LOS ANGELES COUNTY
COMMISSION ON HIV

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

COMMISSION ON HIV MEETING

Thursday, October 10, 2019
9:00 AM – 12:15 PM

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

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

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) and Health Districts (HDs).

1. APPROVAL OF THE AGENDA:

A. Agenda **(MOTION #1)**
B. Code of Conduct
C. Membership Roster
D. Committee Assignments
E. Commission Member Conflict of Interest
F. October – December 2019 Commission Meeting Calendar
G. Geographic Maps

LOS ANGELES COUNTY
COMMISSION ON HIV

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

Thursday, October 10, 2019 | 9:00 AM – 12:15 PM

St. Anne's Conference Center
Foundation Room
155 N. Occidental Blvd., 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 4, 2019

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 72 hours' 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 72 horas antes de la junta.

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

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

adjusted and/or modified, at the co-chairs' discretion, during the course of 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. – 9:02 A.M.
	I. ADMINISTRATIVE MATTERS		
1.	Approval of Agenda	**MOTION #1**	9:02 A.M. – 9:04 A.M.
2.	Approval of Meeting Minutes	**MOTION #2**	9:04 A.M. – 9:06 A.M.
	II. REPORTS		
3.	Executive Director/Staff Report		9:06 A.M. – 9:10 A.M.
	A. Welcome and Introductions		
	B. Mandatory Member Training		
	C. Annual Meeting Reminder		
4.	Co-Chair Report		9:10 A.M. – 9:45A.M.
	A. Meeting Management Reminders		
	B. Recognition of National Latinx HIV/AIDS Awareness Day		
	C. COH Co-Chair Elections		
	D. Black/African American Community (BAAC) Task Force Recommendations		
	III. DISCUSSION		
5.	Impact of HIV/AIDS in the Latinx Community | Panel Discussion		9:45 A.M. – 10:30 A.M.
	III. REPORTS		
6.	Housing Opportunities for People Living with AIDS (HOPWA) Report		10:30 A.M – 10:35 A.M.
7.	Ryan White Program Parts C, D and F Report		10:35 A.M – 10:40 A.M.
8.	California Office of AIDS (OA) Report		10:40 A.M. – 10:50 A.M.
	A. California HIV Planning Group Update		
9.	LA County Department of Public Health Report		10:50 A.M. – 11:05 A.M.
	A. Division of HIV/STD Programs (DHSP) Report		
	B. Vaccine Preventable Disease Program (VPDP)		
	IV. BREAK		11:05 A.M. – 11:15 A.M.

V. ANNOUNCEMENTS 11:15 A.M. – 11:20 A.M.

10. Opportunity for members of the public to announce community events, workshops, trainings, and other related activities.

IV. REPORTS

11. Standing Committee Reports 11:20 A.M. – 12:15 P.M.

A. Standards and Best Practices (SBP) Committee
   (1) Non-Medical Case Management Standard of Care | 30 Day Public Comment
B. Operations Committee
   (1) Membership Management
   (2) Policies and Procedures
   (3) Training
      (a) 2019 COH Mandatory Member Training
B. Planning, Priorities & Allocations (PP&A) Committee
   (1) Ryan White Program (RWP) Program Years (PY) 31-32 Planning Updates
C. Public Policy Committee
   (1) County, State and Federal Legislation & Policy
      (a) Ending the HIV Epidemic Update
      (b) Public Charge Rule

12. Caucus, Task Force and Work Group Reports 12:15 P.M. – 12:20 P.M.

A. Assessment of the Administrative Mechanism (AAM) Work Group
B. Aging Task Force
C. Black African American Community (BAAC) Task Force
D. Consumer Caucus
E. Goals and Objectives Work Group
F. Women's Caucus
G. Transgender Caucus

13. Cities, Health Districts, Service Provider Area (SPA) Reports 12:20 P.M. – 12:05 P.M.

VII. MISCELLANEOUS

14. Public Comment 12:05 P.M. – 12:10 P.M.

Opportunity for members of the public to address the Commission On items of interest that are within the jurisdiction of the Commission

15. Commission New Business Items 12:10 P.M. – 12:13 P.M.

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

16. Announcements 12:13 P.M. – 12:15 P.M.

Opportunity for members of the public to announce community events, workshops, trainings, and other related activities

17. Adjournment and Roll Call 12:15 P.M.

Adjournment for the meeting of October 10, 2019

PROPOSED MOTION(S)/ACTION(S)	
MOTION #1:	Approve the Agenda order, as presented or revised.
MOTION #2:	Approve the Minutes, as presented or revised.

COMMISSION ON HIV MEMBERS:			
Al Ballesteros, MBA, Co-Chair	Grissel Granados, MSW, Co-Chair	Susan Alvarado, MPH	Traci Bivens-Davis, MA
Jason Brown	Danielle Campbell, MPH	Raquel Cataldo	Pamela Coffey (Alasdair Burton, Alternate**)
Michele Daniels (Craig Scott, Alternate**)	Erika Davies	Susan Forrest (Alternate*)	Aaron Fox, MPM
Jerry D. Gates, PhD	Felipe Gonzalez	Bridget Gordon	Joseph Green
Karl Halfman, MA	Diamante Johnson (Kayla Walker-Heltzel, Alternate**)	William King, MD, JD, AAHIVS	Lee Kochems, MA
David P. Lee, MPH, LCSW	Abad Lopez	Miguel Martinez, MSW, MPH	Anthony Mills, MD
Carlos Moreno	Derek Murray	Katja Nelson, MPP	Miguel Alvarez (Alternate*)
Frankie Darling-Palacios	Raphael Peña (Thomas Green, Alternate**)	Mario Pérez, MPH	Juan Preciado
Joshua Ray (Eduardo Martinez, Alternate**)	Ricky Rosales	Nestor Rogel (Alternate*)	LaShonda Spencer, MD
Martin Sattah, MD	Kevin Stalter	Maribel Ulloa	Justin Valero
Amiya Wilson (LoA)	Greg Wilson	Russell Ybarra	
MEMBERS:	**42**		
QUORUM:	**22**		

LEGEND:
LoA= Leave of Absence; not counted towards quorum
Alternate*= Occupies Alternate seat adjacent a vacancy; counted toward quorum
Alternate=** Occupies Alternate seat adjacent a filled primary seat; counted towards quorum in the absence of the primary seat member

LOS ANGELES COUNTY
COMMISSION ON HIV

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

CODE OF CONDUCT

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

All participants and stakeholders should adhere to the following:

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

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

LOS ANGELES COUNTY COMMISSION ON HIV

2019 MEMBERSHIP ROSTER| UPDATED 10/07/19

APPROVED BY COH ON 7/12/18

SEAT NO.	MEMBERSHIP SEAT	Commissioners Seated	Committee Assignment	COMMISSIONER	AFFILIATION (IF ANY)	TERM BEGIN	TERM ENDS	ALTERNATE
1	Medi-Cal representative			***Vacant***		July 1, 2019	June 30, 2021	
2	City of Pasadena representative	1	SBP	Erika Davies	City of Pasadena Department of Public Health	July 1, 2018	June 30, 2020	
3	City of Long Beach representative	1	PP&A	Susan Alvarado	City of Long Beach Department of Health and Human Services	July 1, 2019	June 30, 2021	
4	City of Los Angeles representative	1	PP	Ricky Rosales	AIDS Coordinator's Office, City of Los Angeles	July 1, 2018	June 30, 2020	
5	City of West Hollywood representative	1	PP&A	Derek Murray	City of West Hollywood	July 1, 2019	June 30, 2021	
6	Director, DHSP	1	EXC|PP&A	Mario Pérez, MPH	DHSP, LA County Department of Public Health	July 1, 2018	June 30, 2020	
7	Part B representative	1	PP&A	Karl Halfman, MA	California Department of Public Health	July 1, 2018	June 30, 2020	
8	Part C representative	1	EXC|PP	Aaron Fox, MPM	Los Angeles LGBT Center	July 1, 2018	June 30, 2020	
9	Part D representative	1	PP&A	LaShonda Spencer, MD	LAC + USC MCA Clinic, LA County Department of Health Services	July 1, 2019	June 30, 2021	
10	Part F representative	1	PP	Jerry D. Gates, PhD	Keck School of Medicine of USC	July 1, 2018	June 30, 2020	
11	Provider representative #1			***Vacant***		July 1, 2019	June 30, 2021	
12	Provider representative #2	1	SBP	David Lee, MPH, LCSW	Charles Drew University	July 1, 2018	June 30, 2020	
13	Provider representative #3	1	EXC/PP&A	Miguel Martinez, MSW, MPH	Children's Hospital Los Angeles	July 1, 2019	June 30, 2021	
14	Provider representative #4	1	PP&A	Raquel Cataldo	Tarzana Treatment Center	July 1, 2018	June 30, 2020	
15	Provider representative #5			***Vacant***		July 1, 2019	June 30, 2021	
16	Provider representative #6	1	PP&A	Anthony Mills, MD	Southern CA Men's Medical Group	July 1, 2018	June 30, 2020	
17	Provider representative #7	1	PP&A	Frankie Darling-Palacios	Los Angeles LGBT Center	July 1, 2019	June 30, 2021	
18	Provider representative #8	1	PP	Martin Sattah, MD	Rand Shrader Clinic, LA County Department of Health Services	July 1, 2018	June 30, 2020	
19	Unaffiliated consumer, SPA 1	1	EXC/OPS	Michele Daniels	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	Craig Scott (OPS/PP)
20	Unaffiliated consumer, SPA 2	1	PP&A	Abad Lopez	*Unaffiliated Consumer*	July 1, 2018	June 30, 2020	
21	Unaffiliated consumer, SPA 3	1	EXC|PP&A	Jason Brown	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	
22	Unaffiliated consumer, SPA 4	1	EXC|SBP	Kevin Stalter	*Unaffiliated Consumer*	July 1, 2018	June 30, 2020	
23	Unaffiliated consumer, SPA 5			***Vacant***		July 1, 2019	June 30, 2021	
24	Unaffiliated consumer, SPA 6	1	PP	Pamela Coffey	*Unaffiliated Consumer*	July 1, 2018	June 30, 2020	Alasdair Burton (PP)
25	Unaffiliated consumer, SPA 7	1	PP&A	Raphael Péna	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	Thomas Green (PP&A/SBP)- LoA
26	Unaffiliated consumer, SPA 8			***Vacant***		July 1, 2018	June 30, 2020	Susan Forrest (PP&A/OPS)
27	Unaffiliated consumer, Supervisorial District 1	1	OPS	Carlos Moreno	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	
28	Unaffiliated consumer, Supervisorial District 2			***Vacant***		July 1, 2018	June 30, 2020	Nestor Rogel (PP)
29	Unaffiliated consumer, Supervisorial District 3	1	SBP	Joshua Ray	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	Eduardo Martinez (SBP/PP)
30	Unaffiliated consumer, Supervisorial District 4			***Vacant***		July 1, 2018	June 30, 2020	
31	Unaffiliated consumer, Supervisorial District 5	1	PP&A	Diamante Johnson	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	Kayla Walker-Heltzel (PP&A/OPS)
32	Unaffiliated consumer, at-large #1	1	PP&A	Russell Ybarra	*Unaffiliated Consumer*	July 1, 2018	June 30, 2020	
33	Unaffiliated consumer, at-large #2	1	OPS	Joseph Green	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	
34	Unaffiliated consumer, at-large #3	1	SBP	Felipe Gonzalez	*Unaffiliated Consumer*	July 1, 2018	June 30, 2020	
35	Unaffiliated consumer, at-large #4	1	EXC/OPS	Bridget Gordon	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	
36	Representative, Board Office 1	1	EXC	Al Ballesteros, MBA	JWCH Institute, Inc.	July 1, 2018	June 30, 2020	
37	Representative, Board Office 2	1	EXC|OPS	Traci Bivens-Davis	Community Clinic Association of LA County	July 1, 2019	June 30, 2021	
38	Representative, Board Office 3	1	EXC|PP|SBP	Katja Nelson, MPP	APLA	July 1, 2018	June 30, 2020	
39	Representative, Board Office 4	1	SBP	Justin Valero	California State University, San Bernardino	July 1, 2019	June 30, 2021	
40	Representative, Board Office 5			***Vacant***		July 1, 2018	June 30, 2020	
41	Representative, HOPWA	1	PP&A	Maribel Ulloa	City of Los Angeles, HOPWA	July 1, 2019	June 30, 2021	
42	Behavioral/social scientist	1	PP	Lee Kochems	*Unaffiliated Consumer*	July 1, 2018	June 30, 2020	
43	Local health/hospital planning agency representative			***Vacant***		July 1, 2019	June 30, 2021	
44	HIV stakeholder representative #1	1	EXC	Grissel Granados, MSW	Children's Hospital Los Angeles	July 1, 2018	June 30, 2020	
45	HIV stakeholder representative #2	1	EXC/OPS	Greg Wilson	In the Meantime Men's Group	July 1, 2019	June 30, 2021	
46	HIV stakeholder representative #3	1	EXC|OPS	Juan Preciado (LoA)	Northeast Valley Health Corporation	July 1, 2018	June 30, 2020	
47	HIV stakeholder representative #4			***Vacant***		July 1, 2019	June 30, 2021	
48	HIV stakeholder representative #5	1	OPS	Danielle Campbell, MPH	UCLA/MLKCH	July 1, 2018	June 30, 2020	
49	HIV stakeholder representative #6	1	SBP	Amiya Wilson (LoA)	Unique Women's Coalition	July 1, 2019	June 30, 2021	
50	HIV stakeholder representative #7	1	PP&A	William D. King, MD, JD, AAHIVS	W. King Health Care Group	July 1, 2018	June 30, 2020	
51	HIV stakeholder representative #8			***Vacant***		July 1, 2018	June 30, 2020	Miguel Alvarez (SBP/OPS)
	TOTAL:	40						

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

LOA: Leave of Absence

LOS ANGELES COUNTY
COMMISSION ON HIV

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

COMMITTEE ASSIGNMENTS

Updated: October 7, 2019 | Information Subject to Change

EXECUTIVE COMMITTEE

Regular meeting day: 4th Thursday of the Month
Regular meeting time: 1:00-3:00 PM
Number of Voting Members= 13 | Number of Quorum= 7

COMMITTEE MEMBER	MEMBER CATEGORY	AFFILIATION
Grissel Granados, MSW	**Co-Chair, Comm./Exec.***	**Commissioner**
Al Ballesteros, MBA	**Co-Chair, Comm./Exec.***	**Commissioner**
Traci Bivens-Davis, MA	Co-Chair, Operations	Commissioner
Jason Brown	Co-Chair, PP&A	Commissioner
Michele Daniels	At-Large Member*	Commissioner
Erika Davies	Co-Chair, SBP	Commissioner
Aaron Fox, MPM	Co-Chair, Public Policy	Commissioner
Bridget Gordon	At-Large Member*	Commissioner
Miguel Martinez	Co-Chair, PP&A	Commissioner
Katja Nelson, MPP	Co-Chair, Public Policy	Commissioner
Mario Pérez, MPH	DHSP Director	Commissioner
Juan Preciado (LoA)	Co-Chair, Operations	Commissioner
Kevin Stalter	Co-Chair, SBP	Commissioner
Greg Wilson	At-Large Member*	Commissioner

OPERATIONS COMMITTEE

Regular meeting day: 4th Thursday of the Month
Regular meeting time: 10:00 AM-12:00 PM
Number of Voting Members= 10 | Number of Quorum= 6

COMMITTEE MEMBER	MEMBER CATEGORY	AFFILIATION
Traci Bivens-Davis, MA	**Committee Co-Chair***	**Commissioner**
Juan Preciado (LoA)	**Committee Co-Chair***	**Commissioner**
Miguel Alvarez	**	Alternate
Danielle Campbell, MPH	*	Commissioner
Michele Daniels (Craig Scott, Alternate)	*	Commissioner
Susan Forrest	**	Alternate
Bridget Gordon	*	Commissioner
Joseph Green	*	Commissioner
Kayla Walker-Heltzel	**	Alternate
Carlos Moreno	*	Commissioner
Greg Wilson	*	Commissioner

PLANNING, PRIORITIES & ALLOCATIONS (PP&A) COMMITTEE		
Regular meeting day: 3rd Tuesday of the Month **Regular meeting time: 1:00-4:00 PM** **Number of Voting Members= 17 | Number of Quorum= 9**		
COMMITTEE MEMBER	MEMBER CATEGORY	AFFILIATION
Jason Brown	**Committee Co-Chair***	Commissioner
Miguel Martinez, MPH, MSW	**Committee Co-Chair***	Commissioner
Susan Alvarado	*	Commissioner
Raquel Cataldo	*	Commissioner
Susan Forrest	*	Alternate
Karl Halfman, MA	*	Commissioner
William D. King, MD, JD, AAHIVS	*	Commissioner
Abad Lopez	*	Commissioner
Anthony Mills, MD	*	Commissioner
Derek Murray	*	Commissioner
Diamante Johnson (Kayla Walker-Heltzel, Alternate)	*	Commissioner
Frankie Darling Palacios	*	Commissioner
Raphael Pena (Thomas Green, Alternate- LoA)	*	Commissioner
LaShonda Spencer, MD	*	Commissioner
Maribel Ulloa	*	Commissioner
Russell Ybarra	*	Commissioner
TBD	DHSP staff	DHSP

PUBLIC POLICY (PP) COMMITTEE		
Regular meeting day: 1st Monday of the Month **Regular meeting time: 1:00-3:00 PM** **Number of Voting Members= 10 | Number of Quorum= 6**		
COMMITTEE MEMBER	MEMBER CATEGORY	AFFILIATION
Aaron Fox, MPM	**Committee Co-Chair***	Commissioner
Katja Nelson, MPP	**Committee Co-Chair***	Commissioner
Pamela Coffey (Alasdair Burton, Alternate)	*	Commissioner
Jerry Gates, PhD	*	Commissioner
Lee Kochems, MA	*	Commissioner
Eduardo Martinez	**	Alternate
Nestor Rogel	*	Alternate
Ricky Rosales	*	Commissioner
Martin Sattah, MD	*	Commissioner
Craig Scott	**	Alternate

STANDARDS AND BEST PRACTICES (SBP) COMMITTEE

Regular meeting day: 1st Tuesday of the Month
Regular meeting time: 1:00-4:00 PM
Number of Voting Members = 8 ¦ Number of Quorum = 5

COMMITTEE MEMBER	MEMBER CATEGORY	AFFILIATION
Kevin Stalter	**Committee Co-Chair***	**Commissioner**
Erika Davies	**Committee Co-Chair**	**Commissioner**
Thomas Green (LoA)	**	Alternate
Felipe Gonzalez	*	Commissioner
David Lee, MPH, LCSW	*	Commissioner
Katja Nelson, MPP	**	Commissioner
Joshua Ray (Eduardo Martinez, Alternate)	*	Commissioner
Justin Valero	*	Commissioner
Amiya Wilson (LoA)	*	Commissioner
Wendy Garland, MPH	DHSP staff	DHSP

CONSUMER CAUCUS

Regular meeting day: 2nd Thursday of Each Month
Regular meeting time: Immediately following Commission Meeting
Open membership to consumers of HIV prevention and care services

AGING TASK FORCE (ATF)

Regular meeting day: last Tuesday of the Month
Regular meeting time: 10am-12:00pm
Open membership

BLACK/AFRICAN AMERICAN COMMUNITY (BAAC) TASK FORCE

Regular meeting day/time: Contact Commission Office
Open membership

TRANSGENDER CAUCUS

Regular meeting day/time: TBD; Contact Commission Office
Open membership

WOMEN'S CAUCUS

Regular meeting day: 3rd Wednesday of Each Month
Regular meeting time: 10am-12:00pm
Open membership

CAUCUS MEMBER	MEMBER CATETORY	AFFILIATION

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 10/07/19

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
ALVARADO	**SUSAN**	Long Beach Dept. of Health and Human Services	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			HIV Biomedical Prevention
			Medical Care Coordination (MCC)
			HIV and STD Prevention
ALVAREZ	**Miguel**	No Affiliation	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**	Community Clinic Association of LA County	No Ryan White or prevention contracts
BURTON	**Alasdair**	No Affiliation	No Ryan White or prevention contracts
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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
CATALDO	**Raquel**	Tarzana Treatment Center	Case Management, Home-Based
			Case Management, Transitional - Jails
			Housing Services
			Medical Transportation
			Mental Health, Psychotherapy
			Oral Health
			Substance Abuse, Residential
			Substance Abuse, Transitional
			Substance Abuse, Detox
			Biomedical Prevention
			Medical Nutrition Therapy
COFFEY	**Pamela**	Unaffiliated consumer	No Ryan White or prevention contracts
DANIELS	**Michele**	Unaffiliated consumer	No Ryan White or prevention contracts
DARLING-PALACIOS	**Frankie**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			Health Education/Risk Reduction (HERR)
			HIV Counseling and Testing (HCT)
			Housing Services
			Medical Care Coordination (MCC)
			Mental Health, Psychiatry
			Mental Health, Psychotherapy
			Non-Occupational HIV PEP
			Biomedical Prevention
			STD Screening and Treatment
DAVIES	**Erika**	City of Pasadena	HIV Counseling and Testing (HCT)
FORREST	**Susan**	Office of Division and Re-entry, Departmet of Health Services, County of Los Angeles	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
FOX	**Aaron**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			Health Education/Risk Reduction (HERR)
			HIV Counseling and Testing (HCT)
			Housing Services
			Medical Care Coordination (MCC)
			Mental Health, Psychiatry
			Mental Health, Psychotherapy
			Non-Occupational HIV PEP
			Biomedical Prevention
			STD Screening and Treatment
GATES	**Jerry**	AETC	Part F Grantee
GONZALEZ	**Felipe**	Unaffiliated consumer	No Ryan White or prevention contracts
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
GREEN	**Thomas**	APAIT	HIV Counseling and Testing (HCT)
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
JOHNSON	**Diamante**	Unaffiliated consumer	No Ryan White or prevention contracts
KOCHEMS	**Lee**	Unaffiliated consumer	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
LEE	**David**	Charles R. Drew University of Medicine and Science	HIV/AIDS Benefits Specialty Services
			HIV Counseling, Testing, and Referral Prevention Services
LOPEZ	**Abad**	Unaffiliated consumer	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
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)
MORENO	**Carlos**	Unaffiliated consumer	No Ryan White or prevention contracts
MURRAY	**Derek**	City of West Hollywood	No Ryan White or prevention contracts
NELSON	**Katja**	APLA Health & Wellness	Benefits Specialty Case Management, Non-Medical (LCM) Case Management, Home-Based Health Education/Risk Reduction (HERR) HIV Counseling and Testing (HCT) Mental Health, Psychotherapy Nutrition Support Oral Health Biomedical Prevention Medical Care Coordination (MCC)
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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
PRECIADO	**Juan**	Northeast Valley Health Corporation	Mental Health, Psychotherapy
			Benefits Specialty
			Mental Health, Psychiatry
			Oral Health
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
RAY	**Joshua**	Unaffiliated consumer	No Ryan White or prevention contracts
ROGEL	**Nestor**	Alta Med	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Case Management, Home-Based
			HCT Mobile Testing
			HIV Biomedical Prevention
			Medical Care Coordination (MCC)
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Promoting Healthcare Engagement Among Vulnerable Populations
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
SCOTT	**Craig**	Unaffiliated consumer	No Ryan White or prevention contracts
SPENCER	**LaShonda**	LAC & USC MCA Clinic	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
STALTER	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
ULLOA	**Maribel**	HOPWA-City of Los Angeles	No Ryan White or prevention contracts
VALERO	**Justin**	California State University, San Bernardino	No Ryan White or prevention contracts
WALKER	**Kayla**	No Affiliation	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
WILSON	**Amiya**	Unique Wome's Coalition	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

HIV Calendar

October 2019

Sun	Mon	Tue	Wed	Thu	Fri	Sat
29 Week 40	30 10:00 AM Goals and Objectives Meeting	1 10:00 AM Standards & Best Practices (SBP)	2	3	4	5
6 Week 41	7 10:30 AM Consumer Caucus Meeting 1:00 PM Public Policy Committee	8	9	10 9:00 AM Commission Meeting 1:00 PM [CANCELLED] Consumer Caucus Meeting Member Orientation	11	12
13 Week 42	14 8:00 AM HOLIDAY - COLUMBUS DAY | COH Office Closed	15 1:00 PM Planning, Priorities & Allocations (PP&A)	16	17	18	19
20 Week 43	21	22	23	24 10:00 AM Operations Committee Meeting	25	26
27 Week 44	28	29 1:00 PM Aging Task Force	30	31 3:30 PM Executive Committee Meeting	1	2

HIV Calendar

November 2019

Sun	Mon	Tue	Wed	Thu	Fri	Sat
27 Week 44	28	29 1:00 PM - 3:00 PM Aging Task Force	30	31	1	2
3 Week 45	4 1:00 PM - 3:00 PM Public Policy Committee	5 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	6	7	8	9
10 Week 46	11 8:00 AM - 5:00 PM HOLIDAY - VETERANS DAY | COH Office Closed	12	13	14 9:00 AM - 1:00 PM Commission Meeting 1:00 PM - 3:00 PM Consumer Caucus Meeting	15	16
17 Week 47	18 10:00 AM - 12:00 PM Transgender Caucus Meeting	19 2:00 PM - 4:00 PM Planning, Priorities & Allocations (PP&A)	20 9:30 AM - 11:30 AM Women's Caucus	21	22	23
24 Week 48	25	26	27 8:00 AM HOLIDAY - THANKSGIVING DAY | COH Office Closed	28 HOLIDAY - THANKSGIVING DAY | COH Office Closed 10:00 AM - 12:00 PM Operations Committee Meeting (CANCELLED) 1:00 PM - 3:00 PM Executive Committee Meeting (CANCELLED)	29	30

HIV Calendar

December 2019

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1 Week 49	2 1:00 PM - 3:00 PM Public Policy Committee	3 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	4	5	6	7
8 Week 50	9	10	11	12 9:00 AM - 1:00 PM Commission Meeting 1:00 PM - 3:00 PM Consumer Caucus Meeting	13	14
15 Week 51	16	17 1:00 PM - 3:00 PM Planning, Priorities & Allocations (PP&A)	18	19	20	21
22 Week 52	23	24	25 8:00 AM - 5:00 PM HOLIDAY - CHRISTMAS DAY | COH Office Closed	26 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	27	28
29 Week 1	30	31	1	2	3	4

4. CO-CHAIR REPORT:

C. COH Co-Chair Elections | Duty Statement

D. Black/African American Community (BAAC) Task Force Recommendations

LOS ANGELES COUNTY
COMMISSION ON HIV

DUTY STATEMENT

COMMISSION CO-CHAIR

(APPROVED 3-28-17)

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

ORGANIZATIONAL LEADERSHIP:

① Serve as Co-Chair of the **Executive Committee**, and leads those monthly meetings.

② Serve as ex-officio member of all standing Committees:
- attending at least one of each standing Committee meetings annually or in Committee Co-Chair's absence

③ Meet monthly with the Executive Director, or his/her designee, to prepare the Commission and Executive Committee meeting agendas and course of action,
- assist Commission staff in the preparation of motions, backup materials and information for meetings, as necessary and appropriate.

④ Lead Executive Committee in decision-making on behalf of Commission, when necessary.

⑤ Act as final Commission-level arbiter of grievances and complaints

MEETING MANAGEMENT:

① Serve as the Presiding Officer at the Commission, Executive Committee and Annual meetings.

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

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

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

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

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

COMMITMENT/ACCOUNTABILITY TO THE OFFICE:

① Put personal agenda aside and advocate for what's in the best interest of the Commission
② Devote adequate time and availability to the Commission and its business
③ Assure that members' and stakeholders' rights are not abridged
④ Advocate strongly and consistently on behalf of Commission's and people living with and at risk for HIV, interests
⑤ Always consider the views of others with an open mind
⑥ Actively and regularly participate in and lead ongoing, transparent decision-making processes
⑦ Respect the views of other regardless of their race, ethnicity, sexual orientation, HIV status or other factors

FOR PRESENTATION AT
10/10/19 COH MEETING

LOS ANGELES COUNTY
COMMISSION ON HIV

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

October 10, 2019

Introduction

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

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

Healthcare Disparities in the Black/AA Community

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

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

Black/AA Care Continuum as of 2016[3]

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

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

Objectives:

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

General/Overall Recommendations:

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

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

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

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

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

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

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

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

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

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

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

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

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

Population-Specific Recommendations:

Black/African American Trans Men:

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

1. Conduct a Countywide needs assessment of the Trans masculine community that focuses on sexual risk behaviors.

2. Use Williams Institutes' research/data using Sexual Orientation Gender identity (SOGI) (method agencies use to collect patient/client data on sexual orientation and gender identity) to develop Trans male-specific programming.

3. Include Trans men in program decision making.

4. Develop a Trans masculine-specific PrEP campaign which will resonate with and reach Trans men in such a way that the message is not convoluted and therefore lost within the overall PrEP messaging. Messaging should include language around safety and gender affirmation - a campaign that says "Trans masculine individuals . . . this is for YOU." Perhaps include a myth buster around the notion that all Trans men are straight and only date and are sexually involved with cis men; a message that says we know sexual appetites are fluid for Trans men and that is why PrEP is important.

5. Educate/train medical and mental health providers to be more inclusive of Trans masculine bodies and its many different nuances.

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

Black/African American Trans Women:

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

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

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

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

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

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

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

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

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

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

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

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

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

Conclusion

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

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

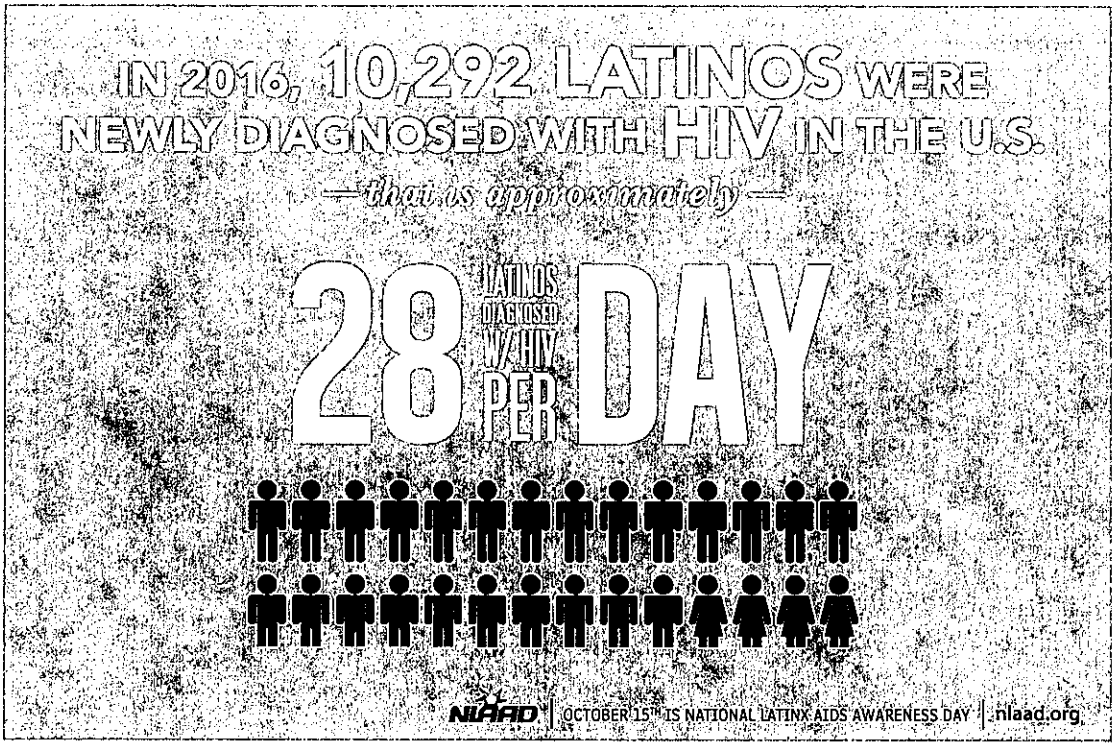
On behalf of the BAAC Task Force, we thank the Executive Committee for its consideration of the above recommendations and look forward to its plan of action in response.

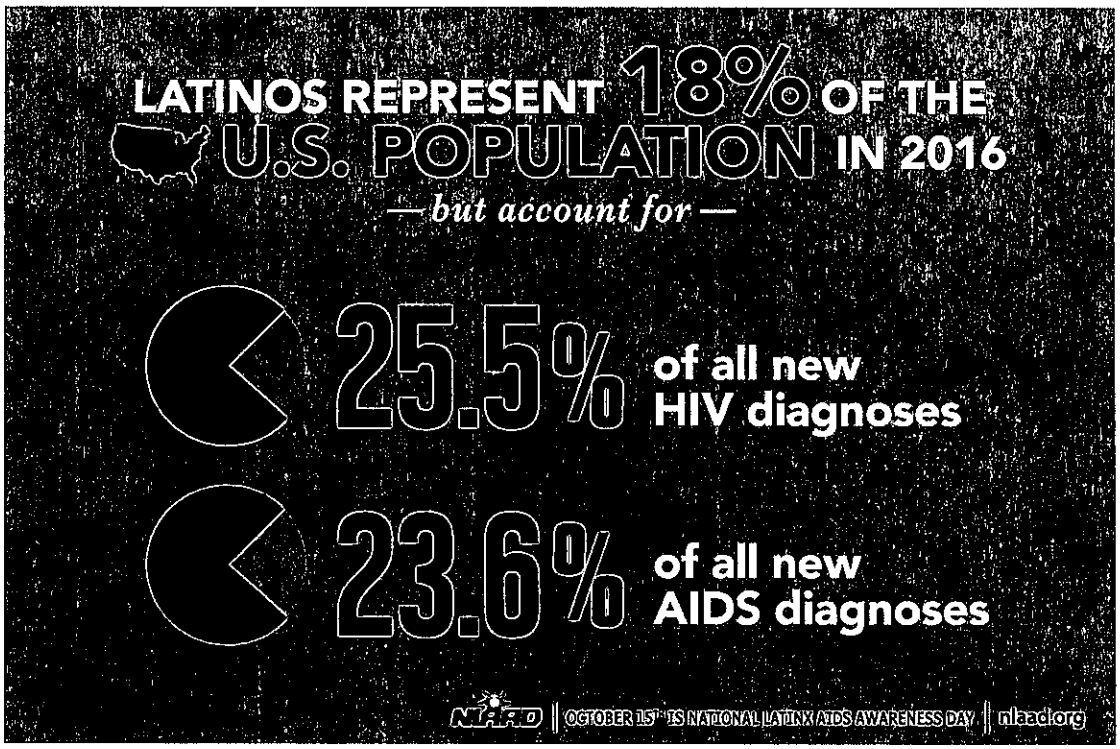
Special thanks to the following BAAC Task Force members and community stakeholders who volunteered their time and contributed to the development of recommendations: Greg Wilson (COH), Traci Bivens-Davis (COH), Bridget Gordon (COH), Dr. LaShonda Spencer (COH), Danielle Campbell (COH), Yolanda Sumpter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

Endnotes

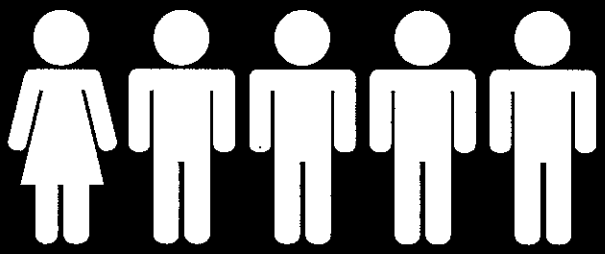
1. Census.gov/quickfacts/fact/table/losangelescountycalifornia; RH1225218
2. 2017 Annual HIV Surveillance Report; Ryan White program Clients Living with HIV YR 28 (03/01/2018 – 02/28/19)[i]
3. Los Angeles County HIV/AIDS Strategy (LACHAS) – P26; Table 5
4. Ryan White Program Clients YR 28 (3/1/18-2/28/19)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

5. IMPACT OF HIV/AIDS IN THE LATINX COMMUNITY | PANEL DISCUSSION


IN 2016, 10,292 LATINOS WERE NEWLY DIAGNOSED WITH HIV IN THE U.S.
— that is approximately —
28 LATINOS DIAGNOSED W/ HIV PER DAY
NLAAD | OCTOBER 15TH IS NATIONAL LATINX AIDS AWARENESS DAY | nlaad.org


LATINOS REPRESENT 18% OF THE U.S. POPULATION IN 2016
— but account for —
25.5% of all new HIV diagnoses
23.6% of all new AIDS diagnoses
NLAAD | OCTOBER 15TH IS NATIONAL LATINX AIDS AWARENESS DAY | nlaad.org

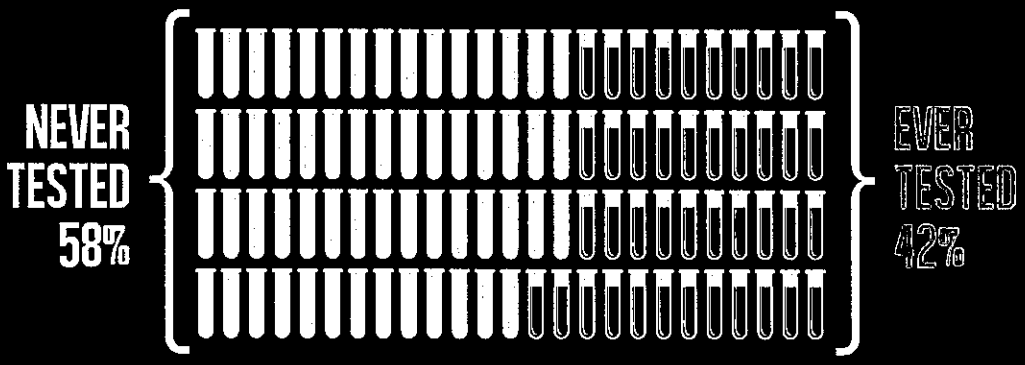
1 IN 6 LATINOS
LIVING WITH HIV ARE UNAWARE
THEY HAVE IT



Latinos who are unaware cannot take advantage of HIV treatment and may unknowingly transmit HIV to others.

NIAAD

58% OF LATINOS 18 YEARS OLD AND OVER HAVE NEVER BEEN TESTED FOR HIV IN THEIR LIFETIME



NIAAD | OCTOBER 15TH IS NATIONAL LATINX AIDS AWARENESS DAY | nlaad.org

PrEP (A DAILY PILL TO PREVENT HIV) IS DISPROPORTIONALLY REACHING LATINOS

White users 73%

Latino users 13%

Black users 10%

other users

NLAAD | OCTOBER 15TH IS NATIONAL LATINX AIDS AWARENESS DAY | nlaad.org

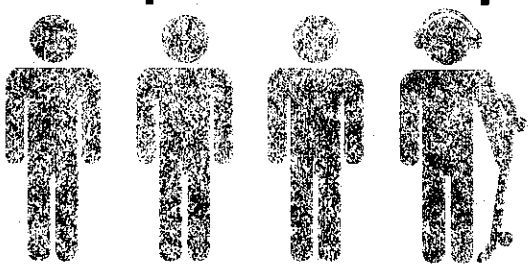
48%

UNDETECTABLE VIRAL LOAD;

(undetectable equals untransmittable)

AMONG LATINOS IN 2016, GAY AND BISEXUAL MEN ACCOUNT FOR 75% OF THE NEW HIV CASES. CIS AND TRANS LATINA WOMEN AND HETEROSEXUAL MEN MAKE UP THE REMAINING 25%

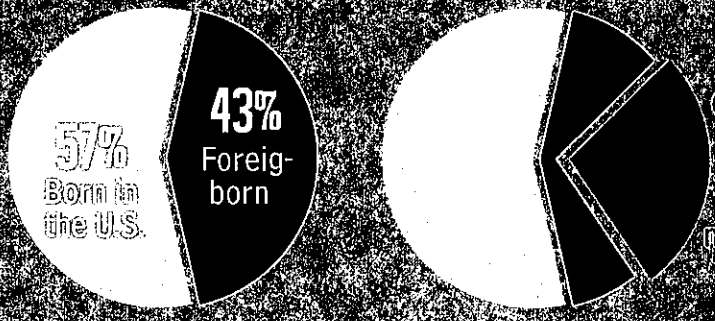
3 IN 4
Latinos infected with HIV in 2016 were gay or bisexual men



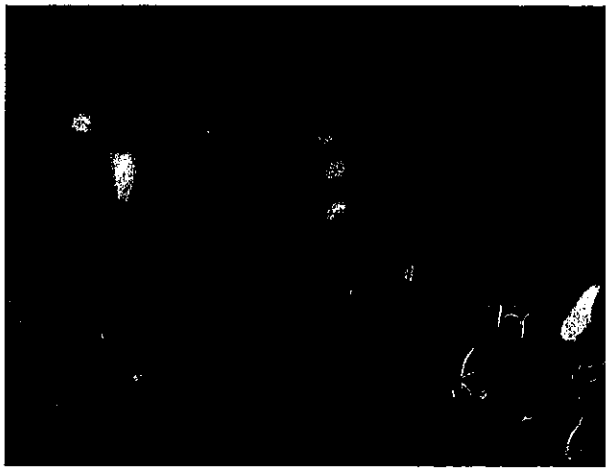
2 IN 3
of this group were between the ages of 13 and 34

NLAAD | OCTOBER 15TH IS NATIONAL LATINX AIDS AWARENESS DAY | nlaad.org

43% OF LATINOS DIAGNOSED WITH HIV WERE FOREIGN-BORN; AMONG THESE, 66% WERE GAY & BISEXUAL MEN (2008-2013)



NLAAD | OCTOBER 15TH IS NATIONAL LATINX AIDS AWARENESS DAY | nlaad.org



Spotlight on Communities

An Economic Profile of the Latino Community *in Los Angeles County*

4,842,320

Latinos in Los Angeles County, accounting for 48.2% of the county's population.

Latinos account for 38.4% of California's population, and 17.1% of the nation's population.

Nationality of Latino Angelenos

Mexico	78%
El Salvador	9%
Guatemala	6%
Honduras	1%
Puerto Rico	1%
Nicaragua	1%
Peru	1%
Cuba	1%
Colombia	1%
Other	2%

Per capita income is

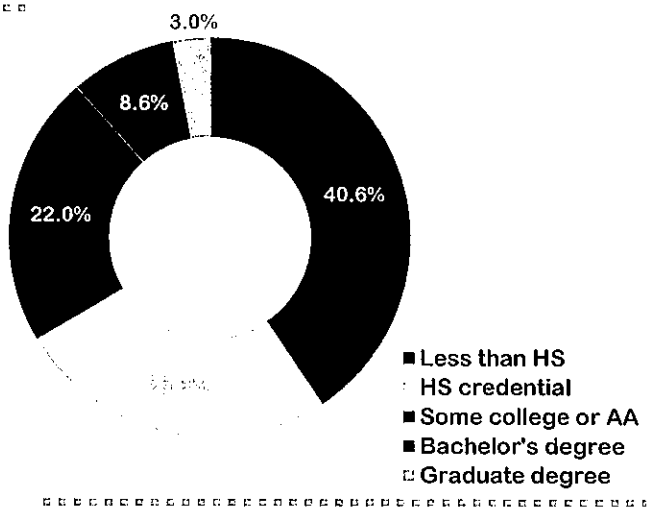
$16,940

compared to the Los Angeles County average of $28,340.

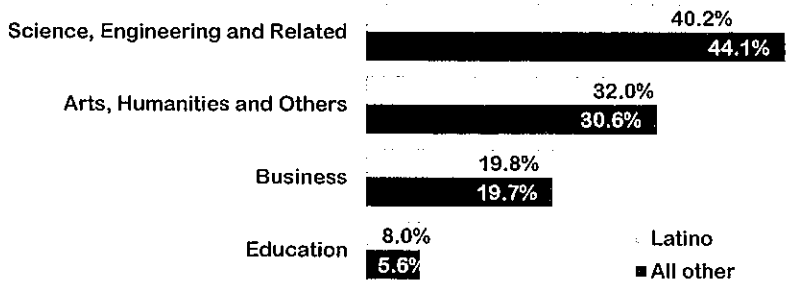
This is 1.0% lower the per capita income of Latinos across the state and 2.9% lower than those across the nation.

Educational attainment

59.4% of Latinos aged 25 years and older have at least a high school diploma, compared to 77.3% of all other residents in Los Angeles County.



BA degrees by discipline:



The most popular BA degrees among Latinos in Los Angeles County are in Science and Engineering, followed by Arts, Humanities and Other fields.

Latino households in Los Angeles County ◁ **1,221,540**

Median household income is

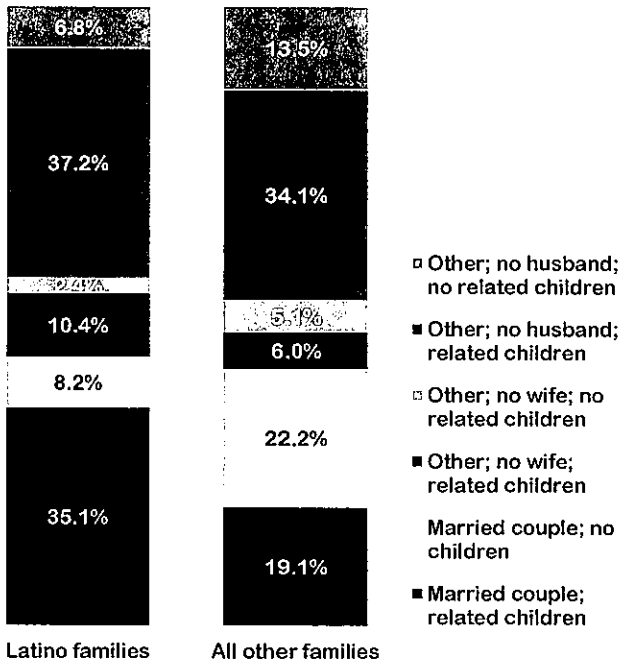
▷ **$46,850** compared to the Los Angeles County median of $59,135.

This is 5.7% less than the median Latino household income across the state and 4.6% lower than that across the nation.

Poverty ▶ 181,485

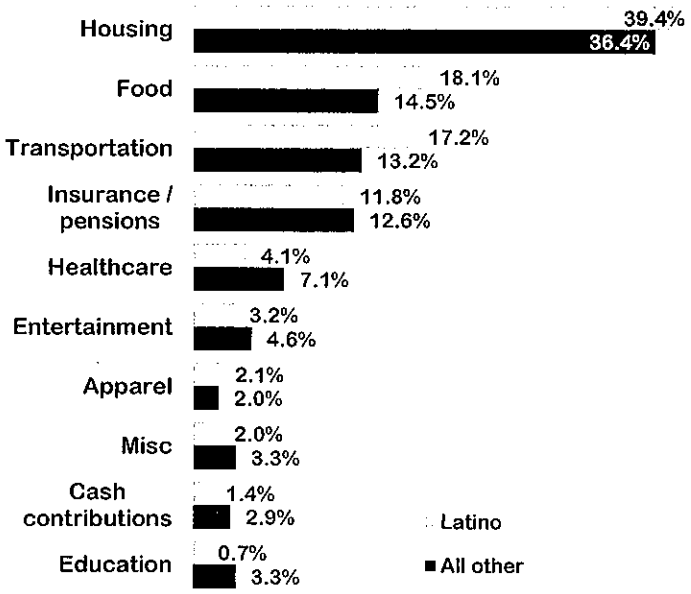
Latino families are in poverty, accounting for 18.5% of all Latino families in Los Angeles County.

Poverty by family type:



▷ Of all Latino families in poverty, 37.2% are single mothers with children under 18 years of age at home, and 35.1% are married couples with children.

Household expenditures ▼



Average annual expenditures for Latino households is

▷ **$33,970**

compared to the Los Angeles County median of $46,380 for all other households in Los Angeles County.

▽

As with other Los Angeles County households, Latino households spend the largest share of their expenditures on housing.

Total local household spending in Los Angeles County in 2015 was

$41.5 billion

Economic impact ▼

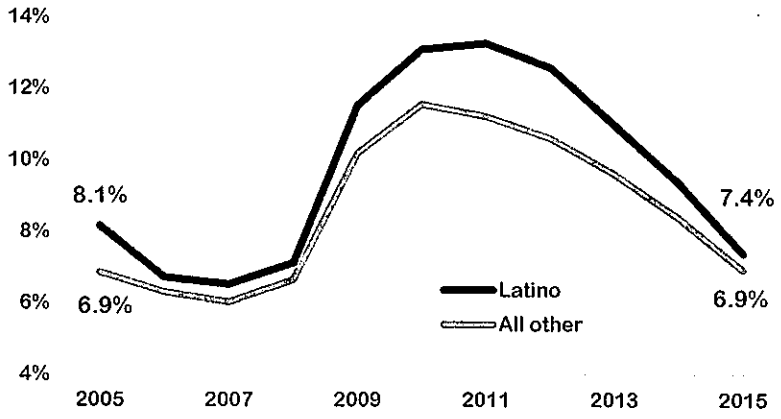
The economic impact in Los Angeles County of the household spending in 2015 of Latino households was

▷ **$60.1 billion**

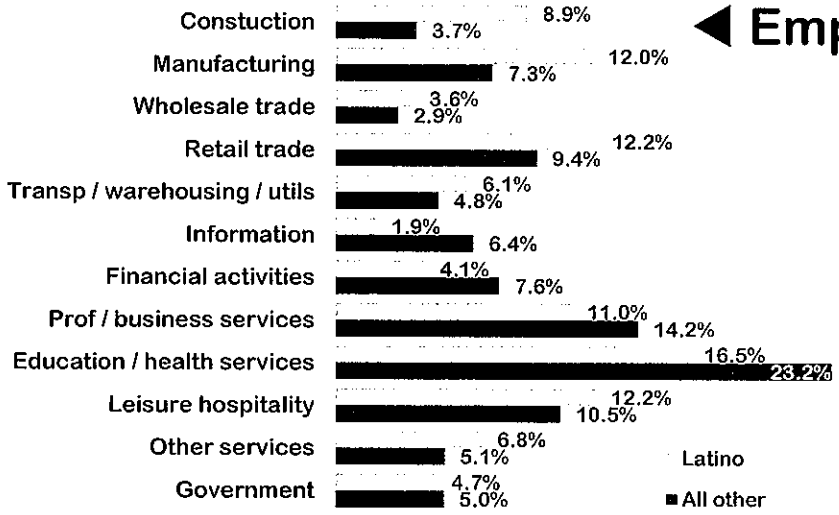
in economic output (or revenues for local firms), supporting 443,770 jobs in Los Angeles County with total labor income of $22.7 billion and federal, state and local tax revenues of $7.3 billion.

Unemployment ▶

The unemployment rate of Latinos in Los Angeles County is half of a percentage point above all other workers in Los Angeles County.



2,246,400 Latinos in Los Angeles County that hold a job.



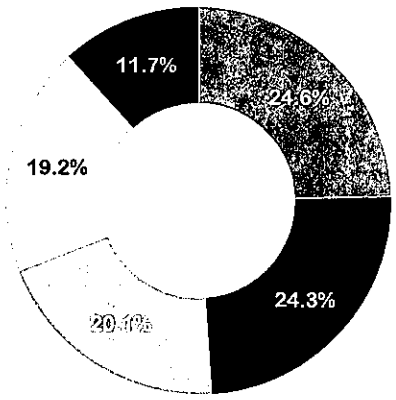
◀ Employment by industry

About 16.5% of Latino Angelenos are in the education and health services industry, compared to 23.2% for all other workers in Los Angeles County.

Latinos are more likely to be employed in manufacturing and construction firms than the average LA County worker.

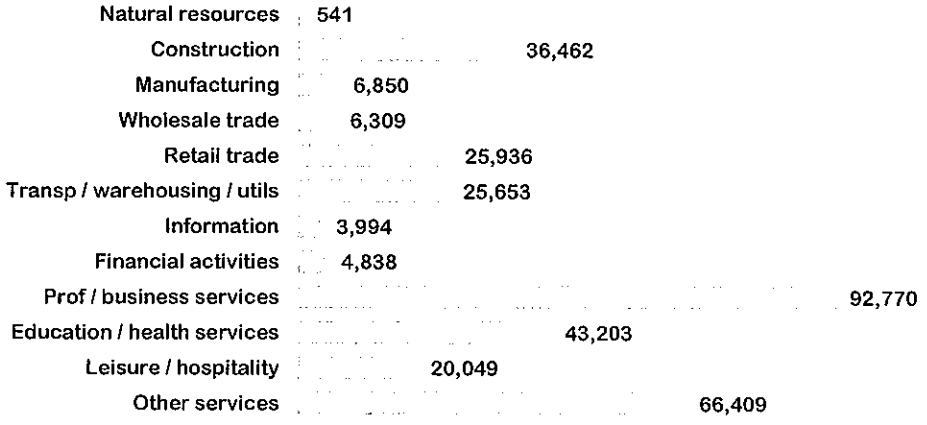
Employment by occupation ▼

Almost 25% of working Latinos in Los Angeles County are employed in service occupations. The second most common occupation is sales / office, accounting for approximately the same number of LA's Latino working population.



333,970 Firms in Los Angeles County at least partly owned by Latinos in 2012, an increase of 108,180 since 2007.

Firms by industry ▼

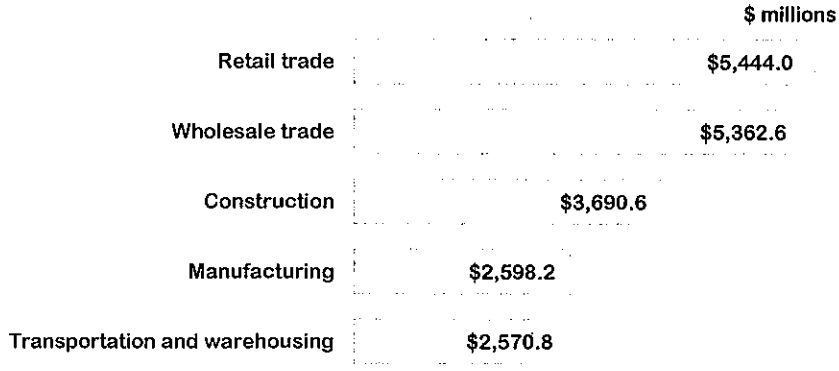


About 28% of Latino-owned firms are engaged in "Professional and business services," which includes consultancy firms, regional managing offices, and employment placement agencies, while 20% are in other services, and 13% are in education/ healthcare.

Total sales generated by Latino-owned firms in Los Angeles County in 2012 were

$32.8 billion

Top industries by sales ▼



In terms of sales, Latino-owned firms in retail trade earned the most, with **$5.4 billion** in sales in 2012, 17 percent of all sales earned by Latino-owned firms. It was followed by firms in wholesale trade, earning **$5.4 billion**, and construction, earning **$3.7 billion**.

Economic impact ▼

The economic impact in Los Angeles County of Latino-owned firms in 2012 was

$54.1 billion

in economic output (or revenues for local firms), supporting **409,230** jobs in Los Angeles County with total labor income of **$20.6 billion** and federal, state and local tax revenues of **$9.0 billion**.

Demographic data on pages 2 through 5 were derived from the U.S. Census Bureau's *American Community Survey* one-year estimates for Los Angeles County, 2015.

Household expenditure data was derived from the U.S. Census Bureau's 2015 *Consumer Expenditure Survey* for the western region.

Data for Latino-owned businesses on pages 6 and 7 were derived from the U.S. Census Bureau's 2012 *Survey of Business Owners*.

Economic impacts on pages 4 and 7 were estimated using IMPLAN with 2015 model data for Los Angeles County and are expressed in current dollars. Adjustments were made to indirect impacts to avoid double-counting when estimating the economic impact of the Latino community's expenditures.

7. RYAN WHITE PROGRAM PARTS C, D AND F REPORT

LOS ANGELES COUNTY
COMMISSION ON HIV

Ryan White HIV/AIDS Program Parts

The Ryan White HIV/AIDS Program is divided into five Parts, following from the authorizing legislation. Note that all Parts utilize the same service categories.

- PART A provides grant funding for medical and support services to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs). EMAs and TGAs are population centers that are the most severely affected by the HIV/AIDS epidemic.

- PART B provides grant funding to states and territories to improve the quality, availability, and organization of HIV health care and support services. Grant recipients include all 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and the 5 U.S. Pacific Territories. In addition, Part B also includes grants for the AIDS Drug Assistance Program (ADAP).

- PART C provides grant funding to local community-based organizations to support outpatient HIV early intervention services and ambulatory care. Part C also funds planning grants, which help organizations more effectively deliver HIV care and services.

- PART D provides grant funding to support family-centered, comprehensive care to women, infants, children, and youth living with HIV.

- PART F provides grant funding that supports several research, technical assistance, and access-to-care programs. These programs include:

  - The Special Projects of National Significance Program, supporting the demonstration and evaluation of innovative models of care delivery for hard-to-reach populations;

  - The AIDS Education and Training Centers Program, supporting the education and training of health care providers treating people living with HIV through a network of eight regional centers and three national centers;

  - The Dental Programs, providing additional funding for oral health care for people with HIV through the HIV/AIDS Dental Reimbursement Program and the Community-Based Dental Partnership Program; and

  - The Minority AIDS Initiative, providing funding to evaluate and address the impact of HIV/AIDS on disproportionately affected minority populations.

Retrieved from: https://hab.hrsa.gov/about-ryan-white-hivaids-program/about-ryan-white-hivaids-program.
October 2016.

8. CALIFORNIA OFFICE OF AIDS (OA) REPORT

the OA Voice
Issue: October 2019

This newsletter is organized to align the updates with Strategies from the ***Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention, and Care Plan*** (Integrated Plan). The Integrated Plan is available on the Office of AIDS' (OA) website at www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/IP_2016_Final.pdf.

In This Issue:

Staff Highlight:

The AIDS Drug Assistance Program (ADAP) Client Services Unit (CSU) is celebrating our second annual Customer Service Week, 09/30-10/4. The CSU was established in June of 2017. The unit is responsible for responding to all incoming calls as well as processing various data components of the program, including work items created by ADAP enrollment workers and Self-Verification Forms received by ADAP clients. Staff in the CSU work on a broad set of tasks, all of which helps clients enroll and maintain their ADAP benefits. Here is an example of how CSU staff help clients.

An existing ADAP client was calling to confirm that his Self-Verification Form had been received and processed. The client thanked us for helping with his prescription co-pays, as it alleviates a lot of financial burden on him and his family. He made a joke that he wished we could also pay for his medical out-of-pocket co-pays as well, because of frequent doctor visits due to an unresolved back injury. Reviewing his account, CSU noticed that the client was on private health insurance through his employer. The CSU asked if the client was aware of the new Employer Health Insurance Premium Payment (EB-HIPP) program, which could potentially cover those co-pays for him. He was absolutely elated to find out that the EB-HIPP Program also covered his portion of his medical and dental premiums. CSU staff provided him the information needed to work with his employer and get enrolled. The client called later, thanking the CSU Team and to say he was finally able to afford a much-needed back surgery that he had been postponing for far too long.

We at the Office of AIDS (OA) are proud of our CSU staff, who work directly with Californians living with HIV to ensure they have access to HIV medications, as well as assistance to pay for medical care for those who are eligible. In addition, they work with ADAP enrollment workers to assist those seeking PrEP, including enrolling people in the PrEP-Assistance Program that can assist with payment of medication and medical visits.

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

PrEP Assistance Program (PrEP-AP):

As of September 13, 2019, there are 183 PrEP-AP enrollment sites covering 105 clinics that currently make up the PrEP-AP Provider network. As of September 18, 2019 there are 2,582 clients enrolled in the PrEP-AP.

A comprehensive list of the PrEP-AP Provider Network can be found at https://cdphdata.maps.arcgis.com/apps/webappviewer/index.html?id=6878d3a1c9724418aebfea96878cd5b2.

Strategy D: Improve Linkage to Care

The ADAP Branch released a new client portal within the ADAP Enrollment System. ADAPs new client portal went live on September 3, 2019. The initial release has allowed clients to:

- View their client ID; enrollment site and enrollment worker contact information; eligibility status and eligibility end date; and the next action needed to maintain eligibility (whether they are to recertify or re-enroll and when).
- Recertify if there are no changes to residency and health insurance/other third-party payer coverage, and annual household income remains within program limits.
- View information pertaining to their Insurance Assistance Program (if applicable) such as their program type (OA-HIPP, EB-HIPP, or MDPP), insurance carrier, eligibility status and eligibility end date.
- Receive automatic notifications (e.g., when re-enrollment/recertification date is nearing and if eligibility has ended).

As of September 16, 2019, 100 clients have registered for a profile, and six clients have extended their eligibility by recertifying with the client portal.

Strategy E: Improve Retention in Care

Project Open Hand Recognized for Quality Improvement:

The Center for Quality Improvement and Innovation recently recognized Project Open Hand with a Leadership in Quality Award. Project Open Hand, an HIV Care Program (Ryan White Part B) provider based in San Francisco has implemented a robust quality improvement process to improve nutritional health of persons with HIV through prepared meals, groceries, nutritional assessments, and other food and nutrition services. They also developed a process to routinely screen and identify clients receiving services at Project Open Hand who are not virally suppressed, not on antiretroviral therapy, and not retained in care. For clients who fall under any of those categories, a tailored nutritional plan to optimize patients' nutritional status, immune status, and overall well-being is prepared and documented in ARIES. The team is also implementing a process to track service utilization for these clients and a process to successfully link identified clients to case management and medical service providers that are within walking distance of Project Open Hand. This project is informing performance measure development for Food Bank/Home-Delivered Meals service category. The QI project was supported by San Francisco Department of Public Health, HIV Health Services, and implemented in collaboration with San Francisco Community Health Center and Tom Waddell Urban Health Center.

ADAP released Management Memorandum 2019-17: ADAP Recertification Process Update: informing enrollment workers that the OA has updated the ADAP recertification process allowing clients to recertify over the phone. This option is available to ADAP clients who continue to meet ADAP eligibility requirements. If clients have not had any changes to residency and health insurance/other third-party payer coverage, and annual household income remains within program limits, they can recertify over the phone by contacting the ADAP Call Center, their ADAP Advisor, or ADAP Enrollment Worker.

Strategy H: Improve Integration of HIV Services with Sexually Transmitted Disease (STD), Tuberculosis, Dental, and Other Services

The OA and the STD Control Branch has begun updating the *Laying the Foundation for Getting to Zero Integrated HIV Surveillance, Prevention and Care Plan* to respond to the new Federal *Ending the HIV Epidemic in America* plan, as well as broadening California's scope to focus on *Ending the Epidemics: STD, HCV and HIV*. Input from stakeholders and people living with HIV will be solicited in the next two months, and an initial draft will be ready for the Centers for Disease Control and Prevention (CDC) review by 12/31/19.

Phase I of the Federal *Ending the HIV Epidemic in America* plan is rolling out. There are 8 counties in California included in Phase I, which selected the top 50 counties and 7 states that contain the largest portion of people living with HIV in the United States. The counties include: Alameda, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, and San Francisco.

Through CDC funding, each county will update their county's Epidemiologic Profile, write a strategic analysis, and create a Getting to Zero plan by September 29, 2020 that will be implemented from September 30, 2020 through September 29, 2024.

Additional Health Resources and Services Administration (HRSA) HIV/AIDS Program funding is also available to the 8 counties to implement strategies, interventions, approaches, and core medical and support services to reduce new HIV infections in the United States. The overarching goal for this funding is to reduce new HIV infections in the United States to less than 3,000 per year by 2030.

Through HRSA Health Center Program, HRSA-funded health centers will receive additional funding to increase HIV testing in high impacted areas by conducting expanded outreach within their communities and increasing routine and risk-based testing of health center patients. Those who are identified as living with HIV will be linked to care and prescribed antiretroviral therapy. Those who are identified as HIV-negative but at high risk of HIV exposure will be linked to PrEP.

These monies are in addition to the ongoing CDC Prevention Funds, and HRSA's Ryan White Parts A, B, C, D, and F.

Strategy J: Increase Rates of Insurance/Benefits Coverage for PLWH or on PrEP ADAP's Insurance Assistance Programs

As of September 18, 2019, the number of ADAP clients enrolled in each respective ADAP Insurance Program are shown in the chart at the top of Page 4.

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

OA's Harm Reduction Unit manages the California Syringe Exchange Certification Program, which allows qualified organizations to apply directly to CDPH/OA for authorization to provide syringe services.

There are three applications in process with CDPH/OA. 1) CDPH will be making a final

ADAP Insurance Assistance Program	Number of Clients Enrolled	Percentage Change from August
Employer Based Health Insurance Premium Payment (EB-HIPP) Program	592	+2.2%
Office of AIDS Health Insurance Premium Payment (OA-HIPP) Program	4,595	-0.43%
Medicare Part D Premium Payment (MDPP) Program	1,743	-0.28%
Total	**6,930**	**-0.17%**

decision on an application by Northern Valley Harm Reduction Coalition in Butte County. 2) Public comment has closed on the syringe services program application for Gender Health Center in Sacramento County. The final decision on the application from CDPH will be made by November 8, 2019. 3) CDPH is also taking public comment on an application for a proposed syringe service program in Inyo County by the Northern Inyo Health District. Public comment closes October 11, 2019. Information on pending applications including information on public comment can be found on OA's website at https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_prev_secpapp.aspx.

For questions regarding this report, please contact: angelique.skinner@cdph.ca.gov.

10. STANDING COMMITTEE REPORTS:

A. Standards and Best Practices (SBP) Committee
   (1) Non-Medical Case Management Standard of Care - 30 Day Public Comment

C. Planning, Priorities and Allocations (PP&A) Committee
   (1) Ryan White Program (RWP) Years 31-32 Planning Update

D. Public Policy (PP) Committee
   (1) County, State and Federal Legislation & Policy
      (a) Ending the HIV Epidemic Update
      (b) Public Charge Rule

10. STANDING COMMITTEE REPORTS (cont'd):

A. Standards and Best Practices (SBP) Committee

(1) Non-Medical Case Management Standard of Care - 30 Day Public Comment

LOS ANGELES COUNTY
COMMISSION ON HIV

NON-MEDICAL CASE MANAGEMENT STANDARDS OF CARE

DRAFT FOR PUBLIC COMMENT

PUBLIC COMMENT PERIOD:
October 10 – November 15, 2019

Email comments to HIVComm@lachiv.org

LOS ANGELES COUNTY
COMMISSION ON HIV

Standards of Care Review
Guiding Questions

Utilize the questions below to guide your review and feedback to the Commission on HIV.

Service-Specific Questions

1. Are the standards up-to-date and consistent with national standards of high quality HIV care?

2. Are the standards reasonable and achievable for providers?

3. Will the services engage and meet consumer needs? Are the proposed standards client-centered?

4. Is there anything missing with regard to accessing non-medical case management services?

For more information on Ryan White Standards of Care visit https://targethiv.org/library/service-standards-guidance-ryan-white-hivaids-program-granteesplanning-bodies

LOS ANGELES COUNTY
COMMISSION ON HIV

NON-MEDICAL CASE MANAGEMENT STANDARDS OF CARE

INTRODUCTION

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

The Los Angeles County Commission on HIV developed the Non-Medical Case Management Standards of Care to establish the minimum standards of care necessary to achieve optimal health among people living with HIV (PLWH), regardless of where services are received in the County. The development of the Standards includes guidance from service providers, consumers, and members of the Los Angeles County Commission on HIV, Standards and Best Practices Committee.

NON-MEDICAL CASE MANAGEMENT OVERVIEW

Case management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet clients' health and human services needs. It is characterized by advocacy, communication, and resource amendment and promotes quality and cost-effective interventions and outcomes.[1] The Health Resources and Services Administration (HRSA) defines Non-Medical Case Management Services (NMCM) as a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible. The objective of NMCM is to improve client access to services.

Non-Medical Case Management Services (NMCM) includes all types of case management models such as intensive case management, strengths based case management, and referral case management (Appendix A). An agency may offer a specific type of case management model depending on its capacity and/or the contract from the DHSP. Depending on the type of case management offered, NMCM may also involve assessing the client's support network, key family members, and other individuals that play a direct role in the client's health and well-being.

Service components include:

- Initial assessment of service needs
- Development of a comprehensive, Individual Service Plan
- Timely and coordinated access to needed health and support services and continuity of care
- Client specific advocacy and review of utilization of services

[1] Introduction to the Case Management Body of Knowledge. Commission for Case Manager Certification (CCMC). https://www.cmbodyofknowledge.com/content/introduction-case-management-body-knowledge

- Continuous client monitoring to assess Individual Service Plan progress
- Revisiting the Individual Service Plan and adjusting as necessary
- Ongoing assessment of client needs and, if appropriate based on the case management model offered, other key individuals in the client's support network

All contractors must meet the Universal Standards of Care in addition to the following Non-Medical Case Management Standards of Care.[2] In the past, the Los Angeles County Department of Public Health, Department of HIV & STD Programs (DHSP) has contracted Linkage Case Management and Transitional Case Management for Youth and Post-Incarcerated Populations under NMCM Services.

KEY COMPONENTS

Non-Medical Case Management coordinates services for people living with HIV to improve health outcomes and facilitate client self-sufficiency. Case managers at provider agencies are responsible for educating clients on available HIV non-medical support services as well as serving as liaisons in improving access to services. Case managers are responsible for understanding HIV care systems and wrap around services, advocating for clients, and assessing and monitoring client progress on an ongoing basis. Case managers identify client service needs in all non-medical areas and facilitate client access to appropriate resources such as health care, financial assistance, HIV education, mental health and other supportive services. Non-Medical Case Management services should be client-focused, increase client empowerment, self-advocacy and medical self-management, as well as enhance their overall health status.

CLIENT ASSESSMENT & REASSESSMENT

All Non-Medical Case Management providers must complete an initial assessment, within 30 days of intake, through a collaborative, interactive, face-to-face process between the Case Manager and client with the client as the primary source of information. With client consent, assessments may also include additional information from other sources such as service providers, caregivers, and family members to support client well-being and progress. Staff members must comply with established agency confidentiality policies (Refer to Universal Standards, Section 1) when soliciting information from external sources. The initial assessment may be scalable based on client need and the type of case management offered by the agency. Accommodations may be made for clients who are unable to attend an appointment within the 30-day timeframe due to health reasons.

It is the responsibility of staff at the provider agency to conduct reassessments with the client as needed and based on contract guidelines from the Department of HIV & STD Programs (DHSP). If a client's income, housing status, or insurance status has changed since assessment or the most recent reassessment, agencies must ensure that the data on the Client Information Form is updated accordingly.

The client assessment identifies and evaluates the medical, non-medical, physical, environmental, and financial strengths, needs and resources. It is conducted to determine:

- Client needs for treatment and support services
- Client capacity to meet those needs
- Ability of the client social support network to help meet client need
- Extent to which other agencies are involved in client care

[2] Universal Standards of Care can be accessed at http://hiv.lacounty.gov/Projects

- Areas in which the client requires assistance in securing services

Assessment and reassessment topics may include, but are not limited to:

- Client strengths and resources
- Medical care
- Nutrition/food
- Housing or housing related expenses
- Family and dependent care
- Transportation
- Linguistic services
- Social support system
- Community or Family violence
- Financial resources
- Employment and education
- Legal needs
- Knowledge and beliefs about HIV
- Agencies that serve client and household

Case managers will identify medical and non-medical service providers and make appointments as early as possible during the initial intake process for clients that are not connected to primary medical care. Services provided to the client and actions taken on behalf of the client must be documented in progress notes and in the Individual Service Plan, which is developed based on the information gathered in the assessment and reassessments.

INDIVIDUAL SERVICE PLAN

The purpose of the Individual Service Plan is for the client and case manager to collaboratively develop an action plan that includes short-term and long-term client goals based on needs identified in the assessment. The Individual Service Plan should include specific service needs, referrals to be made, clear timeframes and a plan for follow up.

Individual Service Plans will be completed for each client within two weeks after the comprehensive assessment or reassessment. Similar to the assessment process, the service plan is an ongoing process and working document. It is the responsibility of case managers to review and revise Individual Service Plans as needed, based on client need.

As part of the Individual Service Plan, case managers must ensure the coordination of the various services the client is receiving. Coordination of services requires identifying other staff or service providers with whom the client may be working. As appropriate and with client consent, program staff acts as a liaison among clients, caregivers, and other service providers to obtain and share information that supports optimal care and service provision. If a program is unable to provide a specific service, it must be able to make immediate and effective referrals. Staff is responsible for facilitating the scheduling of appointments, transportation, and the transfer of related information.

Individual Service Plans (ISP) will, at minimum, include the following:

- Client and case manager names
- Client and case manager signatures and date on the initial ISP and on subsequent, revised ISPs

- Description of client goals and desired outcomes
- Timeline for when goals are expected to be met
- Action steps to be taken by client and/or case manager to accomplish goals
- Status of each goal as client progresses

CLIENT MONITORING

Implementation, monitoring and follow-up involve ongoing contact and interventions with, or on behalf of, the client to achieve the goals on the Individual Service Plan (ISP). Staff is responsible for evaluating whether services provided to the client are consistent with the ISP, and whether there any changes in the client's status that require a reassessment or updating the ISP. Client monitoring ensures that referrals are completed and needed services are obtained in a timely, coordinated fashion.

Programs shall strive to retain clients in Non-Medical Case Management services to ensure continuity of medical and support services care. Follow-up strives to maintain a client and family participation in care and can include telephone calls, written correspondence and/or direct contact. Such efforts shall be documented in the progress notes within the client/family record.

In addition, programs will develop and implement a contact policy and procedure to ensure that clients/families that are homeless or report no contact information are not lost to follow-up.

STAFFING REQUIREMENTS AND QUALIFICATIONS

Staff will have the knowledge, skills, and ability to fulfill their role including striving to maintain and improve professional knowledge related to their responsibilities, basing all services on assessment, evaluation, or diagnosis of clients, and providing clients with a clear description of services, timelines and possible outcomes at the initiation of services.

Case Managers and Case Manager Supervisors should have experience in or participate in trainings on:

- HIV/AIDS and related issues
- Effective interviewing and assessment skills
- Appropriately interacting and collaborating with others
- Effective written and verbal communication skills
- Working independently
- Effective problem-solving skills
- Responding appropriately in crisis situations

Table 1. NON-MEDICAL CASE MANAGEMENT SERVICES STANDARDS OF CARE

SERVICE COMPONENT	STANDARD	DOCUMENTATION
Staff Requirement and Qualifications	Case Managers with experience in clinical and/or case management in an area of social services. Bachelor's degree in a related field preferred.	Staff resumes on file
	Case Management Supervisors with experience in clinical and/or case management in an area of mental health, social work, counseling, nursing with specialized mental health training, psychology. Master's degree in a related field preferred.	Staff resumes on file

Client Assessment and Reassessment	Assessments will be completed within 30 days of the initiation of services and at minimum should assess whether the client is in care. Accommodations may be made for clients who are unable to attend an appointment within the 30-day timeframe due to health reasons.	Completed assessment in client chart signed and dated by Case Manager
	Staff will conduct reassessments with the client as needed and in accordance with DHSP contract guidelines.	Completed reassessment in client chart signed and dated by Case Manager.
Individual Service Plan (ISP)	ISPs will be developed collaboratively between the client and Case Manager within two weeks of completing the assessment or reassessment and, at minimum, should include: • Description of client goals and desired outcomes • Action steps to be taken and individuals responsible for the activity • Anticipated time for each action step and goal • Status of each goal as it is met, changed or determined to be unattainable ISPs should be completed as soon as possible given case management services should be based on the ISP.	Completed ISP in client chart, dated and signed by client and Case Manager
	Staff will update the ISP every six months, or as needed based on client progress or DHSP contract requirements, with client outcomes or ISP revisions based on changes in access to care and services.	Updated ISP in client chart, dated and signed by client and Case Manager
Client Monitoring	Case Managers will ensure clients are accessing needed services and will identify and resolve any barriers clients may have in following through with their ISP. Responsibilities include, at minimum: • Monitor changes in the client's condition • Update/revise the ISP based on progress • Provide interventions and follow-up to confirm completion of referrals • Ensure coordination of care among client, caregiver(s), and service providers	Signed, dated progress notes on file that include, at minimum: • Description of client contacts and actions taken • Date and type of contact • Description of what occurred • Changes in the client's condition or circumstances • Progress made toward ISP goals • Barriers to ISPs and actions taken to resolve them • Linked referrals and interventions and current status/results of same

	• Advocate on behalf of clients with other service providers • Empower clients to use independent living strategies • Help clients resolve barriers to completing referrals, accessing or adhering to services • Follow up on ISP goals • Maintain client contact at minimum one time per year, as needed, or based on DHSP contract requirements. • Follow up missed appointments by the end of the next business day	• Barriers to referrals and interventions/actions taken • Time spent • Case manager's signature and title

ACKNOWLEGEMENTS

The Los Angeles County Commission on HIV would like to thank the following people for their contributions to the development of the Universal Standards of Care.

Standards & Best Practices Committee Members

Kevin Stalter Co-Chair
Erika Davies Co-Chair
Amiya Wilson
David Lee, MSW, LCSW, MPH
Felipe Gonzalez
Joshua Ray
Justin Valero, MA
Katja Nelson, MPP
Miguel Alvarez
Thomas Green
Wendy Garland, MPH

Content Reviewers

[add names]

APPENDIX A

Case Management Models

Referral (Brokerage) Case Management
This is the first formally articulated approach to case management. Focuses on assessing needs, referring to services, and coordinating and monitoring on-going treatment. The case manager coordinates services provided by a variety of agencies and professionals. Similar to Linkage Case Management, a previously funded contract by DHSP, where the case management is short-term and primarily focused on linking clients to primary HIV medical care.

Strengths-based Case Management
Developed in response to concerns that services and systems focus mainly on limitations and impairments vs. strengths and capabilities, this model focuses on individual strengths, the helping relationship as essential, contact in the community, and a focus on growth, change and consumer choice. Case managers provide direct services.

Intensive Case Management
Developed to meet the needs of high service users, focuses on low staff to client ratios, outreach, services brought to the client, and practical assistance in a variety of areas. May include outreach and counseling services, including skill-building, family consultations and crisis intervention. Caseloads are not normally shared.

Retrieved from https://www.homelesshub.ca/resource/step-step-comprehensive-approach-case-management

10. STANDING COMMITTEE REPORTS (cont'd):

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

(1) Ryan White Program (RWP) Years 31-32 Planning Update

Ryan White Program Clients Living with HIV YR28 (03/01/2018 - 02/28/2019), Los Angeles, California

Overlap across Ryan White Priority Populations in Year 28[a] (N = 15,747)

Count *% of row population*	Youth Aged 18-29	MSM of Color[b]	Women	Transgender Persons[c]	50 Years and Older	African Americans	PWID	Homeless	Recent Incarceration
Youth Aged 18-29	*2,022*	1,387 68.6%	159 7.9%	56 2.8%	-	580 28.7%	62 3.1%	29 1.4%	252 12.5%
MSM of Color[b]	1,387 16.0%	*8,656*	18 0.2%[d]	286 3.3%	2,706 31.3%	2,093 24.2%	235 2.7%	761 8.8%	715 8.3%
Women	159 8.9%	18 1.0%[d]	*1,792*	-	828 46.2%	585 32.6%	64 3.6%	156 8.7%	105 5.9%
Transgender Persons[c]	56 16.3%	286 83.4%	-	*343*	98 28.6%	96 28.0%	15 4.4%	77 22.4%	68 19.8%
50 Years and Older	-	2,706 43.7%	828 13.4%	98 1.6%	*6,191*	1,320 21.3%	382 6.2%	405 6.5%	390 6.3%
African Americans	580 17.3%	2,093 62.3%	585 17.4%	96 2.9%	1,320 39.3%	*3,360*	142 4.2%	542 16.1%	566 16.9%
PWID	62 8.4%	235 31.9%	64 8.7%	15 2.0%	382 51.9%	142 19.3%	*736*	145 19.7%	199 27.0%
Homeless	291 19.3%	761 50.5%	156 10.4%	77 5.1%	405 26.9%	542 36.0%	145 9.6%	*1,506*	423 28.1%
Recent Incarceration	252 17.4%	715 49.3%	105 7.2%	68 4.7%	390 26.9%	566 39.0%	199 13.7%	423 29.2%	*1,451*

[a] *Limited to membership in two priority populations; a client could be in more than two priority populations as population defintions are not mutually exclusive*

[b] *MSM defined as PLWH who were male sex at birth and who have sex with men as primary risk category*

[c] *Includes 338 transgender women, 4 transgender men and 1 other gender*

[d] *MSM of color reported includes all genders if MSM is the mode of transmission and race/ethnicity is not White*

Estimated HIV Care Continuum Outcomes across Priority Populations (N = 15,747)

	Engaged in Care[e]		Retained in Care[f]		Virally Suppressed[g]	
Youth Aged 18-29	1,911	94.5%	1,431	70.8%	1,507	74.5%
MSM of Color[b]	8,293	95.8%	6,917	79.9%	7,078	81.8%
Women	1,736	96.9%	1,507	84.1%	1,522	84.9%
Transgender Persons[c]	335	97.7%	273	79.6%	251	73.2%
50 Years and Older	5,913	95.5%	5,185	83.8%	5,285	85.4%
African Americans	3,161	94.1%	2,511	74.7%	2,512	74.8%
PWID	695	94.4%	561	76.2%	559	76.0%
Homeless	1,419	94.2%	1,096	72.8%	1,014	67.3%
Recent Incarceration	1,380	95.1%	1,087	74.9%	980	67.5%
Total Clients	15,011	95.3%	12,462	79.1%	12,854	81.6%

[e] *Engagement in Care defined as 1 ≥ viral load, CD4 or genotype test reported in the 12 month period based on HIV laboratory data as of 04/20/2019*

[f] *Retention in care defined as 2 ≥ viral load, CD4 or genotype test reported >30 days apart in the 12 month period based on HIV laboratory data as of 04/20/2019*

Data Source: HIV CaseWatch data as of 04/02/2019
Excludes Ryan White services not recorded in HIV CaseWatch
Subpopulations are not mutually exclusive

Ryan White Program Clients Living with HIV YR28 (03/01/2018 - 02/28/2019), Los Angeles, California

[g] Viral suppression defined as most recent viral load test <200 copies/mL in the 12 month period based on HIV laboratory data as of 04/20/2019

Data Source: HIV CaseWatch data as of 04/02/2019
Excludes Ryan White services not recorded in HIV CaseWatch
Subpopulations are not mutually exclusive

Priority Populations Among HIV-Positive Ryan White Program Clients
YR28 (03/01/2018 - 02/28/2019), Los Angeles, California

Overlap in Priority Population Membership[a]

Count *% of row population*	Youth 29 and Younger	MSM of Color	Women	Transgender Persons	50 Years and Older	African Americans
Youth 29 and Younger	*2,022*	1,387 68.6%	159 7.9%	56 2.8%	-	580 28.7%
MSM of Color[b]	1,387 16.0%	*8,656*	18 0.2%	286 3.3%	2,706 31.3%	2,093 24.2%
Women	159 8.8%	18 1.0%	*1,792*	-	828 46.2%	585 32.7%
Transgender Persons	56 16.3%	286 83.4%	-	*343*	98 28.6%	96 28.0%
50 Years and Older	-	2,706 43.7%	828 13.4%	98 1.6%	*6,191*	1,320 21.3%
African Americans	580 17.3%	2,093 62.3%	585 17.4%	96 2.9%	1,320 39.3%	*3,360*

Service Utilization

Service Category	Youth 29 and Under	MSM of color	Women	Transgender Persons	50 Years and Older	African Americans	Total RW Clients
Total Unduplicated Clients[c]	*2,022*	*8,656*	*1,792*	*343*	*6,191*	*3,360*	*15,747*
Home-Based Case Management	-	**58**	**31**	**1**	**134**	**23**	**162**
Housing Services	**16**	**54**	**37**	**4**	**74**	**39**	**132**
Residential Care Facilities for the Chronically Ill	*13*	*25*	*37*	*2*	*59*	*28*	*97*
Transitional Residential Care Facilities	*3*	*29*	-	*2*	*16*	*11*	*36*
Medical Case Management (Medical Care Coordination)	**1,274**	**4,146**	**700**	**200**	**2,312**	**1,802**	**7,326**
Medical Nutritional Therapy	**2**	**12**	**10**	-	**16**	**17**	**32**
Medical Outpatient	**681**	**3,733**	**700**	**117**	**1,751**	**528**	**5,930**
Mental Health Services	**43**	**212**	**24**	**12**	**91**	**10**	**289**
Non-Medical Case Management	**507**	**1,950**	**341**	**75**	**1,308**	**763**	**3,471**
Benefits Specialty	*244*	*1,558*	*273*	*51*	*1,130*	*364*	*2,610*
Transitional CM Incarcerated	*183*	*338*	*61*	*25*	*190*	*408*	*809*
Transitional CM Youth	*111*	*93*	*10*	*1*	-	*2*	*115*
Nutrition Support	**51**	**884**	**271**	**42**	**1,246**	**558**	**1,794**
Delivered Meals	4	219	69	13	377	161	476
Food Bank	48	736	233	32	1,000	458	1,472
Oral Health Care	**211**	**2,183**	**519**	**76**	**2,139**	**612**	**4,079**
Outreach Services[d]	**36**	**53**	**25**	**8**	**19**	**39**	**112**
Substance Abuse - Outpatient	**1**	**4**	-	-	-	**1**	**5**
Substance Abuse - Residential	**18**	**66**	**4**	**5**	**38**	**44**	**140**

Data Source: HIV CaseWatch data as of 04/02/2019

[a] *Limited to membership in two priority populations; a client could be in more than two populations*

[b] *MSM categorization is heavily based on transmission mode and allows genders other than male.*

[c] *The sum of clients served for all categories exceeds total number of RWP clients as clients may receive more than one service*

Priority Populations Among HIV-Positive Ryan White Program Clients
YR28 (03/01/2018 - 02/28/2019), Los Angeles, California

[d] *Restricted to records in HIV CaseWatch (excludes clients who were not able to be contacted).*

10. STANDING COMMITTEE REPORTS:

D. Public Policy (PP) Committee

(1) County, State and Federal Legislation & Policy

(a) Ending the HIV Epidemic Update

(b) Public Charge Rule

LEGAL AID FOUNDATION OF LOS ANGELES
90 YEARS 1929-2019

HIV/ AIDS Perspective: The New Public Charge Rule

A new definition of public charge

Things immigration will now look at to determine whether you are a public charge:

- Age
- Health
- Family Status
- Assets, Resources and Financial Status
- Education and Skills

New Public Charge Rule, effective 10/15/19

- What *is* included now? (See LAFLA informational sheet)
- What *is not* included? (See LAFLA informational sheet)
- HIV/AIDS Programs –
  - The rule does not include Ryan White programs, the AIDS Drug Assistance Program (ADAP), HOPWA (Housing Opportunities for People with AIDS) or medical, dental or behavioral health services provided through community health centers. The use of state, local and tribal funded non-cash programs are also not included in the rule.

Additional Resources

- Please see LAFLA referral lists

CALIFORNIA
HIV / AIDS POLICY
RESEARCH CENTERS

Understanding Public Charge for People Living with or at Risk for HIV

The U.S. government recently proposed changes to its public charge rule. Because of these changes, you may be concerned that using public benefits, including HIV services, could put you or your family at risk for deportation or hurt your chances of getting legal status. This fact sheet is designed specifically to help people living with HIV and at risk for HIV to better understand the potential impact of the proposed changes.

The 5 most important things to know right now are...

1. **HIV treatment and prevention is vital.** Any disruption to your care may cause significant health problems. Before you make any decisions not to access HIV prevention or treatment services or discontinue services you currently receive, get help to understand how this rule may apply to you and how it may apply to the public benefits and services you may receive. *For more information on resources, see question 3.*

2. **Public charge may not apply to you!** If the rule does not apply to you, you do not need to worry about using public benefits and HIV services. *For more information, see questions 2 and 4.*

3. **The public benefits and services you use may not be included in the current nor the proposed rule.** This means you do not need to stop using these programs. *For more information, see questions 5 through 8.*

4. **Nothing has changed yet!** The proposed rule has not yet been implemented and even if it is implemented, it will not be retroactive, meaning the government will not consider any use of public benefits before the rule's implementation. This means you do not need to make any changes to how you access the public benefits and services in the proposed rule. *For more information, see question 9.*

5. **Federal and state laws protect the privacy of those who seek help from public programs.** Benefit agencies may only share information with other government agencies to administer their programs, with limited exceptions. If you are asked for information regarding your immigration status, follow 2 rules: (a) only provide information that is required; and (b) never misrepresent anything when completing public benefit applications or dealing with any government agency.

For more details about public charge, please see below:

<table>
<tr><td>1. What is public charge?</td><td colspan="2">Public charge is the language used by the government to describe someone who they think will become dependent on government assistance for their primary source of support to live in the U.S. Immigration officials apply a public charge rule to help decide whether to approve an application for a green card (i.e. legal permanent residence or LPR status) or when deciding who they will allow to enter into the U.S.</td></tr>
<tr><td rowspan="2">2. Does the public charge rule apply to me?</td><td colspan="2">The current public charge rule and the proposed changes to the rule makes clear that the rule applies only to some people. These categories remain the same.</td></tr>
<tr><td>Yes, the public charge rule may apply to you if you fall into one of categories below:
You are currently applying for your green card in the U.S.(but see exceptions)*
You currently have a green card but have been out of the country for more than 6 months
You are outside of the U.S. and trying to enter the U.S. lawfully</td><td>No, the public charge rule does not apply to you if you fall into one of the categories below:
You are a U.S. citizen
You have a green card (LPR status)
You have a green card and are applying for citizenship
You were granted Withholding of Removal, Convention Against Torture, or your case was administratively closed by the Department of Justice
You are applying for the following status: Refugee, Asylum, T Visa, U Visa, VAWA self-petitioner, SIJS (Special Immigrant Juvenile Status), renewal for DACA, TPS (Temporary Protected Status) and other special categories.
You are applying for your green card and currently have the following status: Refugee, Asylum, T Visa, U Visa, and VAWA</td></tr>
<tr><td>3. What if I don't know my current immigrant status?</td><td colspan="2">Knowing your current immigrant status is the first step to knowing if the public charge rule does or does not apply to you. If you have any questions about how to find out more information about your immigration status, contact an immigration attorney or Department of Justice-accredited representative. Click here or go to http://www.cdss.ca.gov/Benefits-Services/More-Services/Immigration-Services/Immigration-Services-Contractors to find a California state-funded resource near you.</td></tr>
</table>

*Exceptions: If you are applying for your green card and currently have the following status: Refugee, Asylum, T Visa, U Visa the public charge rule does not apply to you.

4. Does the public charge rule apply to me if I am currently undocumented?	If you are currently undocumented, the most important thing to do is to determine whether you have any opportunity to get legal status. You may be able to apply for asylum, a U visa, a green card through a family member, or some other kind of legal status. If there is no path for you to get any legal status, then you will not be evaluated for public charge at this time. If there is a path to legal status, then you will want to see if the public charge rule will be applied to you. *See question 2.*
5. What is the current public charge rule?	The current public charge rule includes consideration of a variety of factors and looks specifically for the applicant's use of the following public benefits programs: • Cash assistance (e.g. General Relief/Assistance, Supplemental Security Income (SSI), Temporary Assistance for Needy Families (CalWorks)) • Programs paying for institutionalization for long-term care (e.g. nursing home care or mental health institution)
6. What are the proposed changes to the public charge rule?	The proposed changes to the rule includes consideration of the applicant's use of the following public benefits in addition to the ones listed above: • Food stamps or Supplemental Nutrition Assistance Program (CalFresh) • Section 8 Project-Based Voucher and rental assistance, Section 8 Housing Choice Vouchers and other federally subsidized public housing • Non-Emergency Medicaid (Medi-Cal) • Medicare Part D Low-Income Subsidy Under both the current rule and the proposed rule, the individual applicant's use of public benefits is considered. Use of public benefits by family members (e.g. U.S. citizen children), even those benefits listed above, are and will not be considered to be use of a public benefit(s) by the applicant.
7. What about public services and benefits programs not listed above?	Based on the current rule and proposed rule, use of any public benefits and health services that are <u>not</u> included in questions 5 and 6 above are <u>not</u> considered. This means applicants that are evaluated for public charge do not have to worry about using any public benefits and services that are <u>not</u> listed above. For many people, this means that as long as you are not using federal Medicaid (Medi-Cal) programs, you do not have to worry about getting help with life-saving HIV medications or HIV treatment and prevention services (e.g. AIDS Drug Assistance Program (ADAP) or Ryan White CARE Act programs).

8. Are there any other differences between the current public charge test and the proposed changes?	Yes. There are other ways that the government is proposing to make the public charge rule harsher for some people. While each applicant under the proposed changes would be evaluated under the rule as an individual, the person's circumstances will be looked at carefully. They will look at a person's age, health, family status, financial assets and resources, education, and skills. Additionally, the proposed changes include weighing heavily certain factors such as income, as well as a person's ability to work, go to school or care for themselves. Being unable to do these things would be considered a negative factor.
9. Are the proposed changes to the public charge rule in effect?	No, not yet. The earliest possible date for the proposed changes to be implemented are ***after*** (1) the public has had a chance to comment on the proposed rule; (2) the government reviews the comments and responds to them; and (3) 60 days have passed after those two things have happened. Any benefits listed under Question 6 that you use before the rule is finalized and the 60 days have passed will not be considered for public charge. Check here or go to https://protectingimmigrantfamilies.org for updates on the proposed rule.

CALIFORNIA
HIV / AIDS POLICY
RESEARCH CENTERS

Entendiendo La Carga Publica
Para Personas que Viven con VIH y Para Quienes Están en Riesgo de Contraerlo

El gobierno de los Estados Unidos propuso recientemente cambios a su regla de carga pública. Debido a estos cambios, usted puede estar preocupado que el uso de beneficios públicos, incluyendo los servicios para el VIH, podría poner a usted o a su familia en riesgo de deportación o perjudicar sus posibilidades de obtener un estatus migratorio legal. Esta hoja informativa está diseñada específicamente para ayudar a las personas que viven con VIH, al igual que para quienes están en riesgo de contraer el VIH, a comprender mejor el impacto potencial de los cambios propuestos.

Las 5 cosas más importantes que usted debe saber en este momento son:

1. **El tratamiento y prevención del VIH es vital.** Cualquier interrupción en su cuidado puede causar problemas de salud significativos. Antes de tomar cualquier decisión de no acceder los servicios de prevención o tratamiento del VIH o suspender los servicios que recibe actualmente, obtenga ayuda para comprender cómo esta regla podría aplicarse a usted y los beneficios y servicios públicos que usted puede recibir. *Para obtener más información sobre los recursos, consulte la pregunta 3.*

2. **¡Es posible que la carga pública no se aplique a usted!** Si la regla no se aplica a usted, no se tiene que preocupar por el uso de los beneficios públicos y los servicios para el VIH. *Para más información, consulte las preguntas 2 y 4.*

3. **Los beneficios y servicios públicos que usted usa, puede ser que no estén incluidos en la regla actual ni en la propuesta.** Esto significa que usted no necesita dejar de usar estos programas. *Para más información, consulte las preguntas 5 a 8.*

4. **¡Nada ha cambiado todavía!** La regla propuesta aún no se ha implementado, e incluso si llegase a implementarse, no será retroactiva, lo cual significa que el gobierno no considerará ningún uso de los beneficios públicos antes de la implementación de la regla. Esto significa que usted no necesita realizar ningún cambio en cómo accede los beneficios y servicios públicos en la regla propuesta. *Para más información, consulte la pregunta 9.*

5. **Las leyes federales y estatales protegen la privacidad de aquellos que buscan ayuda de programas públicos.** Las agencias de beneficios solo pueden compartir información con otras agencias gubernamentales para administrar sus programas, con excepciones limitadas. Si se le solicita información sobre su estado de inmigración, siga las siguientes dos reglas: (a) Solo proporcione la información que se requiere; y (b) Nunca de información que no sea cierta al llenar solicitudes de beneficios públicos o al tratar con una agencia gubernamental.

Para más detalles sobre la carga pública, por favor lea lo siguiente:

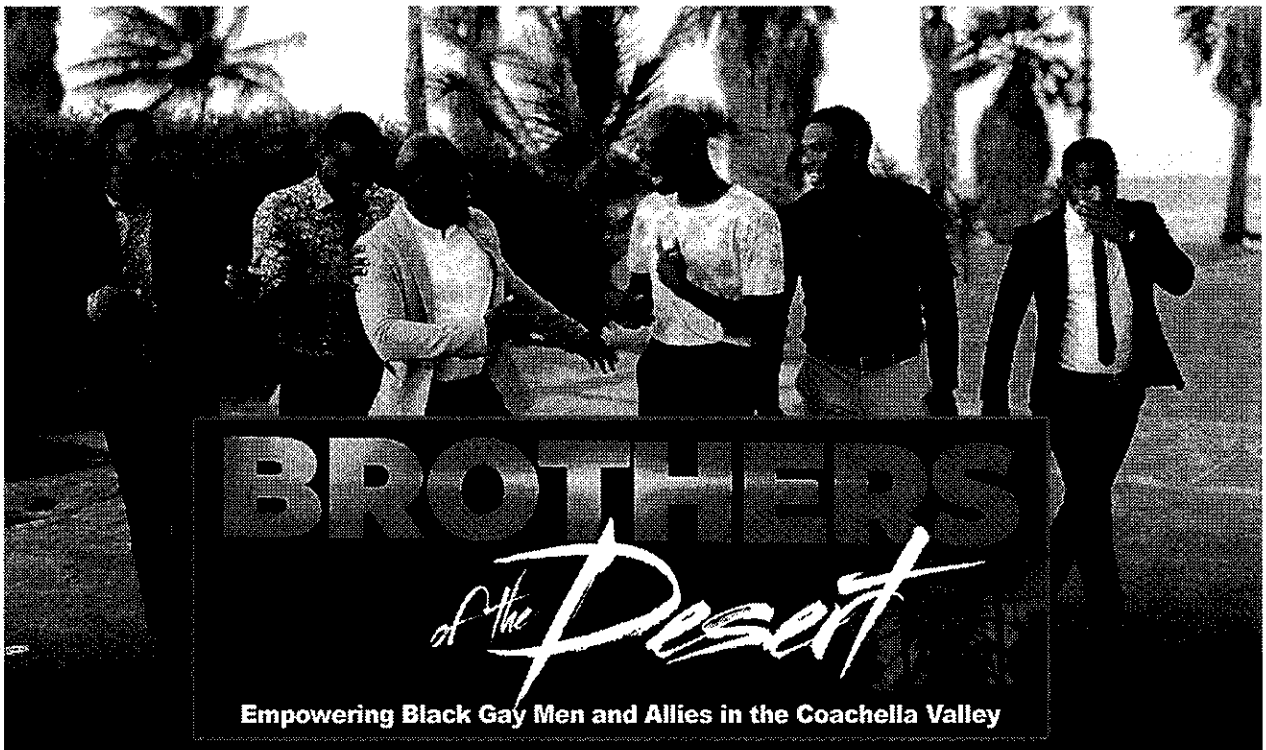
<table>
<tr><td>1. ¿Qué es la carga pública?</td><td colspan="2">Carga Pública es el lenguaje utilizado por el gobierno para describir a alguien que ellos creen que dependerá de la asistencia del gobierno como fuente principal de apoyo para vivir en los Estados Unidos. Los funcionarios de inmigración aplican una regla de carga pública para ayudar a decidir si aprueban una solicitud de tarjeta verde (es decir, residencia permanente legal o estado LPR, por sus siglas en inglés) e igualmente para decidir a quiénes le permitirán ingresar a los Estados Unidos.</td></tr>
<tr><td rowspan="2">2. ¿La regla de carga pública se aplica a mí?</td><td colspan="2">La regla actual de carga pública y los cambios propuestos a la regla dejan claro que la regla se aplica solamente a algunas personas. Estas categorías siguen siendo las mismas.</td></tr>
<tr><td>Sí, la regla de carga pública puede aplicarse a usted, si usted pertenece a una de las siguientes categorías:
Usted actualmente está solicitando su tarjeta verde en los Estados Unidos (favor, consulte las excepciones) *
Usted actualmente tiene una tarjeta verde pero ha estado fuera del país por más de 6 meses.
Usted actualmente está fuera de los Estados Unidos e intenta ingresar a este país legalmente.</td><td>No, la regla de carga pública no se aplica a usted si usted pertenece a una de las siguientes categorías:
Usted es ciudadano de los Estados Unidos.
Usted tiene una tarjeta verde (estado LPR).
Usted tiene una tarjeta verde y está solicitando la ciudadanía.
Se le otorgó Retención de Remoción, Convención contra la Tortura, o su caso fue cerrado administrativamente por el Departamento de Justicia.
Usted está solicitando uno de los siguientes estados: Refugiado, Asilo, Visa T, Visa U, auto-peticionario VAWA, SIJS (Estado de Inmigrante Especial para Jóvenes), renovación de DACA, TPS (Estado de Protección Temporal) y otras categorías especiales.
Usted está solicitando su tarjeta verde y actualmente tiene el siguiente estado: Refugiado, Asilo, Visa T, Visa U y/o VAWA.</td></tr>
</table>

*Excepciones: si está solicitando su tarjeta verde y actualmente tiene el siguiente estatus legal estado: Refugiado, Asilo, Visa T, Visa U, la regla de carga pública no se aplica a usted.

3. ¿Qué pasa si no sé cuál es mi estado actual de inmigrante?	Conocer su estado actual de inmigrante es el primer paso para saber si la regla de carga pública se aplica a usted o no. Si tiene alguna pregunta sobre cómo obtener más información sobre su estado migratorio, comuníquese con un abogado de inmigración o un representante acreditado por el Departamento de Justicia. Para encontrar un recurso financiado por el estado de California cerca de usted, por favor visite el siguiente enlace: http://www.cdss.ca.gov/Benefits-Services/More-Services/Immigration-Services/Immigration-Services-Contractors.
4. ¿La regla de carga pública se aplica a mí si actualmente estoy indocumentado?	Si está indocumentado actualmente, lo más importante es determinar si tiene alguna oportunidad de obtener un estatus migratorio legal. Es posible que pueda solicitar Asilo, Visa U, tarjeta verde a través de un miembro de la familia, o algún otro tipo de estatus legal. Si no hay un camino para que usted obtenga un estatus legal, entonces usted no será evaluado para carga pública en este momento. Si existe un camino hacia el estatus legal, entonces usted posiblemente será evaluado para carga pública. *Consulte la pregunta 2.*
5. ¿Cuál es la regla de carga pública actual?	La regla actual de Carga Pública incluye la consideración de una variedad de factores y busca específicamente el uso del solicitante en los siguientes programas de beneficios públicos: • Asistencia en efectivo (por ejemplo, asistencia / asistencia general, Seguridad de Ingreso Suplementario (SSI, por sus siglas en inglés), asistencia temporal para familias necesitadas (CalWorks, por sus siglas en inglés) • Programas que pagan por la institucionalización de la atención a largo plazo (por ejemplo, atención en un hogar de ancianos o institución de salud mental)
6. ¿Cuáles son los cambios propuestos a la regla de carga pública?	Los cambios propuestos a la regla incluyen el uso del solicitante en los siguientes programas de beneficios públicos, además de los enumerados anteriormente: • Cupones para alimentos o Programa de asistencia nutricional suplementaria (CalFresh, por sus siglas en inglés) • Los cupones basados en proyectos de la Sección 8 y la asistencia para el alquiler, los cupones de elección de vivienda de la Sección 8 y otras viviendas públicas con subsidio federal • Medicaid que no sea de emergencia (Medi-Cal) • Subsidio de bajos ingresos de Medicare Parte D Bajo la regla actual y la regla propuesta, se consideraría el uso individual del solicitante de los beneficios públicos. El uso de beneficios públicos por parte de miembros de la familia (por ejemplo, niños ciudadanos de los EE. UU.), incluso los beneficios mencionados anteriormente, no son y no serán considerados como uso de un beneficio público por el solicitante.

7. ¿Qué pasa con los servicios públicos y los programas de beneficios que no se mencionan arriba?	Con base en la regla actual y la regla propuesta, el uso de cualquier beneficio público y servicio de salud que no esté incluido en las preguntas 5 y 6 anteriores no será considerado. Esto significa que los solicitantes que son evaluados para carga pública no tienen que preocuparse por el uso de los beneficios y servicios públicos que no se mencionan anteriormente. Para muchas personas, esto significa que mientras no esté utilizando los programas federales de Medicaid (Medi-Cal), no tiene que preocuparse por obtener ayuda con medicamentos contra el VIH que salvan vidas o servicios de prevención y tratamiento del VIH (por ejemplo, Programa de Asistencia de Medicamentos para el SIDA (ADAP, por sus siglas en inglés) o programas del Ryan White CARE Act).
8. ¿Hay alguna otra diferencia entre la prueba de cargo público actual y los cambios propuestos?	Sí. Existen otras formas en que el gobierno está proponiendo hacer que la regla de carga pública sea más severa para algunas personas. Aunque cada solicitante bajo los cambios propuestos sería evaluado según la regla como un individuo, las circunstancias de la persona se analizarían cuidadosamente. Observarían la edad, la salud, el estado familiar, los activos y recursos financieros, la educación y las habilidades de la persona. Además, los cambios propuestos incluyen evaluar y contar ciertos factores como los ingresos, la capacidad de la persona para trabajar, ir a la escuela o cuidar de sí mismo. No poder hacer estas cosas sería considerado un factor negativo.
9. ¿Están en vigor los cambios propuestos a la regla de carga pública?	No aún no. La fecha más temprana posible para la implementación de los cambios propuestos es después de que ha pasado lo siguiente: 1) Que el público haya tenido la oportunidad de comentar sobre la regla propuesta; (2) Que el gobierno revise los comentarios y responda a ellos; y 3) Que hayan pasado 60 días después de que los dos puntos anteriores hayan sucedido. Todos los beneficios enumerados en la pregunta 6 que usted use antes de que la regla entre en vigor y que hayan transcurrido los 60 días, no se considerarán carga pública. Visite este enlace o consulte https://protectingimmigrantfamilies.org para obtener actualizaciones sobre la regla propuesta.

16. ANNOUNCEMENTS



BROTHERS of the Desert

Empowering Black Gay Men and Allies in the Coachella Valley

Living Your Best Black Gay Life

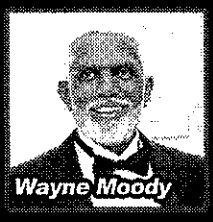
Saturday, November 9, 2019 (10am-4pm)

The LGBTQ Community Center of the Desert

1301 N Palm Canyon Drive, Palm Springs 92262

For more information contact us at: **info@brothersofthedesert.org**

Registration is required visit: **http://brothersofthedesertbestlife.eventbrite.com**



A day to focus on building a stronger, aware
and just community for Black Gay Men and Allies.

Health | Spirituality | Mindfulness | Communication | Intimacy | Finance

Announcement **September 30, 2019**

Palm Springs, CA – A one-day wellness summit focusing on Black gay men in the Coachella Valley and beyond will be held on Saturday, November 9, at the LGBTQ Center in Palm Springs, 1301 N Palm Canyon Drive.

The event features innovative workshops, interactive discussions and entertaining presentations on a diverse range of topics, such as relationships and intimacy, spirituality, the impact of racism, sexual pleasure, creative expression, financial planning, building community, health care and more.

"Living Your Best Black Gay Life" is the theme of the summit, which is designed to connect Black gay men and promote a better quality of life across the social-cultural-economic spectrum. The event is sponsored by Brothers of the Desert (BOD), a Black gay men's empowerment group dedicated to philanthropy, volunteerism, mentorship, education, advocacy and social networking.

"The summit is designed for Black gay men but is not limited to Black gay men only." said Tim Vincent, acting co-chair for BOD. "Allies of the Black gay community are welcome to attend and support the cause as we marshal resources to change the dynamics that produce isolation, disconnection and inequities among Black gay men in the Coachella Valley."

The day-long summit begins with breakfast and registration from 8:00 a.m. to 10 a.m., workshops and discussions will take place between 10 a.m. and 4 p.m., and a post summit social event will occur between 5 p.m. and 7 p.m. Lunch is also provided.

Ron Oden, former mayor of Palm Springs and Bryan Gallo from NBC Palm Springs will lead off the event and presenters include, Dr. Leo Moore, Perry Lang, Gamal Palmer, Christopher Burton, Robert Ficklin, Wayne Moody, Michael Everett and Aunsha Hall.

Space is limited, and registration is required. A donation of $20 is suggested but no one will be turned away for a lack of funds.

To register go to: http://brothersofthedesertbestlife.eventbrite.com
For more information contact: Tim Vincent at info@brothersofthedesert.org

The LA County Commission on HIV is pleased to announce HIV Connect, an online tool for community members and providers looking for resources on HIV and STD testing, prevention and care, service locations, and housing throughout LA County.