters my home?

While you do not have the right to run away from ICE officers, you do have the right to ask if you are free to leave. If the ICE officer says yes, then you have the right to leave. You also have the right to assert your Fifth Amendment right to remain silent throughout this process if ICE attempts to question you within your home.

For more information, visit:https://www.aclusocal.org/en/know-your-rights/what-do-if-immigration-agents-come-your-door; https://www.ilrc.org/sites/default/files/resources/family_preparedness_plan.pdf

3. Can I be arrested at a health clinic?

Yes. ICE currently maintains a "sensitive locations" policy that restricts action at health clinics and hospitals. This policy states that officers are not supposed to attempt to detain people in clinics. However, this is merely a policy and not binding law. Because this is only a policy and not binding law, it is still legal for ICE officers to conduct raids at health clinics and hospitals. Officers are required to possess a valid warrant or have permission in order to search for you in the private areas of clinics, such as patient examination rooms. This requirement does not apply to public areas of clinics, including waiting rooms and other areas where there is not a reasonable expectation of privacy.

For more information, see: Katz v. United States, 389 U.S. 347, 351 (1967); https://www.ice.gov/ero/enforcement/sensitive-loc

4. If I am ordered to go to the courthouse to pay fines, am I safe there?

Courthouses are not covered under the "sensitive locations" policy. This means that ICE officers are fully authorized to conduct searches at and detain people in courthouses. Because courthouses are public places, ICE officers can enter and search for you without a warrant if they have probable cause to believe that you are in violation of immigration laws.

For more information, visit: https://www.ice.gov/ero/enforcement/sensitive-loc

5. Can a plain clothes ICE officer arrest me?

Yes. According to an ICE statement made earlier this year, "ICE personnel are authorized to wear 'street clothes' and do not have a standard uniform they are required to wear to work. At times, when conducting targeted arrests officers may wear tactical safety gear with law enforcement markings. ICE officers identify themselves to those individuals with whom they engage, whether for the purposes of questioning or arrest." However, while ICE officers must "identify themselves," reports have shown some officers will simply call themselves "police" or "law enforcement" and not "immigration" or "ICE." ICE officers will sometimes also wear uniforms that do not display any information identifying them as immigration enforcement agents. ICE policy currently requires that agents receive the permission of non-ICE agencies to use their name as a "cover" (or disguise). ICE officers are not required to notify the public when they are under cover as such. ;

For more information, visit: http://www.westword.com/news/ice-agents-are-infiltrating-denvers-courts-and-theres-a-video-to-prove-it-8826897; http://www.latimes.com/local/lanow/la-me-immigration-deportation-ruses-20170219-story.html

6. Should I be avoiding public places, like supermarkets?

ICE generally conducts targeted raids or searches in places where they have determined they can detain specific individuals. ICE generally does not conduct wide "sweeps" of public places, like supermarkets. However, ICE is authorized to do so. If ICE officials choose to conduct searches or immigration raids in public spaces, keep the following in mind:

- No matter what, do not run away or do anything to raise suspicion – this could likely give ICE officials the right to detain you
- If you are being detained, you have the right to remain silent and to speak to an attorney
- If you are not being detained, you have the right to leave

For more information, visit: https://www.aclu.org/know-your-rights/what-do-if-youre-stopped-police-immigration-agents-or-fbi; https://www.ice.gov/ero/enforcement/sensitive-loc

7. Can agents search my wallet or purse to look for my ID or otherwise identify me or ascertain my immigration status?

The Fourth Amendment of the United States Constitution gives you the right to be free from "unreasonable searches and seizures." This right protects you and your belongings from being searched by an ICE officer without a warrant, without your consent, or without reasonable suspicion that you committed a crime. However, at the border and at ports of entry, including within the domestic terminals of airports, ICE officers are authorized to conduct "routine searches" of you and your belongings without a warrant, without your consent, and without reasonable suspicion that you committed a crime.

If an ICE officer has "reasonable suspicion" that you have committed an immigration violation or other crime, then you may be stopped you and required to provide your immigration documents if you are not a United States citizen. In some states, you are required to identify yourself by name when asked. However, unless stopped at the border or other port of entry, you have the right to remain silent and may refuse to answer questions about your immigration status.

For more information, visit: https://www.aclu.org/know-your-rights/what-do-if-youre-stopped-police-immigration-agents-or-fbi ; https://www.aclu.org/other/constitution-100-mile-border-zone

8. Should I sign documents I am given by ICE if I am detained?

No. If you are being detained or questioned by an ICE officer, you should never sign a document without first speaking to a lawyer. If you are in detention, you have the right to an attorney and should ask to speak one before signing any documents.

For more information, visit:
https://www.ilrc.org/sites/default/files/resources/family_preparedness_plan.pdf;
https://www.nilc.org/get-involved/community-education-resources/know-your-rights/

9. What about sanctuary cities and states?

Sanctuary cities are places where local law enforcement officials refuse to surrender or transport to Immigration and Customs Enforcement officers immigrants who might be eligible for removal. This type of transfer becomes necessary when an immigrant is being detained in a city, state, or county jail or prison for participating in certain activities that allow the government to remove them from the U.S.[1] Federal immigration officials must rely on local officials to enforce federal immigration laws against a removable immigrant in state or local custody. Because numerous federal courts have found that state and local compliance with federal immigration laws is voluntary, state and local policies around the transfer of removable immigrants in custody can be outcome determinative. In sanctuary cities and

1. For more information on crimes that may make a non-citizen removable, see Question 24.

states, a removable immigrant held in local or state custody might not be turned over to federal immigration officers for removal.

Most recently, Donald Trump issued an executive order expanding the category of migrants prioritized for removal to include any immigrant who comes into contact with law enforcement. This expansion, if enforced, would discourage immigrants from contacting police and reporting crimes and is therefore detrimental to the safety of the wider community. Sanctuary cities and states seek to directly alleviate this safety concern.

It is important to remember first and foremost that sanctuary city policies are not always followed and that these policies are always subject to change. Regardless of whether you are interacting with local, state, or federal law enforcement officials, use caution and exercise your constitutional rights.

For more information on how to exercise these rights during interactions with law enforcement officials, visit: https://www.aclu.org/files/assets/bustcard_eng_20100630.pdf

For more information on how sanctuary cities work, visit: https://www.washingtonpost.com/graphics/national/sanctuary-cities/

II. DETENTION AND REMOVAL

10. What is an Order of Removal?

If you receive a Final Order of Removal, it means you are expected to leave the U.S. to return to your home country. While there are ways to challenge that order, you should contact an immigration attorney as soon as possible to be able to do so. If a decision in your case is final, meaning you've already tried fighting the order and lost, there are severe immigration consequences for not following the order.

11. How do I know if I am under an Order of Removal?

If you don't know whether or not you are under a Final Order of Removal, the first step would be to look into the status of your case. While it is not always perfect (no system is), a call to U.S. Citizenship and Immigration Services' National Customer Service Center (NCSC)'s 1-800 number is a solid place to start. Call 1 (800) 375-5283 and make sure to have your receipt or tracking number.

12. How can I help someone who has been detained by ICE?

You can confirm where they are being detained by contacting ICE during normal business hours at (888) 351-4024, or by going online to https://locator.ice.gov/odls/homePage.do. People detained by ICE should be informed of the following:

1) Constitutional rights, including their rights to remain silent and obtain legal counsel; and

2) The importance of refusing to sign documents provided by ICE unless they have the opportunity to consult with an attorney about those documents.

For more information, visit:
https://www.ilrc.org/sites/default/files/resources/family_preparedness_plan.pdf;
https://www.ice.gov/contact

13. What impact could my HIV status have if I am detained by ICE?

USCIS policy requires that officers and agents disregard HIV status when determining admissibility, meaning that HIV should have no direct impact on the outcome of your detention and your ability to adjust your status. For more information on how to continue accessing your HIV treatment while you are in detention, see question 14. For more information on how your HIV-status might impact your status as a Lawful Permanent Resident, see question 28.

For more information, visit: https://www.uscis.gov/archive/archive-news/human-immunodeficiency-virus-hiv-infection-removed-cdc-list-communicable-diseases-public-health-significance

14. If I am removed, will I still have access to treatment and my medication?

ICE detention standards specify that "[m]edical personnel shall provide all detainees diagnosed with HIV/AIDS medical care consistent with national recommendations and guidelines disseminated through the U.S. Department of Health and Human Services, the CDC, and the Infectious Diseases Society of America." The standards further provide for the availability and accessibility of "all Food and Drug Administration (FDA) medications currently approved for the treatment of HIV/AIDS." Additionally, these standards call for the development and implementation of "distribution procedures to ensure timely and confidential access to medications" so that "newly admitted detainees can continue with their treatments without interruption." Finally, the standards provide for detainees currently undergoing HAART to "receive up to a 30-day supply of their medications" upon release.

It is therefore imperative that you immediately notify both your HIV treatment provider and your Removal Officer of your HIV-positive status. If you are being removed to Mexico, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panama, Belize, or elsewhere, please see below links for country-specific resources on how to continue accessing treatment upon your release.

For more information, visit: https://www.ice.gov/doclib/detention-standards/2011/4-3.pdf;

If you are a healthcare provider and your patient has been detained, read this fact sheet on how to ensure your continuity of care while in detention:
https://aidsetc.org/sites/default/files/resources_files/AETC%20Tip%20Sheet%20for%20ICE%20detainees%20JAN2017.pdf

If being removed to Mexico or Central America, read these fact sheets on how to ensure your continuity of care after removal: https://aidsetc.org/resource/umbast-factsheets

15. If I am removed, what will happen to my children?

If you are removed and you have not made any legal preparations for the care of your children before being removed, the government will place your children into the child welfare system. If your child is placed into the welfare system, you may temporarily or even permanently lose parental rights over your children. If your children are admitted into the child welfare system, you should never sign any documents related to their child welfare cases without first speaking to an attorney.

There are several things you can do to protect your parental rights and prevent your children from being placed into the child welfare system. You can make arrangements for your children to live with a friend or relative if you are removed. There are three general types of arrangements that you can make:

1. **Informal arrangement without legal papers:**

   Under this arrangement, a friend or family member takes physical custody of your children simply by having your children stay with that friend or family member. Talk to whomever you would like your children to stay with ahead of time and make sure they have the ability and resources to keep your children for an extended period of time. This arrangement allows for you to keep all of your parental rights and easily reclaim your children when you are released. This arrangement does not allow for whoever is caring for your children to make decisions on your behalf. Because this arrangement is informal and not in writing, it does not have any legal protection if any conflicts were to arise.

2. **Guardianship - Power of Attorney:**

   Under this arrangement, a friend or family member takes both physical and legal custody of your children by adding to the first option a signed and notarized legal document. With legal custody, your friend or family member now has the authority to make certain parental decisions on your behalf and defend against any conflicts around custody. This arrangement allows for you to keep some of your parental rights while temporarily giving others to your friend or family member while they care for your children. Because this agreement is not an official court order, it will not enable your friend or family member to apply for public benefits for your children. Furthermore, it will not enable your friend or family member to make any medical decisions or request in-school disability services for your children. Contact the Los Angeles HIV Law & Policy Project for more information on how to prepare a legally enforceable guardianship agreement for if you are removed.

3. **Family-court approved custody arrangement:**

   Under a family-court approved custody arrangement, a friend or family member takes both physical and legal custody and adds to the second option the right to apply for public benefits, make medical decisions, and request in-school disability services for your children. This is the most formal and stable arrangement, and also the most difficult to reverse. Under this arrangement, your parental rights are significantly limited, even if you eventually retain physical custody of your children.

If you are detained and have not made or cannot quickly make one of the above three arrangements, you should request to be released by informing your Removal Officer that you have dependent children and ask that the Removal Officer exercise discretion in your case.

In 2013, ICE issued "11064.1: Facilitating Parental Interests in the Course of Civil Immigration Enforcement Activities," a directive that gives ICE Field Office Directors the discretion to protect a detainee's parental rights during the course of removal proceedings. Because this directive is non-binding guidance, ICE may elect not to release you. If you cannot get released, try and locate your children and stay in contact with them. Your effort to communicate with your children is important evidence that you want to maintain your parental relationship even if your children are admitted to the child welfare system. If your children are admitted, they will be assigned a child welfare caseworker, and it is equally important that you stay in touch with them.

For a comprehensive guide on how to protect your parental rights if you are removed, visit: https://www.womensrefugeecommission.org/rights/gbv/resources/document/download/1023

III. U-VISA

16. What options do victims of crimes have when it comes to immigration and protection?

The U-Visa program creates protections for undocumented victims of certain crimes, including for survivors of domestic violence, occurring in the United States. The program gives applicants and their immediate family members the ability to obtain U-Visas with a cap of 10,000 U-Visas given to principal applicants per year. To obtain a U-Visa, you must prove that you "suffered substantial physical or mental abuse as a result of having been a victim of criminal activity." Additionally, applications must contain a Certification signed by the law enforcement agency tasked with investigating or prosecuting the underlying crime for which you are seeking a U-Visa. The Certification must confirm that you "were helpful, and currently being helpful, or will likely be helpful" in that investigation or prosecution.

For more information, visit: https://www.uscis.gov/humanitarian/victims-human-trafficking-other-crimes/victims-criminal-activity-u-nonimmigrant-status/victims-criminal-activity-u-nonimmigrant-status;
https://www.ilrc.org/sites/default/files/resources/proseuvisamanual_english.pdf

17. What is a U-Visa?

Also known as a "U nonimmigrant status," a U-Visa is a special visa given to victims of certain crimes who cooperate with law enforcement in the investigation or prosecution of criminal activity. A U-Visa allows recipients to lawfully remain in the United States, gives them a path to naturalization, and waives certain normal bars to admissibility that might otherwise prevent someone from adjusting their status. This status can also be extended to the person's immediate family.

For more information, visit: https://www.uscis.gov/humanitarian/victims-human-trafficking-other-crimes/victims-criminal-activity-u-nonimmigrant-status/victims-criminal-activity-u-nonimmigrant-status ; https://www.uscis.gov/system/files_force/files/form/i-918instr.pdf?download=1

18. Are U-Visas still being issued?

Yes. USCIS recently implemented a policy where two service centers will begin permanently processing U-Visa requests rather than one, which suggests that U-Visas will continue to be issued well into the future.

For more information, visit: https://www.uscis.gov/humanitarian/victims-human-trafficking-other-crimes/victims-criminal-activity-u-nonimmigrant-status/u-nonimmigrant-status-program-updates.

19. Is it safe to share information with USCIS for a U-Visa?

The U-Visa program maintains a strict policy of confidentiality, meaning that no one will know, including your abuser or the person who committed a crime against you, if you have applied for a U-Visa. The files remain sealed if an application is approved, and will only be unsealed if your petition is denied. The USCIS confidentiality rules do not protect your information from being disclosed to certain government agencies for very specific, non-immigration related purposes.

For more information, visit: https://www.uscis.gov/policymanual/HTML/PolicyManual-Volume1-PartA-Chapter5.html

IV. REFUGEES & ASYLUM

20. If I was assaulted or abused elsewhere and am now here in the United States on a work visa, can I apply for asylum?

Any non-citizen can apply for asylum, regardless of their immigration status. In order to apply for asylum, you must file your application for asylum within 12 months of your arrival to the United States. This requirement may be waived if you qualify for one of the following exceptions and still file your application within a reasonable time:

A. **changed circumstances** materially affecting your eligibility for asylum:
   - Changes in the applicant's home country conditions
   - Changes in U.S. law
   - Changes in the applicant's personal circumstances (e.g. political activism, converting to a new religion)

B. **extraordinary circumstances** relating to your delay in filing:
   - Events in your life that directly caused you to miss the deadline
   - Serious illness
   - Mental or physical disability
   - Death, serious illness, or incapacity of your legal representative or immediate family member
   - Ineffective assistance of counsel

If you satisfy the above filing requirement or qualify for a waiver, then your application for asylum may be approved depending on the nature of the abuse or assault that you experienced. Your application for asylum will only be approved if you can prove that you:

(1) have a **well-founded fear** of persecution: a subjective fear of persecution that has an objective basis

(2) based on **past persecution** OR **risk of persecution in the future** if and upon return to your country of origin; courts have offered varying definitions of this element, including:
   - "a threat to life or freedom on account of race, religion, nationality, political opinion or membership of a particular social group is always persecution."[2]
   - "the infliction of suffering or harm upon those who differ in a way regarded as offensive."[3]
   - usually physical but sometimes also emotional or psychological.[4]

(3) because of your membership in a **particular social group**:
   - defined by a common, immutable characteristic:
     - race
     - nationality
     - sexual orientation
     - gender identity
     - political opinion/belief
   - that group members cannot change or should not be required to because it is fundamental to their identity or conscience

2. Matter of Laipenieks, 18 I&N Dec. 433, 457 (BIA 1983)
3. Korablina v. INS, 158 F.3d 1038, 1043 (9th Cir. 1998); Miranda v. INS, 139 F.3d 624, 626 (8th Cir. 1998)
4. Mashiri v. Ashcroft, 383 F.3d 1112, 1120 (9th Cir. 2004); Duarte de Guinac v. INS, 179 F.3d 1156, 1163 (9th Cir. 1999)

(4) the persecutor is a **government actor** OR a **non-governmental actor that the government is unwilling or unable to control**
- persecutor is a police officer
- persecutor is part of a gang or cartel that the government cannot control

21. Can I be turned away because I am not "in danger" in my home country?

In some cases, yes. Eligibility for asylum requires that an applicant have a "well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion." USCIS Asylum Officers are responsible for determining whether this is the case based on your individual situation and could therefore deny your application if they feel you do not satisfy this requirement.

For more information, visit: https://www.uscis.gov/faq-page/asylum-eligibility-and-applications-faq#t12802n40175

V. LAWFUL PERMANENT RESIDENTS (LPRS)

22. Is there any assistance available for people living with HIV who wish to adjust their status?

There are a number of legal services organizations addressing immigration-related needs. These include organizations dedicated to serving people living with HIV. Links to both can be found below:

Central American Resource Center ("CARECEN")
2845 W. 7th St.
Los Angeles, CA 90005
(213) 385-7800
www.carecendc.org

Esperanza Immigrant Rights Project
1530 James M. Wood Blvd.
Los Angeles, CA 90015
(213) 251-3505
www.esperanza-la.org

Public Counsel Immigrants' Rights Project
610 S. Ardmore Ave.
Los Angeles, CA 90005
(213) 385-2977, extension 600
http://www.publiccounsel.org/practice_areas/immigrant_rights

Legal Aid Foundation of Los Angeles - Immigration
634 S. Spring St. Suite 400A
Los Angeles, CA 90014
(800) 399-4529
https://lafla.org/help/services/immigration/

Immigration Legal Assistance Project of the Los Angeles County Bar Association
300 N. Los Angeles St., Room 3107
Los Angeles, CA 90012
Monday – Friday: 8:00 am to Noon and 1:00 am to 3:00 pm
(213) 485-1873
https://www.lacba.org/give-back/immigration-legal-assistance-project

Immigrant Defenders Law Center
634 S. Spring St.
Los Angeles, CA 90014
(213) 634 - 0999
https://www.immdef.org/

23. Can children in their twenties file a petition on behalf of their parents for an adjustment of status?

U.S. citizens that are 21 years of age or older can file a petition on behalf of their parents. However, this petition is still limited by typical bars to admission, such as unlawful presence or criminal convictions. The child must also be able to prove that they earn the minimum income required by USCIS for sponsorship. If a child does not earn the minimum income required by USCIS, they can find someone else who does and is will to co-sponsor their parent.

For more information, visit: https://www.uscis.gov/policymanual/Print/PolicyManual-Volume7-PartA.html; http://www.immigratetoamerica.org/guide-to-immigrating-your-parents-to-america-part-b/

24. Can old criminal convictions (e.g., a DUI) affect my immigration status or proceedings?

A criminal conviction for an aggravated felony can make a noncitizen without lawful status inadmissible. An aggravated felony is any crime of theft or violence for which the punishment could be one year's imprisonment. This means they probably cannot adjust their status through a family petition. A criminal conviction for an aggravated felony can make any noncitizen, even Lawful Permanent Residents, removable. Generally, a DUI is not considered an aggravated felony (Leocal v. Ashcroft, 543 U.S. 1 (2004)).

In addition to criminal convictions for aggravated felonies, a criminal conviction for a crime of moral turpitude can also affect immigration proceedings. Crimes of moral turpitude is a set of crimes defined by court cases, and includes crimes that involve intent to defraud, intent to cause great bodily harm, or theft with intent to permanently deprive an owner of their property. Two or more convictions for crimes of moral turpitude can make a noncitizen without lawful status inadmissible, and may make any noncitizen removable. One conviction for a crime of moral turpitude within the first five years of entry can also make a noncitizen without lawful status inadmissible, and may make any noncitizen removable. A DUI is generally not considered a crime of moral turpitude unless there are extenuating circumstances such as multiple DUIs or a DUI on a suspended license.

For crimes involving controlled substances, noncitizens will be removable and inadmissible with a few minor exceptions. The petty offense exception (crimes where the maximum sentence does not exceed one year and the term of imprisonment sentence does not exceed six months count as petty offenses and do not trigger inadmissibility) generally does not apply to petty drug offenses, except when a minor under eighteen years of age is convicted of simple possession or use of a controlled substance. Finally, the Court of Appeals for the Ninth Circuit, which is binding in California, has found that a person whose drug conviction was expunged under the Federal First Offender Act cannot be found inadmissible for admitting facts related to the drug crime.

To find out if your criminal record will negatively impact your immigration proceedings, you should request a copy of your California Department of Justice report ("rap sheet") and seek a legal opinion.

For more information, visit:
https://www.ilrc.org/sites/default/files/resources/california_chart_jan_2016-v2_0.pdf;
https://www.ilrc.org/sites/default/files/resources/n.6-aggravated_felonies.pdf; *Jimenez v. Holder*, 597 F.3d 952 (9th Cir. 2010).

25. Is it recommended for non-residents to begin their applications for residency right now?

In general, the current administration has expressed more hostility towards noncitizens than previous administrations. However, if you have immigration priority and do not have any criminal convictions, it may be best to submit your application as soon as possible because of how long the process takes. If you have been convicted of, or even arrested for, any crimes, or if you entered the United States without inspection, you should not submit your application for residency without first consulting an attorney.

26. Does same sex marriage legalization help with my same-sex spouse's immigration status?

Yes. Spouses have immigration priority above other family-based petitions. Because same-sex couples can legally marry, married same-sex couples enjoy this priority. However, same-

sex spouses are still subject to the usual bars to admission, including criminal convictions and unlawful presence.

For more information, visit: https://www.uscis.gov/policymanual/Print/PolicyManual-Volume7-PartA.html

27. Why do immigration proceedings take longer (three months) for those who enter through Ciudad Juárez?

Currently, the U.S. consulate in Ciudad Juarez is the only location that processes immigrant visas that allow foreigners to live in the U.S. before obtaining permanent legal residency. Applicants must undergo medical and biometrics examinations and sit for an interview at the consulate, a process that can take up to four days or more.

For more information, visit: http://www.motherjones.com/politics/2011/02/immigration-green-card-juarez-cartel-violence/; http://www.durrani.com/ConsularProcessing-CiudadJuarez.html

28. Can my HIV-positive status affect my status as a Lawful Permanent Resident?

Section 212(a)(1)(A)(i) of the Immigration and Nationality Act (INA) bars from admission to the United States any foreign-born national who has been diagnosed with any illness specified as a "communicable disease of public health significance." HIV used to be characterized as a communicable disease of public health significance, and it was therefore a basis for banning people living with HIV from entering the United States from 1993 through January 4, 2010. Short-term visa or lawful permanent residence applicants could be denied simply for being HIV-positive. On November 2, 2009 (effective January 4, 2010), HIV was declassified as a communicable disease of public health significance. The HIV is ban no longer in place and will not impact your status as a Lawful Permanent Resident. However, many states, including California, criminalize people living with HIV who do not disclose their HIV-status to their sexual partners. Criminal convictions for HIV-specific crimes may trigger bars to admissibility and adjustment of status.

For more information, please visit: https://www.uscis.gov/ilink/docView/AFM/HTML/AFM/0-0-0-1/0-0-0-17255.html

29. What is the process to go from being a Lawful Permanent Resident (LPR) to becoming a citizen?

The process of going from LPR to U.S. citizen is called naturalization, and requires completion and submission of Form N-400, the "Application for Naturalization." Before completing and submitting Form N-400, it is important to determine if you are indeed eligible for naturalization. To be eligible for naturalization, you must satisfy two requirements: (1) continuous residence; and (2) good moral character.

1. ***Continuous Residence***
   Continuous residence means you have not left the United States for six months or more. In other words, if you leave the United States for more than six months, then you have disrupted your continuous residence and are generally ineligible for naturalization. An LPR is eligible for naturalization if they can establish continuous residence as an LPR for at least five years at the time of filing. Generally, the five-year clock begins to run at the time USCIS approves an applicant's adjustment application. However, for certain classes of LPRs, the five-year clock begins to run before the actual approval date. You will have to make a list of every time you have left the U.S. since becoming an LPR. Doing so will help you to calculate whether you satisfy the continuous residence requirement.

2. ***Good Moral Character***
   In addition to the continuous residence requirement, you must also demonstrate that you are a person of good moral character. This is a legal term of art, which means that it is a special term with a specific meaning. To determine whether you are a person of good moral character, Form N-400 asks several questions about your criminal history. Lying in your response automatically results in a finding that you lack good moral character. Certain criminal convictions also automatically result in a finding that you lack good moral character. This means that if you have been convicted[5] of an aggravated felony,[6] persecution of others, genocide, torture, or severe violations of religious freedom. Other offenses may be temporary bars that prevent an LPR from naturalizing for a certain period of time after the offense. Some convictions may make you removable, which means you can be immediately removed.[7] Applying for naturalization is risky because it alerts DHS to your where you are located. If you have been convicted of a crime that makes you removable, then you may not want to apply for naturalization. Before you apply for naturalization, it is strongly suggested that you review your criminal record with an immigration attorney to determine whether you are permanently ineligible, temporarily ineligible, or immediately removable.

After completing and submitting Form N-400 along with the $640 filing fee, you must submit your fingerprints for a biometrics exam, sit for an interview, and pass English and civics tests. You do not have to take the English test (but must still take and pass the civics test) if at the time you file for naturalization you are 50 years old and have lived in the United States as a green card holder for 20 years, or if at the time you file for naturalization you are 55 years old and have lived in the United States as a green card holder for 15 years. You do not have to take the civics test if you have a medical disability certified by a physician and have submitted Form N-648. Upon completion of all these steps, you will be invited to an oath-taking ceremony where you will take the Oath of Allegiance and exchange your Lawful Permanent Resident Card ("green card") for a Certificate of Naturalization.

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5. Under the Immigration and Naturalization Act, a conviction is a formal finding of guilt entered by a court of law. A conviction also exists when adjudication does not proceed but a judge or jury still finds an alien guilty and some form of punishment has been imposed.
6. For more information on what constitutes an aggravated felony, see Question 24.
7. For more information on which convictions make a noncitizen automatically removable, see Question 24.

For detailed information on naturalization eligibility, visit:
https://www.uscis.gov/sites/default/files/files/article/chapter4.pdf

For detailed information on what to expect from the naturalization process, visit:
https://www.uscis.gov/sites/default/files/files/article/chapter5.pdf

For information on permanent criminal bars to naturalization, visit:
https://www.uscis.gov/policymanual/HTML/PolicyManual-Volume12-PartF-Chapter4.html

For information on non-permanent criminal bars to naturalization, visit:
https://www.uscis.gov/policymanual/HTML/PolicyManual-Volume12-PartF-Chapter5.html

For information on exceptions to the naturalization requirements, visit:
https://www.uscis.gov/us-citizenship/citizenship-through-naturalization/exceptions-accommodations

30. If I receive public benefits as a Lawful Permanent Resident, will this affect my citizenship application?

No. Public benefits are government programs that provide financial, medical, housing, and social support services to people of sufficient need. They include General Relief, food stamps ("CalFresh" in California), SSDI, SSI, Medicare ("MediCal" in California), Medicaid, and Cash Assistance Program for Immigrants ("CAPI"). A person who receives public benefits is called a public charge. The lawful receipt of public benefits while you are an LPR will not affect your application for naturalization. If you obtain public benefits by fraud or deceit, or you otherwise obtain public benefits illegally, you may likely be ineligible for naturalization for lack of good moral character. But if you legally apply for and receive public benefits as a Lawful Permanent Resident, your application for naturalization will be unaffected.

Unlike with applications for naturalization, your receipt of public benefits may affect your application for admission to the United States or your application for adjustment of status to become a Lawful Permanent Resident. Under Section 212(a)(4) of the Immigration and Naturalization Act, an individual is inadmissible to the United States and cannot adjust their status if they are "likely at any time to become a public charge." Not all public benefits, however, are treated the same: receiving cash assistance like general relief will be considered, but not non-cash benefits like MediCal or Food Stamps. Simply receiving cash assistance is not enough to warrant a finding that you are likely to become a public charge. USCIS has created guidelines for determining the likelihood that receipt of a certain public benefit will result in a finding that the recipient is likely to become a public charge. Such determinations take into account the following factors:

- Age
- Health
- Family status
- Assets
- Resources
- Financial status

- Education
- Skills

For more information, please visit: https://www.uscis.gov/greencard/public-charge; https://www.uscis.gov/news/fact-sheets/public-charge-fact-sheet.

31. Can I be removed as a Lawful Permanent Resident if I have a criminal history?

Yes. Convictions for several types of criminal offenses can and likely will result in the removal of an LPR. A conviction is a formal finding of guilt by a court of law. A conviction also exists when a defendant pleads guilty without a formal trial, and a punishment is imposed. An LPR can be removed if they are convicted of:

1. a crime of moral turpitude within five years after the date of admission
2. a crime that may be punished by one year or more
3. multiple crimes involving moral turpitude
4. an aggravated felony
5. a violation that involves high speed flight from an immigration checkpoint
6. failure to register as a sex offender

For a complete list of crimes and other conditions that may result in the immediate removal of an LPR, consult Section 237 of the Immigration and Naturalization Act, "Removal Statutes" at: https://www.uscis.gov/ilink/docView/SLB/HTML/SLB/0-0-0-1/0-0-0-29/0-0-0-5684.html
https://www.uscis.gov/ilink/docView/SLB/HTML/SLB/0-0-0-1/0-0-0-29/0-0-0-5684.html

32. What is the Legal Immigration Family Equity Act of 2000 (LIFE Act)?

The Legal Immigration Family Equity (LIFE) Act and LIFE Act Amendments of 2000 (Pub. L. 106-553 and -554) enable certain individuals who are present in the U.S. who would not normally qualify to apply for adjustment of status to obtain a green card (permanent residence) regardless of the following:

1. The manner in which they entered the U.S.;
2. Working in the United States without authorization; or
3. Failing to continuously maintain lawful status since entry

To qualify for this provision, you must be the beneficiary of a labor certification application (Form ETA 750) or an immigrant visa petition (Forms I-130, Petition for Alien Relative or I-140, Immigrant Petition for Alien Worker) that someone else filed for you **on or before April 30, 2001**. In most cases, you must pay an additional $1,000 fee and complete additional forms.

For information about the Legal Immigration Family Equity Act of 2000, and how it impacts immigration relief under INA §245(i) please visit: https://www.uscis.gov/green-card/other-ways-get-green-card/green-card-through-legal-immigration-family-equity-life-act.

VI. DEFERRED ACTION FOR CHILDHOOD ARRIVALS (DACA)

33. Will DACA be repealed?

Yes. The Trump administration announced in the late Spring of 2017 that it intended to preserve DACA. This means that DACA applications were still being reviewed, renewed, and approved. There were at least two documented cases of DACA recipients being removed after receiving criminal convictions. Several cases challenging DACA were filed in Texas and 10 other states. Former Department of Homeland Security (DHS) Secretary Jim Kelly suggested that it is unlikely that DACA will survive a legal challenge in the federal courts. On August 24, 2017, several government officials also indicated that the Trump administration is likely to end DACA. Attorney Jeff Sessions confirmed this on September 5, 2017, by issuing a directive to the Department of Homeland Security to rescind (end) the program.

For updated information on DACA, visit: https://www.nilc.org/issues/daca/ ; https://www.nilc.org/issues/daca/top-5-things-to-know-about-daca-ending/.

To review the relevant guidance issued by the Department of Homeland Security, visit: https://www.dhs.gov/news/2017/09/05/memorandum-rescission-daca.

34. Will DACA recipients be removed?

Authorizations already granted are valid until they expire. Any person wanting to clarify their rights under this program should not leave the country and should seek immediate legal assistance.

VII. VISAS

35. What are the different types of visas?

There are two categories of visas: non-immigrant and immigrant visas. Non-immigrant visas are issued to foreigners who wish to enter the U.S. and stay temporarily. Immigrant visas are issued for the purpose of immigrating to the U.S. The following is a list of the basic types of non-immigrant visas:

- B-1: Business visitor
- A: Diplomat or foreign government official
- J: Exchange visitor (physician, professor, scholar, teacher)
- F: Student
- H-2A: Temporary farmworker
- H-2B: Temporary non-farm seasonal worker
- U: Victim of criminal activity in the United States
- T: Victim of human trafficking
- V: Spouse or child of a Lawful Permanent Resident

The following is a list of the basic types of immigrant visas:

- K-3: Spouse of a U.S. citizen awaiting approval of Form I-130
- K-1: Fiancé of a U.S. citizen
- E1, 2, 3: Employer-sponsored visas
- DV: Diversity visa

For a complete list of both non-immigrant and immigrant visas, visit: https://travel.state.gov/content/visas/en/general/all-visa-categories.html.

36. How are the visas treated differently?

Generally, a non-immigrant visa holder is ineligible to adjust their status to that of Lawful Permanent Resident. An immigrant visa holder is eligible to adjust their status to that of Lawful Permanent Resident.

37. What if I have overstayed my visa and left the country multiple times?

Generally, if you have remained in the United States beyond the date specified on your Form I-94, your visa will be automatically cancelled and Customs and Border Patrol may refuse to allow you to reenter the United States. The length of your overstay, whether removal proceedings have been initiated, and how you attempt to reenter determine what consequence you will most likely incur

Outcome 1:

If you:
(1) overstay for less than 180 days; and
(2) seek to reenter before the start of removal proceedings;
Then, you may apply for a new visa, but will have to convince the Department of State that you will not overstay again.

Outcome 2:

If you:
(1) overstay for more than 180 but less than 364 days; and
(2) you seek to reenter *before* the start of removal proceedings;
Then, you will be barred from reentering for three ("3") years

Outcome 3:

If you:
(1) overstay for 365 days or more; and
(2) seek to reenter *before* the start of removal proceedings; and
(3) you attempt to reenter *with* inspection
Then, you will be barred from reentering for ten ("10") years

Outcome 4:

If you:
(1) overstay for 365 days or more; and
(2) seek to reenter *after* the start of removal proceedings; or
(3) attempt to reenter *without* inspection
Then, you will be *permanently* barred from reentering the United States

The three- and ten-year bars may be waived if you are the spouse or child of a U.S. citizen or Lawful Permanent Resident and if denying you entry or admission would result in extreme hardship to your U.S.-citizen or LPR-spouse or parent. A permanent bar, however, is extremely difficult, if not impossible, to waive.

For more information on the time-bars and waiver, visit:
https://www.uscis.gov/ilink/docView/AFM/HTML/AFM/0-0-0-1/0-0-0-17138/0-0-0-18383.html#0-0-0-1851

38. Will my tourist visa be impacted if I begin receiving public benefits?

A tourist with a B-2 visa is generally ineligible to receive public benefits. B-2 tourist visas are generally withheld from non-citizens who are likely to become public charges. The unlawful receipt of public benefits while present on a B-2 visa will very likely preclude you from adjusting your status or reapplying for another visa in the future.

39. If my visa expired, can my family member request a renewal on my behalf?

The renewal requirements vary depending on your age and country of origin. In some cases, the interview will be waived if you are younger than 14 years old or older than 80 years old. Visit your consulate's website for more information about the renewal process.

VIII. HIV CARE FOR IMMIGRANTS

40. Is anything going to happen to the Ryan White Program?

Currently, the Ryan White program is still intact. Despite proposed budget cuts to the Department of Health and Human Services (DHS runs the Ryan White program) by the new administration, the DHS budget says that programs like Ryan White are of the "highest priority," so while funding may be reduced, it's likely to continue. Further, there is no sunset provision on the Ryan White program legislation so the law will keep renewing as a matter of course, however, funding could still see reductions so continued advocacy for the program is important.

For more information, visit: http://www.nbcnews.com/feature/nbc-out/amid-dramatic-cuts-hiv-aids-funding-spared-new-trump-budget-n734711;
https://www.vox.com/2017/3/16/14943848/pepfar-ryan-white-trump-budget-hiv-aids;
https://www.nastad.org/blog/update-ryan-white-program-current-status

41. Is the Ryan White Program considered a public benefit?

The Ryan White program is a federally funded program so it would technically be a public benefit. However, unlike other programs such are Medicare or Medicaid, it is available to noncitizens without lawful status. Additionally, while the use of some public benefits may negatively impact immigration proceedings (by making someone inadmissible because they are deemed a public charge), the use of federally funded health services is generally not considered for public charge purposes.

For more information, visit: https://hab.hrsa.gov/about-ryan-white-hivaids-program/about-ryan-white-hivaids-program; https://careacttarget.org/library/webinar-qa-access-health-coverage-immigrants-living-hiv-2016#eight; https://www.uscis.gov/green-card/green-card-processes-and-procedures/public-charge

42. Will I have access to my medication through Ryan White if I am removed?

In order to be eligible for the Ryan White program, a person must reside within the United States. Thus, if a person has been removed and is no longer in the United States, they would not be eligible for the program and would not have access to medication under it.

If you are at risk for being removed back to Mexico or another Central American country, you should review the following resources regarding HIV medication access for your country:

https://aidsetc.org/resource/umbast-factsheets

For more information, visit:
https://hab.hrsa.gov/sites/default/files/hab/Global/pcn1302clienteligibility.pdf;

43. Can I receive Medi-Cal if I marry a Lawful Permanent Resident?

If you are a noncitizen without lawful status, you would not be eligible for non-emergent Medi-Cal regardless of marital status. However, if you marry a resident, you are eligible to apply to adjust your status to become a Lawful Permanent Resident (LPR). If you are approved for LPR status, you then may be eligible for Medi-Cal through your spouse or individually. Eligibility is still subject to other criteria such as age, income limits, and total asset limits.

For more information, visit: http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/Medi-CalFAQs2014b.aspx; http://www.calqualitycare.org/learn/nursing-homes/pay/medical/

IX. HOUSING

44. Will there be cutbacks to Housing subsidies and Social Security disability benefits based on being a non-citizen?

Currently, the HOPWA program, administered through HUD remains in effect and provides housing assistance and related services to low-income persons living with HIV/AIDS. Qualified immigrants (those with legal status) are eligible to receive HOPWA services, while those without legal status still remain generally ineligible for permanent housing services, though they make access some programs such as the PHP (permanent housing placement assistance) and STRMU (short term rent, mortgage, and utility assistance). Currently, immigrants without legal status cannot receive most federal safety net programs, such as Supplemental Security Income or Social Security Disability Benefits, this likely will not change under the current administration.

For more information, visit: https://www.hudexchange.info/programs/hopwa/hopwa-eligibility-requirements/; https://fas.org/sgp/crs/homesec/RL31753.pdf; http://econofact.org/do-undocumented-immigrants-overuse-government-benefits; http://www.nydailynews.com/undocumented-u-s-immigrants-collect-retirement-benefits-article-1.2761632

45. Can a landlord threaten to call ICE on me?

The State of California and federal fair housing laws prohibit discrimination against tenants on the basis of their national origin (the country or part of the world they may have come from). A landlord can get into trouble for treating a tenant badly because of their national origin. While a landlord is not allowed to ask a person about their immigration status, a landlord could contact ICE based on suspicions. Because of the increasing use of this harmful threat, lawmakers in California are trying to change the law (AB 291).

For updates on the bill, please visit: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180AB291.

X. SERVICE PROVIDERS

46. Can social workers protect their patients' immigration-related information?

The best way for social workers to protect their patients' immigration-related information is to avoid documenting this information in writing. Despite protections related to the confidentiality of a person's health records, there are exceptions to those very important rules such as court orders issued by a judge and subpoenas issued through a legal process. Unless and until the law changes, social workers can serve as the first line of defense by omitting a person's immigration status wherever possible.

47. How do we protect information of people who are undocumented?

Providers can first start by creating policies and protocol around this issue in collaboration with legal counsel. By establishing an organization or agency-wide practice, you can be thoughtful in your response to situations when you are being asked to disclose such sensitive information. If you can avoid collecting this information or any associated documentation

that would be most helpful. Understandably, however, there are programs which require collecting immigration status information. Consider in what ways you and your organization can advocate for greater protections at a policy level.

For more information about policy advocacy focused on increasing access to healthcare for all in California visit Health Access at: http://www.health-access.org/about/aboutus-overview.html.

XI. IDENTITY DOCUMENTS

48. What if my Social Security card says "for work only"?

There a few types of Social Security cards that differ according to immigrants' legal status.

Type 1: This card has no additional writing on it. This is because at the time the card was issued, the person was a U.S. Citizen or a Lawful Permanent Resident.

Type 2: This card has the following words written on the card: "VALID FOR WORK ONLY WITH DHS AUTHORIZATION." This card is issued to individuals who entered the country lawfully on a temporary basis. In order to be able to work with this Social Security card, the person would need to also provide a work authorization document called an "Employment Authorization Document" or "EAD".

Type 3: This card has the following words written on the card: "NOT VALID FOR EMPLOYMENT." This card is for people who entered the country lawfully without authorization for work but who may have a valid non-work reason for a Social Security number. This may be because a federal law requires the person to have a social security number in order to access a benefit or service.

For more information about the different types of Social Security cards, visit: https://www.ssa.gov/ssnumber/cards.htm.

49. Does California have restrictions regarding state identification cards ("California ID")?

In order to get California identification, an immigrant must prove their identity and must also prove that they are legally present in the United States. Some examples that can prove you are legally present include:

- U.S. citizen naturalization or citizenship document, including a U.S. passport;
- Permanent Resident Card (commonly referred to as a "green card") issued by the U.S. Citizenship and Immigration Services (USCIS), Department of Homeland Security (DHS); and

- Applicants who are non-immigrants, but are authorized to be in the U.S., they may present a Temporary Resident Identification card or other temporary resident documentation issued by the federal government.

50. What is California's Driver's License for Undocumented Residents?

California Assembly Bill AB-60 changed the law regarding Driver's Licenses in California. As of January, 2015, undocumented residents can apply for an AB 60 Driver's License which authorizes a person to drive anywhere throughout the state of California. It may not, however, be used for identification purposes and has a noticeable feature on the front of the license indicating that the license if only for driving purposes according to AB 60 law. While this license cannot be used against the person as evidence of a person's immigration status or citizenship, there are immigration enforcement-related reasons to not carry this card when you are not driving.

See Question 51 below for more information.

51. Should I get the AB 60 Driver's License? If yes, should I carry it at all times?

If you are driving in California, you should consider getting a Driver's License in California made especially for undocumented immigrants, the AB 60 Driver's License. This will ensure that you are not violating California's traffic laws that make driving without a license unlawful. However, you may not want to carry this license around with you when you are NOT driving. While carrying this card may not be used to determine a person's immigration status or citizenship, or for state and local police to hold you for reasons other than valid traffic violations, federal law enforcement authorities (including immigration enforcement) may seek to use it as proof of your undocumented status.

For more information about AB 60 Driver's Licenses, see:
https://www.ilrc.org/sites/default/files/resources/ab_60_4_27_15.pdf.

XII. UPDATES

52. Are there any new healthcare laws that I should know about?

Because the landscape of health-related laws seems to be shifting frequently, the best way to keep track of up to date healthcare laws that may impact people living with HIV is to check the following websites:

Federal AIDS Policy Partnership (http://federalaidspolicy.org/category/access/)
"Established in 2002, the Federal AIDS Policy Partnership (FAPP) is a national coalition of local, regional, and national organizations advocating for progressive federal HIV/AIDS legislation and policy. FAPP members are organizations that devote significant resources in support of federal HIV/AIDS public policy advocacy. FAPP is managed by a twenty-person Convening Group that consists of at-large members and a liaison from each of the affiliated working groups."

Health Access (http://www.health-access.org/health-care-reform/health4all-further-expansions.html)

"HEALTH ACCESS CALIFORNIA is the statewide health care consumer advocacy coalition, advocating for quality, affordable health care for all Californians. As a coalition organization representing consumer groups, communities of color, immigrants, people with disabilities, children, seniors, women, people of faith, and organized labor. Health Access seeks to connect grassroots organizing to policy work, on-the-ground mobilization with savvy Sacramento strategy. Coalition member organizations can count on Health Access for timely analysis and tools so that whatever time and effort they have for health advocacy is spent in the most effective way possible."

53. Are there any new immigration laws that I should know about?

Because the landscape of immigration law and policies seem to be shifting frequently, the best way to keep track of up to date immigration law and policy changes that may impact people living with HIV is to check the following websites:

Immigration Legal Resource Center (https://www.ilrc.org/press-room)

"The Immigrant Legal Resource Center (ILRC) is a national nonprofit resource center that provides immigration legal trainings, technical assistance, and educational materials, and engages in advocacy and immigrant civic engagement to advance immigrant rights."

Immigration Equality (http://www.immigrationequality.org/blog/)

"Since 1994, Immigration Equality has been proud to advocate for and represent lesbian, gay, bisexual, transgender, queer (LGBTQ), and HIV-positive immigrants seeking safety, fair treatment, and freedom. As the only LGBTQ organization with a staff of immigration attorneys, Immigration Equality impacts both the individuals we serve and the immigration system as a whole."

HEALTH CARE PROVIDERS AND IMMIGRATION ENFORCEMENT

Know Your Rights, Know Your Patients' Rights

APRIL 2017

The threat of increased federal immigration enforcement has raised concerns among immigrant families, some of whom may decide to forego necessary medical services out of fear that they could be putting themselves and their family members at risk. This factsheet provides advice to hospitals, medical centers, community health centers, other health care facilities, and advocates on how to prepare for and respond to (a) enforcement actions by immigration officials and (b) interactions with law enforcement that could result in immigration consequences for their patients.[1]

Immigration enforcement power limited by the Fourth Amendment

U.S. Immigration and Customs Enforcement (ICE) is the interior enforcement agency within the U.S. Department of Homeland Security (DHS). U.S. Customs and Border Protection (CBP), another agency within DHS, is responsible for enforcement at or near the nation's borders.

ICE and CBP's power to enforce immigration law is limited by our constitutional protection against *unreasonable search and seizure*. Under the Fourth Amendment to the U.S. Constitution, the reasonableness of a search depends on whether a person has a *reasonable expectation of privacy* in the area searched.[2] The test is: At the time of the search, was it the person's subjective, actual expectation that the place or things searched were private, and was that expectation objectively reasonable, i.e., would it be generally recognized by society?[3] Your patients thus may be more vulnerable to immigration enforcement actions when they are in areas of your facility that are open to the public than when they're in areas that are considered private.

Federal and state privacy laws provide protections that further limit the disclosure of patient information—including immigration status–related information—to law enforcement officials.

Health care providers and their patients have legal rights

- ***Sensitive locations.*** Both ICE and CBP consider hospitals and other health care facilities to be "sensitive locations."[4] Both agencies have issued memoranda that state

[1] The information in this document does not constitute legal advice. You should consult your attorney to obtain advice with respect to any particular issue or problem.

[2] Katz v. United States, 389 U.S. 347 (1967).

[3] See, e.g., *id.*

[4] See Memorandum from John Morton, Director, U.S. Immigration and Customs Enforcement, to Field Office Directors, et al., subject: *Enforcement Actions at or Focused on Sensitive Locations*, Oct. 24, 2011, https://www.ice.gov/doclib/ero-outreach/pdf/10029.2-policy.pdf; *and* Memorandum from David V. Aguilar, Deputy Commissioner, U.S. Customs and Border Protection, subject: *U.S. Customs and Border Protection*

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current and longstanding practice with respect to immigration enforcement in the health care setting.[5] The memoranda say that immigration enforcement actions are to be avoided at sensitive locations, including at hospitals and other health care facilities, unless exigent circumstances exist or the officers conducting the actions have prior approval from certain officials within the enforcement agencies. ICE defines "enforcement actions" as including arrests, interviews, searches, and surveillance done for purposes of immigration enforcement only.[6] Both memos are subject to change, depending on the enforcement priorities of ICE and CBP.

- ***Disclosure of information.*** Health care providers have no affirmative legal obligation to inquire into or report to federal immigration authorities about a patient's immigration status. In fact, the Health Insurance Portability and Accountability Act (HIPAA) privacy rule generally prohibits the use or disclosure of patient information[7] without the patient's consent,[8] except when required by law.[9] Under other exceptions, including when information is requested by law enforcement officials for law enforcement purposes, personal health information *may* be shared, but its release is generally *not required*.[10]
- ***Warrants and consent.*** Health care providers *may refuse* to provide information about patients to law enforcement officials *unless* the request for information is pursuant to a warrant or other court order for a specifically identified individual.[11]
- ***Right to remain silent.*** While immigration enforcement at health care facilities is limited by the "sensitive locations" guidance described previously, immigration agents may enter a public area of a health care facility without a warrant or the facility's consent and may question any person present.[12] These people have a right to remain silent.[13]
- ***"Plain view."*** Officers may also look at anything that is in "plain view" in a public area. An object is in "plain view" if it is obvious to the senses. For example, an immigration official may visually inspect anything—including papers and files—that are clearly visible from the visitors' side of the reception desk. Unless they have a warrant, however, they may not move an object in plain view to expose other portions of it or what is under it.[14] The plain view doctrine extends to sounds within "plain hearing" as well.[15] Therefore,

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Enforcement Actions at or Near Certain Community Locations, Jan. 18, 2013, https://foiarr.cbp.gov/streamingWord.asp?i=1251.

[5] *Id.*

[6] *Id.*

[7] While immigration status or evidence of foreign birth are not, by themselves, considered *personal health information* (PHI) protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), federal guidance includes a catch-all category for "any characteristic that could uniquely identify the individual." 45 C.F.R. § 160.103. Moreover, Social Security numbers and patients' addresses are considered PHI.

[8] See 45 C.F.R. § 164.502(a).

[9] See 45 C.F.R. § 164.512(f)(1).

[10] See 45 C.F.R. § 164.512(f). State laws vary, however, as to whether health care facilities are required to report undocumented status. See, e.g., Arizona's HB 2008. Arizona Revised Statutes §§1-501, 1-502.

[11] See 45 C.F.R. §§ 164.512(e), 164.512(f)(1)(ii)(A).

[12] See *Katz*, 389 U.S. at 351.

[13] U.S. CONST. amend. V. In some states you are required to give your real name if asked to identify yourself.

[14] See generally Arizona v. Hicks, 480 U.S. 321 (1987).

[15] See, e.g., United States v. Baranek, 903 F.2d 1068 (6th Cir. 1990).

speech officers overhear with their unassisted ears while standing in a public area—even if what they overhear comes from a private area—is also considered to be in plain view.

- ***Authorized person.*** To enter a private area (an area not open to the public) of a health care facility, enforcement officers must have either a warrant or consent from an authorized person, i.e., from a predesignated staff member of the health facility.[16]
- ***Warrant—what to check for.*** If immigration authorities or other law enforcement officials present a warrant or other court order, the authorized person—a predesignated health center staff member—should *review the warrant* to ensure that:
  - ✓ it is a valid judicial warrant
  - ✓ it is signed by a judge or magistrate judge
  - ✓ it states the address of the specific premises to be searched
  - ✓ it is being executed during the time period specified on the warrant, if any
- ***Scope of the warrant.*** The designated staff member *should pay close attention and object* if officials go beyond the scope of their authority to search or seize objects as specified in the warrant. For example, if the warrant states that officials may search the emergency room, they may not use this warrant to then search private patient examination rooms.
- ***"Probable cause."*** Health care providers *may refuse to consent to a warrantless search of the facility's private areas*. Nevertheless, officers may search private areas and seize items found there if they have "probable cause" to believe that the search may reveal that unlawful activity is occurring, has occurred, or will occur. An officer has "probable cause" if the facts and circumstances justify a reasonable person's conclusion that people or things connected with unlawful activity will likely be found in a particular place.[17]

Protect your patients' rights and your rights as a health care provider

- ***Establish a written policy designating private areas.*** Establish a written policy identifying which areas of the clinic are closed to the public. Limit access to certain areas only to those who are receiving or providing care, or who are otherwise necessary. To the extent possible, access to private areas intended for patients and their family members should be restricted to essential medical personnel (e.g., doctors and nurses), excluding all other staff and visitors during business hours. For example, the clinic's waiting room may be open to the public, but individuals must be invited to enter examining rooms, offices, and records areas. Alternatively, the waiting room may be open only to patients and people accompanying them, while the public must remain in areas outside the building. Consider cordoning off areas where patients receive treatment from public waiting rooms.
- ***Beware of what's in "public view."*** Be cautious of what information is in open view of the public, such as files visible from the visitors' side of the reception desk.
- ***Avoid collecting immigration status information.*** Avoid asking for patients' immigration status and, if you must collect such information for a patient, avoid

[16] See Katz, 389 U.S. at 351.

[17] See, e.g., Brinegar v. United States, 338 U.S. 160 (1949); Carroll v. United States, 267 U.S. 132 (1925).

including that information in the patient's medical and billing records.

- ***Provide educational materials.*** Provide posters and educational materials advising patients that they have the right (a) to refuse to answer questions from immigration agents and other law enforcement and (b) to insist that their lawyer be present if they are questioned. Make available in your reception area know-your-rights cards that patients can hand to officers while remaining silent.[18] These cards help people assert their rights and defend themselves against constitutional violations. Patients have the right to have a lawyer be present during any interview while in custody of law enforcement. Also, advise patients never to run from immigration officers, because this can give an officer probable cause to arrest them.
- ***Be ready to consult a lawyer.*** Establish a relationship with a local immigration lawyer or with, for example, a member of your board of directors who is an attorney, who can be available if an enforcement officer comes to the clinic.
- ***Designate an authorized staffer.*** Designate a specific staffer (or staffers) as authorized and responsible for handling contacts with law enforcement officers. Train all other staff to inform immigration or other law enforcement officers that only the designated individual is authorized to review a warrant or to consent to their entry into private areas. Train staff to decline to answer questions about a patient unless they are authorized to do so by the designated staff member.
- ***Don't consent; document.*** If immigration officers ask permission, or attempt, to enter a private area, the designated person should state explicitly that they do not consent to the officer(s) entering without a warrant. If the officers say that they will get a warrant, contact a lawyer and try to have the lawyer present before the warrant is served or before the search begins. During the search, document the officers' conduct with detailed notes and photographs.
- ***Review the warrant carefully.*** When presented with a warrant, the designated staff member should review the warrant for validity. If the immigration agents have a valid warrant, they may enter the private areas indicated in the warrant and question anyone present. Remind all patients and other individuals present that they have the right not to answer any questions, other than providing their real name.
- ***Practice.*** Have staff roleplay their responses to an immigration raid on the health care facility so they are prepared to respond confidently to a stressful situation.
- ***Reassure your patients.*** Educate and reassure patients that their health care information is protected by federal and state laws.

Ultimately, immigration enforcement policies and practices under the current administration are evolving, and there's little precedent for the current level of widespread enforcement activity. This document reflects our understanding based on what we know now; we'll update it as we learn more about how immigration officials and officers are treating health care facilities. In the meantime, the best strategy is to arm your staff and your patients with the knowledge they need to protect everyone's right to obtain health care.

[18] See www.ilrc.org/red-cards.

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9. IMMUNIZATION PROGRAM REPORT, DEPARTMENT OF PUBLIC HEALTH

Hepatitis A Infection Prevention & Control

Hepatitis A is a highly contagious liver infection caused by the hepatitis A virus. The hepatitis A virus is usually transmitted through the fecal-oral route, either through person-to-person contact or consumption of contaminated food or water. Contamination can occur when infected persons don't wash their hands properly after using the bathroom and then touching other objects or food items. Surfaces that are frequently touched should be cleaned and sanitized often including:

- Toilet Room Surfaces
- Light Switch Plates
- High Chairs
- Kitchen Surfaces
- Phones
- Tables and Chairs
- Doorknobs
- Computer Keyboards
- Wheelchairs and Walkers
- Recreation Equipment
- Railings
- Remote Controls

Effective Disinfectants

Chlorine Bleach: Mix and use the chlorine solution within 20 minutes. Allow 1 minute of contact time and then rinse with water.

- **5000 ppm:** 1 and 2/3 cups bleach in 1 gallon water. Use for stainless steel, food/mouth contact items, tile floors, nonporous surfaces, counters, sinks and toilets.

Other Disinfectants:

Other disinfectants may be approved for use if they are effective against hepatitis A. This must be clearly indicated on specification sheets or product label.

Note: Most Quaternary Ammonium disinfectants are **not effective** against hepatitis A. They may only be used if specifically stated on their label or specification sheets they are effective against hepatitis A.

Specific Cleaning Methods

Wear Gloves and Protect Your Clothing.

- **Hard Surfaces**
  - Disinfect surface with bleach, or other approved disinfectant ensuring 1 minute of contact time. If surface is in a food preparation area, make sure to rinse with water after.
- **Surfaces that are Corrodible or Damageable by Bleach**
  - Use registered products effective against hepatitis A.

For more information on cleaning and infection control for hepatitis A, call
Environmental Health: 888-700-9995
To report a suspected or confirmed hepatitis A case, contact Morbidity: Phone: (888) 397-3993
Fax: (888) 397-3778
Website: www.publichealth.lacounty.gov/acd/cdrs.htm

Steps to Clean Spills of Vomit or Feces

- Use personal protective equipment such as gloves, masks and gowns.
- Block-off area immediately.
- Clean up visible debris using disposable absorbent material (paper towels or other type of disposable cloths) and minimize aerosols.
- Discard soiled items carefully in an impervious plastic bag.
- Thoroughly clean affected area
- Disinfect area and objects surrounding the contamination with an appropriate disinfectant effective against hepatitis A. See box to the left "Effective Disinfectants" for 5000 ppm sanitizing solution.
- Take off gloves, gown and mask, in that order, and discard before exiting contaminated clean-up area.
- Place discarded PPE in an impervious plastic bag.
- Re-glove and transport bag to a secure trash container; do not allow the bag to come into contact with clothing.
- Always wash your hands after handling any contaminated material, trash or waste.

Proper Handling

- Use chemicals in well-ventilated areas.
- Avoid contact between incompatible chemicals.
- Prevent chemical contact with food during cleaning.
- Handle contaminated material as little as possible and with minimal agitation to reduce aerosols.
- Manage waste safely and dispose in a secure trash container.

Adapted from the County of San Diego Health and Human Services Agency

County of Los Angeles Public Health

Frequently Asked Questions (FAQ)

Hepatitis A

1. What is hepatitis A?

Hepatitis A is a highly contagious (spreads person-to-person) liver disease caused by the hepatitis A virus (germ). Mild cases can last a few weeks while severe cases can last several months.

2. How is hepatitis A spread?

Hepatitis A spreads by putting something in your mouth (object, food, or drink) that has been in contact with the feces (poop) of an infected person. Hepatitis A can be spread by:

- Forgetting to wash your hands after using the bathroom or changing diapers
- Having sexual contact with infected partner(s)
- Consuming food or drinks that are contaminated by the virus

3. Who is at risk for hepatitis A?

People who are homeless are at higher risk for getting hepatitis A. Anyone can get hepatitis A, but you are at a higher risk if you:

- Travel or live in countries where hepatitis A is common
- Live with someone who has hepatitis A
- Use recreational drugs
- Are men who have sex with men
- Have sexual contact with someone who has hepatitis A
- Are homeless

4. What are the symptoms of hepatitis A?

Not everyone shows symptoms. If symptoms develop, they usually appear 2 to 6 weeks after infection. Symptoms can include:

- Fever
- Feeling tired
- Loss of appetite
- Nausea
- Vomiting
- Stomach pain
- Dark urine (pee)
- Grey stool
- Joint pain
- Yellowing of the skin and eyes

5. How is hepatitis A treated?

Treatment includes rest, good nutrition, fluids, and medical monitoring. Some people may need to be hospitalized. Most people who get hepatitis A recover completely and don't have lasting liver damage. It's important to see a doctor if you have symptoms of hepatitis A.

6. How can hepatitis A be prevented?

The best way to prevent hepatitis A is by getting vaccinated. The vaccine is safe and effective. Visit your doctor's office, or call 2-1-1 to find a local clinic or doctor. You can also prevent the spread of hepatitis A by washing hands with soap and water:

- Before eating or preparing food
- After using the bathroom or changing diapers

Who should get vaccinated?

- All children at age 1-year
- Travelers to countries where hepatitis A is common
- Family and caregivers of adoptees from countries where hepatitis A is common
- Men who have sex with men
- Recreational drug users
- People with chronic liver disease or hepatitis B or C
- People with clotting-factor disorders
- Homeless people

For more information:

Los Angeles County, Department of Public Health
http://www.publichealth.lacounty.gov/acd/Diseases/HepA.htm

California Department of Public Health
https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/OVHP.aspx

Centers for Disease Control and Prevention (CDC)
https://www.cdc.gov/hepatitis/hav/index.htm

CDCP-ACDC-0099-01 (09/28/17)

COUNTY OF LOS ANGELES
Public Health

LOS ANGELES COUNTY
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September 28, 2017

PROVIDER ALERT

Increased Risk of Hepatitis A among Men Who Have Sex with Men Due to Ongoing Outbreaks

- **A large-scale outbreak of hepatitis A among men who have sex with men (MSM) is ongoing in 16 European countries**
- **A 15-fold increase in hepatitis A cases has been observed among MSM in NYC in 2017**
- **An outbreak of hepatitis A has been declared in Los Angeles County primarily affecting persons who are homeless or who actively use drugs but may spread to other individuals for whom hepatitis A vaccine is already recommended**
- **LAC DPH continues to recommend 2 doses of hepatitis A vaccine for all MSM who have never been vaccinated or are unsure of their vaccination status in accordance with guidelines published by the Centers for Disease Control (CDC) and the Advisory Committee on Immunization Practices (ACIP)**

Dear Providers:

The Los Angeles County Department of Health (LAC DPH) is currently tracking several hepatitis A outbreaks among men who have sex with men (MSM) globally. In the United States, outbreaks have been reported in New York City (NYC) and Colorado (CO). In addition, 16 countries in Western Europe that historically have low levels of endemic hepatitis A have reported recent outbreaks of hepatitis A infection among MSM. The European and CO strains of hepatitis A have been identified in NYC cases. Data from separate recent outbreaks in LA County among MSM indicate transmission networks that include NYC and Europe, and travel is frequent among these jurisdictions.

A current outbreak of hepatitis A in LA County among persons who are homeless or who actively use drugs poses a risk of spread to the MSM community. LAC DPH would therefore like to encourage all providers to offer hepatitis A vaccine to all patients who report MSM activity.

ACIP recommends that all MSM receive two doses of single-antigen hepatitis A vaccine; the second dose should be administered 6-12 months after the first dose. Two hepatitis A single-antigen vaccines are licensed in the United States: Vaqta® (Merck) and Havrix® (GSK), administered intramuscularly. The adult formulation, for persons 19 years of age and older, is 1.0 mL. Pediatric formulation (0.5 mL) should be used for persons 1 through 18 years of age. A combination hepatitis A and hepatitis B vaccine is also licensed: Twinrix® (GSK), which should be administered in a three-dose schedule, with the second dose administered 1 month after the first dose, and the third dose administered 6 months after the first dose.

Hepatitis A vaccine is an inactivated vaccine that is well-tolerated and has an excellent safety profile. Seroconversion after the first dose is estimated at greater than 95% and at nearly 100% after the second dose. Hepatitis A vaccine may be given to persons with compromised immune systems. Evidence suggests that vaccination provides immunity for at least 25 years; pre- and post-vaccination serologic testing is not recommended to confirm vaccine "take" or prior exposure.

Hepatitis A is transmitted person-to-person through the fecal-oral route. Among MSM, hepatitis A can be spread through direct anal-oral contact or contact with fingers or objects that have been in or near the anus of an infected person and contaminated with stool. Hepatitis A can also be spread through contaminated food or water, which most often occurs in countries where hepatitis A is common.

As a reminder, there is an ongoing outbreak of invasive meningococcal disease (IMD) primarily among MSM continues in Southern California. MSM who are not HIV-infected should receive a single MenACWY vaccine dose or a booster if the most recent dose was given ≥5 years ago. All HIV-infected persons should receive two doses of the conjugate meningococcal (MenACWY) vaccine at least 8 weeks apart and a booster 5 years later and every 5 years thereafter throughout life. Please see the LA Health Alert for more details: http://publichealth.lacounty.gov/eprp/Health%20Alerts/Mening%20HIV%20MSM%20071917%20FINAL.pdf

Recommendations

Providers should offer hepatitis A vaccine to all MSM who have not been vaccinated or do not know their vaccination status.

Serologic testing is NOT indicated to evaluate exposure history or immunity prior to administering vaccine. An extra dose of vaccine is safe to administer whether the patient has had previous infection or vaccination-induced immunity.

Immediately report all suspect and confirmed HAV cases to the LAC DPH Morbidity Unit by calling 888-397-3993. After hours call 213-974-1234. Providers must report while suspected cases are still at the healthcare facility to facilitate immediate interview by a public health investigator and prophylaxis of contacts.

Vaccination Resources

HAV Vaccine Resources Medi-Cal: HAV vaccine is covered for patients enrolled in both fee-for-service and managed care plans. Vaccine administration is covered if administered in a provider's office or by an in-network pharmacy. No prior authorization is required. Patients or those assisting them can call the plan's member services number listed on the back of their Medi-Cal Benefits Identification Card to obtain information on pharmacy services. Prior to referring a patient to an in-network pharmacy for HAV vaccination, please contact the pharmacy to verify vaccine availability.

AIDS Drug Assistance Program (ADAP): HAV vaccine is included on the ADAP formulary.

LAC DPH Clinics: Free HAV vaccine is available at the LAC DPH Public Health Centers for any uninsured and underinsured at-risk people. Visit http://publichealth.lacounty.gov/chs/Docs/ImmSchedule.pdf for clinic times and locations.

Additional information on recent hepatitis A outbreaks is available at the following links:

LAHAN:
http://publichealth.lacounty.gov/eprp/Health%20Alerts/DPH%20HAN%20Hep%20A%20Outbreak%20091917.pdf

Information on hepatitis A outbreaks among MSM in NYC and Europe:

MMWR: https://www.cdc.gov/mmwr/volumes/66/wr/mm6637a7.htm
ECDPC: https://ecdc.europa.eu/en/news-events/epidemiological-update-overview-hepatitis-eu-countries-1-august-2017
WHO: http://www.who.int/csr/don/07-june-2017-hepatitis-a/en/

If you have further questions, please call the LA County DPH Acute Communicable Disease Control Program: Weekdays 8:30am-5pm: call 213-240-7941 After hours: call 213-974-1234 and ask for the physician on call.

We greatly appreciate your assistance.

Sincerely,

Jeffrey D. Gunzenhauser, MD

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Interim Health Officer

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11. CALIFORNIA OFFICE OF AIDS (OA) REPORT

CALIFORNIA planning group
california department of public health, office of AIDS

OFFICE OF AIDS

California Planning Group (CPG)

DRAFT Meeting Agenda

TUESDAY, October 17, 2017
12:00 PM – 4:30 PM
DOUBLETREE HOTEL
ANAHEIM, CA
(SUBJECT TO CHANGE)

Time	Topic	Presenter
12:00 PM	Registration & Lunch	All
1:00 PM	Welcome/Housekeeping	Co-Chairs Andrea Vazquez, Associate Governmental Program Analyst (AGPA), OA HIV Prevention Branch
1:05 PM	Introductions/ Ice Breaker Activity	Eileen Jacobowitz, Facilitator
1:35 PM	Meeting Starters	Eileen Jacobowitz, Facilitator
1:50 PM	CPG Business	Shelia Cromwell-Nieve, Chair, Membership Committee TBD, Chair, Housing Committee
2:20 PM	AltaMed Social Marketing Campaigns	Natalie Sanchez, Specialty Services Clinic Administrator, AltaMed Health Services Corporation
2:50 PM	Break	
3:05 PM	Team Building Group Activity	All
4:30 PM	Adjourn	

California Planning Group (CPG)

DRAFT Meeting Agenda

WEDNESDAY, OCTOBER 18, 2017
8:15 AM – 5:00 PM
DOUBLETREE HOTEL
ANAHEIM, CA

Time	Topic	Presenter
8:15 AM	Check-In & Breakfast	All
8:45 AM	Welcome & Introductions	Co-Chairs Eileen Jacobowitz, Facilitator
9:00 AM	Meeting Starters	Eileen Jacobowitz, Facilitator
9:15 AM	State Updates (Care)	Majel Arnold, Chief, Office of AIDS (OA) HIV Care Branch
9:45 AM	State Updates (ADAP)	Sandra Robinson, Chief, OA ADAP Branch
10:15 AM	Break & Photo	
10:35 AM	CPG Community Member Updates & Announcements	CPG Community Members Eileen Jacobowitz, Facilitator
11:25 AM	State Updates (Prevention)	Steve Gibson, OA HIV Prevention Branch
11:55 AM	PrEP Updates	Clark Marshall, Health Program Specialist II, OA HIV Prevention Branch
12:25 PM	Lunch	
1:25 PM	Public Comment	Eileen Jacobowitz, Facilitator
1:40 PM	Q&A with OA	Dr. Karen Mark, OA Division Chief
2:00 PM	CPG Nominated Member Updates & Announcements	CPG Nominated Members Eileen Jacobowitz, Facilitator
2:45 PM	Surveillance and Prevention Notice of Funding Opportunity	Steve Gibson, OA HIV Prevention Branch Deanna Sykes, Surveillance Section Chief, OA SRE Branch
3:15 PM	Break	
3:30 PM	State Updates (Surveillance, Research & Evaluation (SRE))	Deanna Sykes, Surveillance Section Chief, OA SRE Branch
4:00 PM	CPG Subject Matter Expert (SME) Updates & Announcements	CPG SMEs Eileen Jacobowitz, Facilitator

Time	Topic	Presenter
4:40 PM	California Prevention Training Center (CAPTC)	Alice Gandelman, Chief, CAPTC
5:00 PM	Adjourn	

California Planning Group (CPG)

DRAFT Meeting Agenda

THURSDAY, OCTOBER 19, 2017
8:00 AM – 12:00 PM
DOUBLETREE HOTEL
ANAHEIM, CA

Time	Topic	Presenter
8:00 AM	Check-In & Breakfast	All
8:30 AM	Welcome	Co-Chairs
8:35 AM	Meeting Starters	Eileen Jacobowitz, Facilitator
8:40 AM	Tarzana Treatment Centers Panel Discussion	Karla Brito Gonzalez, MPH, CHES, PrEP Program Coordinator, Tarzana Treatment Centers
9:10 AM	Legislative Updates	Brian Lew, Assistant Division Chief, OA
9:25 AM	2017-2021 Integrated Plan & Needs Assessment Update	Diem Tran, Needs Assessment Epidemiologist, OA SRE Branch
9:55 AM	Break	
10:10 AM	Integrated Plan Group Activity	Eileen Jacobowitz, Facilitator
11:25 AM	Meeting Reflection	All
11:55 AM	Next Steps	State Co-Chairs Katrina Gonzales, AGPA, OA Support Branch
12:00 PM	Adjourn	

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12. STANDING COMMITTEE REPORTS

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

(1) City of Los Angeles Consolidated Plan Community Meetings

B. Standards and Best Practices (SBP) Committee

(1) U = U

C. Operations Committee

(1) Membership Management:

a. Membership Application(s):

1. Lee Kochems: Behavioral/Social Scientist Seat	MOTION #4
2. Diana Oliva: Provider Representative #2	MOTION #5
3. William King, MD: HIV Stakeholder #7	MOTION #6
4. Andrew Lopez: Alternate, UC Supervisorial District #2	MOTION #7
5. Marcos Garcilazo: Alternate, UC Supervisorial District #1	MOTION #8
6. Monica Sor: UC, Service Planning Area #8	MOTION #9
7. David Cunningham: Alternate, UC Supervisorial District #4	MOTION #10

D. Public Policy Committee

(1) 2017 COH Legislative Docket

City of Los Angeles Consolidated Plan Community Meetings

Each year the City of Los Angeles has an opportunity to develop an annual plan to decide how to best allocate funds received directly from the federal government. These funds are directed to assist businesses to create jobs, to build affordable housing (including fair housing and housing for people with HIV and AIDS), to alleviate homelessness, to provide services and shelter for domestic violence victims, to improve neighborhoods and to provide social services for low and moderate income residents. The annual plan generally follows a longer term five year vision. It is time to develop a new five year plan beginning in 2018 and going forward to 2023.

One of the requirements for the funds and the plan is the involvement of community residents particularly those living in communities most in need of the services. The City has two approaches to seeking community input. The first is direct communication at a series of community meetings. The second is through a survey of community needs (https://www.research.net/r/losangelescityconplan2017).

Please join us at one or all of the following meetings to make your needs known.

DATES FOR CONSOLIDATED PLAN COMMUNITY MEETINGS:

All meetings held 5:30 p.m. -7:30 p.m.		
TUESDAY, OCTOBER 17, 2017 El Nido FamilySource Center 11243 Glenoaks Blvd. Pacoima, CA 91331	**WEDNESDAY, OCTOBER 18, 2017** El Centro de Ayuda Boyle Heights City Hall 2130 E. First Street Los Angeles, CA 90033	**THURSDAY, OCTOBER 26, 2017** South Los Angeles Senior Center (SLASC) 7020 S. Figueroa Street, Los Angeles, CA 90003

Community Consultation with the Los Angeles County Commission on HIV Planning, Priorities and Allocations Committee Meeting

Tuesday, October 17, 2017
1 pm to 4 pm
3530 Wilshire Blvd, Suite 1140
Los Angeles, CA 90010

prevention
access
campaign

Endorsements Updated: August 23, 2017
Issued: July 21, 2016

RISK OF SEXUAL TRANSMISSION OF HIV FROM A PERSON LIVING WITH HIV WHO HAS AN UNDETECTABLE VIRAL LOAD
Messaging Primer & Consensus Statement

There is now evidence-based confirmation that the risk of HIV transmission from a person living with HIV (PLHIV), who is on Antiretroviral Therapy (ART) and has achieved an undetectable viral load in their blood for at least 6 months is negligible to non-existent. (Negligible is defined as: *so small or unimportant as to be not worth considering; insignificant*.) While HIV is not always transmitted even with a detectable viral load, when the partner with HIV has an undetectable viral load this both protects their own health and prevents new HIV infections.[i]

However, the majority of PLHIV, medical providers and those potentially at risk of acquiring HIV are not aware of the extent to which successful treatment prevents HIV transmission.[ii] Much of the messaging about HIV transmission risk is based on outdated research and is influenced by agency or funding restraints and politics which perpetuate sex-negativity, HIV-related stigma and discrimination.

The consensus statement below, addressing HIV transmission risk from PLHIV who have an undetectable viral load, is endorsed by principal investigators from each of the leading studies that examined this issue. It is important that PLHIV, their intimate partners and their healthcare providers have accurate information about risks of sexual transmission of HIV from those successfully on ART.

At the same time, it is important to recognize that many PLHIV may not be in a position to reach an undetectable status because of factors limiting treatment access (e.g., inadequate health systems, poverty, racism, denial, stigma, discrimination, and criminalization), pre-existing ART treatment resulting in resistance or ART toxicities. Some may choose not to be treated or may not be ready to start treatment.

Understanding that successful ART prevents transmission can help reduce HIV-related stigma and encourage PLHIV to initiate and adhere to a successful treatment regimen.

The following statement has been endorsed by:

- Dr. Michael Brady – Medical Director of Terrence Higgins Trust and Consultant HIV Physician, London, UK
- Dr. Myron Cohen – Principal Investigator, HPTN 052; Chief, Division of Infectious Diseases, UNC School of Medicine, North Carolina, USA
- Dr. Demetre C. Daskalakis, MPH – Assistant Commissioner, Bureau of HIV/AIDS Prevention and Control New York City Department of Health and Mental Hygiene, New York, USA

- International AIDS Society – Switzerland
- International Association of Providers of AIDS Care -United States
- International Community of Women Living with HIV - Kenya
- Latino Commission on AIDS - United States
- MSMGF (the Global Forum on MSM & HIV) - United States
- NAM aidsmap - United Kingdom
- National AIDS Trust - United Kingdom
- National Alliance of State and Territorial AIDS Directors (NASTAD) - United States
- National Black Justice Coalition - United States
- New York City Department of Health and Mental Hygiene - United States
- Positive Women's Network - USA - United States
- San Francisco AIDS Foundation - United States
- Sensoa - Belgium
- Sidaction - France
- Southern AIDS Coalition - United States
- Terrence Higgins Trust - United Kingdom
- Whitman-Walker Health - United States
- YouthCO HIV & Hep C Society - Canada

(The full list of organizational endorsements is here.)

People living with HIV on ART with an undetectable viral load in their blood have a negligible risk of sexual transmission of HIV. Depending on the drugs employed it may take as long as six months for the viral load to become undetectable. Continued and reliable HIV suppression requires selection of appropriate agents and excellent adherence to treatment. HIV viral suppression should be monitored to assure both personal health and public health benefits.

NOTE: An undetectable HIV viral load only prevents HIV transmission to sexual partners. Condoms also help prevent HIV transmission as well as other STIs and pregnancy. The choice of HIV prevention method may be different depending upon a person's sexual practices, circumstances and relationships. For instance, if someone is having sex with multiple partners or in a non-monogamous relationship, they might consider using condoms to prevent other STIs.

"NEGLIGIBLE" = so small or unimportant as to be not worth considering; insignificant.

language to stop the stigma and move all communities faster towards ending the epidemic." Jesse Milan, Jr., President & CEO, statement from AIDS United (March, 2017)

7. "Research demonstrating that people living with HIV who are virally suppressed cannot transmit HIV to others is one of the most important developments in HIV prevention in the last decade. It is now more important than ever that we ensure universal access to antiretroviral therapy and educate our communities about the public health benefits of effective HIV treatment." Craig E. Thompson, Chief Executive Officer, statement from APLA Health (March, 2017)

8. "Desmond Tutu HIV Foundation strongly endorses the Prevention Access Campaign core message: Undetectable HIV is Untransmittable HIV (U=U). An HIV-positive person who maintains an undetectable viral load with the aid of regular, successful treatment cannot transmit HIV sexually. This knowledge has the potential to alter negative perceptions around the disease, yet the message still hasn't reached everyone." Statement from Desmond Tutu HIV Foundation (March, 2017)

9. "NAM aidsmap, one of the foremost sources of HIV information in the world, strongly endorses the 'Undetectable Equals Untransmittable' (U=U) Consensus Statement issued by the Prevention Access Campaign. The scientific evidence is clear. Someone who has undetectable levels of virus in their blood does not pose an infection risk to their sexual partners. This understanding transforms the way that HIV is considered with enormous implications for what it now means to live with HIV and the best ways to prevent it." Statement from NAM aidsmap (February, 2017)

10. "NASTAD joins public health experts and leaders in affirming that there is now conclusive scientific evidence that a person living with HIV who is on antiretroviral therapy (ART) and is durably virally suppressed (defined as having a consistent viral load of less than <200 copies/ml) does not sexually transmit HIV." Statement from NASTAD (February, 2017)

11. "All of us here at CATIE, and indeed around the world, are celebrating the most significant development in the HIV world since the advent of effective combination therapy 20 years ago – people living with HIV with sustained undetectable viral loads can confidently declare to their sexual partners "I'm not infectious!" This is an absolute game-changer and those who live with HIV can proudly share this information. At the same time, service providers working in HIV must get up to speed fast and share this far and wide with their communities." Laurie Edmiston, Executive Director, Statement from CATIE - Canadian AIDS Treatment Information Exchange (January, 2017)

12. "The scientific evidence is clear and unequivocal: effective treatment reduces HIV transmission risk to zero. The Consensus Statement highlights unprecedented scientific

18. "We can now say with confidence that if you are taking HIV medication as prescribed, and have had an undetectable viral load for over six months, you cannot pass on HIV with or without a condom." Dr. Michael Brady, Medical Director, Terrence Higgins Trust, London, England (July, 2016)

19. "The force of evidence in both real world and clinical trial experience confirms that individuals with suppressed viral loads have a negligible risk of transmitting HIV. Treatment as prevention, pre-exposure prophylaxis, and traditional prevention measures, like condoms, make up an HIV prevention toolkit based in harm-reduction that allows individuals to make personalized and enlightened decisions to both maintain their health and prevent HIV and STI transmission." Dr. Demetre C Daskalakis, MPH - Assistant Commissioner, Bureau of HIV/AIDS Prevention and Control New York City Department of Health and Mental Hygiene (July, 2016)

20. "Does this work over a long period of time for people who are anxious to be suppressed? The answer is absolutely yes, we now have 10,000 person years (of follow-up) with zero transmissions from people who are suppressed." Dr. Myron Cohen. Medpage; NEJM. (July, 2016)

21. "Among serodifferent heterosexual and MSM couples in which the HIV-positive partner was using suppressive ART and who reported condomless sex...there were no documented cases of within-couple HIV transmission" among 58,000 condomless sex acts. Reporting on PARTNER study Dr. Alison Rodger, et al. JAMA. (July, 2016)

22. "These results are simple to understand – zero transmissions from over 58,000 individual times that people had sex without condoms...[PARTNER study] provides the strongest estimate of actual risk of HIV transmission when an HIV positive person has undetectable viral load – and that this risk is effectively zero." Simon Collins, Steering Committee, PARTNER, i-BASE (July, 2016)

23. "The [Swiss] statement [was the first position statement that] addressed the infectiousness of an HIV-positive person once the virus was stably suppressed for at least 6 months with ART. [T]he [Swiss Federal Commission for AIDS-related Issues] felt, based on an expert evaluation of HIV transmission risk under therapy, that the risk of HIV transmission in such a situation was negligible." Dr. Pietro Vernazza, chief of the Infectious Disease Division, Cantonal Hospital in St. Gallen, Switzerland; Executive Committee, PARTNER Swiss Medical Weekly (Jan., 2016, confirming the original 2008 Swiss statement)'

24. "[T]he HPTN 052 study saw only cases of transmission during ART that occurred shortly (days) after the initiation of therapy. If only transmissions after the first six months of ART are considered (as stipulated in the Swiss statement) the efficacy would have been 100% with a

33."In reality, if you give the treatment the opportunity to get on with its work, you will have zero transmission." Dr. Julio Montaner, Director of the British Columbia Centre for Excellence in HIV/AIDS; Director of IDC and Physician Program Director for HIV/AIDS PHC: TED Talk referring to HPTN 052 (Nov., 2011)

[i] Much of the current prevention messaging refers to this as Treatment as Prevention or TasP. As of the writing of this primer, there have been no confirmed cases of HIV transmission from a person with an undetectable viral load in any studies. The official cut-off point for an undetectable viral load as defined by the WHO ranges from <50 copies/ml in high-income countries to <1,000 copies/ml in low to middle-income countries. **For the purposes of this statement, an undetectable viral load is defined as under <200 copies/ml, which is also the measurement for viral suppression.**

[ii] Only a small proportion of people living with HIV in a large US treatment study regarded themselves as non-infectious after up to three years on antiretroviral therapy (ART), and a third of participants regarded their chance of transmitting HIV to a partner as still 'high', even though only 10% of participants actually had a detectable viral load." NAM aidsmap (2016)

[iii] Acknowledgements: In addition to PAC's Founding Task Force and Bruce Richman (PAC Executive Director), Professor Carrie Foote (Indiana University-Indianapolis; HIV Modernization Movement) and Edwin Bernard (HIV Justice Network) reviewed and provided valuable input on the Primer.

Los Angeles County Commission on HIV (COH) 2018 Training Schedule for Interested Applicants and Commissioners

WORKSHOP LOCATION AND TIME: All workshops will be held at the COH office, located at 3530 Wilshire Blvd., Suite 1140, Los Angeles, CA 90010 FROM 1 PM TO 3 PM. Please RSVP to confirm your attendance to DJauregui@lachiv.org.

Data and Epidemiology Overview: January 29
Participants will review reports used in priority setting and resource allocations decision-making process, needs assessments and the Comprehensive HIV Plan.

Effective Communication and Active Listening: February 15
Participants will assess their personal communication styles and learn strategies on how to communication with others.

Running and Facilitating Meetings: March 15
Participants will learn tips for leading and participating in COH meetings. Participants will learn the "6 Thinking Hats" strategy for encouraging different perspectives and active participation.

Planning Council Refresher & Committee Spotlight: April 19
Get a refresher on Planning Council responsibilities and key policies and procedures. This workshop will discuss the functions of the COH's standing committees and how they inter-relate with each other.

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

Los Angeles County Commission on HIV
2017-2018 Legislative Docket

(Status Updated 10/10/2017)

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

BILL	TITLE	DESCRIPTION	POSITION	STATUS	COMMENTS
STATE ASSEMBLY & SENATE BILLS					
AB 9 (Garcia)	Sales and Uses Taxes; Feminine Hygiene Products	Would exempt the sale, use, storage, and other consumption, of tampons, sanitary napkins, menstrual sponges, and menstrual cups, from State sales and use taxes; would take effect January 1, 2018.	**SUPPORT**	Author changed to two-year bill. Set aside to next year, second of California's two-year legislative session	
AB 39 (Bocanegra)	Hate Crimes Registry	This bill would declare the intent of the Legislature to enact legislation to establish a "Hate Crime Registry" for purposes of creating a repository of information on hate crimes committed in California.	**OPPOSE unless AMENDED**	Died in Appropriation Committee	A repository of data is a good starting point but not clear as to what happens to data once collected. What "summary" will be reported to law enforcement? Can a person potentially be "outed" if suspected, although not proven to have committed a crime? **Supportive of intent.*
AB 74 (Chiu et al)	Housing Grant Funds	This bill would require the Department of Housing and Community Development (HCD) to establish the Housing for a Healthy California Program on or before April 1, 2019, to award grants to eligible grant applicants based on specified guidelines, including that the applicant identify a source of funding; agree to contribute funding for interim and long-term rental assistance; agree to collect and report data; and use the funds for long-term rental assistance and interim housing. The bill would apply to homeless Medi-Cal beneficiaries eligible for Supplemental Security Income and who are likely to improve their health with supportive services; would require HCD to analyze and report program data to specified legislative committees; would declare that it is to take effect immediately as a bill providing for appropriations related to the Budget Bill.	**SUPPORT**	**SIGNED BY THE GOVERNOR**	

BILL	TITLE	DESCRIPTION	POSITION	STATUS	COMMENTS
STATE ASSEMBLY & SENATE BILLS					
AB 182 (Waldren et al)	Heroin and Opioid Abuse	This bill would require the State Department of Health Care Services (DHCS) to implement a comprehensive and, the "Heroin and Opioid Public Education (HOPE) Initiative," a multicultural public awareness education and awareness campaign on the effects and warning signs of heroin and opioid medication abuse. The bill would require DHCS to conduct a survey of households and one focus group, each annually, to gauge the initiative's effectiveness, the results of which would be reported to the Governor and Legislature.	**SUPPORT (Changed from SUPPORT w/ AMENDMENTS)**	**In Committee; Held under submission**	Amend to include harm reduction language and potentially include a broad list drugs, specifically meth; relates to those living with and at risk for HIV/AIDS. Also, states should not be in business of stigmatizing and condemning drug use; references to such should be stricken. **Friendly amendments made. Stigmatizing language removed. Further f/u requested re: broader list of drugs.*
AB 186 (Eggman et al)	Controlled Substance: safer drug consumption program	Until January 1, 2022, this bill would authorize specified counties or cities within those counties to authorize the operation of supervised injection services programs for adults that satisfies specified requirements, including, among other things, a space supervised by healthcare professionals or other trained staff where people who use drugs can consume preobtained drugs, sterile consumption supplies, and access to referrals to addiction treatment. The bill would require any entity operating a program under its provisions to provide an annual report to the city, county, or city and county, as specified. The bill would exempt a person from existing criminal sanctions while he or she is using or operating a supervised injection services program for adults authorized by a city, county, or city and county.	**SUPPORT**	**Inactive**	Upon recommendation to BOS, emphasize this bill as priority for Commission.
AB 210 (Santiago)	Housing Services; Multidisciplinary Personnel Team	This bill would authorize counties to also establish a homeless adult, child, and family multidisciplinary personnel team with the goal of expediting linkage of homeless individuals to housing and supportive services and to ensure continuity of care to allow service providers to share confidential information; would authorize the homeless adult, child, and family multidisciplinary personnel team, to designate qualified persons to be a member of the team and bound each member to the same privacy and confidentiality obligations. The bill would also require confidential records to be managed under maximum protection of privacy.	**SUPPORT w/ AMENDMENT**	**SIGNED BY THE GOVERNOR**	BOS supports bill. Amend to strike out language limiting legal representation to just criminal matters; language should reflect broad representation in all legal matters. Public Counsel recommended same amendments.
AB 265 (Wood/Chiu)	Prescription Drug Discounts	This bill would prohibit a prescription drug manufacturer, operating in California, from offering discounts or other cost savings on any prescription drug if a lower cost (brand name or non-brand name), therapeutically equivalent, as designated United States Food and Drug Administration, as the manufacturer's product.	**SUPPORT w/ AMENDMENT (Changed from OPPOSE unless AMENDED**	**SIGNED BY THE GOVERNOR**	Bill amended to carve-out language for STRs and PrEP as requested. However, Hep C still not included.

BILL	TITLE	DESCRIPTION	POSITION	STATUS	COMMENTS
STATE ASSEMBLY & SENATE BILLS					
AB 291 (Chiu et al)	Housing; Immigration; Extortion	Would stiffen existing laws imposing penalties, up to and including disbarment, of any member of the State Bar for threatening to disclose the suspected immigration status of a party to a civil or administrative action, because said party has exercised a right related to his or her employment. The bill would also prohibit a lessor from using, or threatening to use, the immigration status against a tenant or someone associated with that tenant, for any reason related to the property at hand; would prohibit a lessor from disclosing immigration status, to immigration or law enforcement authorities unless directed or requested by federal authorities. The bill would also declare the immigration or citizenship status of any person as irrelevant to any issue of liability or remedy pertaining to tenant rights unless two exceptions apply.	**SUPPORT**	**SIGNED BY THE GOVERNOR**	
AB 677 (Chiu)	LGBT Disparities Reduction Act	Would take existing reporting requirements identified in the LGBT Disparities Reduction Act, which requires specific State departments who collect voluntary data as to the demographic ancestry and ethnic origin, gender identity, and sexual orientation of Californians, and extend those requirements to additional State agencies and require them to comply as early as possible, but no later than July 1, 2019.	**SUPPORT**	**SIGNED BY THE GOVERNOR**	
AB 800 (Chiu)	Hate Crimes Hotline	This bill would require the State Attorney General to establish a toll-free public hotline telephone number for the reporting of hate crimes, and for the dissemination of information about the characteristics of hate crimes, protected classes, civil remedies, and reporting options; would require the Attorney General to post, maintain, and publicize a reporting form for hate crimes and hate incidents online.	**SUPPORT**	In Committee; Held under submission	Will not move this year likely due to unanswered questions regarding implementation
AB 888 (Low)	Cal Grants: Private Postsecondary Educational Institutions	Would require, beginning in 2018, every private postsecondary educational institution that receives Cal Grant funding to annually report to the Legislature its student disciplinary actions, including, but not limited to, its rate of expulsion, for the previous academic year in connection with whether the disciplined students were Cal Grant recipients, and whether the disciplinary action was taken in connection with students who fit one or more of a list of specified categories; would specify that each report shall not include personally identifiable information about the disciplined students.	**SUPPORT**	Set aside to next year	Author changed to two-year bill due to complexity of Cal Grants and Title IX issues.

BILL	TITLE	DESCRIPTION	POSITION	STATUS	COMMENTS
STATE ASSEMBLY & SENATE BILLS					
AB 1033 (Garcia)	Sexual Battery: Condoms	This bill would make it felony sexual battery to without consent removes a condom during sexual intercourse, intentionally uses a condom that has been tampered with, tampers with a condom that is used in the act of sexual intercourse or knowingly misrepresents to the other person that some form of contraception other than a condom is being used.	**OPPOSE**	In Committee; Held under submission	Concerns: could potentially further stigmatize and criminalize HIV; evidence of conduct hard to prove; intent to harm requirement is hard to prove.
AB 1161 (Ting)	Hate Crimes	This bill would require any hate crime policy adopted or revised by a State or local law enforcement agency to include, among other things, the model policy framework developed by the Commission on Peace Officer Standards and Training (POST) and information regarding bias motivation; would require any state or local law enforcement agency that adopts or revises a hate crime policy to consult specified groups.	**SUPPORT**	In Committee; Held under submission	
AB 1534 (Nazarian)	Healthcare Coverage; HIV Specialists; Primary Care Physicians	The bill would require a health care service plan contract or health insurance policy to include an HIV specialist, as defined, as an eligible primary care provider; would require access to HIV specialists to be subject to the regulations, standards, and reporting requirements as mandated by the Department of Managed Health Care and the Insurance Commissioner.	**OPPOSE (Changed from WATCH)**	Inactive	If intent is to expand access to care, the bill does not go far enough to address network adequacy requirement and parity in quality of care across all health systems. Language is unclear on potential impacts to Ryan White-funded services.

BILL	TITLE	DESCRIPTION	POSITION	STATUS	COMMENTS
STATE ASSEMBLY & SENATE BILLS					
SB 17 (Hernandez/Chiu)	Health care: prescription drug costs	This bill would require health care service plans or health insurers that file the above-described rate information to report to DMHC or DOI, on a date no later than the reporting of the rate information, specified cost information regarding covered prescription drugs, including generic drugs, brand name drugs, and specialty drugs, dispensed as provided. DMHC and DOI would be required to compile the reported information into a report for the public and legislators that demonstrates the overall impact of drug costs on health care premiums and publish the reports on their Internet Web sites by January 1 of each year. The bill would require a manufacturer of a prescription drug that is purchased or reimbursed by specified purchasers, including state agencies, health care service plans, health insurers, and pharmacy benefit managers, to notify the purchaser if the wholesale acquisition cost of a prescription drug exceeds a specified threshold. The bill would require the manufacturer to notify the Office of Statewide Health Planning and Development (OSHPD) of specified information relating to that increase in wholesale acquisition cost at the time that the increase takes effect. The bill would require the manufacturer to notify OSHPD of specified information relating to the wholesale acquisition cost of a new prescription drug if the cost exceeds a specified threshold. The bill would require OSHPD to enforce these provisions and would subject a manufacturer to liability for a civil penalty if the information described above is not reported. The bill would authorize OSHPD to adopt regulations or issue guidance for the implementation of these provisions.	**SUPPORT**	**SIGNED BY THE GOVERNOR**	

BILL	TITLE	DESCRIPTION	POSITION	STATUS	COMMENTS
STATE ASSEMBLY & SENATE BILLS					
SB 31 (Lara et al)	California Religious Freedom Act: state agencies: disclosure of religious affiliation information	This bill would prohibit a state or local agency or a public employee acting under color of law from providing or disclosing to the federal government personal information regarding a person's religious beliefs, practices, or affiliation, as specified, when the information is sought for compiling a database of individuals based on religious belief, practice, or affiliation, national origin, or ethnicity for law enforcement or immigration purposes. The bill would also prohibit a state agency from using agency resources to assist with any government program compiling such a database, or from making state databases available in connection with an investigation or enforcement under such a program. The bill would prohibit state and local law enforcement agencies and their employees from collecting personal information on the religious beliefs, practices, or affiliation of any individual, except as part of a targeted investigation, as provided, or where necessary to provide religious accommodations. The bill would also prohibit law enforcement agencies from using agency or department moneys, facilities, property, equipment, or personnel to investigate, enforce, or assist in the investigation or enforcement of any criminal, civil, or administrative violation, or warrant for a violation, of any requirement that individuals register with the federal government or any federal agency based on religion, national origin, or ethnicity. The bill would also terminate, to the extent of any conflict, any existing agreements that make any agency or department information or database available in conflict with these provisions. This bill would declare that it is to take effect immediately as an urgency statute.	**SUPPORT**	**SIGNED BY THE GOVERNOR**	
SB 54 (De Leon)	Law enforcement: sharing data	This bill would, among other things, and subject to exceptions, prohibit state and local law enforcement agencies, including school police and security departments, from using resources to investigate, interrogate, detain, detect, or arrest persons for immigration enforcement purposes, as specified	**SUPPORT (Changed from WATCH to Support)**	**SIGNED BY THE GOVERNOR**	
SB 179 (De Leon et al)	Gender Recognition Act of 2017	This bill would authorize a person (including minors) to amend their birth certificate, driver's license, gender change court order, and/or other state issued forms of identification, to read female, male, or non-binary; would require driver's license applicants to choose a gender category of female, male, or non-binary as part of the applicant's description.	**SUPPORT**	**SIGNED BY THE GOVERNOR**	

BILL	TITLE	DESCRIPTION	POSITION	STATUS	COMMENTS
STATE ASSEMBLY & SENATE BILLS					
SB 219 (Wiener et al)	Seniors Long Term Care Bill of Rights	Would prohibit, except as specified, long-term care facilities from basing treatment and/or care on an individual's actual or perceived sexual orientation, gender identity, gender expression, or HIV status. Would also prohibit, among other things, a facility from refusing to communicate with an individual per their preferred name/pronoun, denying that individual admission, transferring or refusing to transfer a resident within a facility or to another facility, or discharging a resident from based on the same factors; would impose a state-mandated local program.	**SUPPORT**	**SIGNED BY THE GOVERNOR**	
SB 239 (Wiener et al)	Modernizing Discriminatory HIV Criminalization Laws	Would reduce conviction of intentional transmission of an infectious or communicable disease, including HIV, from a felony to a misdemeanor charge; would also apply to third party defendants as well; would mandate the identities of the parties involved be concealed, vacate/dismiss any conviction, charge, and/or related arrest, and mandate any legal records of such a legal event be destroyed by June 30, 2018; would authorize persons convicted of such an offense to petition for a recall or dismissal of their sentence before the trial court that entered the judgment and require courts to then vacate these convictions and grant credit for time already served for any remaining counts; would repeal provisions of existing law requiring persons convicted of prostitution for the first time to complete education on the acquisition of AIDS and to submit to testing for AID; would also repeal provisions requires such a defendant, as a condition of either probation or participating in a drug diversion program, to participate in an AIDS education program.	**SUPPORT**	**SIGNED BY THE GOVERNOR**	Disclosure: APLA co-authored bill and is supported by a host of local stakeholders, i.e. LGBT, Free Speech Coalition, etc.
SB 310 (Atkins)	Name and Gender Change: State Prisons and County Jails	Would remove limitations on a petition for a change of name filed by a person incarcerated in a State prison; would instead establish the right of an inmate in a State or County facility to petition the court for a change of name or gender; would require the facility to address an individual, who has legally obtained a name change, by their new name and to list the prior name only as an alias; would create a state-mandated local program.	**SUPPORT**	**SIGNED BY THE GOVERNOR**	

BILL	TITLE	DESCRIPTION	POSITION	STATUS	COMMENTS
STATE ASSEMBLY & SENATE BILLS					
SB 562 (Lara et al)	Single-Payer Health Insurance Program	This bill would enact the Healthy California Act and create a comprehensive universal single-payer health care program, Healthy California; would provide that the program cover, among other things, the Children's Health Insurance Program (CHIP), Medi-Cal, ancillary care and social services for persons with developmental disabilities, Knox-Keene, and Medicare; would create the Healthy California Trust Fund in the State Treasury, as a continuously appropriated fund, consisting of any federal and state moneys received; would create a nine member Healthy California governing board and establish a public advisory committee to advise the board on policy matters; would prohibit health insurers from offering benefits or coverage offered under the program, except as provided; would authorize providers to collectively negotiate rates of payment for services, prescription and nonprescription drugs, and payment methodologies using a third-party representative, as provided.	**SUPPORT**	**HELD AT DESK**	
SB 695 (Lara/Mitchell)	Sex Offender Registration	Would establish 3 tiers of the State's sex offender registration based on specified criteria, for periods of at least 10 years, at least 20 years, and life, respectively, as specified; would establish specified procedures for removal the sex offender registry for a first or second tier offender who completes their mandated minimum registration period; would require the offender to file a petition at the expiration of his or her minimum registration period; would authorize a hearing on the petition if the petitioner has not fulfilled the requirement of successful tier completion; would also establish eligibility criteria for a tier three offender to petition the court for placement in tier two, under specified conditions.	**SUPPORT**	Re-referred to committee	

NATIONAL ASSOCIATION OF Community Health Centers

The Health Center Funding Cliff is Disrupting Access to Care Now

Because Congress did not extend the Community Health Centers Fund (CHCF) by October 1st, every Community Health Center faces drastic reductions in their federal funding at the beginning of their next budget period. With no fix, health centers face a 70% cut to this grant funding. Because the direct cuts to federal grants do not take place immediately, some policymakers are under the inaccurate impression that the cliff will not impact health centers until January.

In fact, the funding cliff is already creating disruption, and funding uncertainty is forcing cutbacks and operational instability now. For example, even before October 1st, 26% of health centers report that the potential for the funding cliff had already made it harder to recruit and retain staff.*

Funding Uncertainty is Having an Immediate Impact and Forcing Hard Decisions Now

Because the Health Center Funding Cliff is not yet fixed, health centers are considering or already taking a number of actions that will have an immediate impact on their capacity to provide high-quality care to their patients.*

72% will institute a hiring freeze

41% will lay off staff

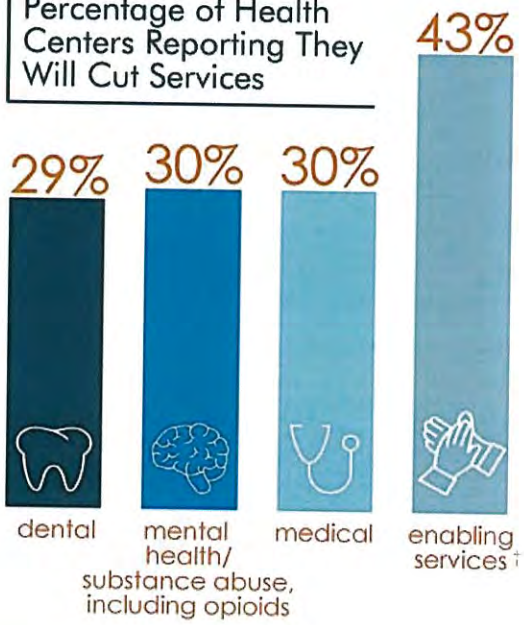
52% will cancel or delay facility renovation or expansion

47% will reduce staff hours and/or hours of operation

53% will cancel or delay performance improvement investments

42% will begin tapping into and spending down reserves

Percentage of Health Centers Reporting They Will Cut Services



Failure to Fix the Health Center Funding Cliff Will Ultimately Lead to Critical Cuts in Access to Care

Ultimately, if the Health Center Funding Cliff is not addressed, the federal Health Resources and Services Administration (HRSA) predicts:

9 million patients will lose access to care

2,800 delivery sites will be closed

51,000+ providers and staff will be laid off

*Based on a national survey fielded to all federally-funded health centers on September 26, 2017. N = 518.
† Non-clinical services that improve access to care and health outcomes, such as case management, transportation, education, and translation.

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For more information, contact research@nachc.org.

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October 2017 | Issue Brief

New Regulations Broadening Employer Exemptions to Contraceptive Coverage: Impact on Women

Laurie Sobel, Alina Salganicoff, and Caroline Rosenzweig

The Trump Administration has issued new regulations that significantly broaden employers' ability to be exempt from the Affordable Care Act's (ACA) contraceptive coverage requirement. The regulation opens the door for any employer or college/university with a student health plan with objections to contraceptive coverage based on religious beliefs to qualify for an exemption. Any nonprofit or closely-held for-profit employer with moral objections to contraceptive coverage also qualifies for an exemption. Their female employees, dependents and students will no longer be entitled to coverage for the full range of FDA approved contraceptives at no cost.

On October 6, 2017, the Trump Administration issued two new regulations greatly expanding the types of employers that may be exempt from the Affordable Care Act's (ACA) contraceptive coverage requirement. These regulations are a significant departure from the Obama-era regulations that only granted an exception to houses of worship. One of the regulations allows nonprofit or for-profit employers with an objection to contraceptive coverage based on *religious* beliefs to qualify for an exemption and drop contraceptive coverage from their plans. The other regulation also exempts all but publicly traded employers with *moral* objections to contraception from rule. These new policies, effective immediately, also apply to private institutions of higher education that issue student health plans. The immediate impact of these regulations on the number of women who are eligible for contraceptive coverage is unknown, but the new regulations open the door for many more employers to withhold contraceptive coverage from their plans.

Contraceptive coverage under the ACA has made access to the full range of contraceptive methods affordable to millions of women. This provision is part of a set of key preventive services that has been identified by the Health Resources and Services Administration (HRSA) for women that must be covered without cost-sharing. Since it was first issued in 2012, the contraceptive coverage provision has been controversial. While very popular with the public, with over 77% of women and 64% of men reporting support for no-cost contraceptive coverage, it has been the focus of litigation brought by religious employers, with two cases (*Zubik v Burwell and Burwell v Hobby Lobby*) reaching the Supreme Court. This brief explains the contraceptive coverage rule under the ACA, the impact it has had on coverage, and how the new regulations issued by the Trump Administration change the contraceptive coverage requirement for employers and affect women's coverage.

How do the new regulations change contraceptive coverage requirements for employers?

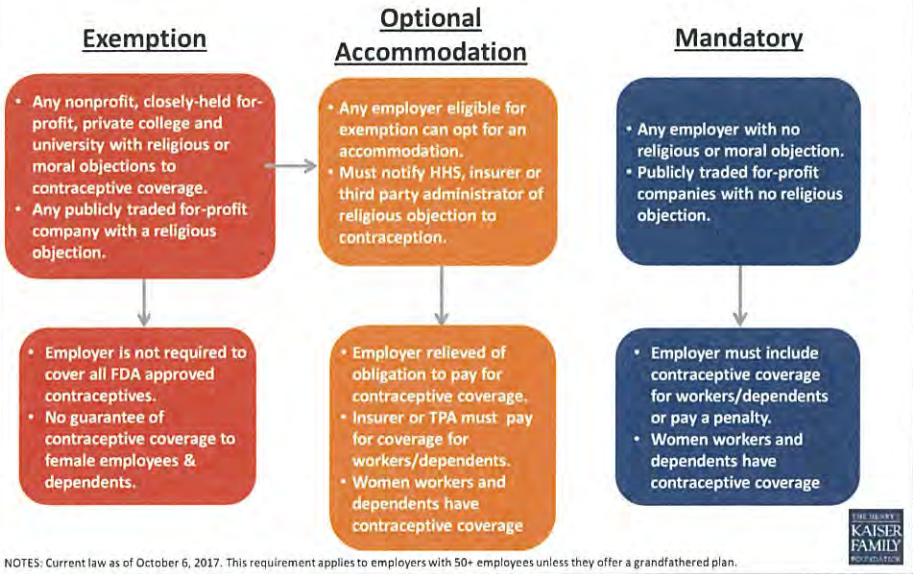
Since they were announced in 2011, the contraceptive coverage rules have evolved through litigation and new regulations. Most employers were required to include the coverage in their plans. Houses of worship could choose to be *exempt* from the requirement if they had religious objections. This exception meant that women workers and female dependents of exempt employers did not have guaranteed coverage for either some or all FDA approved contraceptive methods if their employer had an objection. Religiously affiliated nonprofits and closely held for-profit corporations were not eligible for an exemption, but could choose an *accommodation*. This option was offered to religiously affiliated nonprofit employers and then extended to closely held for-profits after the Supreme Court ruling in *Burwell v. Hobby Lobby*. The accommodation allowed these employers to opt out of providing and paying for contraceptive coverage in their plans by either notifying their insurer, third party administrator, or the federal government of their objection. The insurers were then responsible for covering the costs of contraception, which assured that their workers and dependents had contraceptive coverage while relieving the employers of the requirement to pay for it.

As of 2015, 10% of nonprofits with 5,000 or more employees had elected for an accommodation without challenging the requirement. This approach, however, has not been acceptable to all nonprofits with religious objections.[1] In May 2016, the Supreme Court remanded *Zubik v. Burwell*, sending seven cases brought by religious nonprofits objecting to the contraceptive coverage accommodation back to the respective district Courts of Appeal. The Supreme Court instructed the parties to work together to "arrive at an approach going forward that accommodates petitioners' religious exercise while at the same time ensuring that women covered by petitioners' health plans receive full and equal health coverage, including contraceptive coverage."[2]

On October 6, 2017, the Trump Administration issued new regulations greatly expanding eligibility for the exemption to all nonprofit and closely-held for-profit employers with objections to contraceptive coverage based on religious beliefs or moral convictions, including private institutions of higher education that issue student health plans (**Figure 1**). In addition, publicly traded for-profit companies with objections based on religious beliefs also qualify for an exemption. There is no guaranteed right of contraceptive coverage for their female employees and dependents or students. **Table 1** presents the changes to the contraceptive

Figure 1

Employers Objecting to Contraceptive Coverage: Exemptions and Accommodations Under the Trump Administration Regulations



NOTES: Current law as of October 6, 2017. This requirement applies to employers with 50+ employees unless they offer a grandfathered plan.

coverage rule from the Obama Administration in the new Interim Final regulations issued by the Trump Administration.

The accommodation will be available to employers that previously qualified for the accommodation. They now will also have the choice of an exemption. The federal departments issuing the regulations posit that these new rules will have limited impact on the number of women losing contraceptive coverage. However, it is not clear how many employers previously utilizing the accommodation will now opt for an exemption, resulting in the loss of contraceptive coverage for their employees and dependents. In addition, there are also an unknown number of organizations that were not previously eligible for either the accommodation or exemption that may now opt for an exemption. These new regulations create two new categories of employers who can now qualify for an exemption or can voluntarily chooses an accommodation: 1) publicly traded for-profit companies with a religious objection and 2) nonprofit and closely held for-profit employers who have a *moral* objection to contraceptives, a considerably larger pool of employers than when the exemption was available only to those who were employees of a house of worship or who were eligible for an accommodation in the past.

Table 1: Summary of Changes in the Contraceptive Coverage Regulations for Objecting Entities

	Obama Administration August 2012 to October 5, 2017	Trump Administration Effective October 6, 2017
What types of contraceptives must plans cover without cost-sharing?	At least one of each of the 18 FDA approved contraceptive methods for women, as prescribed, along with counseling and related services must be covered without cost-sharing.	No change
Are any employers "exempt" from the contraceptive mandate?	• Religious institutions defined as "houses of worship." • Grandfathered plans. • No notice to employees is required. Women workers and female dependents must pay for their own contraceptives.	• Religious institutions defined as "houses of worship." • Grandfathered plans. • Nonprofit or for-profit employers (including publicly traded companies), insurers, or private colleges or universities that issue student insurance plans with a *religious* objection to contraceptive coverage. • Nonprofit or closely held for-profit employers, insurers, or private colleges or universities that issue student insurance plans with a *moral* objection to contraceptive coverage. • Notice is only required if the plan previously included contraceptive coverage. Women workers and female dependents must pay for their own contraceptives.
Who pays for contraceptive coverage for employees of organizations receiving an exemption?	• The cost of contraceptives is borne by women workers and female dependents. • There is no guarantee of contraceptive coverage for employees of an exempt organization. • The employer may choose to cover some methods, but has no obligation to cover all 18 FDA methods without cost sharing.	No change

Table 1: Summary of Changes in the Contraceptive Coverage Regulations for Objecting Entities		
	Obama Administration August 2012 to October 5, 2017	**Trump Administration Effective October 6, 2017**
What type of employers may seek an "accommodation" to avoid paying for contraceptives in their plans?	• Closely held for-profit corporations and religiously affiliated nonprofits with religious objections to contraception can opt out of providing and paying for contraceptive coverage. • Notice must be provided to either their insurer, third party administrator, or the federal government of their objection. • Women workers and female dependents receive no cost contraceptive coverage.	• Any entity (except for houses of worship) eligible for an exemption can choose the accommodation instead of the exemption. • Notice must be provided to either their insurer, third party administrator, or the federal government of their objection. • Women workers and female dependents receive no cost contraceptive coverage.
Who pays for contraceptive coverage for employees of organizations receiving an accommodation?	• Insurance companies of firms obtaining an accommodation must pay for contraceptive coverage. • Third-party administrators (TPA) of self-funded health plans must cover the costs of contraceptives for employees. The costs of the benefit are offset by reductions in the fees the TPA pays to participate in the federal exchange.	No change
When can entities change from an accommodation to an exemption?	N/A	• When an employer or private college or university currently using the accommodation opts for an exemption, the revocation of contraceptive coverage will be effective on the first day of the first plan year that begins 30 days after the date of the revocation or 60 days notice may be given in a summary of benefits statement. • The issuer or third party administrator is responsible for providing the notice to the beneficiaries.

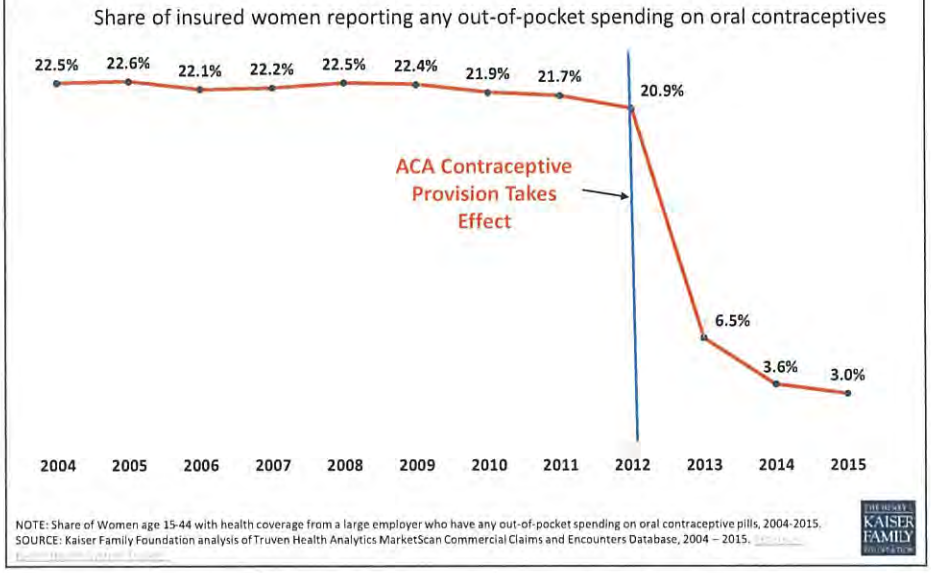
How has the contraceptive coverage rule affected women?

Contraceptive use among women is widespread, with over 99% of sexually-active women using at least one method at some point during their lifetime.[3] Contraceptives make up an estimated 30-44% of out-of-pocket health care spending for women.[4] Since the implementation of the ACA, out-of-pocket spending on prescription drugs has decreased dramatically (**Figure 2**). The majority of this decline (63%) can be attributed to the drop in out-of-pocket expenses on the oral contraceptive pill for women.[5] One study estimates that roughly $1.4 billion dollars per year in out-of-pocket savings on the pill resulted from the ACA's contraceptive mandate.[6] By 2013, most women had no out-of-pocket costs for their contraception, as median expenses for most contraceptive methods, including the IUD and the pill, dropped to zero.[7]

This provision has also influenced the decisions women make in their choice of method. After implementation of the ACA contraceptive coverage requirement, women were more likely to choose any method of prescription contraceptive, with a shift towards more effective long-term methods.[8] High upfront costs of long-acting methods, such as the IUD and implant, had been a barrier to women who might otherwise prefer these more effective methods. When faced with no cost-sharing, women choose these methods more often[9], with significant implications for the rate of unintended pregnancy and associated costs of childbirth.[10]

Figure 2

The Contraceptive Coverage Policy Has Had a Large Impact on Out-Of-Pocket Spending in a Short Amount of Time



NOTE: Share of Women age 15-44 with health coverage from a large employer who have any out-of-pocket spending on oral contraceptive pills, 2004-2015.
SOURCE: Kaiser Family Foundation analysis of Truven Health Analytics MarketScan Commercial Claims and Encounters Database, 2004 – 2015.

Finally, decreases in cost-sharing were associated with better adherence and more consistent use of the pill. This was especially true among users of generic pills. One study showed that even copayments as low as $6 were associated with higher levels of discontinuation and non-adherence,[11] increasing the risk of unintended pregnancy.

Do states with no-cost contraceptive coverage laws allow exemptions to objecting entities?

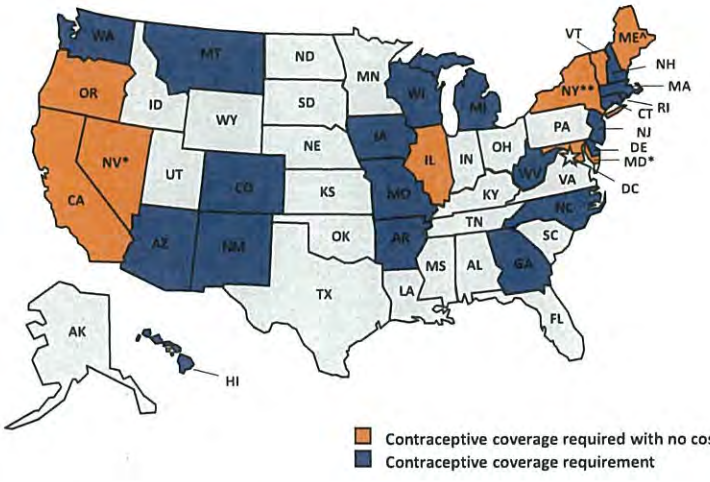
The federal standards under Affordable Care Act created a minimum set of preventive benefits that applied to most health plans regulated by the federal government (self-funded plans, federal employee plans) and states (individual, small and large group plans), including contraceptive coverage for women with no cost-sharing. States have also historically regulated insurance, and many have had mandated minimum benefits for decades. State laws, however, have more limited reach in that they only apply to state regulated fully insured plans, do not have jurisdiction over self-funded plans, where 61% of covered workers are insured.[12] In self-funded plans, the employer assumes the risk of providing covered services and usually contracts with a third party administrator (TPA) to manage the claims payment process. These plans are overseen by the Federal Department of Labor under the Employer Retirement Income Security Act (ERISA) and are only subject to federally established regulations.[13] The ACA sets a minimum standard of coverage for preventive services for all plans. However, state laws regulating insurance, including contraceptive coverage, can require fully insured plans to provide coverage beyond the federal standards.

Eight states have strengthened and expanded the federal contraceptive coverage requirement (CA, IL, MD, ME, NV, NY, OR, VT). Another 20 states have contraceptive equity laws that require plans to cover contraceptives if

they also provide coverage for prescription drugs, but they do not necessarily require coverage of all FDA-approved contraceptives or ban cost-sharing (**Figure 3**).

Figure 3

Many States Have Contraceptive Coverage Requirements



NOTES: *MD and NV laws go into effect January 2018. ^ME law goes into effect January 2019.
SOURCE: Kaiser Family Foundation. State Requirements for Insurance Coverage and Cost Sharing for Contraceptives, State Health Facts, as of September 1, 2017.
** New York Insurance Regulation 62, Minimum Standards for Basic Hospital and Medical Insurance Including Coverage of Contraceptives, January 21, 2017

Many of the 28 states that have passed contraceptive coverage laws (both equity and no-cost coverage) have a provision for exemptions, but the laws vary from state to state and only apply to fully insured plans. This means that there may be a conflict between the state and federal requirements when it comes to religious exemptions. In some states with a contraceptive coverage requirement, some employers who are eligible for an exemption under federal law will not qualify for an exemption under state law (**Table 2**). Employers in those states will have to have to meet the standards established by their state even though they may qualify for an exemption based on the new federal regulations. This conflict may set the stage for future litigation.

Table 2: State Requirements for No-Cost Contraceptive Coverage

State *Date Effective*	Applies to		Coverage required without cost sharing			Exemptions allowed	
	Private plans	Medicaid	With RX all FDA approved	OTC	Vasectomy	Religious	Moral
California *January 2015*	X	MCOs	X			Narrowly defined nonprofit religious employers	None

Table 2: State Requirements for No-Cost Contraceptive Coverage							
State ***Date Effective***	**Applies to**		**Coverage required without cost sharing**			**Exemptions allowed**	
	Private plans	**Medicaid**	**With RX all FDA approved**	**OTC**	**Vasectomy**	**Religious**	**Moral**
Illinois *January 2017*	X		X	X except male con-doms		Any employer, or insurer with a religious objection	Any employer, or insurer with a moral objection
Maryland *January 2018*	X	X	X	X	X	Religious organizations if the coverage conflicts with the organization's bona fide religious beliefs and practices	None
Maine *January 2019*	X		X			Narrowly defined nonprofit religious employers	None
Nevada *January 2018*	X	X	X			Insurers affiliated with a religious organization	None
New York *August 2017*	X		X			Narrowly defined nonprofit religious employers*	None
Oregon *August 2017*	X			X	X	Narrowly defined nonprofit religious employers	None
Vermont *October 2016*	X	X - and all other public health assistance programs	X		X	None	None

NOTES: *Requires the insurer to offer a rider to policyholders so that women will have contraceptive coverage.
SOURCE: Kaiser Family Foundation analysis of state laws and regulations.

Conclusion

The Trump Administration's new regulations substantially expand the exemption to nonprofit and for-profit employers, as well as to private colleges or universities with religious or moral objections to contraceptive coverage. It is unknown how many of these employers and colleges will maintain coverage through the accommodation as before and how many will now opt for the exemption leaving their students, employees and dependents without no-cost coverage for the full range of contraceptive methods. As a result of the new regulation, choices about coverage and cost-sharing will be made by employers and private colleges and universities that issue student plans. For many women, their employers will determine whether they have no-cost coverage to the full range of FDA approved methods. Their choice of contraceptive methods may again be limited by cost, placing some of the most effective yet costly methods out of financial reach.

Endnotes

[1] Sobel L, Rae M, & Salganicoff A. Data Note: Are Nonprofits Requesting an Accommodation for Contraceptive Coverage?. Kaiser Family Foundation. December 1, 2016.

[2] Supreme Court of the United States, per curium opinion, Zubik v. Burwell, May 16, 2016, page 4.

[3] Guttmacher Institute. Contraceptive Use in the United States. September 2016.

[4] Nora V. Becker and Daniel Polsky. Women Saw Large Decrease in Out-Of-Pocket Spending for Contraceptives After ACA Mandate Removed Cost Sharing. Health Affairs 34, no.7 (2015):1204-1211. doi: 10.1377/hlthaff.2015.0127

[5] Cox C, Damico A, Claxton G, Levitt L. Peterson-Kaiser Health System Tracker: Examining high prescription drug spending for people with employer sponsored health insurance. Kaiser Family Foundation. October 27, 2016.

[6] Nora V. Becker and Daniel Polsky. Women Saw Large Decrease in Out-Of-Pocket Spending for Contraceptives After ACA Mandate Removed Cost Sharing. Health Affairs 34, no.7 (2015):1204-1211. doi: 10.1377/hlthaff.2015.0127

[7] Adam Sonfield, Athena Tapales, Rachel K. Jones, and Lawrence B. Finer. Impact of the federal contraceptive coverage guarantee on out-of-pocket payments for contraceptives: 2014 update. Contraception 91 (2015) 44-48.

[8] Caroline S. Carlin, Angela R. Fertig and Bryan E. Dowd Affordable Care Act's Mandate Eliminating Contraceptive Cost Sharing Influenced Choices of Women with Employer Coverage. Health Affairs 35, no.9 (2016):1608-1615. doi: 10.1377/hlthaff.2015.1457

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[10] Ibid.

[11] Lydia E. Pace, Stacie B. Dusetzina and Nancy L. Keating. Early Impact of the Affordable Care Act On Oral Contraceptive Cost Sharing, Discontinuation, And Nonadherence. Health Affairs 35, no.9 (2016):1616-1624; doi: 10.1377/hlthaff.2015.1624

[12] Kaiser Family Foundation. 2016 Employer Health Benefits Survey. September 14, 2016.

[13] Guttmacher Institute. State Policies in Brief: Insurance Coverage of Contraceptives. As of August 1, 2017.