LOS ANGELES COUNTY
COMMISSION ON HIV

Visit us online: http://hiv.lacounty.gov
Get in touch: hivcomm@lachiv.org
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COMMISSION ON HIV
Virtual Meeting
Thursday, February 11, 2021
9:00AM -12:30PM (PST)

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

REGISTER + JOIN VIA WEBEX ON YOUR COMPUTER OR SMART PHONE:

https://tinyurl.com/362zvltl

**link is for members of the public only*

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1-415-655-0001 US Toll Access Code: 145 214 4512

For a brief tutorial on how to use WebEx, please check out this video: https://www.youtube.com/watch?v=iQSSJYcrgIk

PUBLIC COMMENTS

Public Comments will open at the time referenced on the meeting agenda. For those who wish to provide live public comment, you may do so by joining the WebEx meeting through your computer or smartphone and typing PUBLIC COMMENT in the Chat box. For those calling into the meeting via telephone, you will not be able to provide live public comment. However, you may provide written public comments or materials by email to hivcomm@lachiv.org. Please include the agenda item and meeting date in your correspondence. All correspondence and materials received shall become part of the official record.

LIKE WHAT WE DO?

Apply to become a Commissioner at **http://tinyurl.com/HIVCommApplication**

LOS ANGELES COUNTY
COMMISSION ON HIV

REVISED AGENDA FOR THE **VIRTUAL** MEETING OF THE

LOS ANGELES COUNTY COMMISSION ON HIV (COH)

MAIN (213) 738-2816 / FAX (213) 637-4748
EMAIL: hivcomm@lachiv.org WEBSITE: http://hiv.lacounty.gov

Thursday, February 11, 2021 | 9:00 AM – 12:30 PM

To Register/Join by Computer: https://tinyurl.com/362zvltl
**link is for members of the public*
To Join by Telephone: 1-415-655-0001 Access code: 145 214 4512

AGENDA POSTED: February 5, 2021 (Revisions posted February 8, 2021)

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 the Commission office at hivcomm@lachiv.org or leave a voicemail at 213.738.2816.

Los servicios de interpretación para personas con problemas de audición y los servicios de traducción para otros idiomas además del inglés están disponibles sin cargo con al menos 72 horas de anticipación antes de la fecha de la reunión. Para coordinar estos servicios, comuníquese con la oficina de la Comisión en hivcomm@lachiv.org o deje un mensaje de voz al 213.738.2816.

SUPPORTING DOCUMENTATION can be obtained at the Commission on HIV Website at: http://hiv.lacounty.gov. Currently all County buildings are closed to the public due to the COVID-19 public emergency until further notice. To request information, please contact the Commission office via email at hivcomm@lachiv.org or by leaving a voicemail at 213.738.2816.

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 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 AM – 9:03 AM

1. ADMINISTRATIVE MATTERS

A. Approval of Agenda **MOTION #1** 9:03 AM – 9:05 A M

B. Approval of Meeting Minutes **MOTION #2** 9:05 AM – 9:07 AM

2. WELCOME, INTRODUCTIONS AND VIRTUAL MEETING GUIDELINES 9:07 AM – 9:10 AM

3. REPORTS - I

A. Executive Director/Staff Report 9:10 AM – 9:20 AM

(1) Celebration of Service + Retirement | Jane Nachazel-Ruck
(2) County/COH Operational Updates
(3) 2020 COH Annual Report
(4) 2021 COH Work Plan and Activities

B. Co-Chair Report 9:20 AM – 9:30 AM

(1) Meeting Management Reminders
(2) National Black HIV/AIDS Awareness Day (NBHAAD) Recognition
  (a) Black African American Community (BAAC) Task Force Social Media Tool Kit Launch
  (b) Prevention through Active Community Engagement Program (PACE) Region 9 Virtual Panel Discussion
(3) Executive At-Large Member Open Nominations | ONGOING

4. PRESENTATION

A. HealthHIV Technical Assistance in Assessing Planning Council Effectiveness Project Kick-Off 9:30 AM – 10:00 AM

B. Los Angeles County Human Relations Commission Partnership and Strategy Development to Address Conflicts around Diversity, Race and the Other "Isms" 10:00 AM – 10:30 AM

5. REPORTS - II

A. California Office of AIDS (OA) Report 10:30 AM – 10:35 AM

(1) California HIV Planning Group (CPG) Update

B. LA County Department of Public Health Report 10:35 AM – 11:15 A M

(1) Division of HIV/STD Programs (DHSP) Updates
  (a) Programmatic and Fiscal Updates
    (i) Emergency Financial Assistance (EFA)
  (b) Ending the HIV Epidemic (EHE) Activities & Updates
  (c) Clinical Quality Management (CQM) Report

5. REPORTS – II (cont'd)

C. Housing Opportunities for People Living with AIDS (HOPWA) Report 11:15 AM – 11:20 AM

D. Ryan White Program Parts C, D, and F Report 11:20 AM – 11:25 AM

E. Cities, Health Districts, Service Planning Area (SPA) Reports 11:25 AM – 11:30 AM

6. REPORTS - III

A. Standing Committee Reports 11:30 AM – 12:15 PM

(1) Executive Committee

(a) "So You Want to Talk About Race" by Ijeoma Oluo Book Reading **MOTION #3**

(2) Operations Committee

(a) Membership Management

(i) New Member Applications

- Felipe Findley **MOTION #4**
- Gerald Garth **MOTION #5**
- Isabella Rodriguez **MOTION #6**
- Reba Stevens **MOTION #7**

(b) Attendance Review

(c) Membership Application Redevelopment | UPDATE

(d) Mentorship Program | REMINDER + UPDATE

(e) Engagement + Retention Strategies

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

(a) 2021 Paradigms and Operating Values **MOTION #8**

(b) Prevention Planning Work Group | UPDATES

(4) Standards and Best Practices (SBP) Committee

(a) (Updated) Universal Standards of Care **MOTION #9**

(b) Child Care Services Standards of Care | UPDATE

(5) Public Policy Committee

(a) County, State, and Federal Legislation & Policy

(b) County, State, and Federal Budget

B. Caucus, Task Force and Work Group Report 12:15 PM – 12:20 PM

(1) Aging Task Force | March 2, 2021 @ 1-3pm

(2) Black African American Community (BAAC) Task Force | February 22, 2021 @ 1-3pm

(a) Social Media Tool Kit Launch

(3) Consumer Caucus | February 11, 2021 (following COH meeting)

(4) Women's Caucus | February 23, 2021 @ 2-4pm **rescheduled date reflected*

(5) Transgender Caucus | February 23, 2021 @ 10am-12pm

7. MISCELLANEOUS

A. Public Comment 12:20 PM – 12:25 PM

Opportunity for members of the public to address the Commission of items of interest that are within the jurisdiction of the Commission. For those who wish to provide live public comment, you must register and join WebEx through your computer or smartphone. For those calling into the meeting via telephone, you will not be able to provide live public comment. However, you may provide written public comments or materials by email to hivcomm@lachiv.org.

7. MISCELLANEOUS (cont'd)

B. Commission New Business Items 12:25 PM – 12:27 PM

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.

C. Announcements 12:27 PM – 12:30 PM

Opportunity for members of the public to announce community events, workshops, trainings, and other related activities. Announcements will follow the same protocols as Public Comment.

Adjournment and Roll Call 12:30 PM

Adjournment for the meeting of February 11, 2021 in memory of Allen Freehling, founding chair of the Commission on AIDS, and all those who continue to be impacted by COVID.

PROPOSED MOTION(S)/ACTION(S)	
MOTION #1:	Approve the Agenda order, as presented or revised.
MOTION #2:	Approve the Minutes, as presented or revised.
MOTION #3:	Approve Commission and Committee Standing Reading Assignment of "So You Want to Talk About Race" by Ijeoma Oluo, as presented or revised.
MOTION #4:	Approve New Member Application for Felipe Findley and elevate to the Board of Supervisors for appointment, as presented or revised.
MOTION #5:	Approve New Member Application for Gerald Garth and elevate to the Board of Supervisors for appointment, as presented or revised.
MOTION #6:	Approve New Member Application for Isabella Rodriguez and elevate to the Board of Supervisors for appointment, as presented or revised.
MOTION #7:	Approve New Member Application for Reba Stevens and elevate to the Board of Supervisors for appointment, as presented or revised.
MOTION #8:	Approve Planning, Priorities & Allocations (PP&A) Committee 2021 Paradigms and Operating Values, as presented or revised.
MOTION #9:	Approve Standards and Best Practices (SBP) Committee updated Universal Standards of Care, as presented or revised.

COMMISSION ON HIV MEMBERS:			
Bridget Gordon, Co-Chair	David P. Lee, MPH, LCSW Co-Chair	Miguel Alvarez (*Alternate)	Alexander Luckie Fuller
Everardo Alvizo, MSW	Al Ballesteros, MBA	Danielle Campbell, MPH	Raquel Cataldo
Pamela Coffey (Alasdair Burton, **Alternate)	Michele Daniels	Erika Davies	Kevin Donnelly
Jerry D. Gates, PhD	Grissel Granados, MSW	Joseph Green	Felipe Gonzalez
Damontae Hack (*Alternate)	Karl Halfman, MA	Diamante Johnson (Kayla Walker-Heltzel, **Alternate)	Thomas Green (*Alternate)
Nestor Kamurigi (*Alternate)	William King, MD, JD, AAHIVS	Lee Kochems, MA	Anthony Mills, MD
Carlos Moreno	Derek Murray	Paul Nash, CPsychol, AFBPsS FHEA	Katja Nelson, MPP
Frankie Darling-Palacios	Mario J. Pérez, MPH	Juan Preciado	Joshua Ray (Eduardo Martinez, **Alternate)
Ricky Rosales	Harold San Agustin, MD	Martin Sattah, MD	Tony Spears (*Alternate)
LaShonda Spencer, MD	Kevin Stalter	Maribel Ulloa	Guadalupe Velazquez
Justin Valero	Ernest Walker	Amiya Wilson	
MEMBERS:	**43**		
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) 637-4748
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).

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CODE OF CONDUCT

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

All participants and stakeholders should adhere to the following:

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

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

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TO END HIV, WE MUST END RACISM

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

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

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

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

In Solidarity,

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

#EndBlackHIV #KnowYourStatus #EndingtheEpidemic #VOTE

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

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2021 COMMISSION ON HIV MEETING SCHEDULE

To comply with the County of Los Angeles and State of California directives and orders due to the COVID-19 public health pandemic, beginning June 1, 2020 until further notice, all full body, standing and subordinate working unit meetings will be held virtually.

Meeting dates/times are subject to change. For meeting notifications, please subscribe to the Commission's email list at https://tinyurl.com/y83ynuzt or contact Commission's office at hivcomm@lachiv.org or 213.738.2816 for updates.

All Committee and Commission meetings are open to the public and are held virtually via the WebEx platform. For a brief tutorial on how to join a WebEx meeting/event, check out: https://help.webex.com/en-us/nrbgeodb/Join-a-Webex-Meeting

Commission on HIV (COH)	2nd Thursday of Each Month	9:00 AM	-	1:00 PM
Executive Committee	4th Thursday of Each Month	1:00 PM	-	3:00 PM
Operations Committee	4th Thursday of Each Month	10:00 AM	-	12:00 PM
Planning, Priorities & Allocations (PP&A) Committee	3rd Tuesday of Each Month	1:00 PM	-	3:00 PM
Public Policy Committee (PPC)	1st Monday of Each Month	1:00 PM	-	3:00 PM
Standards and Best Practices (SBP) Committee	1st Tuesday of Each Month	10:00 AM	-	12:00 PM
Consumer Caucus	2nd Thursday of Each Month	Following COH Meeting		
Transgender Caucus	4th Tuesday of Each Month	10:00 AM	-	12:00 PM
Women's Caucus	3rd Monday of Each Month	2:00 PM	-	4:00 PM
Aging Task Force (ATF)	1st Tuesday of Each Month	1:00 PM	-	3:00 PM
Black African American Community (BAAC) Task Force	4th Monday of Each Month	1:00 PM	-	3:00 PM

The Commission office continues to remain closed to the public until further notice in compliance with stay at home orders and social distancing requirements. For inquiries, you may contact the Commission office at hivcomm@lachiv.org or 213.738.2816.

LOS ANGELES COUNTY COMMISSION ON HIV

2021 MEMBERSHIP ROSTER| UPDATED 02.08.21

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	EXC|SBP	Erika Davies	City of Pasadena Department of Public Health	July 1, 2018	June 30, 2022	
3	City of Long Beach representative	1	PP&A	Everardo Alvizo	Long Beach Health & 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, 2022	
5	City of West Hollywood representative	1	PP&A	Derek Murray	City of West Hollywood	July 1, 2019	June 30, 2021	
6	Director, DHSP	1	EXC|PP&A	Mario Pérez, MPH	DHSP, LA County Department of Public Health	July 1, 2018	June 30, 2022	
7	Part B representative	1	PP&A	Karl Halfman, MA	California Department of Public Health, Office of AIDS	July 1, 2018	June 30, 2022	
8	Part C representative		PP&A|EXC	Frankie Darling Palacios	Los Angeles LGBT Center	July 1, 2018	June 30, 2022	
9	Part D representative	1		***Vacant***		July 1, 2019	June 30, 2021	
10	Part F representative	1	PP	Jerry D. Gates, PhD	Keck School of Medicine of USC	July 1, 2018	June 30, 2022	
11	Provider representative #1	1	EXC|OPS	Carlos Moreno	Children's Hospital Los Angeles	July 1, 2019	June 30, 2021	
12	Provider representative #2	1	EXC	David Lee, MPH, LCSW	Charles Drew University	July 1, 2018	June 30, 2022	
13	Provider representative #3	1	SBP	Harold Glenn San Agustin, MD	JWCH Institute, Inc.	July 1, 2019	June 30, 2021	
14	Provider representative #4	1	PP&A	LaShonda Spencer, MD	Charles Drew University	July 1, 2018	June 30, 2022	
15	Provider representative #5			***Vacant***		July 1, 2019	June 30, 2021	
16	Provider representative #6	1	PP&A	Anthony Mills, MD	Men's Health Foundation	July 1, 2018	June 30, 2022	
17	Provider representative #7	1	PP&A	Alexander Luckie Fuller	Los Angeles LGBT Center	July 1, 2019	June 30, 2021	
18	Provider representative #8	1	PP	Martin Sattah, MD	Rand Shrader Clinic, LA County Department of Health Services	July 1, 2018	June 30, 2022	
19	Unaffiliated consumer, SPA 1	1	EXC|OPS	Michele Daniels	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	
20	Unaffiliated consumer, SPA 2			***Vacant***		July 1, 2018	June 30, 2022	
21	Unaffiliated consumer, SPA 3			***Vacant***		July 1, 2019	June 30, 2021	
22	Unaffiliated consumer, SPA 4	1	EXC|SBP	Kevin Stalter	*Unaffiliated Consumer*	July 1, 2018	June 30, 2022	
23	Unaffiliated consumer, SPA 5			***Vacant***		July 1, 2019	June 30, 2021	Damontae Hack
24	Unaffiliated consumer, SPA 6	1	SBP	Pamela Coffey	*Unaffiliated Consumer*	July 1, 2018	June 30, 2022	Alasdair Burton (PP)
25	Unaffiliated consumer, SPA 7			***Vacant***		July 1, 2019	June 30, 2021	Thomas Green (SBP)
26	Unaffiliated consumer, SPA 8	1	PP&A	Kevin Donnelly	*Unaffiliated Consumer*	July 1, 2018	June 30, 2022	
27	Unaffiliated consumer, Supervisorial District 1			***Vacant***		July 1, 2019	June 30, 2021	
28	Unaffiliated consumer, Supervisorial District 2			***Vacant***		July 1, 2018	June 30, 2022	Nestor Kamurigi (PP)
29	Unaffiliated consumer, Supervisorial District 3	1	SBP	Joshua Ray	*Unaffilated Consumer*	July 1, 2019	June 30, 2021	Eduardo Martinez (SBP/PP)
30	Unaffiliated consumer, Supervisorial District 4			***Vacant***		July 1, 2018	June 30, 2022	
31	Unaffiliated consumer, Supervisorial District 5	1	PP&A	Diamante Johnson	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	Kayla Walker-Heltzel (PP&A/OPS)
32	Unaffiliated consumer, at-large #1	1	PP&A	Guadalupe Velazquez	*Unaffiliated Consumer*	July 1, 2018	June 30, 2022	Tony Spears
33	Unaffiliated consumer, at-large #2	1	OPS|PP&A	Joseph Green	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	
34	Unaffiliated consumer, at-large #3	1	PP&A	Felipe Gonzalez	*Unaffiliated Consumer*	July 1, 2018	June 30, 2022	
35	Unaffiliated consumer, at-large #4	1	EXC	Bridget Gordon	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	
36	Representative, Board Office 1	1	PP&A	Al Ballesteros, MBA	JWCH Institute, Inc.	July 1, 2018	June 30, 2022	
37	Representative, Board Office 2	1	OPS	Danielle Campbell, MPH	UCLA/MLKCH	July 1, 2019	June 30, 2021	
38	Representative, Board Office 3	1	EXC|PP|SBP	Katja Nelson, MPP	APLA	July 1, 2018	June 30, 2022	
39	Representative, Board Office 4	1	EXC|OPS|SBP	Justin Valero, MA	California State University, San Bernardino	July 1, 2019	June 30, 2021	
40	Representative, Board Office 5	1	PP&A|EXC	Raquel Cataldo	Tarzana Treatment Center	July 1, 2018	June 30, 2022	
41	Representative, HOPWA	1	PP&A	Maribel Ulloa	City of Los Angeles, HOPWA	July 1, 2019	June 30, 2021	
42	Behavioral/social scientist	1	EXC|PP	Lee Kochems	*Unaffiliated Consumer*	July 1, 2018	June 30, 2022	
43	Local health/hospital planning agency representative			***Vacant***		July 1, 2019	June 30, 2021	
44	HIV stakeholder representative #1	1	SBP	Grissel Granados, MSW	Children's Hospital Los Angeles	July 1, 2018	June 30, 2022	
45	HIV stakeholder representative #2	1	SBP	Paul Nash, CPsychol AFBPsS FHEA	University of Southern California	July 1, 2019	June 30, 2021	
46	HIV stakeholder representative #3	1	EXC|OPS	Juan Preciado	Northeast Valley Health Corporation	July 1, 2018	June 30, 2022	
47	HIV stakeholder representative #4	1	SBP	Ernest Walker	Men's Health Foundation	July 1, 2019	June 30, 2021	
48	HIV stakeholder representative #5			***Vacant***		July 1, 2018	June 30, 2022	
49	HIV stakeholder representative #6	1	SBP	Amiya Wilson	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	
50	HIV stakeholder representative #7	1	PP&A	William D. King, MD, JD, AAHIVS	W. King Health Care Group	July 1, 2018	June 30, 2022	
51	HIV stakeholder representative #8			***Vacant***		July 1, 2018	June 30, 2022	Miguel Alvarez (OPS/SBP)
	TOTAL:	**38**						

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

LOA: Leave of Absence

Planning Council/Planning Body Reflectiveness (Updated 01.26.21)

Race/Ethnicity	Living with HIV/AIDS in EMA/TGA*		Total Members of the PC/PB		Non- Aligned Consumers on PC/PB	
	Number	Percentage**	Number	Percentage**	Number	Percentage**
White, not Hispanic	13,965	27.50%	11	23.91%	5	41.67%
Black, not Hispanic	10,155	20.00%	13	28.26%	5	41.67%
Hispanic	22,766	44.84%	18	39.13%	2	16.67%
Asian/Pacific Islander	1,886	3.71%	3	6.52%	0	0.00%
American Indian/Alaska Native	300	0.59%	1	2.17%	0	0.00%
Multi-Race	1,705	3.36%	0	0.00%	0	0.00%
Other/Not Specified	0	0.00%	0	0.00%	0	0.00%
Total	50,777	100%	46	100%	12	100%
Gender	Number	Percentage**	Number	Percentage**	Number	Percentage**
Male	44,292	87.23%	31	67.39%	8	66.67%
Female	5,631	11.09%	13	28.26%	4	33.33%
Transgender	854	1.68%	2	4.35%	0	0.00%
Unknown	0	0.00%	0	0.00%	0	0.00%
Total	50,777	100%	46	100%	12	100%
Age	Number	Percentage**	Number	Percentage**	Number	Percentage**
13-19 years	122	0.24%	0	0.00%	0	0.00%
20-29 years	4,415	8.69%	2	4.35%	1	8.33%
30-39 years	9,943	19.58%	19	41.30%	3	25.00%
40-49 years	11,723	23.09%	10	21.74%	1	8.33%
50-59 years	15,601	30.72%	9	19.57%	6	50.00%
60+ years	8,973	17.67%	6	13.04%	1	8.33%
Other	0	0.00%	0	0.00%	0	0.00%
Total	50,777	99.99%	46	99.99%	12	99.99%

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

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

ALL COMMITTEE MEETINGS ARE HELD VIRTUALLY UNTIL FURTHER NOTICE

COMMITTEE ASSIGNMENTS

Updated: February 08, 2021
Assignment(s) 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**
Bridget Gordon	**Co-Chair, Comm./Exec.***	**Commissioner**
David Lee, MPH, LCSW	**Co-Chair, Comm./Exec.***	**Commissioner**
Raquel Cataldo	Co-Chair, PP&A	Commissioner
Michele Daniels	At-Large Member*	Commissioner
Erika Davies	Co-Chair, SBP	Commissioner
Lee Kochems	Co-Chair, Public Policy	Commissioner
Carlos Moreno	Co-Chair, Operations	Commissioner
Katja Nelson, MPP	Co-Chair, Public Policy	Commissioner
Frankie-Darling Palacios	Co-Chair, PP&A	Commissioner
Mario Pérez, MPH	DHSP Director	Commissioner
Juan Preciado	Co-Chair, Operations	Commissioner
Kevin Stalter	Co-Chair, SBP	Commissioner
Justin Valero	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= 8 | Number of Quorum= 5**		
COMMITTEE MEMBER	**MEMBER CATEGORY**	**AFFILIATION**
Carlos Moreno	**Committee Co-Chair***	**Commissioner**
Juan Preciado	**Committee Co-Chair***	**Commissioner**
Miguel Alvarez	**	Alternate
Danielle Campbell, MPH	*	Commissioner
Michele Daniels	*	Commissioner
Joseph Green	*	Commissioner
Kayla Walker-Heltzel	**	Alternate
Justin Valero	*	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= 18 | Number of Quorum= 10		
COMMITTEE MEMBER	**MEMBER CATEGORY**	**AFFILIATION**
Frankie-Darling Palacios	**Committee Co-Chair***	Commissioner
Raquel Cataldo	**Committee Co-Chair***	Commissioner
Everardo Alvizo, MSW	*	Commissioner
Al Ballesteros	*	Commissioner
Kevin Donnelly	*	Commissioner
Luckie Fuller	*	Commissioner
Felipe Gonzalez	*	Commissioner
Joseph Green	*	Commissioner
Damontae Hack	*	Alternate
Karl Halfman, MA	*	Commissioner
William D. King, MD, JD, AAHIVS	*	Commissioner
Miguel Martinez, MPH	**	Committee Member
Anthony Mills, MD	*	Commissioner
Derek Murray	*	Commissioner
Diamante Johnson (Kayla Walker-Heltzel, Alternate)	*	Commissioner
LaShonda Spencer, MD	*	Commissioner
Maribel Ulloa	*	Commissioner
Guadalupe Velazquez	*	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= 9 | Number of Quorum= 5		
COMMITTEE MEMBER	**MEMBER CATEGORY**	**AFFILIATION**
Lee Kochems, MA	**Committee Co-Chair***	Commissioner
Katja Nelson, MPP	**Committee Co-Chair***	Commissioner
Alasdair Burton	*	Alternate
Jerry Gates, PhD	*	Commissioner
Eduardo Martinez	**	Alternate
Nestor Kamurigi	*	Alternate
Ricky Rosales	*	Commissioner
Martin Sattah, MD	*	Commissioner
Tony Spears	*	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 = 12 | Number of Quorum = 7

COMMITTEE MEMBER	MEMBER CATEGORY	AFFILIATION
Kevin Stalter	**Committee Co-Chair***	**Commissioner**
Erika Davies	**Committee Co-Chair***	**Commissioner**
Grissel Granados	*	Commissioner
Thomas Green	**	Alternate
Felipe Gonzalez	*	Commissioner
Paul Nash, CPsychol, AFBPsS, FHEA	*	Commissioner
Katja Nelson, MPP	**	Commissioner
Joshua Ray (Eduardo Martinez, Alternate)	*	Commissioner
Harold Glenn San Agustin, MD	*	Commissioner
Justin Valero, MA	*	Commissioner
Ernest Walker	*	Commissioner
Amiya Wilson	*	Commissioner
Wendy Garland, MPH	DHSP staff	DHSP

CONSUMER CAUCUS

Regular meeting day/time: 2nd Thursday of Each Month; Immediately Following Commission Meeting
Co-Chairs: Felipe Gonzales & Carlos Moreno
Open membership to consumers of HIV prevention and care services

AGING TASK FORCE (ATF)

Regular meeting day/time: 1st Monday of Each Month @ 10am-12pm
Chair: Al Ballesteros, MBA
Open membership

BLACK/AFRICAN AMERICAN COMMUNITY (BAAC) TASK FORCE

Regular meeting day/time: 4th Monday of Each Month @ 10am-12pm
Co-Chairs: Danielle Campbell, MPH & Greg Wilson
Open membership

TRANSGENDER CAUCUS

Regular meeting day/time: 4th Tuesday of Each Month @ 10am-12pm
Chair: Frankie Darling-Palacios
Open membership

WOMEN'S CAUCUS

Regular meeting day/time: 3rd Monday of Each Month @ 9:30am-11:30am
Co-Chairs: Shary Alonzo & Dr. LaShonda Spencer
Open membership

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 2/08/21

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
ALVAREZ	**Miguel**	No Affiliation	No Ryan White or prevention contracts
ALVIZO	**Everardo**	Long Beach Health & Human Services	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			HIV and STD Prevention
			HIV Testing Social & Sexual Networks
BALLESTEROS	**Al**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis, and Treatment
			Health Education/Risk Reduction (HERR)
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
BURTON	**Alasdair**	No Affiliation	No Ryan White or prevention contracts
CAMPBELL	**Danielle**	UCLA/MLKCH	Oral Health Care Services
			Medical Care Coordination (MCC)
			Ambulatory Outpatient Medical (AOM)
			Transportation Services

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
CATALDO	**Raquel**	Tarzana Treatment Center	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Case Management, Home-Based
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Mental Health
			Substance Abuse, Transitional Housing (meth)
			Transitional Case Management-Jails
			Transportation Services
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)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
FULLER	**Luckie**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testng Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
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)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management-Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
GREEN	**Joseph**	Unaffiliated consumer	No Ryan White or prevention contracts
GREEN	**Thomas**	APAIT (aka Special Services for Groups)	HIV Testing Storefront
			Mental Health
			Transportation Services
HACK	**Damontae**	Unaffiliated consumer	No Ryan White or prevention contracts
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
JOHNSON	**Diamante**	Unaffiliated consumer	No Ryan White or prevention contracts
KAMURIGI	**Nestor**	No Affiliation	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 Testing Storefront
			HIV Testing Social & Sexual Networks

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MARTINEZ	**Eduardo**	AIDS Healthcare Foundation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Mental Health
			Oral Healthcare Services
			STD Screening, Diagnosis and Treatment
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
			Medical Subspecialty
			HIV and STD Prevention Services in Long Beach
MILLS	**Anthony**	Southern CA Men's Medical Group	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
MORENO	**Carlos**	Children's Hospital, Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management - Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
MURRAY	**Derek**	City of West Hollywood	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention
			Oral Healthcare Services

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
NELSON	**Katja**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Health Education/Risk Reduction, Native American
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Nutrition Support
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
PRECIADO	**Juan**	Northeast Valley Health Corporation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Oral Healthcare Services
			Mental Health
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment
			Transportation Services
RAY	**Joshua**	Unaffiliated consumer	No Ryan White or prevention contracts
ROSALES	**Ricky**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SAN AGUSTIN	**Harold**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
SPENCER	**LaShonda**	Charles R. Drew University of Medicine and Science	HIV Testing Storefront
			HIV Testing Social & Sexual Networks
SPEARS	**Tony**	Capitol Drugs	No Ryan White or prevention contracts
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
VELAZQUEZ	**Guadalupe**	Unaffiliated consumer	No Ryan White or prevention contracts
WALKER	**Kayla**	No Affiliation	No Ryan White or prevention contracts
WALKER	**Ernest**	Men's Health Foundation	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
WILSON	**Amiya**	Unique Women's Coalition	No Ryan White or prevention contracts

LOS ANGELES COUNTY
COMMISSION ON HIV

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

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

2020 VIRTUAL ANNUAL COMMISSION ON HIV "CONTINUING THE COMMITMENT TO END HIV ONCE AND FOR ALL" MEETING MINUTES

SECONDARY TELECONFERENCE SITE:
California Department of Public Health, Office of AIDS
1616 Capitol Avenue, Suite 74-616, Sacramento, CA 95814

November 12, 2020

COMMISSION MEMBERS PRESENT	COMMISSION MEMBERS PRESENT *(cont.)*	COMMISSION MEMBERS ABSENT	DPH/DHSP STAFF
Al Ballesteros, MBA, *Co-Chair*	David P. Lee, MPH, LCSW	Danielle Campbell, MPH	Wendy Garland, MPH
Bridget Gordon, *Co-Chair*	Eduardo Martinez *(Alt. to Ray)*	Stephanie Cipres, MPH	Michael Green, PhD, MHSA
Miguel Alvarez *(Alt.)*	Anthony Mills, MD	Michele Daniels	Julie Tolentino, MPH
Everardo Alvizo, MSW	Carlos Moreno	Jerry D. Gates, PhD	
Raquel Cataldo	Derek Murray	Diamante Johnson *(F to Walker-Heltzel)*	**COMMISSION STAFF/CONSULTANTS**
Pamela Coffey/Alasdair Burton	Katja Nelson, MPP		
Frankie Darling-Palacios	Mario Pérez, MPH	Paul Nash, CPsychol AFBPsS FHEA	Cheryl Barrit, MPIA
Erika Davies	Juan Preciado	Joshua Ray, RN *(F. to Martinez)*	Carolyn Echols-Watson, MPA
Kevin Donnelly	Nestor Rogel *(Alt.)*	Tony Spears *(Alt.)*	Dawn McClendon
Aaron Fox, MPM	Ricky Rosales	Kevin Stalter	Jane Nachazel
Felipe Gonzalez	Harold San Agustin, MD	Amiya Wilson	Sonja Wright, MS, Lac
Grissel Granados, MSW	Martin Sattah, MD		
Joseph Green	LaShonda Spencer, MD		
Thomas Green *(Alt.)*	Maribel Ulloa		
Karl Halfman, MS	Justin Valero, MA		
William King, MD, JD, AAHIVS	Kayla Walker-Heltzel, MPH *(Alt. to Johnson)*		
Lee Kochems, MA			
PUBLIC			
Sonya Aadam	Jerry Abraham, MD, MPH	Ivette Ale	Jasmine Aquino
Luis Argueta	Anait Arsenyan	Sunnie Berger	Jane Bowers-Rohde
Miguel Bujanda	Ana Cacao	Zelenne Cardenas	Victor Cardoza
Geneviéve Clavreul, RN, PhD	Claudia Cortez	Tracey Cumberland	Philip Curtis
Maria Diaz	Kiana Dobson	Allison Doolittle	Christopher Elorde

PUBLIC *(cont.)*			
Alisha Ferguson	Dahlia Ferlito	Felipe Findley	Andrew Flores
Ty Gaffney	Stephanie Gallegos	Robert Gamboa	Thelma Garcia
Becky Gonzales	Michael Haymer	Stephanie Haynes	Silvia Jimenez
Damilola Jolayemi	Jackie Jones	Shellye Jones	Alma Justo
Uyen Kao, MPH	Naina Khanna	Jeffrey King	Rhonda Layton-Jones
Joseph Leahy	Roxanne Lewis	Kristi Lopez	Miguel Martinez, MPH, MSW
Giulio Monaco	LCDR Jose Antonio Ortiz, MPH	Meyerer Perez	Harold Phillips, MRP
Craig Pulsipher	Gabriella Rafiele	Maritza Ramirez	Rosa Ramos
Tara Raoufi	Zenaida Reyes	George Reynolds	Terri Reynolds
Barbara Roberts	Marissa Robinson	Bridget Rogala	Edwin Rojas
Devan Rose	Natalie Sanchez	Victor Scott	CDR Michelle Sandoval-Rosario DrPH, MPH
Saron Selassie	Kai Smith	Peter Soto	
Octavio Vallejo, MD, MPH	Arely Vasquez	Guadalupe Velazquez	Ernest Walker
Lauren White			

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

I. CALL TO ORDER, ROLL CALL, AND APPROVAL OF AGENDA: Ms. Gordon opened the meeting at 9:07 am.
Roll Call (**Present)**: Alvarez, Alvizo, Cataldo, Coffey/Burton, Darling-Palacios, Davies, Donnelly, Fox, Gonzalez, Granados, Green (Joseph), Green (Thomas), Halfman, King, Kochems, Lee, Martinez, Mills, Moreno, Murray, Nelson, Pérez, Preciado, Rogel, Rosales, San Agustin, Sattah, Spencer, Ulloa, Valero, Walker-Heltzel, Ballesteros, Gordon.

II. WELCOME, OPENING REMARKS, RECOGNITION OF SERVICE, AND MEETING OBJECTIVES

- Ms. Gordon welcomed all to the meeting. The day's objectives were to: 1. continue community discussion and engagement on Ending the HIV Epidemic (EHE); 2. hear federal and local updates about the status and future of EHE; and, 3. Identify strategies for creating a meaningful, inclusive, and intergenerational movement to end HIV.
- Comments and questions can be typed into the Chat box and should be addressed to everyone. Public comment will be taken up under the agenda's Community Speak Out section. It is limited to two minutes per person. Live public comment can be offered by those registered with WebEx and attending via computer or smart phone. Written comments may be emailed to HIVcomm@LACHIV.org and include meeting date and item. All materials become part of the public record.
- Please be mindful of on-camera activity and screen backgrounds or turn off video. Please mute oneself when not speaking. If connecting through both a computer and telephone, please mute the computer audio to avoid echo.
- A video recording of this meeting and its packet will be posted on the Commission website at http://hiv.lacounty.gov.
- Please refer to the Commission's Code of Conduct. It applies to all attendees and may be found in the meeting packet along with the Commission's Vision and Mission statements, its statement on ending racism, and presenter bios.
- Ms. Gordon recognized and thanked Mr. Ballesteros for his service as Commission Co-Chair. His term ends 12/31/2020. Mr. Ballesteros is the longest serving Commissioner. He began as one of the five community supervisorial representatives in the early 1990s on what was then called the Commission on AIDS. He served from 2000 to 2006 and from 2019 to 2020 as a Committee Co-Chair in addition to serving in numerous task force and work group leadership roles.
- Like a tree, Mr. Ballesteros' commitment and roots run deep in the community and his vision for ending the epidemic stretches boundaries and heights of imagination. A painting of trees was selected to reflect this steadfast work and will be presented when we are able to again meet in person. He has never met a stranger and is an invaluable mentor.
- Mr. Ballesteros thanked Ms. Gordon. He congratulated her on her growth from when she first arrived to developing into an effective advocate especially for women and women of color. It is awesome to see.
- He began as a young adult advocating for youth - and was now Co-Chairing the Aging Task Force. He has deeply appreciated the opportunity to Co-Chair the Commission and being part of progress made. Despite challenges, he feels Commission intentions are to be the best possible. He also expressed appreciation for the Commission staff and our partner DHSP.

- When he first came to this table, the then Commission was funding hospices for the dying. He saw hundreds of people die. Today, we have the awesome opportunity of preventing infections and ending the epidemic. He called everyone to take this work to the next level so that Commissioners now can look back in five or ten years and say, "We ended the epidemic."
- Ms. Gordon felt the focus was now on humanity. Everyone has dealt with the sting of stigma.
- Mr. Lee, incoming Commission Co-Chair, thanked Mr. Ballesteros for his ongoing mentorship.
- Mr. Pérez extended deep thanks on behalf of Los Angeles County (LAC), the Board of Supervisors (Board), the Department of Public Health (DPH), and the Division of HIV and STD Programs (DHSP). He has known Mr. Ballesteros since 1993 and credited him as one who paved the way as a steward and guiding light to hundreds of people. There is no one doing this work in LAC who does not know him. He was grateful for decades of leadership, commitment, resilience, and passion.

III. ENDING THE HIV EPIDEMIC (EHE): What to Expect in 2021 and Insights on Building an Inclusive HIV Movement

- Mr. Ballesteros introduced Harold Phillips, MRP, Senior HIV Advisor and Chief Operating Officer, EHE: A Plan for America, United States Department of Health and Human Services (HHS), Office of Infectious Disease and HIV/AIDS Policy (OIDP). He is charged with both coordination of the initiative's activities and ensuring community awareness and engagement.
- Mr. Phillips also thanked Mr. Ballesteros for the nationwide impact of his authentic and honest voice.
- He noted attendees CDR Michelle Sandoval-Rosario, DrPH, MPH and LCDR Jose Antonio Ortiz, MPH, who constitute the Prevention through Active Community Engagement (PACE) Program Team for Region 9 serving LAC. As of 10/1/2020, PACE moved under OIDP, reporting to Mr. Phillips, while continuing to work at the local level. That will help those in Washington better understand assistance or clarity needed at the community level to move EHE forward.
- The EHE initiative was announced in President Trump's 2019 State of the Union with broad administration support. OIDP has heard President-Elect Biden plans to retain the EHE initiative, but shorten the already challenging goal from ten years to five. No details have been released but, if that will be the new goal, it would require more staff and resources.
- The first full year of EHE implementation was also challenged by COVID-19. Health Resources and Services Administration (HRSA) funding went out in March 2020 to Ryan White jurisdictions as well as to Community Health Centers (CHCs) to scale up PrEP and HIV testing. But stay-at-home orders also began then and many public health staff were diverted to COVID-19 activities. Also due to COVID-19, the Centers for Disease Control and Prevention (CDC) delayed its awards until August 2020.
- On the other hand, innovations like increased telehealth and home delivery of such items as condoms and Syringe Exchange Program (SEP) supplies reflect the creativity that was called for at the launch of the EHE. Likewise, much community engagement shifted to virtual platforms that allowed more and different voices to participate.
- COVID-19 spurred many PLWH who were out of care to engage or re-engage in care since being virally suppressed supports a healthier immune system overall. Some outreach and case managers also found it easier to reach PLWH at home.
- Next year's budget was still working through Congress, but all federal agencies were moving forward with HIV as a priority.
- Despite the innovation and resilience, we are all experiencing trauma both collectively and individually from the pandemic, social unrest, and politics. The CDC was expecting increased Sexually Transmitted Infections (STIs) rates. Prior to COVID-19, surveillance was already reflecting an increase in the percentage of People Who Inject Drugs (PWID) and the United States overall was experiencing an opioid crisis. There is great concern about these coping mechanisms and their intersectionality with HIV. Going forward, partnerships are planned with STI specialty clinics and substance abuse treatment and diagnosis.
- In addition to continuing community engagement, there is a need to ensure new and different voices at the table. COVID-19 offers opportunities to draw in those voices by raising the profile and understanding of the importance of public health. Increased understanding can then inform advocacy for greater funding of HIV, STIs, and public health systems in general.
- EHE's call for innovation in light of COVID-19 can highlight disproportionate impact among certain communities. There can be broad partnerships across HIV and COVID-19 work regarding information, awareness, linkage to care, STIs, viral hepatitis.
- There is support for Centers for Medicare and Medicaid Services (CMS) engagement with EHE in 2021 including discussions at the Assistant Secretary and Deputy Secretary of Health level. Mr. Phillips was working to move that forward now so it will be established and persist into the next administration. There is broad support due to the CMS role as the largest payer for HV care and treatment in the United States and its anticipated role per the United States Prevention Task Force recommendations on HIV testing and PrEP as part of prevention services.
- America's HIV Epidemic Analysis Dashboard (AHEAD) for the six EHE indicators can be reviewed at https://www.hiv.gov. It includes local and national targets for 2025 and 2030 in order to end the epidemic.
- One target is linkage to care after diagnosis within 30 days with the eventual target of viral suppression for those who are linked to care. He recommended data sharing among systems of care, treatment, and support to ensure administrative and

system processes identify wherever people are accessing any services in order to re-engage them in clinical services. These kinds of system level issues can be addressed even under safer-at-home directives in order to move more quickly later.

- Surveillance informs the fourth pillar on responding to outbreaks and clusters. The surveillance system was, however, impacted by COVID-19, e.g., data caught up in cleaning and verification for 2019 data for CDC submission was hampered in March, April, and May. 2020 data was impacted by reduced HIV testing and surveillance teams working on COVID-19. A 11/19/2020 federal level meeting will address how to measure EHE and HIV National Strategic Plan progress in light of that.
- In a few weeks, a draft of the HIV National Strategic Plan will be published in the Federal Register for review and public comment. It covers the entire federal government versus EHE which is focused on HHS. The Plan also includes priority populations for the entire nation: MSM with a focus on Black, Latinx, and Native Americans; Black Women; Transgender Women; Youth, 13 to 24; PWID. This is the third Plan, but the first to call for the end of the epidemic in the United States.
- The first question asked about coordination with the United States Department of Housing and Urban Development (HUD) to provide public housing for PLWH. Mr. Phillips said the HUD Housing Opportunities for Persons With AIDS (HOPWA) Program has worked with EHE since October 2019. HOPWA created an HIV housing tool that outlines for each jurisdiction: HIV housing resources; amount of HOPWA funding; number of clients supported; and available support services. The tool should be posted on AHEAD shortly to help jurisdictions evaluate housing needs.
- The HIV National Strategic Plan provides the framework to further expand HUD support for housing PLWH beyond HOPWA.
- Regarding Year 2, it was asked what was the expectation for EHE and who were legislative EHE champions or those who would benefit by advocacy. Mr. Phillips replied details were not available, but EHE was likely to continue in some form. Support is broad. People often forget the initial Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 was signed by President George H.W. Bush, reauthorized as the Ryan White HIV/AIDS Treatment Modernization Act of 2006 by President George W. Bush, and this EHE initiative by President Trump was likely to continue due to bipartisan appeal.
- Some level of education is always needed whenever new people come in so advocates should be ready for that process.
- Regarding CMS, it was asked if goal activities like engagement and retention services for PLWH and PrEP for HIV- people were in Medicaid. Mr. Phillips noted there are differences among states based on how they implement it. Federal level asks were: 1. Engagement as part of the EHE organizational leadership team; 2. More active engagement in the Presidential Advisory Council on HIV/AIDS (PACHA); 3. Re-issue 2016 bulletin that highlighted various models incentivizing viral suppression updated to include latest PrEP information and links to United States Preventive Services Task Force (USPSTF) recommendations on HIV screening and prevention; 4. Emphasis on viral suppression as a quality measure.
- Another question asked if a change was expected in language to help promote recognition of the transgender/queer communities. The Trump administration seems to vilify the communities while simultaneously seeking to end the epidemic. Mr. Phillips did anticipate a change in language and approach especially from the National Institutes of health (NIH). He suggested watching for the Federal Register notice of the draft HIV National Strategic Plan. Release for public comment was expected around 11/20/2020. Transgender women are a priority population in the Plan. He invited comments.
- Dr. Sattah asked about efforts to reduce stigma to influence testing particularly among youth in schools and churches. Mr. Phillips said NIH hosted a symposium in the fall on recent implementation science regarding stigma and discrimination, e.g., various models, measurement options, impact, evaluation. How to embed this research into the work was being reviewed.
- A community consultation on stigma was also being planned to inform how to best use federal resources in raising awareness of the importance of engaging in care. Do individuals need help navigating the system? Is stigma and discrimination the problem and, if so, what should messages be, where should they be delivered, and how. For example, a poster in a clinic would be ineffective since, by definition, this population is not going there. What spaces should we be in that we have not been in for 40 years – food banks, churches, Goodwill?
- Meanwhile, the Ryan White HIV/AIDS Program (RWHAP) serves over 500,000 individuals with 87% of those in care virally suppressed. Per legislation, however, neither RWHAP nor its providers may use its funds to advertise or do public health awareness campaigns so HHS was hoping to step into that space to determine where and how to deliver those messages.
- On EHE engagement of the aging HIV+ population, Mr. Phillips said the Plan has a call-out box for this population although it was not a priority population based on data. It is, however, known that many communities have significant aging populations and that aging PLWH have distinct needs. Local jurisdictions are urged to consider their data, engage the community, and determine what needs to be in place to assist aging PLWH.
- A question was raised on whether a national plan existed to increase recruitment of HIV medical providers, e.g., incentives to become HIV specialists. Mr. Phillips said two categories of health care workers were prioritized in Fiscal Year (FY) 2021 EHE work – pharmacists and nurses. Work was ongoing to educate pharmacy and nursing schools on EHE initiatives and their graduates' roles in helping with PrEP and treatment adherence. Going forward, they will be working with Historically

Black Colleges and Universities (HBCUs) and Hispanic-serving institutions to help them understand the importance of these issues and how health professionals graduating from these schools can contribute. He also plans to connect with HRSA, Bureau of Health Workforce, to amplify opportunities. Loans and grants are available through HRSA for students enrolling in health professional schools who agree to work in an underserved community, but only some of the support pertains to HIV.

- Regarding EHE's relation to social activism and Social Determinants of Health (SDH), Mr. Phillips replied that younger people engaged in HIV work tend to inherently see it as a social justice issue although a public health lens is more common among long-time workers while acknowledging a social justice intersect. Issues of systemic racism, Black Lives Matter movement, stigma, and discrimination influence a broad range of issues, e.g., location of highways; placement of clinics in relation to transportation; and even, until the mid-1960s, segregation of some clinics and hospitals by race or ethnic group. Medicaid/ Medicare law forced integration of staff and patients in order to receive Medicaid reimbursement. Community conversations should continue to develop solutions tailored to address local racism and discrimination challenges.
- Ms. Gordon noted LAC received just $3 million in EHE funding this past year. While not dismissive, that is far from adequate as a realistic budget to end a long-term issue in areas hardest hit. Further, she asked if EHE included a cure for HIV.
- She also felt that Anthony Fauci, MD, Chief Medical Advisor to the President, and Director, National Institute of Allergy and Infectious Diseases (NIAID) had a unique opportunity to correct the myth that HIV is a moral evil because his voice is now prominent due to the COVID-19 pandemic. That myth has caused untold harm yet has never been addressed.
- That topic and its integration with stigma and discrimination also feeds trauma which impairs the ability to stay healthy. Mr. Phillips agreed and felt there was much work to do in understanding various aspects of trauma and its impact, e.g., trauma that leads to infection, trauma of diagnosis, and trauma of living with HIV. We do hear today about trauma-informed care. He would, however, also like a focus on trauma-informed HIV prevention because staff who specialize in trauma identify HIV, Sexually Transmitted Infection (STI), and Viral Hepatitis risk factors as trauma coping mechanisms. Trauma acts as an accelerant for infectious diseases. While public health cannot address all these issues, it should seek to understand them and identify partners and collaborators to bring to the table to help improve community health.
- Mr. Phillips noted the Trump administration modeled the first year of the Inititive as seed money with a substantial increase for year two. The House flat-funded year two while the Senate proposed an increase of some $200 million. Budget issues remain a great concern. Substantially more funding will be needed if the Biden administration maintains its goal of moving up EHE completion to five years. Another concern will be to disburse any additional funds and apply them quickly. He encouraged local community members to educate their representatives and senators on these issues.
- ➲ Mr. Phillips noted the federal government has apologized for other things in the past. While it was too late for this World AIDS Day, he thought an apology for continuing to allow HIV to be seen as a moral evil could act as a powerful tool in EHE by helping address stigma and discrimination. He will advocate for that as part of the next World AIDS Day.

IV. EHE FROM A LOS ANGELES COUNTY (LAC) PERSEPECTIVE: Funding Overview and Expenditure Report; Key Themes from EHE Plan Feedback; and Take Me Home, Expansion of Home Test Kits

- Ms. Tolentino, Program Manager, EHE, opened the DHSP report noting EHE: A Plan for America was announced in 2019 with implementation starting in 2020 and goals to meet 75% of targets in five years and 90% in ten.
- The local Plan was released 9/16/2020 for 30-days public comment after a virtual EHE Town Hall with over 160 attendees, multiple presentations, promotion via several listservs, and presentation to partners, e.g., at the October Commission and an EHE event for the Spanish-speaking community in collaboration with the Consumer Caucus and the PACE Program.
- DHSP received some 40 pages of feedback. Overarching themes included focusing on highly impacted communities, e.g., youth, communities of color, People Who Inject Drugs (PWID), people experiencing homelessness. These reflect DHSP priority populations, e.g., Black African American MSM, women of color, PWID, the transgender community, youth <29.
- Other notable comment topics were education, provider training on implicit bias, trauma-informed care, medical mistrust, sexual health and HIV. There were also comments about offering continuing education on HIV and LGBTQ+ competency for health care providers as well as community education on HIV prevention and treatment.
- Comments called for the EHE Plan to reduce stigma and fear in accessing services by partnering with colleges, medical associations, workforce organizations and ensuring staff reflect the population served as well as encouraging organizations share staff demographics to increase transparency. Comments also urged Plan language that is gender inclusive and client centered as well as addressing alternatives to incarceration and clarifying the LAC relationship with law enforcement.
- Finally, there were recommendations to create overarching strategies beyond the EHE pillars that address racial justice and support communities of color as well as rethinking Plan structure for ease of comprehension. While the Plan was organized by the CDC, DHSP will be creating an executive summary especially with the broader community in mind.

- Pillar 1, Diagnose, comments included increasing testing access points with the highest impact including: street outreach strategies; routine coupling of HIV testing with Sexually Transmitted Disease STD (STD), Human Papillomavirus (HPV), or COVID-19 testing; implementing low threshold rapid testing opportunities; and including nontraditional testing sites such as barbershops, dental providers, and sexual health express clinics. Comments highlighted that providers across all sectors should be trained and well versed in the importance and implementation of routine testing.
- With expansion of home testing, there was an emphasis on creating processes and systems to ensure people are linked to care including consideration of virtual testing counselor appointments to help the client walk through taking the test and provide support when the client receives the test outcome.
- Important feedback provided a critical lens on the partnership with law enforcement, specifically with the LAC Sheriff's Department for testing services. This feedback is valued. The Plan was being reshaped to further explain the long-standing partnership that DHSP has had with the Sheriff's Department and law enforcement. DHSP will continue to ensure justice-involved individuals receiving HIV services in LAC Jails and juvenile hall. DHSP is committed to changing practices that perpetuate systemic racism, and ensuring services are client-centered and support communities served.
- Pillar 2, Treat, feedback themes included: expanding care models, such as street medicine, to also include prevention; Antiretroviral Therapy (ART) considerations, e.g., development of a Rapid ART Standards of Care (SOC) by the Commission's Standards and Best Practices (SBP) Committee, prioritizing same day ART, DHSP Technical Assistance (TA) for providers to implement rapid ART; increasing knowledge and access to supportive services for both providers and clients.
- Pillar 3, Prevent, comments focused on education among both providers and the community, especially in: creating culturally sensitive materials for specific populations; a proactive approach to education on PrEP innovations such as alternatives to daily oral PrEP and where it can be accessed for free; providers offering same day PrEP.
- Pillar 4, Respond, key comments included: adapting partner services to changing social network/internet environments; ensuring non-HIV providers are aware of partner services; increasing community education on molecular surveillance.
- DHSP is now revising the Plan in light of in-depth discussion of these comments during multiple DHSP EHE team meetings. Not all suggestions can be incorporated in the Plan, but all were being noted for consideration in program development.
- DHSP will work with Commission leadership on next steps regarding Plan concurrence. It is due to the CDC in December.
- Meanwhile, DHSP continues to reach out to new partners and encourages community members to act as EHE initiative ambassadors by sharing about HIV, PrEP, and Undetectable Equals Untransmittable (U=U). Go to LACounty.hiv for updates on EHE as available. Get ProtectedLA.com was also being redeveloped for HIV, STD, and sexual health resources.
- Ms. Garland, Chief Epidemiologist, continued with the DHSP report presenting from her PowerPoint in the packet on the "Launch of the 'Take Me Home' Self-Testing Program in Los Angeles County" starting with an overview of EHE efforts in LAC.
- A key activity under Pillar 1, Diagnose, is to increase HIV testing programs in non-healthcare settings including home testing to increase HIV status awareness, improve diagnosis timeliness, and promote annual screening for timely diagnosis.
- Data for Black MSM, Latinx MSM, and PWID reflect lower awareness underlining the need for different testing modalities. TakeMeHome is a national platform for ordering home test kits to help public health departments to expand testing access especially for those who may hesitate to enter a clinic. This has been particularly important during COVID-19 as it provides an additional access point for HIV testing and can be available for free in participating Health Care Jurisdictions like LAC.
- The TakeMeHome team promotes availability through various app partners, the CDC, and local resources. This partnership model with ordering and distribution is especially helpful now with COVID-19 as it does not impose a staffing burden while providing client level data on a monthly basis. That data provides information DHSP uses to evaluate the reach of services.
- Apps are a valuable modality as nearly 75% of MSM report using them in the last year to meet a partner and reported risks are higher, but 22% of MSM using apps never tested for HIV and 77% of users wanted to be able to order a home test.
- Tests are delivered in about three days with OraQuick providing online videos and resources to support proper test procedures. Clients receiving a preliminary positive result are encouraged to access a confirmatory test. All clients receive a package of resources including information on STD testing, PrEP, U=U, condoms, and a direct number to DHSP. TakeMeHome does additional outreach a couple of weeks post-test to gather information on test results and test feedback.
- Initial discussions started in April 2020 with the first 2,086 test kits purchased in July. Launch was in the Hollywood-Wilshire and Long Beach areas with expansion to all zip codes in September. An October order for 6,613 kits was pending delivery.
- To date, 255 people have ordered kits. Of those, 93% reported male sex at birth with 63% aged 18-29. The majority reporting were Latinx, but 1 in 5 did not report race/ethnicity. DHSP was working with TakeMeHome to improve data.
- Overall, 1 of 3 clients had not previously been tested for HIV including: 1 of 3 Latinx, 3 of 10 cisgender males, 4 of 5 aged 18-19 and 2 of 5 aged 20-24. These early data reflect increased testing in underserved populations. About 10% of clients complete follow-up surveys which are helpful in evaluating and improving the program.

- Next steps include: matching clients with HIV surveillance data to identify the newly diagnosed and confirm linkage to care or offer linkage assistance to PrEP or HIV care; increase promotion through partner agencies and social marketing resources; and, expand self-home testing promotion through contracted HIV testing agencies.
- To a question on DHSP support for clients learning their HIV status when alone, Ms. Garland noted an emphasis on advising clients test results are preliminary, referral to follow-up testing with other resources, and a direct DHSP contact number.
- Concerning services for women, Ms. Garland said current apps were selected based on connection data. The TakeMeHome team was open to exploring other options across LAC.
- Regarding why eligibility for kits includes not having tested for a year, Ms. Garland said DHSP was working within the TakeMeHome framework which is trying to increase testing for those who have never tested or have not tested recently.
- Mr. Pérez, Director, completed the DHSP report. He thanked Ms. Garland for her work in launching TakeMerHome, but also emphasized DHSP was aware of the need to supplement it including with outreach to women, African American men, and the transgender population. It does not replace, but supplements, the broader testing program.
- He began budget review with Part B, an award via the state of some $5 million with $4.5 million in direct services. To date, there was some $2.3 million in expenditures with a full year estimate of $4.6 million mainly in various housing services.
- Minority AIDS Initiative (MAI) funding was $3.768 million with administration costs of $376,000. Some $3.39 million was available for direct services with expenditures through the first part of November of $1.718 million for housing and nonmedical case management services. The full year projection was some $3.3 million in expenditures. MAI is the only funding resource which allows funds to be rolled over one year without penalty.
- The total Ryan White Part A award was $40.571 million. Subtracting the 10% for administration and less than the allowable 5% for Quality Management (QM) left $35.18 million for direct services. Some $17.6 million has been expended to date with a full year projection of $34.18 million leaving an estimated $1 million plus an underspent $500,000 in QM costs.
- Savings of some $1.8 million were noted in Ambulatory Outpatient Medical due to a decline in visits in the COVID-19 environment despite expanded telehealth options.
- Medical Case Management is on a cost reimbursement basis. Costs were higher than estimated due to helping with COVID.
- Mental Health costs were slightly up. DHSP was working with the Department of Mental Health to better understand them.
- Home/Community-Based Health Services were slightly up while Benefits Specialty was slightly down.
- A notable decline was in Outreach Services (Linkage and Re-engagement Program) due to reassignment of multiple DHSP staff and their salary expense to COVID-19 Disaster Services Worker assignments.
- Medical Transportation has declined due to COVID-19 and the program has shifted to agency management which was also likely to result in a decrease of costs. Meanwhile, resources have been increased for Food.
- Assuming expenditures follow projections, MAI expenditures can be shifted to maximize Part A with MAI funds carried over.
- In response to a question, Mr. Pérez reported DHSP has requested maximum flexibility in response to COVID-19. There has been no response so standard regulations remain in place.
- The final table in the packet was a summary of all Part A and MAI, plus Part B from the state. These were estimates based on partial provider invoice returns due to COVID-19 disruptions, yet still reflect less underspending than had been feared. DHSP may require the Commission to re-allocate funding beyond the parameters it has granted to DHSP depending on receipt of further invoices. If so, the matter can be taken up at the Planning, Priorities and Allocations (PPA) Committee.
- Mr. Ballesteros commended DHSP for its work in spending funding down to the extent it has under COVID-19 conditions.

➲ Ms. Tolentino will take back to DHSP a suggestion to partner with sex shops/lingerie stores, and porn sites that include HIV fetish. She welcomed additional suggestions going forward.

➲ Contact Ms. Garland or Paulina Zamudio, MPP, Contracted Community Services, to offer additional suggestions.

V. BREAK

VI. WHAT'S NEXT FOR THE HIV MOVEMENT AND HOW PLANNING COUNCILS CAN DO EQUITY WORK

- Ms. Khanna reported she comes to this work as a woman living with HIV diagnosed in 2002. She currently serves as Executive Director, Positive Women's Network, USA, a membership body founded in 2008 of women and transgender individuals living with HIV. The membership ranges in age from 21 to 72 from diverse national and international backgrounds. Now in 19 states, the organization focuses on local, state, and federal policy advocacy; community organizing grounded in issues; and leadership development in communities most impacted by the epidemic.

- The organization's approach is centered in racial, gender, and economic justice as well as a human rights analysis. It views HIV as a symptom of various social, political, and cultural diseases so to address the HIV epidemic requires addressing the structural issues that create vulnerability for communities independent of HIV.
- With the election, a clear individual and electoral majority elected an administration that hopes to serve the people, but 72 million people still voted for the status quo that was centered in dismantling human rights including the safety net for many communities. That means much work remains to protect people and attain real equity in order to end the HIV epidemic. These same racial inequities are playing out in the COVID-19 pandemic reflecting the same underlying issues.
- While race is addressed in health demographics, it is seldom addressed as a construct used to determine power and access to resources such as health care, healthy food, and green spaces where one can go for a walk. People may not engage in individual acts of racism and yet still benefit by systems that are racially biased in a person's favor.
- Intersectionality recognizes that we do not live in just one axis of social and political power. Our identities are informed by, e.g., race, gender, class, immigration status, and other characteristics. One may experience privilege and oppression at the same time. For example, all women may experience sexism, but it will differ among Black, Latinx, or White women.
- It is important to consider all the many aspects of the identities of PLWH and communities vulnerable to HIV in order to provide services that are appropriate and truly useful.
- At the same time, there are also many forms of automatic privilege. People may not be as aware of areas of privilege as they are of areas of oppression because oppression often creates a stronger experience. Nor does privilege mean that a person has not experienced trauma or worked hard. It does not necessarily mean someone has received more than they deserve, but that others who do not have that privilege are receiving less. Privilege and oppression do not cancel each other out, e.g., a very low-income White person can be oppressed by poverty while also benefiting by being White.
- HIV Racial Justice Now, a collective of Black, Indigenous, and People Of Color (POC) leaders, defined racial justice as the collective practice of POC and allies to identify, dismantle, and heal from the many external and internal harms of structural and internal racism. All three points are important. Harms must be named, dismantled to halt the harm, then healed from.
- The group felt it important to collaborate across communities of color in the service of dismantling white supremacy and building power. Dismantling white supremacy does not mean getting rid of White people but, rather, dismantling the construct of white supremacy that whiteness is somehow better than living in our own truths. Anyone may internalize white supremacy, including POC, just as women may internalize patriarchy.
- Instead, the group envisioned a movement premised on solidarity, collaboration, and coalition in which we move forward together. In all ways our destinies, and the wellbeing of our communities, are linked together.
- Ms. Khanna opened conversation in asking how race as a construct shows up in the work of the Planning Council.
- Ms. Gordon replied it shows up to divide and exclude to the point at which we are ineffective and forget that everybody caught something – all our variations – light, dark, Spanish speaking, not Spanish speaking… Mr. Moreno noted sometimes certain race-based issues must be addressed before the body can move on to the agendized topics for a meeting. For example, some attendees may not understand the impact of race on an agendized topic.
- Ms. Khanna noted sometimes an explicit, deep dive on a racial topic may facilitate agenda decision-making. It can make some people uncomfortable even though it can make decision-making more possible. That can be especially true in multi-racial spaces which can be challenging, even scary, spaces to bring up vulnerabilities, money, jobs, and power dynamics.
- People on a Planning Council arrive with different levels of institutional privilege. Some may not need to worry about what they say at a meeting because they do not expect repercussions at work. Others may need to consider their words closely. Although everyone on a Planning Council has a vote, that does not mean all have the same level of privilege at the table.
- Ms. Khanna suggested considering having conversations about things like race with some shared agreements around safety.
- Racial caucusing can also help in some spaces to develop recommendations for the body, e.g., her organization has a Black Women's Racial Justice Caucus, a White Women's Dismantling Racism Caucus, and a Non-Black People of Color Caucus.
- She elevated comments from the Chat including that conversations about race are essential before getting to the actual work so time should be extended for it. Another axis of power and privilege noted was heteronormativity.
- A kind of apartheid was also called out with open-mindedness not always adopted and resources an underlying theme. Ms. Khanna affirmed that issues show up on Planning Councils in many ways, e.g., priority populations, diversity training which may imply that whiteness is normative, cultural competency which may sidestep existing community organizations, or "snow-capping" where frontline staff may reflect the community but higher level staff may not.
- Micro-aggressions may manifest in many forms in HIV service delivery. For example, grant application language like "urban" or "inner city" can be code words, "community" can be code for PLWH or POC, and "illegal" for undocumented persons.

Even ostensible compliments can be problematic, e.g., saying a person is "well-spoken" or "articulate" may reflect an assumption that the speaker was not expected to have those attributes.

- Often research or presentations may be about communities without being led by people of and from those communities.
- Another process issue can be the use of *Robert's Rules of Order* which can create barriers to participation. *Robert's Rules* can be replaced in many situations to ensure meaningful community involvement and input. When it is used, it is important to ensure attendees understand the process clearly so that they can participate equally and equitably.
- Defensiveness and political compromises may sacrifice those who are not in the room on a particular day when resource allocations are being determined. Allocations should follow impact and, if highly impacted populations are not represented at the table, then there is a responsibility to determine why and how to bring them to the table in a meaningful way. If impacted populations still are unable to attend for whatever reason it is still necessary to ensure that voice is reflected.
- Ms. Khanna offered the following action suggestions: political education of ourselves and our constituencies on race as a construct, and separate constructs of white supremacy and anti-blackness; courageous conversations and building safer spaces in which to hold them; revisiting language; centering the most impacted communities; committing to dismantle racism, patriarchy, and white supremacy within our own organizations. She reminded everyone that this is a journey. Resistance and a commitment to justice have been hallmarks of our communities since the beginning of the HIV epidemic.
- Jeffrey King spoke from the perspective of a Black gay man involved in his community. He found vocabulary, particularly of younger people, has grown to the extent of hyper-intellectualization of the plight of Black people. He felt seeing other than Black people participating in a Black Lives Matter event was almost co-opting the Black experience, Black pain, the way that Black people have been treated. That speaks to privilege to him. A dialogue can be facilitated around Black people without including Black people in the conversation while using these terms: medical mistrust, systemic racism, micro- and macro-aggressions, cultural competency, and so on. What does that mean to the people and how does it play out in public health?
- He was part of the Mental Health LGBTQI+ Task Force. Data presented from Service Planning Areas (SPAs) 4 and 6 offered no representation from Black gay men. When he asked them to explain the gap they replied, "We have to do a better job around that." But that has been a common public health response for 30+ years. Instead, we must engage the people.
- Regarding how racism plays out in the Planning Council, Ms. Granados saw it in the Commission when she sees resources, time, and staff pulled away from those who most need them to, e.g., new, distracting, work groups and caucuses. That also pertains to how people might take up space in meetings or make decisions without the most impacted people present. For example, meetings without Black, transgender, or youth participants go on as though that were not a problem. Meanwhile, we continue to onboard new White male Commissioners without pausing to reconfigure for greater representation.
- Mr. Findley suggested a more concrete approach to the topic by addressing LAC Jail – the largest jail in the world. He participates in a health group connected to Black Lives Matter that was working on alternatives to incarceration and closing Men's Central Jail. While there is no direct connection to HIV, consequences of mass incarceration intersect.
- Ms. Khanna defined "racism" as bias or prejudice in the context of power. According to that definition, and positing white institutional power, it would not be possible for POC to be racist. White allies might study and support anti-racism in their own communities. It is important to acknowledge this is not personal but, rather, the impact of systems and institutions over hundreds of years impacting everyone based on personal aspects, e.g., whether or not they are POC or immigrants.
- She continued that indicating one planned to file a complaint is in essence a harmful claim to deploy power. Caucusing is especially helpful in offering safe spaces to address some of the more sensitive aspects of these issues.
- Dahlia Ferlito, AIDS Coordinator's Office, City of Los Angeles, noted she is an active organizer with White people in anti-racism practice. She offered various resources and recommendations including *White Fragility* by Robin DiAngelo and reflection on the issues with the Alliance of White Anti-Racists Everywhere – Los Angeles at www.AWARE-LA.org.
- Mr. Valero is POC, LGBT, and PLWH so understands the need for these discussions. At the same time, he felt we can be counterproductive in our language. He questioned the impact of approaching someone who has not done much of anything and is not a racist person to say, "You not speaking out is an act of violence." Pragmatically, that can be counterproductive to the cause of eradicating HIV. Building support for the cause includes winning hearts and minds, not alienating people. The intention is not to demonize. Nevertheless, as a person of color he is torn because he realizes there are real inequities, but he also felt people are demonized, too. The Reverend Martin Luther King, Jr. specifically said we will not be able to make progress without our White partners because of the power dynamics.
- He checks all the boxes to be qualified to speak on this – POC, LBGBT, PLWH – and felt we were talking to ourselves and then come outside expecting everyone to know the dictionary of terms. He questioned whether we were being as pragmatic, productive, and efficient as we could be in talking about this, especially when considering topics like allocations. As a POC, he wanted to speak out, because this is not only about diversity of race but also about diversity of ideas.

- Ms. Khanna said this was why she recommended the Commission engage in longer term work. She did not think there was an easy answer. She also felt it OK if all are not comfortable with a conversation. She felt the world was created for some people to be comfortable while others are not so it is OK to ask anyone to be uncomfortable in the service of justice. She believes in the power of our people to hold complexity and discomfort and to fight for those who are most impacted. She also believes that if someone is threatening another that it is important not to let it go.
- Mr. Valero felt we all had the same goals but, as a POC, he was uncomfortable with the way social justice rhetoric was going. If you're a POC, you better get on the bandwagon and talk the way you're supposed to talk, act the way you're supposed to act, and educate White people in the way that you're supposed to educate White people. And if you don't, then you're not down with the Movement. Why is it that we can't have diversity of thought within tactics?
- Jeffrey King was enjoying the conversation. If anyone else is feeling a little tense and uncomfortable, that is an amazing thing because it speaks to what is really important here – honesty and people having the opportunity to express their views, how they feel, and how they experience what is happening. Why is it even important for us to have this discussion at this time in history? Speaking specifically for Black people, it is a no-brainer when we look at data on health outcomes.
- It is also important because we make a lot of assumptions. As a Black person, he was tired of starting a conversation about Black and Brown people only to end up talking about White privilege or comparisons between Black and Brown people and White people, e.g., with data. He would like to have a conversation centered on Latinx people without anyone asking about others. Or a conversation about Black people and health outcomes without anyone asking about White people. Or a conversation with White people, especially White gay men, without anyone saying we should not be discussing that. He felt it minimalizes people to compare one population to another population. Instead, we should hear from each in turn.
- At the end of the day, 30+ years later, World AIDS Day coming up, we are talking about something as if we need to teach people about common decency. Will Black people be talked about in the public health arena if no Black person is in the room? They should be if we are looking at the data and how Black people are disproportionately impacted, in this case by HIV. It should be a no brainer that the public health arena should be far more advanced in addressing the needs of Black people after millions spent in public health interventions if a Black person is in the room 30+ years later banging tables.
- He complimented these conversations, but felt much more time was needed to have them.
- Frankie Darling-Palacios noted we have been having this conversation for over a year. Speaking as a POC, the Commission can partner with anti-racist organizations in LAC so that White people can do their own work and not take up Commission time that needs to be addressed to other topics. At the same time, that would separate those conversations so that someone attending for the first time will not feel uncomfortable or unwelcome.
- Ms. Gordon said one thing precipitating much of this discussion was a perception of too few Black people at the table. Yet, it is hard for a Black person to be at any table due to socio-economic issues, racism, funding, child care, homelessness. That means we have a responsibility to talk about the data whether there are Black people at the table or not.
- Ms. Khanna offered final thoughts before leaving for another meeting. She hoped no one saw these conversations about race, racial injustice, and power as a distraction. This is the actual work that our communities need to do to meet the needs of the communities most impacted by HIV in the United States. She encouraged people to consider their feelings about the day and utilize resources such as *How to Be an Antiracist* by Ibram Kendi, MA, PhD.
- She offered continued support and help with ways to break down barriers to participation, e.g., greater economic compensation, or more convenient hours. She found the Commission's willingness to engage in this conversation hopeful and a testament to what the Commission was willing to do for its community.

VII. COMMUNITY SPEAK OUT: What EHE Means to Me *(Opportunity for Community Members to Share Thoughts, Perspectives, and Words of Inspiration)*

- Felipe Gonzalez and Carlos Moreno facilitated the discussion. Mr. Gonzalez began by thanking everyone for staying and engaging. He felt racism and discrimination warranted dedicating an entire Commission meeting to this issue.
- Even his own community clinic has issues. The previous director, a gay man, prohibited Mr. Gonzalez from placing Commission member recruitment flyers in the front waiting room "because people don't want to hear about HIV."
- Mr. Morales also thanked everyone who has stayed, the presenters, and all the smart and wonderful dialogue.
- This part of the meeting is dedicated to inviting ideas on how to best move forward with ending the HIV epidemic. He noted, however, that the dialogue over the past 45 minutes or so exemplified the concern he raised earlier about meetings being sidetracked. He encouraged Commissioners to address bias work outside the Commission to minimize that risk.

- Today's presentations were exciting in envisioning a present and possible future in which people take HIV testing into their own hands at home in new and innovative ways. Also exciting, the promise of improved HIV education for primary care doctors sufficient for them to integrate routine HIV care into their practices without the need for HIV specialist referral.
- Frankie Darling-Palacios shared thoughts specifically about outreach to the transgender community. There is difficulty in accessing meetings as well as difficulty in navigating being both a service provider and serving the community. Seven years working in public health addressing the most marginalized communities has provided the opportunity to be humbled, come to a space of learning about other communities, and support those directly impacted in being heard – especially by finding voices most needed by this body and doing the work to ensure they are present, e.g., outreach to youth policy convenings to advise them of Commission meetings. Acknowledging privilege due to having a degree, being lighter-skinned, and being a United States citizen highlights the need to have these difficult conversations and the call to bring new voices onboard.
- Mr. Valero wanted to plan for next year especially meeting people where they are. Many more youth are moving to areas like Whittier, Norwalk, Diamond Bar, Chino Hills. East LAC provider availability is poor so youth may have health insurance now, but transition to Ryan White or Medi-Cal in the next few years. He wanted to connect with that population before they need to access services on an emergency basis. Related to that, he wanted to engage with more private health care partners to help in this transitional work and inform their patients about PrEP, testing, Treatment as Prevention (TasP).
- Jeffrey King had a few thoughts on what EHE meant to him. First, he felt it time to take a deep dive because many of these conversations have not changed in 30+ years. In addition, speaking for Black people, we need to own the issue, foster solutions, and take responsibility for the outcomes in these partnerships.
- We can no longer accept from service providers language like, "Black people are a hard to reach population." Or accept from research presenters, "Our retention rate among Black people was very low," or "It was hard to find Black people." It is difficult to hear a presentation from the Department of Mental Health (DMH) reflecting 0% Black gay men in SPAs 4 and 6. He suggested the Standards and Best Practices (SBP) Committee incorporate a requirement for community mobilization and a Community Advisory Board (CAB) representative of that community in every Standard of Care (SOC).
- Dr. Clavreul encouraged everyone to look at each other as individuals and respect each other. She has approached all people that way throughout her life and it has worked well for her.
- Mr. Murray appreciated today's conversation. He was glad of it, felt it was badly needed, and was glad people were honest. Yet, the question remains how we can solve racial and socioeconomic disparities with the COVID-19 pandemic when we are only scratching the surface 30+ years into the HIV pandemic. He added that as Commissioners we are all appointed public officials representing the people. As such, we should listen deeply to each other, not take offence or take things personally.

VIII. CLOSING REMARKS AND INSPIRATION FOR 2021

- Ms. Gordon thanked everyone for participating in this meeting authentically. There is much work, but we can go through it.
- Mr. Lee appreciated the open communication and honesty from everyone. He started this work in 1988. We were talking about disparities then, have since, and will again. He called this body to think about how to address it anew.

ADJOURNMENT AND ROLL CALL: The meeting adjourned at 1:50 pm in memory of Tom West. He represented the City of West Hollywood on the Commission and on the Prevention Planning Council from its inception until he became the City of West Hollywood City Clerk in 2005. The Commission honored Mr. West's long service to the community.
Roll Call (**Present)**: Alvizo, Coffey/Burton, Darling-Palacios, Donnelly, Granados, Halfman, Green (Thomas), Kochems, Mills, Moreno, Murray, Nelson, Pérez, Preciado, Rogel, Rosales, San Agustin, Sattah, Spencer, Valero, Ballesteros, Gordon.

The time is now.

Ending the HIV Epidemic

2020: RISING ABOVE THE CHALLENGE

FINAL DRAFT | 1.28.21

ANNUAL REPORT
JANUARY-DECEMBER 2020

Los Angeles County Commission on HIV

www.hiv.lacounty.gov

Tel: (213) 738-2816

LOS ANGELES COUNTY COMMISSION ON HIV

3530 Wilshire Blvd., Suite 1140, Los Angeles CA, 90010

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VISION AND MISSION STATEMENTS

VISION

A comprehensive, sustainable, accessible system of prevention and care that empower 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 (LAC) Commission on HIV (COH) 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 COH 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 inclusive of all Service Planning Areas (SPAs) and Health Districts (HDs).

ROLES AND RESPONSIBILITIES

The Los Angeles County Commission on HIV (COH) serves as the local planning council for the planning, allocation, coordination and delivery of HIV/AIDS and Sexually Transmitted Diseases (STD) services. The COH is composed of 51 members appointed by the Board of Supervisors (BOS) and represent a broad and diverse group of providers, consumers, and stakeholders. Thirty-three percent of the membership are people living with HIV who are consumers of the federally funded Ryan White Program.

As an integrated planning body for HIV/STD prevention and care services in Los Angeles County, through its five standing committees (Executive, Operations, Planning, Priorities and Allocations (PP&A), Public Policy, and Standards & Best Practices (SBP), the COH is responsible for:

- Setting care/treatment priorities/allocations
- Developing a comprehensive prevention and care plan
- Assessing the administrative mechanism of service delivery
- Evaluating service system effectiveness
- Service coordination
- Conducting needs assessments
- Setting minimum service standards/outcomes
- Defining ways to best meet the needs
- Resolving service system grievances
- Promoting the availability of services
- Evaluating other streams of funding
- Advising the BOS on all County HIV and STD funding
- Policy development and advocacy work
- Advising the Board on other HIV and STD-related matters

2020: RISING ABOVE THE CHALLENGE

2020 was a year like no other in the recent history of mankind. The year was marked by several global challenges, leading with the devastating impact of the novel coronavirus (COVID-19) pandemic and the nation's reckoning with the ills of racism anti-Blackness in

America and beyond. COVID-19 laid bare before our eyes what the HIV movement has recognized as the biggest wall preventing our victory over HIV - racism is the root cause of health and social disparities. The same communities of color who have overwhelmingly shouldered the burden COVID-19 infections, deaths, and hospitalizations, are the same communities that suffer from HIV and STDs the most. At the end of 2018, approximately 0.6% of the 10.3 million Los Angeles County (LAC) residents were living with HIV. The group with the plurality of people with HIV (PWH) are Latinx cisgender men who have sex with men (~40%), followed by White cisgender men who have sex with men (26%), followed by Black/African-American cisgender men who have sex with men (23%).[1] The balance of males with HIV are injection drug users of multiple racial/ethnic groups as well as cisgender American Indian/Alaskan Native, Asian or Pacific Islander men who have sex with men. Black/African American males, female and transgender persons and American Indian/Alaskan Native males are disproportionately impacted with HIV compared to their share of the LAC population.

Despite the unprecedented events of 2020, the COH rose above the challenges of the pandemic and made notable accomplishments in moving closer to ending the HIV epidemic, once and for all. The Commissioners showed exemplary leadership in their courageous counter-response to the novel coronavirus. In the midst of the COVID-19 pandemic, the fight to end the HIV/AIDS pandemic which started in the 1980s, continues to ravage communities. With the biomedical and treatment advances accrued over the years to fight HIV, we can no longer excuse another day and another case of HIV. We have the tools to prevent HIV and keep those living with HIV, healthy and thriving. The COH 2020 Annual Report reflects upon its key 2020 accomplishments in acknowledgement of the core values that have sustained the HIV movement.

#StrongerTogether: Rapid Mobilization and Response to the COVID-19 Public Health Emergency

The COH cancelled its March 13, 2020 in-person meeting out of abundance of caution due to the growing cases of the novel coronavirus. Commissioners, staff, and stakeholders swiftly mobilized to care for themselves and connected with friends and community members to ensure their safety and access to essential supplies for the duration of the shelter in place order. Commissioners affiliated with medical clinics, acted quickly to protect their staff, and maintain critical services for PWH and communities at risk for HIV, STD, and COVID-19. Collectively, the Commission contributed to a stronger public health response as evidenced by the following key accomplishments:

- The COH, in partnership and consultation with the DHSP and local HIV service organizations, developed a letter to the community offering medical advice and resources to help promote and protect the health and safety of people living with HIV (PLWH) in response to the novel coronavirus pandemic. The letter, published in English and Spanish, was much needed and reached over 6,000 individuals through the COH's listserv, website and social media platforms. (Novel Coronavirus, COVID-19 and People Living with HIV A Message to the Community and Our Partners March 16, 2020)

[1] Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2019. Published May 2020. http://publichealth.lacounty.gov/dhsp/Reports.htm. Accessed 1/5/21.

- Service calls for maintaining access HIV medicines and care increased around the initial rounds of shelter in place orders. In response, staff reorganized the COH and HIV Connect websites to publish a series of COVID-19 information bulletins to keep the community informed of critical resources, such as medical care, social services, and other public health messages. (Information and Resource Updates from the Commission on HIV: Sustaining the HIV Movement Amidst the COVID-19 Public Health Emergency)

- Rapidly transitioned from in-person to virtual meetings using WebEx. Staff and Commissioners are to be commended for quickly learning and adapting to the WebEx videoconferencing platform. Despite technical challenges, the COH saw an increase in meeting participants due to the ease of participating through videoconferencing technology.

- The COH's number of GovDelivery subscribers grew from 6,000 to over 14,000 by the end of 2020, an indication of increased community participation in the Commission's work and activities.

- Answering the call for duty, COH staff served as Disaster Service Workers (DSWs) to support the COVID-19 contact tracing teams, Project Room Key, food delivery calls for seniors, and the general elections. Staff maintained full business operations and responded to calls for service referrals while teleworking and with staff deployed to DSW assignments.

Compassion in Time of COVID-19

Without question, COVID-19 has affected people from all walks of life and with even more profound impact on communities of color and people experiencing poverty and homelessness. Many individuals have lost their jobs, social support networks, and access to care. In response, the COH used its Board-directed charge and resources to demonstrate compassion in the following ways:

- Increased stipends for unaffiliated consumer members from $100 to $150 as allowed by the COH bylaws in recognition of the economic hardships faced by PWH due to the pandemic.

- In collaboration with DHSP, the COH conducted a communitywide bilingual COVID-19 Impact Survey to assess and understand the impact of the novel coronavirus on Commissioners, PWH, service providers, and individuals at high risk for HIV and STDs. The survey was administered mid-March to May and nearly 300 individuals responded. Of those, 219 were PLWH, and 12% completed the survey in Spanish. Service providers reported transitioning most clinical services to telehealth and working longer and more intense hours to balance work and family commitments. Some indicated that they had been furloughed at the time of the survey and feared losing their jobs. In addition, service providers reported challenges of being supportive from a distance, lack of personal protective equipment (PPE), and surge capacity (resources and staffing). For consumers, they reported feelings of anxiety, isolation, and stress. Some reported complete loss of income. Consumers and providers reported an increase in demand for food, ride sharing transportation, financial assistance, mobile phones, mental health services, childcare, home delivered food and medicines. For some, their housing situation became more

unstable. Lack of access to high-speed and broad band internet and reliable computers was also reported. To respond to these community needs, the COH worked with DHSP to increase food pantry services, ensured that access to HIV medications and core medical services were maintained, and PPE kits were made widely available PWH using a network of HIV service sites throughout the County.

- The Aging Task Force (ATF) developed the recommendations to the COH, DHSP, and other County and City partners to address the unique needs of older adults (individuals who are aged 50 and older) population. According to the Health Resources and Service Administration (HRSA), the Ryan White program client population is aging. Of the more than half a million clients served by Ryan White program, 46.1 percent are aged 50 years and older and this continues to grow. While Ryan White clients in LAC show higher engagement and retention in care, and viral suppression rates, within the 50+ population there exists disparities by racial/ethnic, socioeconomic, geographic, and age groups stratification. The ATF recommendations were centered around the core issues of ongoing research and needs assessment, workforce and community education and awareness, and expansion of HIV/STD prevention and care services for older adults.

- Under the leadership of the Planning, Priorities and Allocations (PP&A) Committee, the COH worked with DHSP to allocate and shift funding as appropriate, to critical medical and support services including but not limited to emergency financial assistance, housing, and mental health. PP&A continued to lead the COH's multi-year priority setting and resource allocation process to avoid interruption of care for PWH.

- A most notable achievement for the COH was the accelerated pace at which the service standards for the Emergency Financial Assistance (EFA) was completed and approved. In June 2020, the COH, approved the EFA service standards and requested that DHSP move expeditiously to put in place the contractual mechanisms to implement EFA services especially during these economically challenging times. The Standards and Best Practices (SBP) Committee worked diligently with providers, consumers, subject matter experts, and DHSP staff to develop the EFA standards. EFA provides limited one-time or short-term payments to assist a Ryan White Part A client with an urgent need for essential items or services due to hardship. The purpose of EFA is to ensure clients can pay for critical services that play a role on whether a client is able to stay engaged in medical care and/or adhere to treatment. By the end of 2020, DHSP implemented training for Medical Care Coordination (MCC) teams on how to provide EFA to eligible clients and enacted contracts with 2 agencies to administer the program. The COH continues to work with DHSP to troubleshoot, improve the program, and minimize barriers to services.

- The COH updated and approved the psychosocial support services standards in September to keep PWH in care and maintain their quality of life. The purpose of psychosocial support services is to remove or lessen barriers to care and treatment through counseling services and mental health support. The implementation of psychosocial services would help in meeting the increase in demand for mental health services and social support during the pandemic and the recovery phase of the County's emergency response.

- COVID-19 has deeply impacted women and families with school-aged children. To support women living with HIV, the SBP Committee updated the childcare service

standards and harnessed feedback from key partners such as local HIV providers that serve a large number of women of child-bearing age and the Women's, Consumer, and Transgender Caucuses. The childcare standards are slated for approval in early 2021.

Commitment to Allyship and Racial Justice: To End HIV, We Must End Racism

Institutionalized racism affects general health care as well as HV/AIDS health intervention and services in communities of color. The overrepresentation of Black individuals in various disease categories, including HIV/AIDS/STDs, is rooted in racism. To accelerate an end to HIV, communities from across the County and the nation must build alliances dedicated to ending racism. While the COH has grappled with its own stance and discomfort in addressing privilege and manifestations of implicit bias in the body, there continues to be willingness for members to be more self-reflective and engage in trainings. While these steps may seem small, they are a starting point for engaging in the lifelong journey of unlearning and undoing racism.

- On February 12, the Black/African American Community Task Force (BAAC TF) in commemoration of the National Black HIV/AIDS Awareness Day led a panel composed of Black/African American medical providers who shared their experiences and best practices in serving Black/African Americans impacted by HIV/AIDS and STDs in LAC, how to address barriers and social determinants of health that disproportionately affect Black/African Americans, and solutions in ending the HIV epidemic.

- Under the leadership of the BAAC TF, the COH released a Statement Solidarity to acknowledge that the Black community shoulders the unequal and unacceptable burden of HIV and STDs. Racism is the root cause health, social, economic and inequities, injustice and generational trauma in the United States. The unacknowledged history of the colonization of Native Americans, slavery, and the sustained forms of structural racism in the United States, continue to manifest in police brutality, generational poverty and trauma, and anti-Blackness. The COH joined the Board of Supervisors, Department Directors, and leaders across the country in condemning the killing of George Floyd and the far too many Black men, women, and children that have perished in the hands of police for engaging the daily rituals of life and for simply breathing and living.

- The BAAC TF submitted recommendations aimed at expanding access to the County's contracting process to Black-led organizations to Prosper LA. The Task Force advocated for an inclusive contracting process to identify agencies who have a track record of proven and effective grassroots/community empowerment efforts that reach specified Black/African American audiences. A strong network of County-funded organizations that are Black-led and serve the Black community would improve trust, outreach, linkages to care, retention in care, and other interventions that are effective in reducing new HIV cases.

- Under the leadership of the Public Policy Committee, the COH's 2020 Policy Priorities sought to advance health equity, reduce HIV-related stigma, and address social determinants of health such as poverty, education, violence, substance use, food insecurity, and transportation in order to improve health outcomes for PLWHA and special populations at highest risk for contracting HIV. The PP Committee worked with the BAAC TF, Transgender Caucus and other subgroups of the COH to facilitate more cross-collaborations on policy actions.

- The COH submitted comments to the Housing and Urban Department (HUD) opposing a proposed rule change that would deny affordable housing to transgender individuals and leave them even more vulnerable to HIV disease acquisition and progression. In LAC, transgender individuals shoulder a disproportionate burden of HIV, with poorer health outcomes across the HIV continuum.

- The COH supported community mobilization efforts that led to the passage of AB2218 Transgender Wellness and Equity Fund. AB2218 opens the way for the California Department of Public Health to establish funding grants to organizations serving people that identify as transgender, gender nonconforming, or intersex (TGI), to create or support TGI-specific housing programs and partnerships with hospitals, health care clinics, and other medical providers to provide TGI-focused health care, and related education programs for health care providers.

Community Engagement

One of the hallmarks of the HIV movement is sustaining a robust community engagement in ending HIV. Throughout 2020, the COH worked diligently to convene virtual spaces for meaningful deliberations and forums about ending HIV in the context of COVID-19.

- In an effort to continue community engagement and connect individuals to services during the COVID-19 pandemic, the COH launched the Virtual Lunch and Learn (VLL) series to hear from service providers how the public health crisis has affected services and programs they offer, and share challenges, successes and lessons learned during these unprecedented times. In addition, the series provided a virtual space for participants to share insights and recommendations on how to sustain the HIV movement in LAC amidst the COVID-19 pandemic. From May through November, the COH held 11 virtual panels and educational series featuring speakers and experts in the HIV field and community health. Approximately 300 individuals attended these series and provided a critical space for community support in time of physical distancing and sheltering in place.

- The Operations Committee led the recruitment efforts and training for new and returning Commissioners. The community interest in serving on the COH remained strong as evidenced by the recruitment of 11 new Commissioners. Six virtual training sessions where completed between September through November with strong participation including members of the public.

- The COH launched the Mentorship/Peer Collaborator Program in October and held a virtual orientation for participants in November. The goal of the program is to nurture leadership by providing one-on-one support for each new Commissioner. Peer collaboration fosters a culture of understanding and decision making where each member appreciates their unique contribution to the group.

- Young gay and bisexual men, especially those who come from Black, Latinx, and Native communities, are disproportionately represented in the HIV epidemic. Active and sustained involvement is an integral part of an inclusive community planning process. To that end, the COH engaged with youth serving organizations and youth receiving HIV/STD prevention and care services in developing recommendations for outreach, engagement and retention on the COH and HIV community advisory boards. Consultations youth

stakeholders led to the development of youth-friendly social media content for the COH's Facebook and Twitter messages.

Ending the HIV Epidemic in the Context of COVID-19

The U.S. Department of Health and Human Services has set a national agenda, the Ending the HIV Epidemic (EHE): A Plan for America initiative to reduce new HIV cases by at least 90% by 2030. The 2020 theme for World AIDS Day (WAD) was "Ending the HIV/AIDS Epidemic through Resilience and Impact". The theme was especially poignant as the HIV community had been newly challenged by, and often led the response to, COVID-19 in communities around the globe. COVID-19 not only forced us to adapt our response to HIV/AIDS in communities to ensure continuity of services, but also reinforced the urgency of ending the HIV/AIDS epidemic in the U.S. and around the world. The theme was a reminder of what we can achieve together when we focus on impact by using data to deliver high quality, people-centered HIV prevention and treatment services to those most in need, tackling stigma and discrimination, and empowering communities. It reaffirmed the essential role of resilience, which enables individuals and communities to meet the challenge of HIV/AIDS even in times of adversity.

- The COH forged ahead with its commitment to ending HIV by hosting several meetings for ongoing community input in shaping local strategies aimed at addressing HIV health inequities and elevating consumer voices in all aspects of service delivery, community planning, and policy development.

- Promoted the DHSP EHE Townhall meetings in English and Spanish in September and October and reached over 6,000 subscribers to the COH information network. The townhalls aimed to engage the community at large in developing the local EHE plan. COH created a standing agenda item at meetings to ensure ongoing flow of communication and feedback on the plan and ideas for service enhancements. The COH formally submitted recommendations on the draft EHE plan to DHSP during the public comment period.

The COH dedicated for community dialogues and presentations around EHE to facilitate information sharing and coordination of services across multiple key stakeholders and service delivery partners.

- The University of California Center for HIV Identification, Prevention and Treatment Services (CHIPTS) presented their EHE-related research at the August COH Meeting. The topics were: (1) Regional Response to HIV Eradication Efforts in California Counties presented by Steve Shoptaw, PhD; 2) Use of Technology-based PrEP Services to Improve Uptake, Adherence, and Persistence presented by Ronald A. Brooks, PhD and Dilara K. Üsküp, PhD; and 3) Preparing for Long-Acting Injectable Treatment for HIV in Los Angeles presented by David Goodman-Meza, MD, MAS
- The Los Angeles Homeless Services Authority (LAHSA) joined the September COH meeting to provide an update on the County's Homeless Count, Project RoomKey and permanent housing for PLWH.
- The City of Los Angeles Housing Opportunities for Persons with AIDS (HOPWA) provided information on the $2.8 million in funding they received under the CARES Act and solicited input from Commissioners and the community on how to use those resources.

- In response to the community's interest and concerns about the impact of COVID-19 on PLWH, Dr. Eric S. Daar, M.D., Chief, Division of HIV Medicine Harbor-UCLA Medical Center, Investigator, Lundquist Institute discussed the Intersection of COVID-19 and HIV at the October COH meeting.
- The theme for the Annual Meeting, held in November, was "Continuing the Commitment to End HIV, Once and For All" and demonstrated the Commission's commitment community and engagement to end HIV. Guest speaker, Harold Phillips, Senior HIV Advisor and Chief Operating Officer of Ending the HIV Epidemic: A Plan for America. US Department of Health and Human Services, Office of Infectious Disease and HIV/AIDS Policy (OIDP), shared federal updates on what to expect in 2021 and insights on building an inclusive HIV movement. DHSP colleagues provided an overview of EHE funding awards received by the Division and status of program expenditures. Staff also shared common themes and feedback received from the community on the draft EHE plan. Examples of general feedback include focusing on highly impacted communities and vulnerable populations (communities of color, youth, transgender population, people who inject drugs (PWID)/substance users , people experiencing homelessness, etc.) and creating an overarching strategy or goal specific to anti-racism, supporting communities of color, racial justice.
- Given the importance of prevention and linkage to care, DHSP also provided an overview of the Take Me Home HIV Self-Testing program and their plans to expand the program throughout the County. TakeMeHome is a national platform for ordering home HIV test kits that helps public health departments to expand testing access to community members who might hesitate about walking into a clinic. According to the DHSP 2019 Annual HIV Surveillance Report, among the estimated 57,700 persons aged ≥ 13 years living with HIV at yearend 2017, approximately 11% or 6,400 persons were unaware of their infection. Knowing one's HIV status is a critical strategy for ending HIV.

- The Annual Meeting also featured Naina Khanna, Executive Director, Positive Women's Network, USA who presented on how HIV planning councils can engage in more intentional work on achieving health equity. The group's discussion on racism and privilege elicited an uncomfortable, yet necessary conversation on authentic forms inclusivity and racial and social justice.

Los Angeles County has been a national pace setter in developing and implementing responsive and innovative programs to curb the HIV/STD epidemics. With the continued support and revitalized commitment to ending HIV, resilience and optimism, the COH looks forward to working the Board of Supervisors and County leadership to finally end HIV, once and for all. **The time to end HIV is now and to end HIV, we must end racism.**

COMMISSIONERS (JANUARY - DECEMBER 2020)

Miguel Alvarez, Alternate
Everardo Alvizo, MSW, City of Long Beach Representative
Alvaro Ballesteros, MBA, Co-Chair, Supervisorial Board Office 1 Representative
Traci Bivens-Davis, MA, Supervisorial Board Office 2 Representative (resigned 6/16/20)
Alasdair Burton, Alternate
Danielle Campbell, MPH, Supervisorial Board Office 2 Representative
Raquel Cataldo, Supervisorial Board Office 5 Representative

Pamela Coffey, Unaffiliated Consumer, Service Planning Area 6
Michele Daniels, Unaffiliated Consumer, Service Planning Area 1
Frankie Darling-Palacios, Provider Representative
Erika Davies, City of Pasadena Representative
Kevin Donnelly, Unaffiliated Consumer, Service Planning Area 8
Aaron Fox, MPM, Ryan White Part C Representative
Jerry D. Gates, PhD, Ryan White Part F Representative
Felipe Gonzalez, Unaffiliated Consumer, At-Large
Bridget Gordon, Co-Chair, Unaffiliated Consumer, At-Large
Grissel Granados, MSW, HIV Stakeholder Representative
Joseph Green, Unaffiliated Consumer, At-Large
Thomas Green, Alternate
Karl Halfman, MA, Ryan White Part B Representative
Diamante Johnson, Unaffiliated Consumer Supervisorial District 5
William King, MD, JD, AAHIVS, HIV Stakeholder Representative
Lee Kochems, MA, Behavioral/Social Scientist Representative
David P. Lee, MPH, LCSW, Provider Representative
Eduardo Martinez, Alternate
Anthony Mills, MD, Provider Representative
Carlos Moreno, Provider Representative
Derek Murray, City of West Hollywood Representative
Paul Nash, PhD, HIV Stakeholder Representative
Katja Nelson, MPP, Supervisorial Board Office 3 Representative
Mario Pérez, MPH, Ryan White Part A Representative
Juan Preciado, HIV Stakeholder Representative
Joshua Ray, Unaffiliated Consumer Supervisorial District 3
Nestor Kamurigi, Alternate
Ricky Rosales, City of Los Angeles Representative
Harold Glenn San Agustin, MD, Provider Representative
Martin Sattah, MD, Provider Representative
Tony Spears, Alternate
LaShonda Spencer, MD, Provider Representative
Kevin Stalter, Unaffiliated Consumer, Service Planning Area 4
Maribel Ulloa, Housing Opportunities for People with AIDS (HOPWA) Representative
Justin Valero, Supervisorial Board Office 4 Representative
Kayla Walker-Heltzel, Alternate
Amiya Wilson, HIV Stakeholder Representative
Greg Wilson, HIV Stakeholder Representative (resigned 6/11/20)

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Cheryl A. Barrit, Executive Director
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Sonja Wright, Senior Board Specialist
Yeghishe Nazinyan, Epidemiologist/COH-DHSP Liaison

LOS ANGELES COUNTY COMMISSION ON HIV (COH) 2021 MASTER WORK PLAN
DRAFT/FOR REVIEW and DISCUSSION ONLY (1.5.21)

Co-Chairs: Bridget Gordon & David Lee		
Approval Date:	**Revision Dates:**	
Purpose of Work Plan: To focus and prioritize key activities for COH Committees and subgroups for 2021. **Prioritization Criteria:** Select activities that 1) represent the core functions of the COH; 2) advance the goals of the local Ending the HIV Epidemic (EHE) Plan; and 3) align with COH staff and member capacities and time commitment; 4) ongoing COVID public health emergency response and recovery priorities.		
#	**TASK/ACTIVITY**	**TARGET COMPLETION DATE**
1	Collaborate with the Human Relations Commission and other trainers to design and implement trainings and facilitated discussions on managing conflicts, interpersonal relationships, and implicit bias.	Start February/Ongoing
2	Planning Council effectiveness evaluation technical assistance provided by HealthHIV. • Will evaluate the effectiveness of the structure, policies and procedures, membership, and stakeholder/consumer engagement integrated HIV planning groups.	June
3	Conduct EHE focused strategic planning for the Commission. • Strategic planning sessions will lead to the development of an EHE operational plan for the Commission. • Conduct an in-depth analysis of EHE plan and operationalize relevant activities for the Commission. • Determine how to best support and supplement the work of the DHSP EHE Steering Committee. • Operationalize specific roles and goals for the Commission to end the HIV epidemic in LA County in 10 years. • Collaborate with Commission Liaison to the DHSP EHE Steering Committee to learn and understand how to best support and supplement each other's work.	May-June
4	Develop an EHE Community Engagement and HIV Service Promotion Speaker's Tool Kit for Commissioners to use in community outreach and presentations. • Toolkit seeks to increase community awareness of EHE and local services. through Commission meetings, Virtual Lunch and Learn events; HIV Connect resource website; social media; virtual and in-person (pending DPH guidance) health and resource fairs (these may be ongoing activities)	March
5	Implement National Minority AIDS Council (NMAC) BLOC training for consumers • Customized training aimed at supporting consumer leadership development.	June
6	Implement activities aimed at integrated prevention and care planning, priority setting and resource allocation.	Start Jan/Ongoing
7	Review BAAC and ATF charge and implement recommendations best aligned with the purpose and capacity of the Commission	Start Jan/Ongoing
	****Subject to change and does not include ongoing activities for Committees and subgroups.****	

Los Angeles County Commission on HIV
Commitment to Racial Justice Framework
(DRAFT 1.20.21/Executive Committee 1/28/21)

Purpose and Background:

To end HIV, once and for all, we must confront racism in all forms. Guided by the Los Angeles County Board motion establishing an anti-racist policy agenda, this document proposes an overarching framework to guide the Commission on HIV's efforts to advance racial justice and eliminate HIV disparities.

The principles outlined this framework seek to challenge COH practices, behaviors, and ways of thinking to root out racism, implicit and explicit biases, and create allies from all sectors of the community. To accelerate an end to HIV, Commissioners must build alliances dedicated to ending racism. Black/African American males, female and transgender persons and American Indian/Alaskan Native males are disproportionately impacted with HIV compared to their share of the LAC population.

While the COH has grappled with its own stance and discomfort in addressing privilege and manifestations of implicit bias within the body, there continues to be a willingness amongst members to be more self-reflective and engage in trainings. While these steps may seem small, they are a starting point for engaging in a lifelong journey of unlearning and undoing racism.

I. Build skills to engage in difficult conversations

Confronting racism is an uncomfortable but a necessary ongoing conversation. It is proposed that Commissioners first engage in ongoing coaching and training on interpersonal communication skills and how to engage in difficult conversations. The ongoing training strives to normalize dialogues about race and other forms of "isms" and move the tone of the discussions from a place of silence, denial, and personal attacks to courageous and inclusive conversations.

Proposed Actions:

- Partner with the Los Angeles County Human Relations Commission for ongoing coaching, training, facilitation support, and one-on-one or small group mediation, as needed. The Human Relations Commission is committed to working with the Executive Committee and the full body in developing customized trainings for the Commission. The Board has directed the Human Relations Commission and the Chief Executive Office (CEO) to track the outcomes and progress made under the Board's motion and policies that address

racial justice. An ongoing partnership between the two Commissions would be mutually beneficial to achieve similar goals and objectives.

- Encourage self-paced learning by recommending books on racism and building alliances. Commissioners may join discussion groups in the community to help process critical information and reflect on personal commitment to racial justice.
- Consider other trainers recommended by the Black/African Community Task Force on topics such as, but not limited to, implicit bias, medical mistrust, and historical/generational trauma.

II. Embrace key areas from the Los Angeles County Board motion establishing an anti-racist policy agenda within the context of the Commission on HIV's charge and functions.

A. Recognize, affirm, and declare that racism is a public health matter. Racism against Black people has reached crisis proportions that result in large disparities in family stability, health and mental wellness, education, employment, economic development, public safety, criminal justice, and housing.

Actions:

- Center the work of the COH around the needs of the Black community and use the Black/African American Community Task Force recommendations to help inform the body's deliberations, decisions, and priorities.
- Consider reviewing HIV and STD data in the context of other health, social, and economic issues and how overlapping data may be used to help understand and appreciate the magnitude of HIV disparities.
- Take time to read and support recommendations and issues emanating from the various COH caucuses and task forces (i.e., Women, Transgender, Consumer, Aging, Black/African) and strive to understand the role of intersectionality in the context of HIV/STD.

B. Address the eliminate racism and bias in the County.

Actions:

- Participate in trainings on implicit bias, medical mistrust, privilege, power dynamics, and other relevant topics provided by the County and partners in the academic and non-profit sectors.

- As part of the COH membership application and renewal process, consider identifying at least one concrete way Commissioners could demonstrate their commitment to racial justice as part of member responsibilities.
- Achieve consensus on how Commissioners would name and call out racism, bigotry, and other forms of "isms" when they manifest in group discussions and deliberations. In calling out manifestations of racism, one must be thoughtful about the language used and focus must be placed on the behavior, not the individual. The Human Relations Commission may play a role in facilitating this process and teach Commissioners the skills needed to adopt attitudes of mutual acceptance and respond productively to conflicts and differences.

C. Evaluate existing County policies, practices, operations, and programs through a lens of racial equity in order to more effectively promote and support policies that prioritize physical and mental health, housing, employment, public safety, and justice in an equitable way for African Americans.

Actions:

- Continually assess and reflect on the composition of the COH and gauge how people of color are represented in decision-making and leadership positions.

- Prioritize the recruitment and leadership development of members who represent communities disproportionately impacted with HIV compared to their share of the LAC population (Black/African American males, female and transgender persons and American Indian/Alaskan Native males).

- Rank HIV service categories and allocate resources based on data and populations that demonstrate the greatest need for prevention and care services.

- Use racial equity lens to help shape service standards and improve service delivery systems.

- Champion public policies that dismantle structural racism and those that advance equitable access to universal healthcare, education, social services, and economic opportunities.

HIV PLANNING BODY ASSESSMENT

Los Angeles County Commission on HIV

INTEGRATED HIV/AIDS PLANNING IHAP TA CENTER

HealthHIV

HEALTHHIV STAFF

Marissa Tonelli

Director of Health Systems Capacity Building

Eve Kelly

Capacity Building Coordinator

Axum Taylor

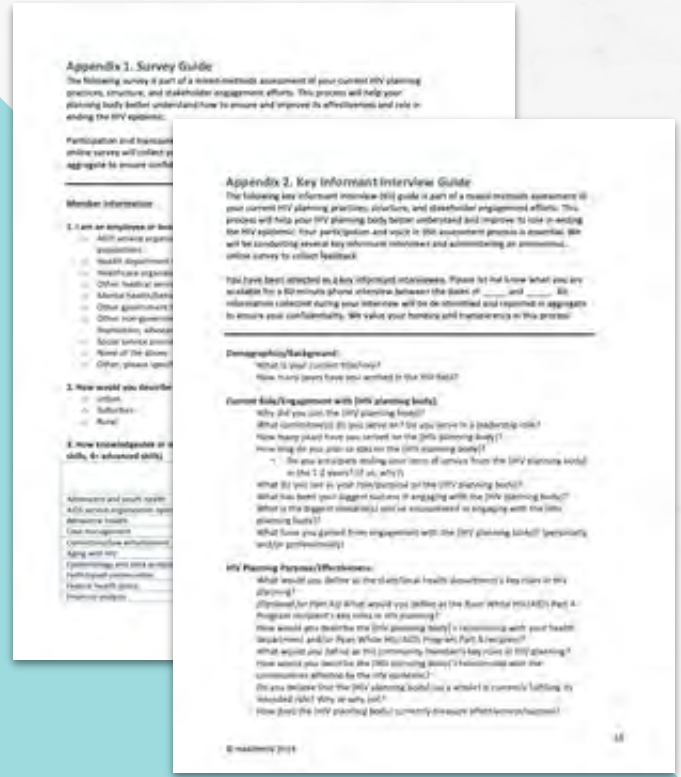
Capacity Building Intern

Issue: Effectiveness of HIV Planning

Barriers to HIV planning effectiveness can include:

- Planning burnout among community members, health department staff and key stakeholders
- Need for integration and/or alignment of planning activities and plan development
- Lack of meaningful community engagement and member representation and inclusion in HIV planning
- Limited feedback loops to track planning bodies' impact on HIV health outcomes
- Inefficiency in updating policies and procedures to reflect changing HIV and healthcare landscapes

Solution: Comprehensive HIV Planning Body Assessment


Appendix 1. Survey Guide

Appendix 2. Key Informant Interview Guide

- HealthHIV developed a first-of-its-kind HIV planning body assessment tool
- Piloted with three diverse HIV planning bodies
- Rationale for tool: Gather community and HIV planning member insights and feedback to improve effectiveness of HIV planning

Goal

Identify key strengths and areas for improvement related to the effectiveness of an HIV planning body's operating structure, policies and procedures, membership, and stakeholder/consumer engagement.

Outcomes

Clear, actionable findings and implications based on a confidential survey, key informant interviews, and document review presented back to the planning body to facilitate reflection and strategy development.

HealthHIV

"Effectiveness" is defined by how well the planning body's structure, policies and procedures, and consumer engagement supports its ability to carry out its mission and objectives.

DEFINE "EFFECTIVENESS"

ASSESSMENT AREAS

Topics Covered in the assessment tools:

- Membership demographics, background and skills
- Member engagement and understanding of role
- Planning body structure & policies
- Recruitment and orientation activities
- Relationship with external stakeholders
- How outcomes are measured
- Engagement in EHE
- Key successes and areas for improvement
- Future goals/anticipated challenges

HealthHIV

ASSESSMENT TOOL(S)

Anonymous Survey

All members and key stakeholders
40 questions (multiple choice and open ended)
Fielded online (via SurveyMonkey™)

Key Informant Interviews (KIIs)

6-8 members selected with diverse perspectives
28 open ended questions
Conducted by phone in 60-75 minutes

HealthHIV

How Do We Maintain Confidentiality?

Survey Confidentiality:

- HealthHIV does *not* collect any names or emails at any process in the survey.
- HealthHIV will report all response data summarized together; *never* an individual's responses.
- Any long-answer responses will be summarized with other responses and de-identified to keep the respondent anonymous

Key Informant Interview (KII) Confidentiality:

- KII responses are reported as a group; summarized and de-identified if comments/statements at all specific.

HealthHIV

Your Role

- Reflect on the questions and *answer openly and honestly*; the online survey should take about 20-25 mins
- Do not complete the online survey more than once on different devices (e.g. phone and laptop)
- Ask or reach out if you have any concerns (Eve@HealthHIV.org)
- Engage with HealthHIV in a discussion of key findings to develop specific strategies for improving effectiveness

When Does the Survey Launch?

Survey launches … NOW! Please take it directly after this meeting if possible.

Survey closes: March 5th (3 weeks)

Questions? Contact Eve at Eve@HealthHIV.org

HealthHIV

QUESTIONS?

THANK YOU

The survey is open now

eve@healthhiv.org
marissa@healthhiv.org
axum@healthhiv.org

HealthHIV

HealthHIV IHAP-TAC 2020-2021

Planning Body Assessment Steps/ Anticipated Timeline

Key Activity	Anticipated Start/End Date
HealthHIV reviews documentation (e.g. Orientation & Membership materials, bylaws)	12/1/20 - 1/15/21
HealthHIV conducts kick-off call with LA County Commission on HIV (Commission) Executive Committee to outline objectives and intended outcomes of external assessment	1/28/21
Commission (with HealthHIV input) identifies individuals for six key informant interviews	1/28/21 - 2/5/21
HealthHIV/Commission discuss and review communication plan/strategy to engage membership and gain buy-in	1/28/21 - 2/5/21
HealthHIV adapts survey and interview guide to meet Commission's intended outcomes and objectives	1/28/21 - 2/5/21
Commission reviews adapted online survey and interview guide	2/8/21 - 2/15/21
HealthHIV/Commission disseminate online survey via email and SurveyMonkey link	2/17/21 - 3/12/21
HealthHIV conducts KIIs	2/22/21 - 3/12/21
HealthHIV analyzes survey and KII data	3/15/21 - 4/9/21
HealthHIV/Commission review and discuss initial findings with key stakeholders/leadership	4/19/21 - 4/30/21
HealthHIV finalizes written report	4/30/21
HealthHIV/Commission convene meeting (in-person or virtual) with full membership to present findings and discuss recommendations and strategies	May 2021
HealthHIV finalizes written report with detailed objectives and strategies to address areas for improvement	By 6/30/21

the OA Voice

Issue: February 2021

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_ADA.pdf.

In This Issue:

HIV Awareness:

OA is observing **National Black HIV/AIDS Awareness Day** (NBHAAD). NBHAAD is celebrated annually on February 7th, to increase awareness, support those living with HIV, and highlight the work being done to reduce HIV in Black/African American communities. The theme this year is "We're in This Together," meant to emphasize we all play a role in ending HIV. Together we can do our part to promote access to HIV education, testing, prevention and lifesaving treatment for those living with HIV or at risk. OA extends its appreciation and gratitude to California organizations providing Black/African Americans HIV education, testing, prevention and care. Their commitment is empowering the Black/African American communities to come together and enrich the health of communities throughout California.

Black/African American communities are significantly impacted by physical and structural determinants of health to include racism, homophobia, transphobia, access to housing and mass incarceration, to name a few. These factors contribute to the impact of increased HIV diagnosis, lack of access to critical information, and low uptake of preventative and lifesaving measures such as Pre-exposure prophylaxis (PrEP) and Post-exposure prophylaxis (PEP), HIV treatment, and re-engagement and retention to care.

According to CDPH HIV Surveillance data, in 2018, Black/African Americans made up approximately 6% of California's population, yet they accounted for 17% of living HIV cases and 18% of new HIV diagnoses. A factsheet demonstrating the breakdown of demographics and health outcomes is located at https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/Black-AfricanAmerican_FactSheet2018_ADA.pdf.

As a part of the National Ending the HIV Epidemic (EHE) initiative, CDC has launched Let's Stop HIV Together, a campaign aimed to empower communities, partners, and healthcare providers nationwide. It can be found at https://www.cdc.gov/stophivtogether/index.html.

General Office Updates:

COVID-19:

OA is committed to providing updated information related to COVID-19. We have disseminated a number of documents in an effort to keep our clients and stakeholders informed. Please refer to our OA website at www.cdph.ca.gov/programs/cid/doa/pages/oamain.aspx, to stay informed.

Racial Justice and Health Equity:

The Racial Health Equity (RHE) Workgroup is emerging from the holiday season for another year of examining health disparities and determining what is needed to achieve racial justice within OA and among the people we serve. The first bi-monthly all-staff RHE meeting will discuss the National HIV Strategy (NHAS), specifically NHAS GOAL 3: Reduce HIV-Related Disparities and Health Inequities.

USPSTF Values & Action Statement on Systemic Racism in Preventive Care:

The U.S. Preventive Services Task Force (USPSTF) published an editorial titled, "The USPSTF Values Statement and Actions to Address Systemic Racism Through Clinical Preventive Services," in the *Journal of the American Medical Association (JAMA)*. Authored by members of the Task Force, this editorial affirms that, while clinical preventive services improve health and wellbeing, systemic racism in the healthcare system prevents many Black, Indigenous, and Hispanic/Latino people from fully benefitting from these services. The editorial also advances a roadmap designed to address systemic racism and help eliminate health inequities.

To read the full statement, please go to the *JAMA* website at https://jamanetwork.com/journals/jama/fullarticle/2775793.

HIV/STD/HCV Integration:

As the lead state department in the COVID-19 response, CDPH has re-directed hundreds of staff to this effort. Because of this, the integration efforts of the OA, STD Control Branch, and Office of Viral Hepatitis Prevention are postponed indefinitely. Please refer to our OA website at www.cdph.ca.gov/programs/cid/doa/pages/oamain.aspx, to stay informed.

Ending the Epidemics:

OA will provide information on the innovative interventions selected by each one of the six EHE counties. These interventions are based on significant community input and will be described in the Integrated plan strategies they impact. In this issue, we will highlight San Diego County. Over the next several months, all six county plans will be described.

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

With Ending the Epidemics funding, San Diego County will be developing a mobile PrEP Program, selecting "PrEP Champions" including Latinx and Black Gay/MSM, Transgender people to support outreach and education connected with mobile PrEP clinics. The mobile clinics will provide PrEP medical evaluation, PrEP prescriptions, ongoing PrEP medical care, and linkage to benefits navigators as needed.

PrEP-AP:

As of February 2, 2021, there are 204 PrEP-AP enrollment sites covering 156 clinics that currently make up the PrEP-AP Provider network. A comprehensive list of the PrEP-AP Provider Network can be found at https://cdphdata.maps.arcgis.com/apps/webappviewer/index.html?id=6878d3a1c9724418aebfea96878cd5b2.

Data on active PrEP-AP clients can be found in the two tables below.

Strategy B: Increase and Improve HIV Testing

An HIV home-testing distribution demonstration project continues through Building Healthy Online Communities (BHOC) in the six California Consortium Phase I Ending the HIV Epidemic in America counties. The program, TakeMeHome, is advertised on gay dating apps, where users see an ad for home testing and are offered a free HIV-home test kit. In the first 4 months, between September 1 and December 31, 2020, 842 tests were distributed, including 171 tests distributed in December. Of those ordering a test in December, 38% reported never before receiving an HIV test, 62% were 18 to 29 years of age. Of those reporting ethnicity, 40% were Latinx, and 60.3% of those reporting sexual history indicated 3 or more partners in the past 12 months. To date, 119 recipients have filled out an anonymous follow up survey, with 98% indicating that they would recommend TakeMeHome HIV test kits to a friend.

San Diego's Ending the HIV Epidemic in America plan includes providing Routine HIV Testing Implementation Grants for community health centers and other non-profit health care providers. Increasing the number of medical sites that conduct routine HIV testing will help identify those who are living with HIV but unaware of their infection.

Active PrEP-AP Clients by Age and Insurance Coverage:

	PrEP-AP Only		PrEP-AP With Medi-Cal		PrEP-AP With Medicare		PrEP-AP With Private Insurance		TOTAL	
Current Age	N	%	N	%	N	%	N	%	N	%
18 - 24	199	4%	---	---	---	---	114	3%	313	7%
25 - 34	1,295	29%	2	0%	1	0%	824	18%	2,122	47%
35 - 44	831	18%	---	---	4	0%	421	9%	1,255	28%
45 - 64	392	9%	---	---	22	0%	248	5%	662	15%
65+	15	0%	---	---	129	3%	18	0%	162	4%
TOTAL	**2,732**	**61%**	**2**	**0%**	**156**	**3%**	**1,625**	**36%**	**4,514**	**100%**

Active PrEP-AP Clients by Age and Race/Ethnicity:

	Latinx		White		Black or African American		Asian		American Indian or Alaskan Native		Native Hawaiian/ Pacific Islander		More Than One Race Reported		Decline to Provide		TOTAL	
Current Age	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
18 - 24	137	3%	86	2%	34	1%	34	1%	---	---	4	0%	5	0%	13	0%	313	7%
25 - 34	962	21%	647	14%	154	3%	225	5%	3	0%	5	0%	31	1%	95	2%	2,122	47%
35 - 44	641	14%	376	8%	77	2%	83	2%	1	0%	4	0%	10	0%	63	1%	1,255	28%
45 - 64	293	6%	259	6%	43	1%	45	1%	2	0%	1	0%	2	0%	17	0%	662	15%
65+	21	0%	131	3%	5	0%	4	0%	---	---	---	---	1	0%	---	---	162	4%
TOTAL	**2,054**	**46%**	**1,499**	**33%**	**313**	**7%**	**391**	**9%**	**6**	**0%**	**14**	**0%**	**49**	**1%**	**188**	**4%**	**4,514**	**100%**

Both PrEP-AP charts prepared by: ADAP Fiscal Forecasting Evaluation and Monitoring (AFFEM) Section, ADAP and Care Evaluation and Informatics Branch, Office of AIDS. Client was eligible for PrEP-AP as of run date: 1/31/2021 at 12:00:47 AM Data source: ADAP Enrollment System. Site assignments are based on the site that submitted the most recent application.

Strategy D: Improve Linkage to Care

A new mobile application and resource guide is being developed in San Diego County to increase knowledge among persons living with or vulnerable to HIV. These innovative interventions will provide availability and accessibility of HIV testing, services, ART and PrEP resources, and varied support services. Ending the Epidemic funding will be used to develop and maintain current information and resources.

Strategy G: Improve Availability of HIV Care

Benefits Navigation will expand in San Diego using Ending the Epidemic funding. Benefits Counselors will assist clients enroll in Medi-Cal, Covered California, ADAP, PrEP-AP, CalFresh, pharmaceutical patient assistance programs and other needs as identified. This also addresses **Strategies A, H, J and O**.

In addition, they will establish HIV drop-in clinics and provide alternative clinic hours (evenings and weekends) for those who have not been successfully engaged in conventional medical scheduled appointments. As a reminder, Strategy H is to Improve Integration of HIV Services with Sexually Transmitted Disease (STD), Tuberculosis, Dental, and Other Services; and Strategy O is to Further Leverage Existing Resources to Better Meet the Needs of People at Risk for and Living with HIV in California.

Strategy J: Increase Rates of Insurance/Benefits Coverage for PLWH or on PrEP

ADAP's Insurance Assistance Programs:

As of February 2, 2021, the number of ADAP clients enrolled in each respective ADAP Insurance Program are shown in the chart below.

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

The CDPH Office of Viral Hepatitis Prevention (OVHP) has released the *California Fatal Opioid Overdose and HIV or Hepatitis C Virus (HCV) Vulnerability Assessment*. The report summarizes an analysis conducted by the OVHP and OA to identify California counties at highest risk of a rapid increase in fatal opioid overdoses and HIV or HCV infections related to injection drug use. CDPH found some counties were at greater risk than others, but that all counties—urban, suburban, and rural—were affected and would benefit from expanding preventive services, including medication for opiate use disorder, naloxone distribution, syringe services,

ADAP Insurance Assistance Program	Number of Clients Enrolled	Percentage Change from December
Employer Based Health Insurance Premium Payment (EB-HIPP) Program	588	-2.97%
Office of AIDS Health Insurance Premium Payment (OA-HIPP) Program	6,397	+0.82%
Medicare Part D Premium Payment (MDPP) Program	1,995	+1.32%
Total	**8,980**	**+0.67%**

and HIV/HCV testing and linkages to care. See the CDPH website to learn more about your county and find tools to address these epidemics at https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/ViralHepatitisData.aspx.

The U.S. Department of Health and Human Services (HHS) has released the third HIV National Strategic Plan (HIV National Strategic Plan for the United States: A Roadmap to End the HIV Epidemic (2021-2025) covering 2021-2025, and continues to identify people who inject drugs as one of the disproportionally affected populations. The HIV Plan supports the scale-up of syringe services programs in the United States as a safe, effective, and cost-saving intervention to reduce the transmission of HIV, viral hepatitis, and other infections. Nationally, an increase in the use of fentanyl and other injected substances is linked to an 11% increase in HIV diagnoses among people who inject drugs from 2016 to 2018 and threatens the substantial decline of HIV incidence among people who inject drugs over the past 10 years.

San Diego County is developing wrap-around services for people who inject drugs, providing comprehensive HIV, HCV and STD testing, status-neutral health care navigation to PrEP or ART, and linkage to substance use disorder treatment and mental health resources as wanted. This is one of their strategies within their Ending the HIV Epidemic in America plan. And on January 26, the San Diego Board of Supervisors voted to end a 23-year ban on funding syringe services and directed their chief administrative officer to present a comprehensive harm reduction plan to prevent infectious disease transmission and overdose within 90 days.

Strategy M: Improve Usability of Collected Data

As part of their federal Ending the HIV Epidemic plan, San Diego is going to improve its Surveillance Program to increase data entry for real time data analysis, and to monitor for possible HIV clusters in order to provide prompt response. They will also develop molecular epidemiology.

Strategy N: Enhance Collaborations and Community Involvement

One Ending the Epidemic strategy San Diego is implementing is increased community forums, education and outreach, and leadership and mentorship training. In addition, additional support will be provided to the San Diego HIV Planning group to enhance HIV surveillance, prevention and care planning and evaluation.

OA Budget and Legislative Updates

Changes to State Syringe Access Laws:

Assembly Bill (AB) 2077 (Ting, Statutes of 2020) went into effect January 1, 2021 and made several changes to state law related to syringe possession and distribution. Most importantly, the bill removed all conditions on possession of syringes for personal use, and extended authorization of physicians and pharmacists to furnish syringes without a prescription until January 1, 2026. California law now states that:

- It is lawful to possess syringes for personal use in California. Syringes possessed for personal use are not defined as “drug paraphernalia” pursuant to state law.
- There is no limit on the number of syringes someone may possess for personal use, no age limit for possession, and it is lawful to possess syringes obtained from any source.
- Syringes may be furnished without a prescription by staff and volunteers of SSPs, pharmacists, and physicians.

For questions regarding this issue of *The OA Voice*, please send an e-mail to angelique.skinner@cdph.ca.gov.

State of California—Health and Human Services Agency
California Department of Public Health

Tomás J. Aragón, M.D., Dr.P.H.
Director and State Public Health Officer*Acting Director*

GAVIN NEWSOM
Governor

February 4, 2021

TO: ALL INTERESTED PARTIES

SUBJECT: REQUEST FOR APPLICATIONS FOR HIV PREVENTION DEMONSTRATION PROJECTS, STRATEGIC RAPID ANTIRETROVIRAL THERAPY 2021-2023

Funding for the Strategic Rapid Antiretroviral Therapy (ART) demonstration project was established in Senate Bill 870 and will support the development of up to four, two-year public health demonstration projects. Selected applicants will be awarded in a competitive award process to provide innovative, evidence-based approaches to rapid linkage to, and retention in, quality health care for people living with HIV (PLWH). Emphasis will be placed on telehealth-based programs that provide stigma-free, trauma informed, culturally/linguistically competent and innovative demonstration projects to administer and deliver strategic rapid ART services to PLWH and substantially reduce the time to viral suppression, providing clinical benefits to clients and reducing risk of HIV transmission. Projects must be "strategic" in that they intentionally prioritize individuals from the most underserved populations who are most disproportionately affected by HIV, and must do so by implementing a combination of in-person and telehealth services. As indicated by HIV surveillance data, the populations most vulnerable to HIV are Black/African American (AA) and Latinx populations and their intersecting identities which may include gay, bisexual, or other men who have sex with men (MSM), transgender MSM, transgender women, cisgender women, and/or people who inject drugs. California Department of Public Health, Office of AIDS (CDPH/OA) will consider other populations for which local and/or national data indicates a disproportionate impact by HIV (e.g. Native Hawaiian and Other Pacific Islanders (NHOPI) or American Indian/Alaskan Native (AI/AN) populations as data indicates that they are disproportionately affected by HIV). These populations are the primary focus of this request for applications (RFA).

CDPH/OA seeks applications for innovative demonstration projects to implement strategic rapid ART services for Black/AA and Latinx PLWH who are deemed eligible for rapid ART. OA defines "innovative demonstration projects" as newly developed, novel, original or new to your agency and/or community. Applicants are encouraged to replicate existing, evidenced-based programs and modify them for integration into their agency. **Existing rapid ART programs may apply for this funding provided their**

proposal demonstrates that funds will be used to develop a new component, focus on a currently unserved priority population (e.g. trans women, recently incarcerated or recently released, homeless, etc.), and/or serve a new geographic location in their community where there are gaps in service for linkage to care for PLWH.

OA has determined that local health jurisdictions (LHJs) representing more than 98 percent of all Californians living with HIV and Community Based Organizations within those jurisdictions that meet the RFA criteria, are defined as eligible applicants. These LHJs are:

Alameda	Marin	San Bernardino	Santa Barbara	Stanislaus
Contra Costa	Monterey	San Diego	Santa Clara	Ventura
Fresno	Orange	San Francisco	Santa Cruz	City of Long Beach
Kern	Riverside	San Joaquin	Solano	
Los Angeles	Sacramento	San Mateo	Sonoma	

OA looks forward to receiving applications from all eligible entities to support implementation of strategic rapid ART services to improve health outcomes, reduce HIV-related health disparities, reduce new HIV infections, and achieve maximal results in addressing the HIV epidemic in California.

The Strategic Rapid ART RFA can be accessed here:
https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_RFA.aspx

Please note the following important dates:

- Strategic Rapid ART Community Zoom Webinar will be held on **February 12, 2021 from 1:00 P.M to 2:30 P.M. PDT**. Register in advance for this meeting: https://zoom.us/meeting/register/tJMqf-GurjspHtXot9VcoFvA6TT-HX3kze8z After registering, you will receive a confirmation email containing information about joining the meeting.
- Questions about the Strategic Rapid ART RFA must be submitted in writing by email to StrategicRapidART@cdph.ca.gov by **February 12, 2021 by 5:00 P.M. PDT**.
- Questions and responses will be posted on this webpage by **February16, 2021 by 5:00 P.M. PDT**.
- Mandatory electronic Letter of Intent (LOI) is due on **February 17, 2021 by 12:00 Noon PDT**. RFA Attachments will be sent to those who submit LOI.
- Electronic application submission is due on **March 15, 2021 by 5:00 P.M. PDT**.
- Please see the RFA for LOI and application submission information.

If you have any questions about the information in this letter, please send an e-mail to StrategicRapidART@cdph.ca.gov.

Sincerely,

Marisa Ramos, Ph.D.
Office of AIDS Division Chief
Center for Infectious Diseases
California Department of Public Health

Cc: Betsie Cialino
Chief, HIV Prevention Branch Office of AIDS

Sharisse Kemp, MSW
Interim Chief, HIV Prevention Branch Office of AIDS

Matthew Willis
HIV/STD Program Specialist, Acting Chief
High Impact Prevention Section Office of AIDS

Alejandro Contreras, MSW, ASW
HIV Program Capacity Building and Health Equity Coordinator,
High Impact Prevention Section, Office of AIDS

Ending the HIV Epidemic (EHE) Progress to Date

Commission on HIV Meeting
February 11, 2021

Community Engagement

Developed and finalized EHE Plan.

- EHE Regional Meeting – Jan 2020, Commission Meetings (Nov. 2019, Oct. 2020, Dec. 2020), EHE Townhall - Sept. 2020, EHE Event in Spanish - Oct. 2020, EHE Steering Committee Small Group Discussion - Oct. 29, 2020
- Public Comment period: Sept. 16 - Oct. 16
- Received letter of concurrence from Commission on 12/16/20

Learning from community partners on development and promotion of services and programs.

- Commission continues to make recommendations on services and programs. Recently received recommendations include COH directives, Black/African American Community Task Force recommendations & Aging Task Force recommendations.
- EHE Steering Committee formed.
- Discussing recommendations from LA County HIV Mental Health Task Force on need for bilingual Spanish speaking providers.

Community Mobilization Program developed, solicitation released, and undergoing application review.

- Anticipated Board of Supervisors review date: April 2021
- Program resources and materials in development.

Strengthening partnerships with agencies including new voices and partnerships.

- Continuing to develop partnerships with EHE Steering Committee agencies.
- Developing and maintaining partnerships with local and County entities, agencies supporting people experiencing homelessness, substance use disorder, among others.

Ongoing EHE trainings and presentations to increase promotion, awareness, and community engagement.

- CHIPTS EHE Regional Learning Collab, C2PLA YCAB events, HERR/VP contract training, etc.

EHE website continues to be updated to align with strategies.
www.LACounty.HIV

EHE listserv created, first newsletter distributed 1/20/21.
To be added email EHEInitiative@ph.lacounty.gov

Pillar 1: Diagnose

General Updates

- Pillar 1 lead hired November 2020.
- HIV testing landscape brief on County testing access points and modalities in development.

Routine opt out HIV testing in healthcare and other institutional settings in high prevalence communities.

- Emergency Department partnerships and implementation delayed due to COVID.

Increase at least yearly re-screening of persons at elevated risk for HIV by utilizing telehealth technology to identify clients who are due for re-screening and increase communication with clients.

Proposed Activities in EHE Plan	Potential EHE Steering Committee Member Role	Name
Pillar 1 Diagnose		
Expand routine testing in Emergency Departments and community clinics	Work with DHSP to identify sites in high morbidity areas or work with clinics you already have relationships with; then work to meet with clinical leadership and advocate for expanded testing	Louise M. Jerry A. Lindsey H.
Increased re-screening of clients with elevated HIV risk (recent STD, recent negative HIV test, PEP) get repeat HIV testing in 3-6 months	Work with DHSP funded HIV Testing Service (HTS) providers, clinics, or community-based organizations to develop protocols to improve rescreening	Bridget R. Luis G.
Home test kit programs (Take Me Home and kits given to HTS providers)	Identify and implement ways to increase uptake and use of home test kits to engage clients in future/ongoing HIV prevention	Javontae W. Zelenne C. Ty S. Barbara R. Raniyah C.

Expanded HIV testing in non-healthcare settings through HIV self-test kits.

- Partnership with national *Take-Me-Home* Initiative launched in August 2020, 588 test kits ordered from August-January 2021 through online website/apps. CDC is partnering with *Take-Me-Home* which will increase access and availability of test kits.
- 7,200 Orasure tests ordered for program expansion. Protocol and supporting documents developed for HIV Testing contracts. Agency training held 1/27/21.
- Identifying additional opportunities to reach individuals unlikely to receive traditional in-person testing (SSP agencies, homeless service providers, mental health providers, etc.).

Pillar 2: Treatment

Rapid ART and Same Day Linkage to Care

- Coordinator hired November 2020.
- Developing protocol for HIV Navigators, clinics, and identifying partners for pilot sites.
- Developing survey for HIV providers and HIV testing agencies to assess current systems and capacity to adopt protocols.
- Receiving Rapid ART Coaching from EHE TA Provider.

Exploring partnerships to assess and address gaps in mental health services

- Identifying partners to conduct a landscape analysis (DMH).
- Exploring potential for region-wide telehealth mental health services with emphasis on the monolingual Spanish speaking community.
- Identifying opportunities for mental health services serving highly impacted populations (Black MSM, Women of Color, and other EHE populations of focus).

Contingency Management Pilot Program

- Draft program proposal developed for youth-focused program to encourage viral suppression and engagement in care. Delayed implementation due to COVID response.

Emergency Financial Assistance Program

- Launched November 2020, 4 months after Commission's Standards of Care were approved.
- Up to $5,000 available to eligible clients to be sent directly to vendors for emergency situations related to rent, utilities, food, etc.
- 33 applications received to date.
- Learning from providers and community on implementation challenges and course-correcting as needed.
- Benefit Specialty Services agency training 2/11/21 for non-MCC clients.

Permanent supportive housing for PLWH

- Launched Rampart Mint housing site which serves 22 clients.

U=U Awareness

- Resource Kit developed and available for use http://publichealth.lacounty.gov/dhsp/U=U_Provider_Kit.htm

Ryan White Service Category Fact Sheets

- DHSP Funded Mental Health Services Fact Sheet distributed.
- Oral Health Fact Sheet in development.

Pillar 3: Prevent

PrEP Landscape Analysis

- Assessing PrEP resources and services among providers and clinics in District 2/South LA and Lancaster.
- Exploring whether data is available on pharmacies providing PrEP after passage of SB 159.

PrEP retention and engagement in preventative care

- Needs assessment conducted with PrEP Centers of Excellence on telePrEP.
- Implementing telePrEP at 3 sites to identify clients who are due for re-screening and increase provider-patient communication.
- Increasing linkage to PrEP for residents recently diagnosed with early syphilis for linkage to PrEP.

Increase capacity of Syringe Services Programs (SSPs) to link clients to HIV prevention

- Initial meetings with identified partners (SAPC, City of LA, SSP agencies, EHE Steering Committee, etc.)
- DHSP participating in LA County Meth Task Force.
- Collaborative meetings held with LB Health and Human Services.

Pillar 3 Prevent		
PrEP/PEP landscape analysis	Identify and work with community providers serving priority populations or in highly impacted areas of LAC who are not offering PrEP and PEP	Bridget R. Louise M. Luis G. Raniyah C. (maybe)
Improve PrEP retention for clients at continued HIV risk	Work with DHSP funded PrEP Centers of Excellence or other PrEP providers on their protocols (how they deal with missed appts, lost clients, etc.) Identify and implement projects to improve retention	Bridget R. Matt B. Lindsey H.
TelePrEP	Identify ways technology should be used to make PrEP as accessible and low barrier as possible	Devon R. Erin J-W.
PrEP support groups	Study and propose best case use for PrEP support groups as a way to potentially increase use and retention	Lindsey H.
Syringe Services Programs (SSPs)	Participate in planning meetings to review SSPs programs and assist in expanding testing and referral to HIV prevention	Barbara R. Bridget R. Luis G. Lindsey H.
Other ideas?	Addressing the meth epidemic in high impact areas	Lindsey H.

EHE Steering Committee

- Workgroup meetings held for RAPID Linkage to Care and TelePrEP
- Upcoming workgroup meetings to be scheduled: HIV testing, Mental health, Syringe Services Programs (SSPs).
- Incorporating U=U messaging into LGBTQ+ healthcare provider training curriculum.
- Exploring opportunities to provide HIV self-test kits to clients within organizations.
- Assisting with resources on community mobilization.
- 3 full meetings, 1 small group meeting, 2 workgroup meetings, 1:1 calls with each Steering Committee Member held to date.

Additional Updates

- Continuing to work to be able to expand staff capacity.
- Reviewed and discussed Black/AA Task Force recommendations. Will attend March Task Force meeting.
- Partner development calls ongoing (UCLA C-LARAH, DHS, DPH, CHIPTS, etc.)
- Ongoing meetings with EHE TA providers.
- EHE Plan translated into Spanish, undergoing final review.

Resources

- Join the EHE listserv! Email EHEInitiative@ph.lacounty.gov to subscribe.
- EHE website www.LACounty.HIV
- AHEAD dashboard for key indicators and data across all EHE jurisdictions https://ahead.hiv.gov/
- For HIV, STD, and sexual health info, resources, and testing locations visit www.GetProtectedLA.com

LA County HIV | Ending the HIV Epidemic

Division of HIV and STD Programs

December 2020
Volume 1, Issue 1

Clinical Quality Management (CQM) Report

DHSP CQM PROGRAM UPDATES

The purpose of this newsle er is to provide stakeholders of the DHSP CQM Program with important updates and information regarding the EMA (eligible metropolitan area)-wide Clinical Quality Management (CQM) Program.

Per the federal Health Resources and Services Administration (HRSA) Policy Clarification Notice (PCN) 15-02 (Sept, 2020), all recipients and sub-recipients of Ryan White Program (RWP) funds must have a clinical quality management program that aims to improve the care, health outcomes and satisfaction of persons living with HIV (PLWH). Three required domains create a robust CQM program including: Infrastructure, Performance Measurement, and Quality Improvement.

RYAN WHITE PART B

DHSP continues to contribute to the California Department of Public Health's (CDPH) Office of AIDS (OA), RWP Part B CQM Program through participation in their performance measure data analysis process and the HIV Care Providers capacity building activities. OA also participates and provides routine updates on their CQM Program to the Los Angeles County Regional Quality Group (RQG).

INSIDE THIS ISSUE

SPECIAL POINTS OF INTEREST

- Updated Performance Measures
- Inside Mission Possible
- The Grievance Program
- Upcoming QI Ac v es

CQM INFRASTRUCTURE NEWS

CQM Committee – this committee is currently on hold due to DHSP staff COVID-19 reassignments; however, many CQM Program activities have continued. Quarterly meetings of DHSP's CQM Committee are scheduled to resume via a virtual format in 2021.

CQM Plan – the Plan was recently shared with sub-recipients and is currently undergoing a final review. Stay tuned as the final Plan will be distributed soon and posted to the DHSP website.

CQM Quality Improvement (QI) Activities - Many QI activities have continued despite the impact of COVID-19 including:

- **California Reginal Group (CARG);**
- **Los Angeles Regional Quality Group (RQG); and**
- **Mission Possible (MP), DHSP's HIV Quality Improvement Learning Collaborative for MCC Teams.**

Despite the impact of COVID-19 on County partners, the DHSP CQM Program aims to continue to support the delivery of responsive, evidence-based, high quality HIV services.

METRICS AND DEFINITIONS

Engagement in Care : ≥ 1 VL, CD4 or genotype test reported in the 12 months prior to the end of the quarter.

Retention in Care : ≥ 2 VL, CD4 or genotype tests (> 90 day apart) and reported in the 12 months prior to the end of the quarter.

Viral Load Suppression : VL <200 copies/ml at most recent test reported in the 12 months prior to the end of the quarter.

Durable Viral Load Suppression : VL of < 200 copies/ml for all tests throughout the measurement period.

Periodontal Screening/Treatment: (Oral Health (OH) Only): % clients who had a periodontal screening, or treatment ≥ 1 in the measurement period.

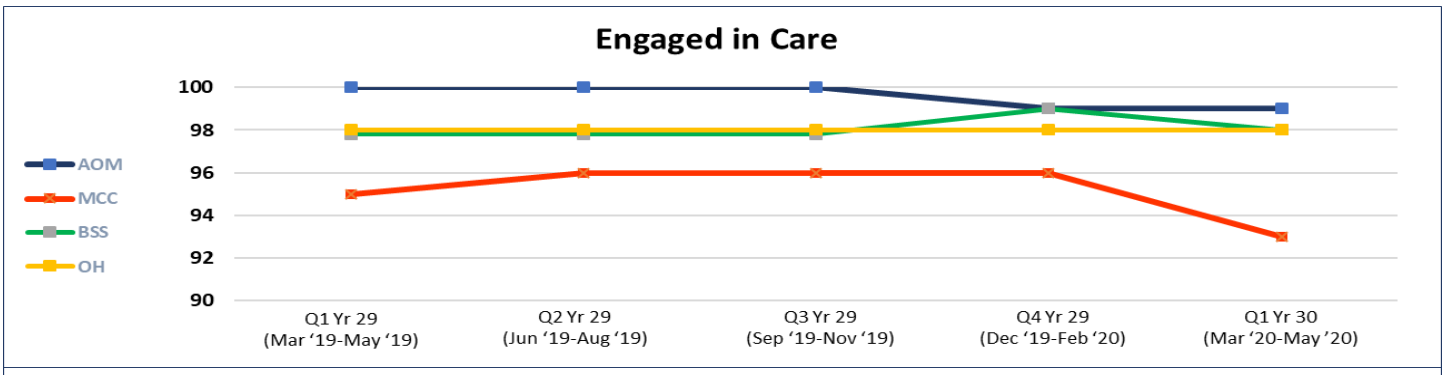
Oral Health Education (OH Only): % clients who received OH education ≥ 1 time in the measurement period.

RWP PERFORMANCE MEASURES—YR. 30 QTR. 1

Performance measurement is a vital part of quality improvement and allows DHSP to determine whether the care that clients receive meets or exceeds the desired quality as s pulated in contracts and established by local and na onal benchmarks. Performance measures provide the data necessary to iden fy opportuni es for improvement and guide progress through tests of change.

As part of the DHSP CQM Program, service-specific performance measures have been developed in alignment with expectations as outlined in HRSA's PCN 15-02. Selection of these measures was based on the goals and objectives of the Los Angeles County HIV/AIDS Strategy for 2020 and Beyond (LACHAS) in combination with HRSA/HAB recommendations and other local, state and national initiatives including the national Ending the HIV Epidemic (EHE) initiative.

Performance measures are reviewed quarterly by the CQM committee and now as part of this newsletter. DHSP's intention is to share these quarterly measures with stakeholders and consumers and determine the need for service-specific and/or system-wide QI initiatives. Our goal is to also stratify these quarterly reports to better evaluate for disparities and target improvement activities.


Engaged in Care
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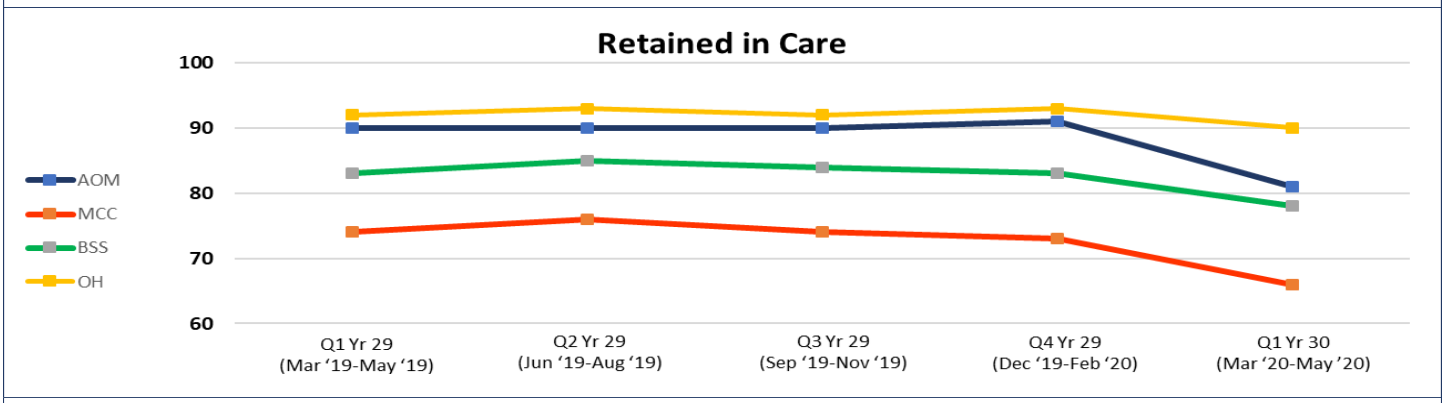
AOM
MCC
BSS
OH
Q1 Yr 29 (Mar '19-May '19)
Q2 Yr 29 (Jun '19-Aug '19)
Q3 Yr 29 (Sep '19-Nov '19)
Q4 Yr 29 (Dec '19-Feb '20)
Q1 Yr 30 (Mar '20-May '20)


Retained in Care
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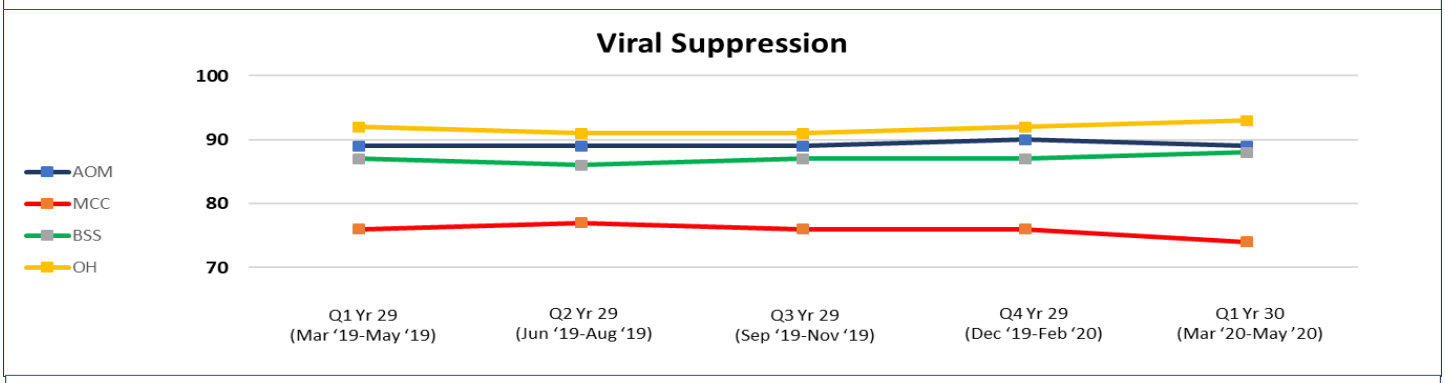
Q2 Yr 29 (Jun '19-Aug '19)
Q3 Yr 29 (Sep '19-Nov '19)
Q4 Yr 29 (Dec '19-Feb '20)
Q1 Yr 30 (Mar '20-May '20)


Viral Suppression
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Q2 Yr 29 (Jun '19-Aug '19)
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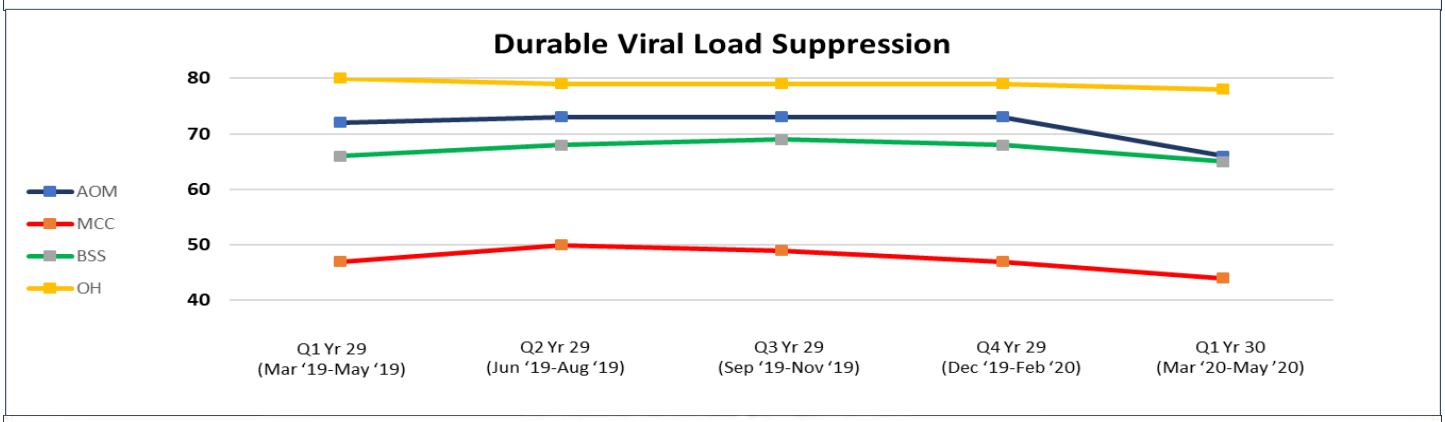
Q4 Yr 29 (Dec '19-Feb '20)
Q1 Yr 30 (Mar '20-May '20)


Durable Viral Load Suppression
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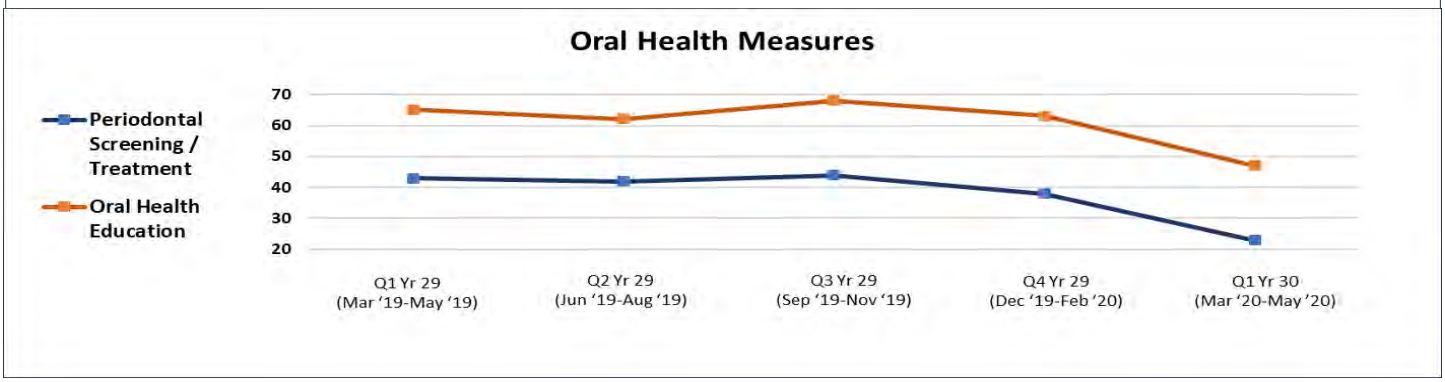
Q1 Yr 29 (Mar '19-May '19)
Q2 Yr 29 (Jun '19-Aug '19)
Q3 Yr 29 (Sep '19-Nov '19)
Q4 Yr 29 (Dec '19-Feb '20)
Q1 Yr 30 (Mar '20-May '20)


Oral Health Measures
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Periodontal Screening / Treatment
Oral Health Education
Q1 Yr 29 (Mar '19-May '19)
Q2 Yr 29 (Jun '19-Aug '19)
Q3 Yr 29 (Sep '19-Nov '19)
Q4 Yr 29 (Dec '19-Feb '20)
Q1 Yr 30 (Mar '20-May '20)

MISSION POSSIBLE: WHAT WAS IT ALL ABOUT?

ABOUT MISSION POSSIBLE

DHSP's QI Collaborative, Mission Possible, was developed to support Medical Care Coordination (MCC) teams in finding new and innovative ways to engage and retain LAC's most vulnerable clients in HIV care. The Collaborative's initial structure consisted of a six-month in-person and on-line collaborative design aimed at improving the MCC team's internal quality improvement capacity to identify and address barriers to care and low viral load suppression rates. However, due to the COVID-19 pandemic, the Mission Possible QI Collaborative quickly pivoted from its original design and focus to respond to the needs of both the MCC teams and PLWH given the global healthcare crisis. The result was a -session, virtual learning collaborative aimed at supporting MCC Teams in the transition to tele-health modalities using quality improvement tools and approaches.

- **March 27, 2020: Kick- ing Telehealth Modalities to Support MCC Services During COVID-19**

  Number of Attendees: 152

  An initial session bringing together MCC teams to discuss the transition to tele-health modalities at the beginning of the COVID-19 pandemic and local stay-at-home orders. DHSP shared programmatic updates including a presentation on a new tele-health data collection option built into the CaseWatch system and an introduction to the on-line workspace, Glasscubes. Two agencies (MHF and LA LGBT) shared their early efforts transitioning MCC teams to tele-health. Elevation Health Partners (EHP) shared valuable tele-health resources and tools.

- **July 22, 2020: MCC Promising Practices in Telehealth Integration**

  Number of Attendees: 111

  Exploration of promising practices and strategies that have been established at community-based organizations; including in person vs. tele-phone or video outreach visits, assessments, and interventions. Teams shared protocols, promising practices, policies, workflows and other tools developed in the wake of the pandemic. Participants also shared their perspectives on the successes and challenges of delivering healthcare "virtually".

  Addi onal topics and objec ves of the mee ng included:

  - Prioritization of in-person services for MCC teams
  - Understanding patient preferences in MCC service modalities
  - Strengthening understanding of disparities and equitable care in tele-health HIV services
  - Sharing input on evolving solutions for obtaining "virtual" patient consent
  - Exploring/compiling promising practices for MCC teams

- **August 19, 2020: Patient Perspectives on MCC Telehealth Services**

  Number of Attendees: 104

  Results from a patient survey were shared with attendees to highlight the patient experience with current MCC tele-health practices. zation of patient preference for in person, telephonic, and video visits was promoted and workflows and practices for how to honor these preferences were explored.

  Additional topics and objectives of the meeting included:

  - Learn and provide input about the new Ryan White Program-funded Emergency Financial Assistance Program
  - Explore the role of health professionals in addressing structural racism and supporting Black lives

MISSION POSSIBLE: WHAT WAS IT ALL ABOUT?

- **September 16, 2020: Empathy Training for MCC Telephonic Encounters**

  Number of Attendees: 136

  EHP provided a training in empathic communication skills tailored for the telephone encounter.

  Additional topics and objectives of the meeting included:

  - Understanding what empathy in healthcare is and the benefits of listening with empathy
  - Becoming familiar with techniques used for listening to underlying feelings, needs and values
  - Studying listening, language and tone skills to strengthen connection in telephone interactions with patients
  - Feeling more comfortable or confident in engaging patients over the phone

- **October 21, 2020: MCC Telephone Work ow: A Deep Dive into MCC Practice**

  Number of Attendees: 115

  After individual coaching sessions were conducted with EHP and MCC teams at two agencies (AltaMed and AHF), EHP helped produce workflows to describe the teams' work and to share with the larger learning collaborative. This session demonstrated the value of workflow development and allowed for exchange of best practices amongst the teams.

  Addi onal topics and objec ves of the mee ng included:

  - Expanding workflow process knowledge and review tools to help create useful workflows
  - Engaging with peers on effective telephone workflow strategies for outreach, initial assessments, and re-assessments among Retention Outreach Specialist (ROS), Medical Care Manager, and Patient Care Manager roles
  - Better understanding the needs of ROS and feel more confident in ROS strategies during COVID-19

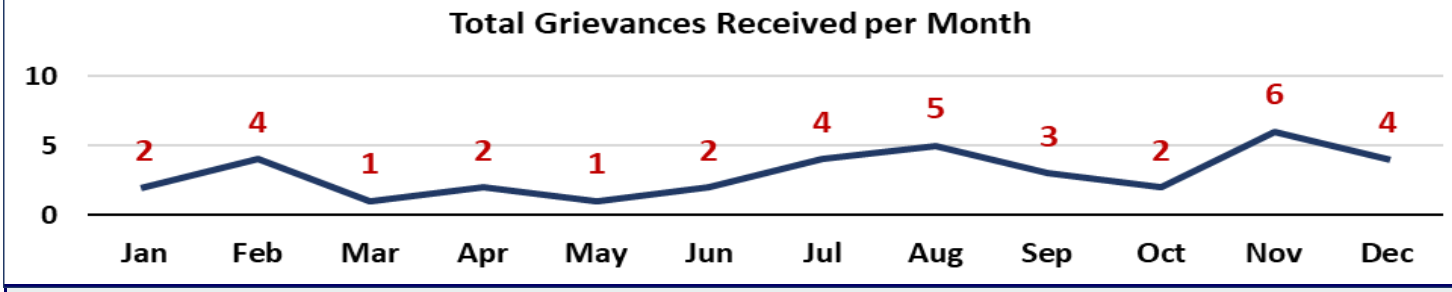
- **November 18, 2020: Closing Celebra on**

  Number of Attendees: 111

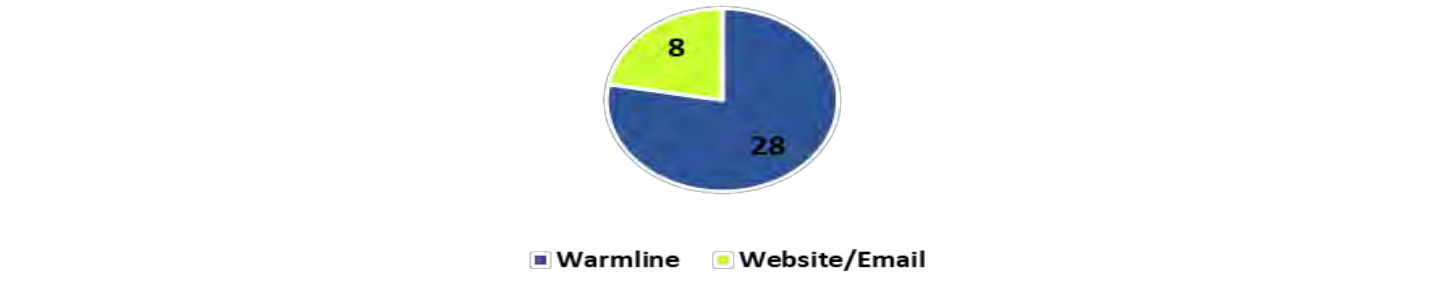
  To celebrate the end of the Mission Possible Collaborative, EHP led the group through a review of the impact of MCC teams during the pandemic and celebrated their hard work and commitment to PLWH. Also on hand, Raniyah Copeland of the Black AIDS Institute shared strategies for how to end the HIV epidemic in Black communities and how to empower clients to be change agents to end the HIV epidemic in their communities.

GRIEVANCE MANAGEMENT PROGRAM

The DHSP Grievance Management Program aims to resolve grievances and/or quality of care issues identified at DHSP funded partner organizations. Grievances are received via DHSP's Grievance Warm-line, website, email or through other agency oversight activities (e.g., contract monitoring) and may include grievances reported by clients, client representatives, agency or DHSP staff, community partners and other stakeholders. DHSP staff work directly with the agency to resolve the grievance through a variety of communication and investigation activities including the development of corrective actions, as appropriate. Every effort is made to resolve grievances within 60 days of receipt.



Grievances Received by Service Category	1Q 20	2Q 20	3Q 20	4Q 20
AOM	3	1	1	2
Substance Abuse	1	1		
RCFCI			1	1
TRCF		2	1	
Mental Health				1
Nutri onal Support				1
Unknown/Unstated, Other/Non-jurisdic onal	3	1	9	7
Grievances Received by Complaint Category				
Inappropriate/Unprofessional Behavior	1	1	6	4
Substandard Care/Service or Facility		2	2	3
Delayed Care/Service	1	1		2
Denial of Service	2	1		1
Excessive Wait Time	2			
Housing Assistance			2	
Other Assistance Needed, Unknown, Non-jurisdic onal	1		2	2



WHAT'S UP NEXT?

DHSP is developing plans to participate in CQII's newest national QI learning collaborative, Create+Equity, and will be partnering with RWP partner agencies AltaMed Health Services and AIDS Healthcare Foundation to focus on unstably housed MCC clients.

REGIONAL QUALITY UPDATES

Los Angeles Regional Quality Group - The Los Angeles Regional Quality Group (RQG) is one of many groups aimed at improving sub-recipient capacity for Clinical Quality Management and committed to furthering the goals and objectives of the Los Angeles County HIV/AIDS Plan (LACHAS) and the national Ending the HIV Epi-demic (EHE) initiative. The RQG is hosted by DHSP and is comprised of one or more staff from RWP-supported HIV care agencies. The RQG meets quarterly to exchange best practices, promote peer learning through sharing of RWP sub-recipient quality initiatives.

Originally an in-person meeting, the group quickly pivoted to a virtual format in response to the COVID-19 pandemic with much of the discussions focused on improving the capacity of RWP sub-recipients to provide care and services using on-line or tele-medicine formats. The group also serves as a forum to share CQM Program updates and activities from CDPH-OA, CARG, and DHSP.

California Regional Group - As part of CQII's End+Disparities ECHO Collaborative, LAC RWP recipients and sub-recipients demonstrated strong involvement in the collaborative to eliminate disparities among highly affected subpopulations: MSM of Color, Youth, Woman of Color, and Transgender Persons. The End+Disparities ECHO Collaborative officially ended in 2019 but California-based participants including DHSP have continued meeting as a regional group, working toward the established viral suppression goals.

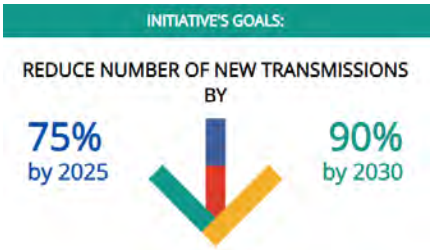
Department of Public Health's Performance Counts

During this unprecedented time, the Department of Public Health's (DPH) Performance Counts report has been adjusted to minimize data on burden on DPH programs. The following data was reported to DPH in November 2020.

Indicators	Actual CY 2017	Actual CY 2018	Actual CY 2019	Projected CY 2020
% of PLWH who are retained in medical care.	53%	54%	52%	51%
% of PLWH who are virally suppressed.	61%	60%	61%	60%
% of RW PLWH who are retained in medical care.	82.2%	79.1%	78.7%	80%
% of RW PLWH who are virally suppressed.	83.4%	81.6%	82.4%	82.5%

ENDING THE HIV EPIDEMIC (EHE)

Ending the HIV epidemic locally requires the signi cant scale up and expanded reach of proven and new interven ons that work towards overarching goals and are under-girded by overarching strategies.



EHE ACTIVITIES

Linkage to HIV medical care (LTC) is one of the six EHE indicators and is calculated as the percentage of people with HIV diagnosed in a given year who have received medical care for their HIV infection within one month of diagnosis.

As a central feature of the LAC EHE Plan, a new rapid linkage to care and HIV treatment ini a on project is underway. While our goal is to improve linkage for all persons newly diagnosed with HIV across LAC, we aim to ensure meeting the needs of groups demonstrating the greatest disparities including cis-gender women, Black/African Americans, youth age 13-19, and persons who inject drugs.

CQM will be involved in tracking our progress through the use of the AHEAD dashboards (along with other states and jurisdictions involved in EHE.) The national goal is LTC at 95% by 2025. The LAC LTC performance level was at 69.9% in 2017, 76.1% in 2018, and showing further improvement witha 2020 Q1 rate of 85.7%.

In 2011, in keeping with Na onal e orts to be er integrate HIV and STD public health e orts, the Department of Public Health combined the HIV Epidemiology Program, the Office of AIDS Programs and Policy, and the Sexually Transmi ed Disease Program to form the Division of HIV and STD Programs (DHSP). DHSP con nues to work closely and collabora vely with community-based organiza ons, other governmental offices, advocates, and people living with HIV/AIDS as it seeks to control the spread of HIV and sexually transmi ed diseases, monitor HIV/AIDS and STD morbidity and mortality, increase access to care for those in need, and eliminate HIV-related health inequali es.

Division of HIV and STD Programs
600 S. Commonwealth Ave., 10th Floor
Los Angeles, CA 90005

For more informa on about the DHSP CQM Program, please contact:

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Associate Medical Director
Cell: (323) 914-3055
Email: RCohen@ph.lacounty.gov

Lisa Klein, RN, MSN, CPHQ
Pronouns: she/hers/hers
Quality Improvement Officer
Office: (213) 351-8350
Email: LKlein@ph.lacounty.gov

COUNTY OF LOS ANGELES
Public Health

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.

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

PART II: MEMBERSHIP APPLICATION FORM
Section 1: Contact Information

1. Name: Felipe Findley
   (Please print name as you would like it to appear in communications)
2. Organization: (if applicable) Watts Healthcare Corporation
3. Job Title: Physician Assistant
4. Mailing Address: _____
5. City: _____ State: _____ Zip Code: _____
6. Provide address of office and where services are provided (if different from above):
   Mailing Address: _____
   City: _____ State: _____ Zip Code: _____

7. Tel.: _____ Fax: _____
8. Email: _____
   (Most Commission communications are conducted through email)
9. Mobile Phone #: (optional): _____

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

Signature: _____ 12/07/2020
Date

Felipe Findley
Print Name

Section 2: Demographic Information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6b. **Age:**

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

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

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

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

Section 3: Experience/Knowledge

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

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

~~David Lee of Drew Cares, cochair of Commission and Yvette Wells, Director of HIV at Watts Health~~

ERROR They did not ask me to represent them FBF

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

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

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

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

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

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

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

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

Section 4: Biographical Information

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

My goal on the Commission is to best represent the interests of the South Los Angeles community where I live and work. I hope to continue to build bridges and bonds between clinicians, support staff, patients and communities most impacted by HIV. Systemic racism, trans/homophobia impacts clinical work environments, impacts medical trust and are key drivers of heath disparities. I will continue to strongly advocate for the wellness of all marginalized groups.

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

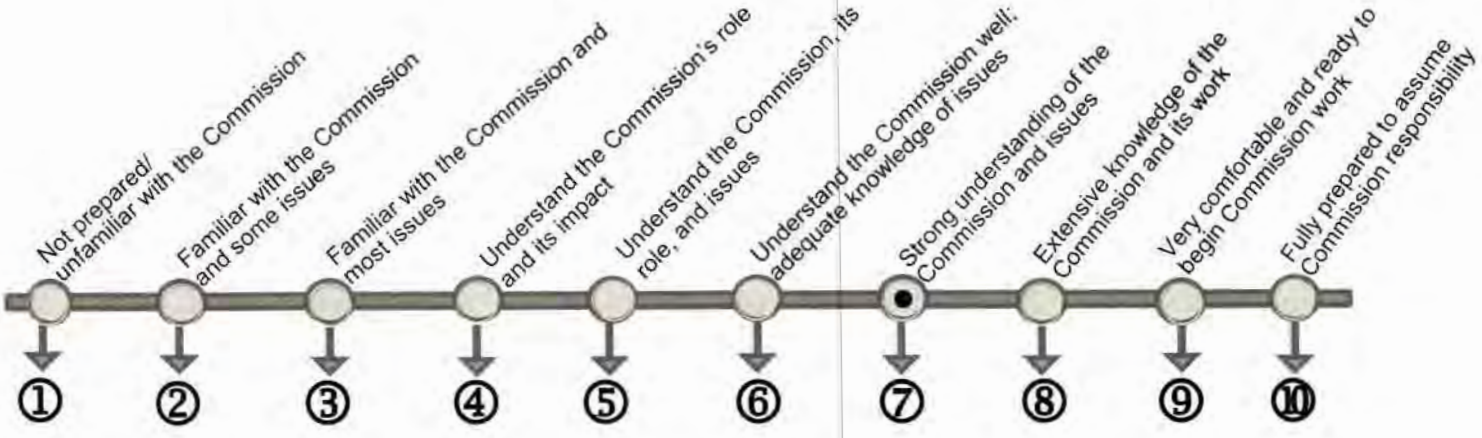
see attachment

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

N/A

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

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



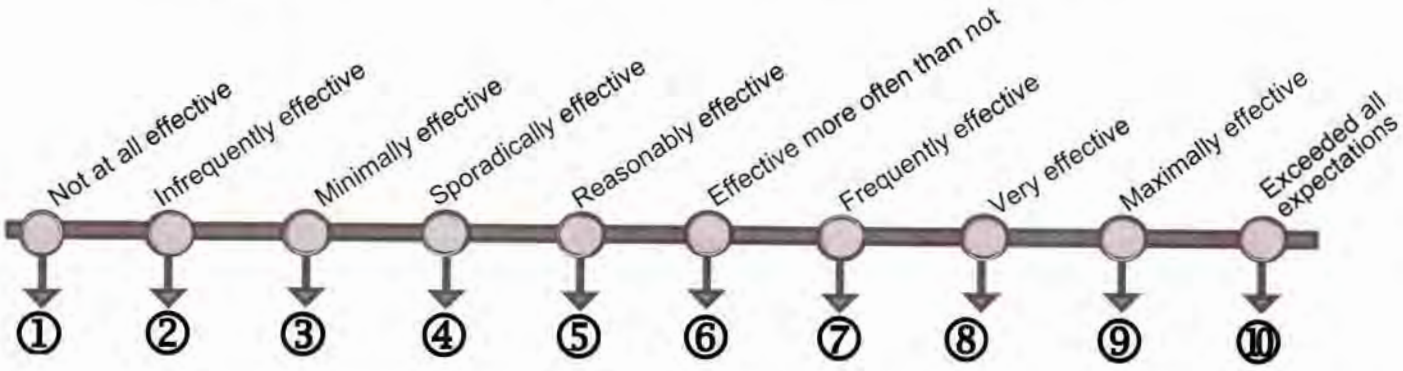
17. **Which of your strengths do you feel will enhance your Commission performance? What skills will you need to develop further for optimal Commission performance? Continue on an additional page if necessary.**

I am passionate and committed. I work well in a team. I believe and support leadership of those most marginalized. I am a clinician and also from a marginalized community and background and so bring these perspectives which will be useful for the Commission.

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

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

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



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

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

N/A

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

N/A

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

N/A

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

N/A

Section 4: Biographical Information #11

Name: Felipe Findley

11. Biography/CV is attached

I was born and raised in the South Lawndale, a predominantly Latinx and Black community of Chicago, Illinois. Like many urban communities, while also having a rich culture and vibrancy, it was also a community rife with gang and police violence, sexism, homophobia and transphobia. Our most significant landmark was Cook County Jail and Courthouse which was three blocks from my home. I was indelibly shaped by both my community's virtues and vices and while I knew of no childhood role model in the medical field, I did know that I wanted to be of service to my community. It wasn't until I joined the US Army as a medic that I felt a sense of purpose and learned about the role of the Physician Assistant. After 4 years in the military, I went to Malcolm X College and ultimately graduated from the Physician Assistant program in 2005. On my last clinical rotation, I worked with a physician who helped build HIV clinics for women in Rwanda, Africa after the genocide. Both her local and international work inspired me to choose to work in the field of HIV which I have been doing ever since. In fact, I have long viewed this work to be the crossroads of medicine, public health, and social justice. This work has also shaped me into being the best version of myself. On the wards of my first clinic position I happened to care for a longtime neighborhood friend who was admitted to my team with a new diagnosis of HIV and Neurosyphilis. On another occasions, the transgender partner of a patient I admitted happened to be an elementary school classmate of mine. Both of these encounters reminded me of the homophobia, transphobia and bullying that exists in my community and on the importance of being a strong advocate for the most marginalized within communities of color. I currently work at Watts Health Center (WHCC) a community similar to the one I grew up in. I provide HIV primary care services, started our Pre-Exposure Prophylaxis clinic and Hepatitis C clinic. My social justice work is detailed in my CV attached here but briefly, I am a founding member of *Frontline Wellness Network,* on the community advisory board *for Center for HIV Identification, Prevention, and Treatment Services* (CHIPTS) active in the *American Public Health Association* (APHA) and a founding member of *Say Their Names Los Angeles.* In summary, I am committed and passionate about the fight against HIV and would be honored to join the Commission as we enter the phase of "Ending the Epidemic."

FELIPE FINDLEY, PA-C, MPAS, AAHIVS

LINKEDIN URL

OBJECTIVE

Become a Commissioner for the Los Angeles County Commission on HIV

CLINICAL EXPERIENCE

PHYSICIAN ASSISTANT/WATTS HEALTHCARE CORPORATION

July 2020 – Present

Provide culturally appropriate HIV treatment and prevention services to the underserved community of South Los Angeles, Watts/Compton areas including LGBTQ+ and Spanish speaking patients. In addition, started the Pre-Exposure Prophylaxis (PrEP) clinic at WHCC as well as started Hepatitis C treatment clinic. Provide lectures and in-services on HIV, PrEP, and Hepatitis C to staff and students. Involved in developing partnership with Arming Minorities Against Addiction and Disease Institute (AMAAD) in gaining HIV, STI testing, treatment and PrEP services for young MSM and transgender high risk negative individuals.

PHYSICIAN ASSISTANT/MEN'S HEALTH FOUNDATION - SOCAL CLUB

July 2019 – July 2020

Provide culturally appropriate HIV treatment and prevention services to the underserved community of South Los Angeles with focus on Black and Brown LGBTQ+ young men and transgender women of color. Also involved in community outreach creating partnerships with neighboring pediatric clinics as well as high schools and school-based clinics. Organizer and educator for social justice trainings at SoCal Club.

PHYSICIAN ASSISTANT/OASIS CLINIC-MLK JR. OPC

July 2014 – May 2018

Provide primary care services and HIV treatment and prevention services to the underserved community of South LA, Watts and Compton area including LGBTQ and Spanish speaking patients. Administrative co-lead for the "Care Improvement Team" creating projects to improve patient care services and team building for clinic staff. Provide lectures and in-services for Oasis and Charles R. Drew staff. Mentor and teach PA students as well as high school students through partnership with Charles R. Drew University and King-Drew Magnet high school.

CLINICAL RESEARCHER/CHARLES R. DREW UNIVERSITY

August 2014 – September 2016

Site Provider for 48-week Pre-Exposure Prophylaxis study of high-risk men who have sex with men (MSM) and transgender women. Performed patient consents per IRB standards at Screening visit and at subsequent visits (Baseline, Weeks 4, 8, 12, 24, 36 and 48) obtained medical history, performed physical exams, evaluated patients for adverse drug reactions, provided patient education and measured drug levels of Truvada components to determine adherence to study medication. Phlebotomy at each visit, performed rapid HIV testing and complete STI screening.

PHYSICIAN ASSISTANT/AIDS HEALTHCARE FOUNDTION

December 2010 – July 2014

Provided primary care services and HIV treatment and preventative services to the underserved community of Downtown, Hollywood and South LA including LGBTQ and Spanish speaking patients.

PHYSICIAN ASSISTANT/JOHN H. STROGER JR. HOSPITAL

September 2006 - December 2010

Provided in-patient medical care to the underserved HIV positive patients of Chicago admitted to HIV service of John H. Stroger Hospital. Contributed to daily rounds, coordinating the medical management with attending physician and clinical pharmacists and rotating residents of the HIV service. Monthly lecturer on HIV 101 topics and orientation of rotating residents, medical and PA students.

PHYSICIAN ASSISTANT/RUTH M. ROTHSTEIN CORE CENTER

September 2006 - December 2010

Provided out-patient primary care and HIV treatment and preventative services to the underserved community of Chicago including LGBTQ and Spanish speaking patients at the Ruth M. Rothstein CORE Center. Educator with Communities in School program teaching HIV and STI prevention in numerous Chicago public high schools.

PHYSICIAN ASSISTANT/HOUSE CALL PHYSICIANS

March 2006 – August 2006

Provided consultations and primary care home visitations with responsibilities including but not limited to medication management, phlebotomy and lab review, wound care assessment and treatment.

EMT-PARAMEDIC/SUPERIOR AMBULANCE COMPANY

December 2001 – August 2002

Provided routine and emergency advanced pre-hospital medical care, operating and maintaining Type 2 ambulance.

MEDICAL SPECIALIST/UNITED STATES ARMY

September 1997 – September 2001(Honorably Discharged)

Administered emergency and routine outpatient and inpatient medical treatment under supervision of nurse, physician and physician assistant while attached to field artillery units and while rotating through Fort Bliss medical clinic and at William Beaumont Army Medical Center. In addition, I participated in military exercises while on deployment to South Korea and Kuwait working in base clinics, in the field, and on mass casualty exercises. Obtained EMT-B, EMT-I and EMT-P certifications while in the US Army.

ACADEMIC EXPERIENCE

GUEST LECTURER/UNIVERSITY OF SOUTHERN CALIFORNIA

November 2020 - Present

Guest lecturer of Psychosocial Dynamics in Healthcare course discussing the clinical approach to addressing the psychosocial factors impacting HIV treatment and prevention.

GUEST LECTURER/MARSHALL B. KETCHUM UNIVERSITY

September 2019 - Present

Guest lecturer of Psychosocial Dynamics in Healthcare course discussing the clinical approach to addressing the psychosocial factors impacting HIV treatment and prevention.

ASSISTANT PROFESSOR/CHARLES R. DREW UNIVERSITY

June 2018 – July 2019

Assistant Professor for Charles R. Drew University (CDU) Physician Assistant program. Courses include Principles of Medicine III, providing a comprehensive review of the etiology, epidemiology, pathophysiology, history & physical presentation/findings, differential diagnosis, diagnostic methods, treatment, prevention and follow-up care of various internal medicine disorders. Teaching clinical medicine topics Ophthalmology and Nephrology in addition to Patient Interview course and Physical Diagnosis course, Psychosocial Dynamics in Health course as well as co-developer of Social Justice Curriculum.

CLINICAL COORDINATOR/CHARLES R. DREW UNIVERSITY

February 2019 – July 2019

Establishing and maintaining Supervised Clinical Practice Experiences (SCPE) clinical sites, responsible for developing Standard Operating Procedures, onboarding processes for second year PA students on clinical rotations in accordance with the Accreditation Review Commission on Education for the Physician Assistant standards. Creating and overseeing End of Rotation (EOR) examinations and case presentations along with setting 2-day agenda with guest speakers and trainings.

CLINICAL SITE PRECEPTOR/CHARLES R. DREW UNIVERSITY

January 2018 – June 2019

Site preceptor at Oasis Clinic - Martin Luther King Jr. Outpatient Center providing clinical instruction in both HIV and primary care for 2018 and 2019 PA cohorts on clinical rotations.

ADJUNCT INSTRUCTOR/CHARLES R. DREW UNIVERSITY

August 2017– June 2018

Adjunct Instructor of Patient Interview course for first year PA cohort leading small group interactive seminars introducing PA students to the fundamental skills necessary to conduct a medical interview with a patient and to be able to present the information in oral and written formats to other medical professionals. Instructional techniques include role-playing, small group discussion, observation and evaluation by instructors, students and simulated patient models.

GUEST LECTURER/CHARLES R. DREW UNIVERSITY

July 2017

Guest lecturer of Psychosocial Dynamics in Healthcare course discussing the psychosocial factors impacting HIV treatment and prevention for both 2018 and 2019 cohorts.

GILEAD SCIENCES SPEAKER'S BUREAU

March 2017 – Present

Speaker for Gilead Sciences Inc. covering three sections: HIV, Community and Pre-Exposure Prophylaxis, providing lectures and education to health professionals and community members on HIV related topics that are both branded (Gilead products) and unbranded that are related to HIV infection, complications, treatment, community impact and prevention.

PACIFIC AIDS EDUCATION AND TRAINING CENTER PROGRAM, CHARLES R. DREW UNIVERSITY - OASIS CLINIC

November 2016 – August 2017

Speaker at the HIV/STI & PrEP [Pre-Exposure Prophylaxis] Summit in South Los Angeles hosted by CDU and sponsored by PAETC. Speaker for PAETC certificate training on Police Violence & Brutality: It's an HIV Public Health Issue.

EDUCATION

MASTER IN PHYSICIAN ASSISTANT STUDIES
BRIDGE PROGRAM (MPAS)
UNIVERSITY OF TEXAS RIO GRANDE VALLEY
GPA 3.5

BACHELOR IN BIOMEDICAL SCIENCES
CHARLES R. DREW UNIVERSITY
GPA 4.0, Suma Cum Laude
Recipient of *Dr. Charles W. Buggs Award*

PHYSICIAN ASSISTANT CERTIFICATE OF COMPLETION
ASSOCIATE OF APPLIED SCIENCE
JOHN H. STROGER HOSPITAL-MALCOLM X COLLEGE
GPA 3.78

ASSOCIATE OF SCIENCE
MALCOLM X COLLEGE
Co-Valedictorian
USA Today All-USA Academic Team 2003
GPA 4.0

LICENSES AND CERTIFICATIONS

National Commission on Certification of Physician Assistants
State of California Licensed Physician Assistant
State of California Licensed Control Substance
HIV Specialist (AAHIVS)
National Registry of EMT's – Basic, Intermediate and Paramedic (not active)
Army Military Operational Specialty: Medical Specialist 91-W (not active)

PROFESSIONAL MEMBERSHIPS

Physician Assistant Education Association (PAEA)

California Academy of Physician Assistants (CAPA)

International AIDS Society (IAS)

American Academy of HIV Medicine (AAHIVM)

GLMA: Health Professionals Advancing LGBTQ Equality

American Public Health Association (APHA)

Community Advisory Board for Center for HIV Identification, Prevention, and Treatment Services (CHIPTS)

Street Medicine Institute

SOCIAL JUSTICE WORK

One of the founding members of *Frontline Wellness Network* a collective of social justice health professionals organizing to end the public health crises of criminalization and incarceration in LA county. Our members include nurses, physician assistants, social workers, acupuncturists, phlebotomists, physicians and students. We see criminalization and incarceration as urgent issues of racial and gender and economic justice and driving forces of health disparities including HIV. For the last 3 years we joined a coalition that successfully defeated LA's plan to build three new jails and that put forward an alternative, Care-First, Jail-Last budget for the city. As part of our organizing campaign I gave lectures to HIV service organizations on the intersections of HIV and mass incarceration including LA CADA, SoCal Club, Men's Health Foundation, APAIT and HOPICS, and the LA County PEP and PrEP Working Group. Now, in response to the police killing of Nick Burgos while hospitalized at Harbor UCLA by LA Sheriff's we are building a campaign to remove law enforcement from hospitals and to commit resources to providers so that they can respond to patient crises in safe and dignified ways.

On the community advisory board *for Center for HIV Identification, Prevention, and Treatment Services* (CHIPTS) which is committed to eliminating new HIV infections by promoting collaborative research, fostering networking, and supporting capacity building, with an emphasis on key populations who face comorbidities both domestically and globally since May 2018. Our current campaign is *Addressing Systemic Racism and its impact on HIV disparities and PrEP uptake*

As part of *American Public Health Association* (APHA) collaborated for over two years with public health professionals and students in the ultimate passing of the resolution "Addressing Police Violence as a Public Health Issue" at the annual APHA conference in November 2018 in San Diego. This resolution has provided evidence-based support for grassroots organizations like the Black Lives Matter Movement among others who are campaigning on issues addressing racism and police violence in this country.

Developed partnership with Charles R. Drew University's Global Health Initiative and *Refugee Health Alliance* arranging medical mission day-trips to Tijuana, Mexico addressing the health needs of the migrant community.

Member of *Say Their Names Los Angeles* which formed in response to the nationwide protests following the killings of George Floyd and Breonna Taylor and through work with dozens of families impacted by police violence in the Los Angeles area, on October 24, 2020, we organized a family speak out with hundreds of families and supporters and debuted 626 tombstones representing the lives lost to law enforcement in Los Angeles since Jackie Lacey took office in December 2013. We created a podcast to continue amplifying the voice, message, demands of families directly impacted by police violence in an effort to forward the social justice movement.

REFERENCES

Available upon request

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

I think my bio and CV describe well my personal and professional experience. Having said that, I think that I work well in a team and am able to collaborate well with others across social/personal identities. One concrete example of the melding of my personal and professional experience has been my role as a founding member of Frontline Wellness Network which has been working tirelessly on a series of social justice campaigns to stop jail construction and move LA County toward a Care First, Jails Last paradigm of addressing social problems. Over a 1.5 year period, to make this fight relevant to the HIV community, I researched and created a presentation on the intersections of HIV and incarceration, nationally and locally, and presented that to a number of HIV service organizations such as APAIT, HOPICS, LA CADA, SoCal Club and the PEP and PrEP Working Group. I believe this work exemplifies my commitment to the Commission's fight against HIV and its social determinants as well as my ability to work with numerous organizations and individuals.

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

I imagine there will inevitably be a number of political and personal differences that may arise in the context of discussions and planning etc. Personally, I think honest disagreement with dialogue is where positive change comes from. So if difficulties arise, I will plan to be an active listener and rely on my fellow Commissioner ' s as well. There are current members of the Commission that I know well so certainly reach out to them for guidance.

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

As I've stated earlier, my plan is to best represent the interests of those living in South Los Angeles where I live and work, which also is the community hardest hit by HIV and STD ' s. I come from a working class, Latinx background and while I do not completely represent the racial-gender-sexual groups most impacted by HIV and STD ' s, I have and will continue to strongly advocate for the wellness of those most impacted. As an example, I am the clinician for Watts Healthcare ' s first PrEP clinic and I have developed closer ties with Arming Minorities Against Addiction and Disease (AMAAD) Institute and through this partnership, creating a dual referral service for young Black and Latinx gay and transgender individuals seeking PrEP or HIV services. I hope to continue this work of bridge building across LA County.

Name: Felipe Findley

Former Business/Professional Experience for the past 10 years

1.	Men's Health Foundation, Los Angeles, CA	July 2019 to July 2020
2.	Charles R. Drew University Physician Assistant Program	August 2017 – July 2019
3.	Martin Luther King Jr. – Oasis Clinic	July 2014 – May 2019
4.	AIDS Healthcare Foundation	January 2011 – July 2014
5.	Hektoen Institute (John H. Stroger Hospital)	September 2006 – December 2010

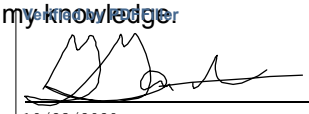
and it can be mailed, e-mailed or picked up at the office. Similarly, the application and is available online from the Commission's website at http://hiv.lacounty.gov. Submit your application by mailing it to or dropping it off at: 3530 Wilshire Blvd, Suite 1140, Los Angeles, CA 90010.
Applications may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

PART II: MEMBERSHIP APPLICATION FORM
Section 1: Contact Information

1. Name: Gerald Garth
   (Please print name as you would like it to appear in communications)
2. Organization: (if applicable) AMAAD Institute
3. Job Title: Director of Programs and Operations
4. Mailing Address: _____
5. City: _____ State: _____ Zip Code: _____
6. Provide address of office and where services are provided (if different from above):
   Mailing Address: _____
   City: _____ State: _____ Zip Code: _____

7. Tel.: _____ Fax: _____
8. Email: _____
   (Most Commission communications are conducted through email)
9. Mobile Phone #: (optional): _____

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

Signature: 
10/23/2020

Gerald Garth
Print Name

10/23/2020
Date

Section 2: Demographic Information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6b. **Age:**

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

6c. **Are you a "consumer" (patient/client) of Ryan White Part A services?** ❑ Yes x

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

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

Section 3: Experience/Knowledge

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

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

n/a

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

n/a

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

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

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

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

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

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

Section 4: Biographical Information

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

As a Commissioner, my personal mission is to serve and represent Black and Latinx LGBTQ+ communities of South Los Angeles. I will prioritize and amplify needs and experiences while building community rapport on behalf of the Commission, as it relates to people living with HIV and those at highest risk.

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

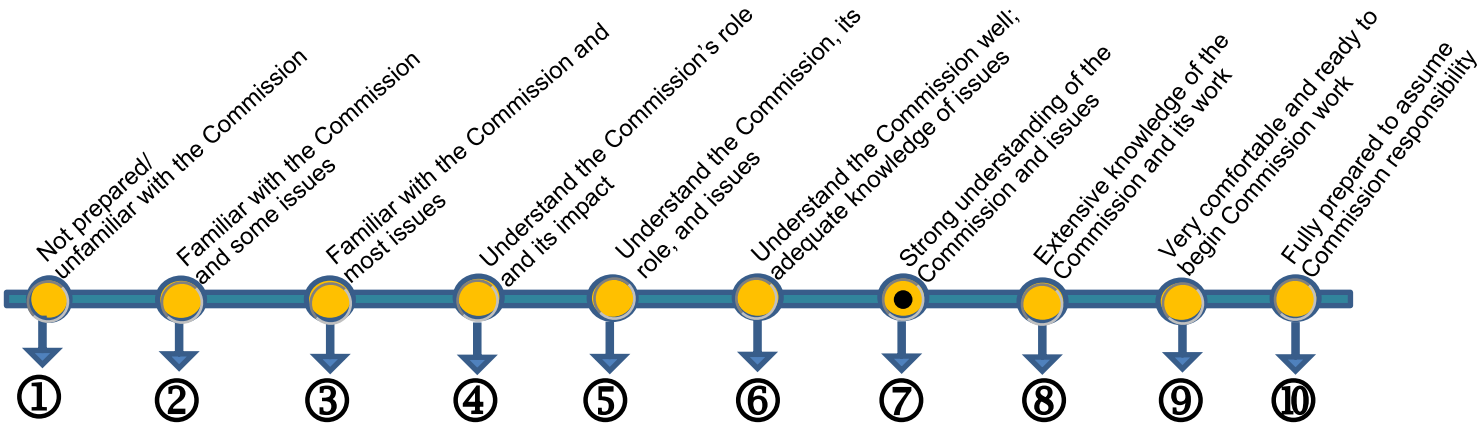
Biography and resume are attached.

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

Supplemental materials are included with biography and resume.

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

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



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

I currently serves as Director of Programs and Operations with the AMAAD Institute (Arming Minorities Against Addiction and Disease) to provide programs and services to LGBTQ+ communities of color in South Los Angeles with a focus in HIV prevention, mental health, reentry services, and substance recovery support. In my role, I develop, implement, and evaluate processes, programs, policies, and strategies to address the uniqueness of the LGBTQ+ experience for people of color (POC).

AMAAD proudly serves and represents South Los Angeles, a geography that is underserved and underrepresented. I am confident in being able to collaborate with and advocate for South LA as a Commissioner.

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

I do not foresee my acclimation as a hurdle, but an opportunity. I recognize that the Commission is a well-intended body set to be of service to the community at large. I pride myself on diplomacy, but also determination. I am confident and committed to the matters at hand as well as being able to advocate respectfully and resolutely by creating and upholding the culture of respect and leading with facts and tact.

I am looking forward to contributing my skills, strengths, and interests to the Commission, recognizing the value I will bring in standing for the communities, agencies, and organizations I represent well.

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

Simply put, representation matters. Having representation that not only represents oneself but is connected to as well is key. This strengthens relationships, builds community, and creates leadership opportunities.

Along with that, the messenger matters, by prioritizing the needs of impacted communities as well as exploring innovative ways to engage, I am confident that my role as a Commissioner while bring the resources, education, and access to the communities who need them most. With that as well, I look forward to building and strengthening new leaders and advocates as well. But one of benefit I look forward to most is the opportunity to lead by example. To lead and liaise, not just for community, but to help strengthen community confidence in the Commission as well.

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

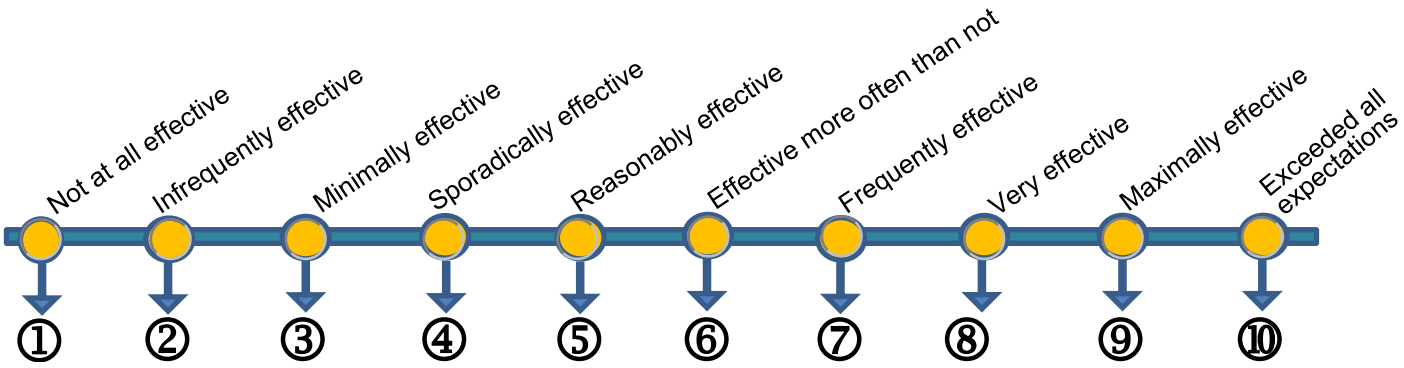
I am excited to bring strengths in critical thinking, relationship building, community relations, strategic planning and development, reporting, evaluation, and presentation and overall reimagining authority and accountability.

By bringing these diverse strengths and skills, I' m confident in enhancing the operations and organization of the Commission. In the role, I will be committed to growing skills in Commission administration.

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

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

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



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

n/a

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

n/a

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

n/a

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

n/a

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

n/a

A. Personal Statement

My personal mission has always been to serve and represent the most underrepresented beginning from my many years of volunteerism and leadership with my church. Over the years, my professional development began to reflect that same heart for service.

My work began to reflect my growing passion for addressing community need. Having worked in tax accounting for seven years, I developed many strengths and skills in administration, yet my inspiration has strengthened and evolved.

After years of working in accounting, I felt it was important to align my skills and strengths with work that was in step with my values: to help people, to make a difference in our communities, and to impact lives through individual and structural change, particularly recognizing that most of the nation's most affected groups are ones either I myself or a loved one represent—more particularly, Black people.

My community-based organizational work began with Black AIDS Institute in finance and administration. Very shortly after, I shifted from administration to programs as a programs specialist. In the role, I was responsible for the coordination and organization of programs, events, and outreach.

Through my commitment to service and a number of grateful opportunities, I was promoted 5 times in 3 years (the most in organizational history) from programs specialist to communications coordinator to outreach coordinator to training coordinator to Manager of Prevention and Care.

In my roles, I am proud to have trained and developed many staff— including first time HIV tester/ counselors, recent high school and college graduates, formerly incarcerated individuals, and other individuals that others might deem "hard to employ." By building, adapting, and applying tools and resources, and creating unique, yet evidence-based approaches, in these key roles, I was able to create new opportunities and develop curricula that empowered, educated, and equipped the individuals and communities that were anecdotally undereducated and underresourced.

As the organization's scope grew from mobilization, information dissemination, and training to include a more continued focus in providing culturally appropriate and adequate care for many of the most underserved groups in Los Angeles and the nation, most particularly Black people living with HIV/AIDS (PLWHA) and those at highest risk, including gay and bisexual men, youth, and women, I am proud to have successfully launched and led the Black AIDS Institute's first HIV testing program in its nearly 20 year existence.

Over the course of our initial testing program, our team served over 1000 individuals, linking individuals to treatment and prevention tools as well as education through materials, workshops, and trainings. Not only did I lead the project of building, developing, and managing the Black AIDS Institute's first ever direct services and testing, linkage, and navigation program, I served as lead for the six-organization partnership:

1. JWCH Institute, HIV testing and care and other supportive services
2. Men's Health Foundation, providing gay men's health services, including PrEP
3. T.H.E Clinic, for uninsured, underinsured, and/or undocumented clients
4. The Wellness Station, with a particular focus in Black women's testing and care needs
5. REACH LA, specializing in Black and Latinx youth services

Reinforcing the power of collaboration, as Training and Capacity Building Coordinator, I led BTAN (Black Treatment Advocates Network), a national network of HIV/AIDS stakeholders including service providers, community members and leaders, educators, and people living with HIV/AIDS to mobilize Black communities across the country to confront HIV, responsible for 12 cities across the country.

In the African American HIV University (AAHU), a yearlong national fellowship to increase HIV knowledge, advocacy, and science literacy among community leaders while also building organizational capacity. I am proud to have been the only Black AIDS Institute staff member to have ever completed the program.

Completing as salutatorian, my experience as a Fellow compelled me to work with leadership to rework and advance the program to be meet the growing needs of working adults and other nontraditional studies to include virtual learning and including modules that developed public speaking skills. After my completion of as Fellow, the following year, I served as lead leading recruitment, Fellows management, curriculum management, and one of our team of two.

My first year leading AAHU was the highest recruitment (30 active Fellows, up from 5 the previous year) and the strongest Fellows competence and satisfaction data in the history of the program. This is no coincidence. Strong leadership by example that represents lived experience and those committed to the process are necessary elements of any program.

As Outreach and Communications Coordinator, I was responsible for creating, developing, and evaluating programs and events tailored for individual communities around HIV treatment, prevention, education, and stigma, recognizing the necessity of not only building skills, but building leadership is key in regard to programs that serve unrepresented, yet most impacted communities.

I created Revolution in Color, a sexual health and leadership development program designed for young Black and Latinx GBTQ+ men ages 18-35 centered around HIV testing, prevention, education, and healthy decision making.

Stay UP: Unapologetically Positive was a spin-off of Revolution in Color, uniquely designed for the young men living with HIV of the group. These group sought to build empowerment, increase education, and create a safe and affirming space to share experiences and build skills specific to their lives on such matters like treatment, disclosure, managing life, and healthy relationships.

Other programs included the Peer Mentor Program which was designed to provide support and development based on lived experiences of individuals living with HIV and WomenAWARE (Advocating for Wellness, Awareness, Reduction, and Empowerment), a series of trainings that looked at the intersectional needs of women and HIV.

After nearly 4 years with the Black AIDS Institute, I was excited to accept the role of Manager of Programs Operations with the AMAAD Institute (Arming Minorities Against Addiction & Disease).

Recognizing the continued need for structural work to address HIV in Black communities, that is, working to shift and inform policy, advocacy, and education, I began to broaden my work beyond direct services. My work began to address inequity and disparities from multiple lenses, largely structural oppression, such as implicit bias in care, racism, classism, and other types of oppression, and their impacts on the care and wellness of Black people.

In my growing function at AMAAD, now serving as Director of Operations, I oversee all of the organization's programs and public policy efforts. This work includes addressing intersectional needs-- homelessness, substance use, employment, incarceration, and mental health concerns—and their impact on HIV treatment and prevention.

Through marries these passions and skills, I am proud to have forged the growth of AMAAD from 2 staff members to now almost 20 in my 2 and a half years with the organization. I have recognized that ongoing opportunities to include individuals in their own development and the development of their communities through leadership opportunities is paramount.

In my role, I consistently build create protocols, procedures, and policies to help grow and prepare the organization for growth. I have developed, implemented, and evaluated processes, programs, and strategies that address the uniqueness of the Black experience, particularly among youth, LGBTQ+, and other underserved communities through trainings, public policy efforts, advocacy, and team oversight as well as overseeing monitoring and evaluation, media and communications, staffing and training, and strategic partnerships and initiatives.

More ongoing initiatives that I am proud of include my commitment to acknowledging the role of media, messaging, and marketing in community health and wellness. Many of my media roles include: former editor of the Black AIDS Weekly, a national weekly newsletter serving as the premier voice for Black HIV content; contributing editor to Plus Magazine; contributing writer for the Advocate and Message magazine, addressing stigma, miseducation, and highlighting new voices in the fight against HIV; "Positive" columnist for Heart & Soul Magazine, showcasing Black women and their experiences addressing HIV; and former editor in chief for Chill Magazine, a print and social brand addressing the unique experiences of millennial men of color.

Knowing the necessary skill of strong writing and public speaking skills as a part of leadership development, I founded Your Story, Your Words, a writing workshop series for young Black gay and bisexual men. In partnership with the California HIV Policy Research Centers, this effort set to hone technical and creative writing skills for these men to use their own experiences in their own voice to inform policy change. From that,

another proud creation, W.O.R.D. (Writing Our Reality Down), began as a quarterly event originated to showcase the works of these developing voices.
My personal commitment to ongoing has compelled me to higher education as well. In my second year at Antioch University Los Angeles for a Masters of Nonprofit Management, I have begun to explore other, more competitive programs to enhance and advance myself as a leader of leaders.

B. Positions and Honors

1. Black LGBTQ+ Activists for Change (BLAC), Co-Founder (2020)
2. Young Black Gay Men's Taskforce, Chair (2018-current)
3. Black LGBTQ+ Action Coalition, Creator (2018)
4. Leadership of Christopher Street West (2017-current)
    a. Director of Finance for LA Pride
    b. Chair of Finance Committee with Board of Directors
    c. Co-chair of Community Advisory Board
    d. Co-chair of Programs Committee
        i. Program development
        ii. Monitoring and evaluation
    e. Board Development Committee Member of CSW
5. Director of Partnerships and Community Relations, Vision Church Los Angeles (2019- current)
6. Equality California Leadership Academy, Fellow (2017)
7. California HIV Policy Research Centers, Fellow (2018)
8. Out Again Big Tobacco, Policy Committee Chair (2019-current)
9. Black Treatment Advocates Network Los Angeles, Advocacy Committee Chair (2013-2015)
10. Independent Development Programs Advocate Award (2019)
11. Most Outstanding New Magazine, Chill Magazine editor in chief, Eddie and Ozzie Award (2018)
12. Member of NABJLA, National Association of Black Journalists Los Angeles (2019)

D. Additional Information: Research Support and/or Scholastic Performance

Press (not exhaustive):

1. http://laindependent.com/amaad-institute-offers-sense-of-community-to-lgbt-people/
2. https://medium.com/@blackaids.org/nmac-national-prep-summit-600d96959453
3. http://wavenewspapers.com/amaad-institute-offers-sense-of-community-to-lgbt-people/
4. https://blackpressusa.com/amaad-institute-offers-sense-of-community-to-lgbt-people/
5. https://blackpressusa.com/amaad-institute-offers-sense-of-community-to-lgbt-people/?fbclid=IwAR2BVSvR6dlaIxO8xxowNeF7Bq_malc974Avcv-ZvN3CPix62Mnw00inQ90
6. https://dallasvoice.com/prepping-prep/
7. https://www.hivlawandpolicy.org/resources/pjp-update-january-2017 (CHRC)
8. https://www.antioch.edu/los-angeles/?name
9. https://www.hivplusmag.com/stigma/2018/11/29/what-does-world-aids-day-mean-2018#media-gallery-media-14
10. https://www.hivplusmag.com/my-health-my-way/2018/7/09/gerald-garth
11. https://issuu.com/heremedia/docs/plus_128_jan_feb_digital
12. https://www.hivplusmag.com/together-we-know/2016/12/01/world-aids-day-2016-years-biggest-hiv-developments

13. https://defendernetwork.com/lifestyle/health/30-days-hiv-campaign-hopes-raise-awareness/
14. http://faithaidsday.com/faithletter/
15. http://events.r20.constantcontact.com/register/event?oeidk=a07ecbj970l8005e243&llr=kgbgkheab
16. https://hivdatf.wordpress.com/trainings/past/hiv-criminalization/
17. https://www.eqca.org/wp-content/uploads/Fair-Share-for-Equality-Report-2017.pdf
18. https://www.hivplusmag.com/my-health-my-way/2018/3/22/whole-body-health
19. https://www.microsoft.com/en-us/microsoft-365/customer-stories/789574-amaad-non-profit-m365

GERALD R. GARTH, JR.

PROFESSIONAL SUMMARY

Dynamic, motivated, and experienced strategist with a passion for leadership development, policy and advocacy, and research, evaluation, and training, particularly for underserved communities including Black people, Black LGBTQ+ people, women, youth, people living with HIV, people experiencing homelessness, people experiencing mental health concerns, people experience substance use, reentry community, and faith communities. With a proven record of managing projects from concept to completion, leadership ability, organizational skills, flexibility, and skilled in building cross-functional teams and critical decision-making. Adaptable and transformational leader with the ability to work independently, developing opportunities that further establish organizational goals.

SKILLS

- Leadership and organizational skills
- Communication, team building, mentorship,
- Risk management
- Cost management
- Critical thinking
- Project management
- Policy Research and Data Analysis
- Government, legislative Affairs and Advocacy
- Training and Presentation
- Creativity and attention to detail

WORK HISTORY

[October 2017-present] [Arming Minorities Against Addiction & Disease (AMAAD) Institute] [Los Angeles, CA]
[Director of Operations and Policy]
[Manager of Policy and Training]

[Manage development of programs; ensure strategic objectives; oversee the production of policy positions; coordinates activities; represent organization at public meetings and forums; responsible for public relations initiatives; develop work plans and plans of action; develop and maintain research, monitoring, and evaluation; oversee media and communications, training and development, strategic partnerships]

[Manager of Program Operations]

[Organizational and team development & management; program delivery; quality control and compliance; monitoring and evaluation; develop/ implement organizational strategies—recruitment, retention, professional development, communications]

[November 2013-June 2017] [Black AIDS Institute] [Los Angeles, CA]
[Manager of Prevention and Care]

[Oversee, develop, and manage organizational policies, procedures, and protocols; manage program monitoring and evaluation, HIV prevention, testing, linkage, support services, and communications; led national initiatives; hire, train, monitor and evaluate staff]

[Training & Capacity Building Coordinator/ Outreach Coordinator]

[Develop, effectively implement, brand, design, manage CDC community programs; led contacts management, monitoring, and analytics; led organizational content creation and information dissemination—online and print; led national program recruitment and retention]

[Program/ Communications Specialist]

[Work interdepartmentally with Training and Capacity Building, Mobilization, Communications, and the Office of President in program planning, implementation, reporting, and evaluation, et al; led all organization's social media, print, web, and media messaging and contributions]

EDUCATION

[Antioch University]
[Master of Nonprofit Management]

[December 2016] [University of Phoenix]
[Bachelor of Arts in English]

POSITIONS AND HONORS

1. Black LGBTQ+ Activists for Change (BLAC), Co-Founder (2020)
2. Young Black Gay Men's Taskforce, Chair (2018-current)
3. Black LGBTQ+ Action Coalition, Creator (2018)
4. Leadership of Christopher Street West (2017-current)
    a. Director of Finance for LA Pride
    b. Chair of Finance Committee with Board of Directors
    c. Co-chair of Community Advisory Board
    d. Co-chair of Programs Committee
        i. Program development
        ii. Monitoring and evaluation
    e. Board Development Committee Member of CSW
5. Director of Partnerships and Community Relations, Vision Church Los Angeles (2019- current)
6. Equality California Leadership Academy, Fellow (2017)
7. California HIV Policy Research Centers, Fellow (2018)
8. Out Again Big Tobacco, Policy Committee Chair (2019-current)
9. Black Treatment Advocates Network Los Angeles, Advocacy Committee Chair (2013-2015)
10. Independent Development Programs Advocate Award (2019)
11. Most Outstanding New Magazine, Chill Magazine editor in chief, Eddie and Ozzie Award (2018)
12. Member of NABJLA, National Association of Black Journalists Los Angeles (2019)

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

PART II: MEMBERSHIP APPLICATION FORM
Section 1: Contact Information

1. Name: Isabella Rodriguez
   (Please print name as you would like it to appear in communications)
2. Organization: (if applicable) _____
3. Job Title: _____
4. Mailing Address: _____
5. City: _____ State: _____ Zip Code: _____
6. Provide address of office and where services are provided (if different from above):
   Mailing Address: _____
   City: _____ State: _____ Zip Code: _____

7. Tel.: _____ Fax: _____
8. Email: _____
   (Most Commission communications are conducted through email)
9. Mobile Phone #: (optional): _____

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

01/04/2021
Date

Signature: _____

Isabella Rodriguez
Print Name

Section 2: Demographic Information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6b. **Age:**

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

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

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

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

Section 3: Experience/Knowledge

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

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

Susan Forrest and Felipe Gonzalez

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

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

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

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

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

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

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

Section 4: Biographical Information

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

For over twenty years of being part of the HIV/Trans, Queer community, I have never seen such staggering statistics (CDC 2017). Statistics have been scarce and not enough attention from the federal level has been paid to a growing community. As a Latina Trans woman I feel it is important that I join the many HIV advocates that I have known throughout the years, and continue to provide education, break the stigma, and cultivate the young voices of tomorrow.

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

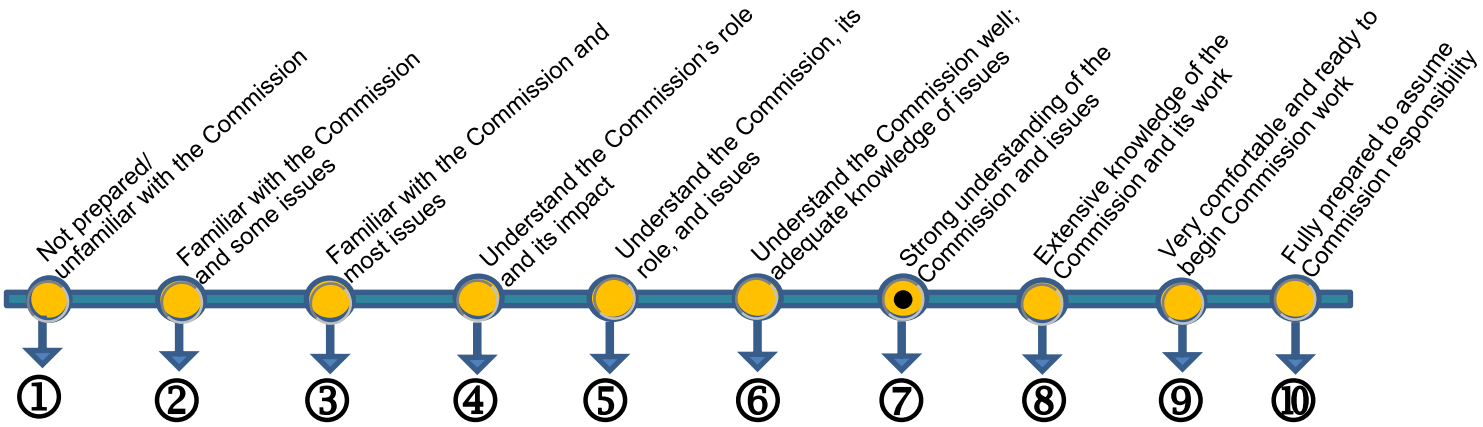
Please see attached Resume.

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

N/A

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

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



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

One can be a member of a community but never fully understand the severity of what it means to have a love one die from AIDS complications, or have a friend tell you she is positive. I was this person. As a Health Educator for the trans community I organized an Advocacy Pageant, I represented my agency in the Drug and Alcohol Task Force, I collaborated with various agencies and played an active, professional role in the community. As a result of all this involvement I always remained detached from the work I was doing. I figured If I don't partake in risky behavior I will never get it. But as a member of a high risk population I am finding it harder and harder to stay negative. I am finding it is harder to stay resolute and unwavering in my goals to stay safe. The stigma, discrimination, and trans phobia is just the tip of the Iceberg, and I am finally ready to come to the table, not in a professional capacity but as member of a community who is concerned for the lives of trans people.

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

I think my greatest hurdle is too hang in there when things get tough. When I am dealing with issues that affect me on a visceral level I tend to walk away. I am a very emotional person. One of the reasons why I walked away from the community 7 years ago was because I did not know how to self-care. I internalized the problems of my community, and I became stuck. It has been a while since I have worked with the trans community and In that time a lot has changed. The one thing that I can keep on doing is to find allies within the Commission, harbor friendships that can help me in the things I want to accomplish. Combating HIV is not one populations problem, it is everyone's, and only then can we begin to see change.

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

The greatest benefit that I can bring to my community is the fact that I'm not from an agency. I also have perspective that is transparent and honest. I am a community member who can offer a perspective that is not biased and one of my goals is to fully commit to the Commission and the community members I serve.

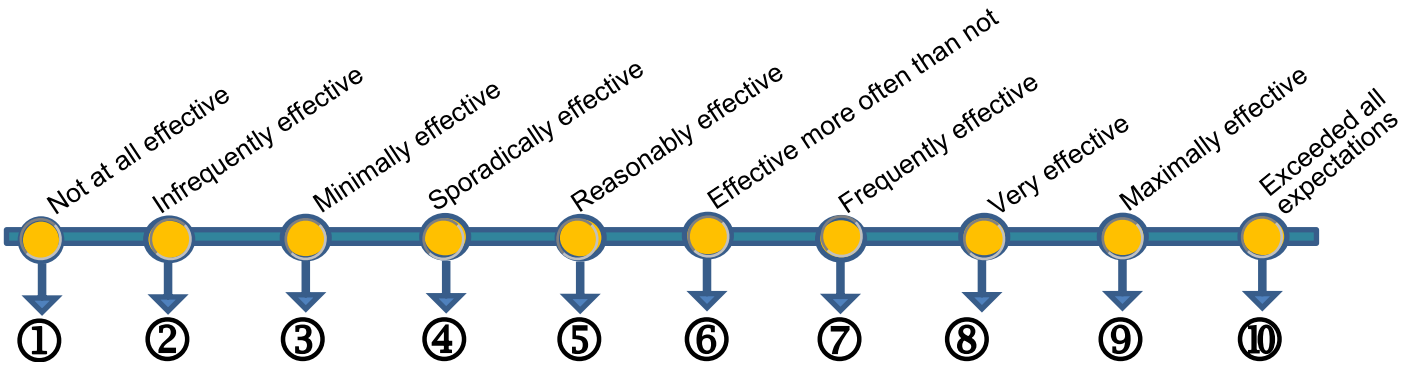
17. **Which of your strengths do you feel will enhance your Commission performance? What skills will you need to develop further for optimal Commission performance? Continue on an additional page if necessary.**

One of the strengths that I will bring to the table is complete honesty. While I think it is important to talk about "community viral load" and "inter-sectional oppression" we need to be able to see how this oppression is affecting our communities, we need to be able to look at these intersectionality's and attach a face to it otherwise our war against HIV doesn't become personal. One of the great tools that I took from higher education was critical thinking. I can look at what is happening in a book and be able to theorize it, politicize it, and feel what is happening in the moment of decision. I am an introvert, and my oratorical skills are not the best. I do not like the limelight, but I love to write.

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

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

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



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

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

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

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

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

CLICK HERE TO PRINT FORM

CLICK HERE TO CLEAR FORM

ISABELLA V. RODRIGUEZ

EXPERIENCE

Transgender Law Center
Los Angeles, CA **03/2011 – 10/2013***
Community Organizer

- Mobilize the transgender community to advocate for state legislation.
- Organize various projects and committees with health clinics and the Los Angeles Homeless Services Authority to create policies that include gender identity language.
- Manage the Los Angeles division and oversee planning and program implementation.
- Lead Organizer/Coordinator for annual Leadership Conference.
- As part of the engagement with the community, I was part of the Transgender Service Provider Network, and the HIV Drug and Alcohol Task Force.

Asian Pacific AIDS Intervention Team
Los Angeles, CA **01/2009 – 3/2011**
Health Educator

- Provide HIV Education to At Risk Transgender Women
- Coordinate bi monthly events for the Transgender Community
- Provide Comprehensive Risk Counseling and Services
- Coordinate and facilitate information sessions for Trans Community and the Department of Public Health-Office of AIDS Programs and Policy.
- Responsible for submitting monthly reports and meeting the objectives of contract with the county of LA.

Hallworth Design **5/2007 – 1/2009**
Los Angeles, CA
Project Manager

- Provide HIV Education to At Risk Transgender Women
- Coordinate bi monthly events for the Transgender Community
- Provide Comprehensive Risk Counseling and Services
- Coordinate and facilitate information sessions for Trans Community and the Department of Public Health-Office of AIDS Programs and Policy.
- Responsible for submitting monthly reports and meeting the objectives of contract with the county of LA.

Donna Ferrato Archives **01/2005 - 04/2007**
New York, NY
Administrative/Personal Assistant

- Independently contracted to create and implement a filing system for her body of work.
- Organize four successful art shows previewing new work.
- Implement marketing plans and manage sales of photography collections.
- Monitor and maintain financial records for her non-profit organization and personal business.

SCO Family of Services **04/2002 –12/2004**
Brooklyn, New York
Executive Assistant to the Director of Foster Care Services

- Responsible for inputting Payroll and Accounts Receivable.
- Maintain personnel and client files.
- Implement agency wide tracking system for employee data.
- Maintain calendar for executive team.
- Work closely with youth to organize mentorship programs.

EDUCATION

California State University | Long Beach, CA **06/2014 – 1/2020**
Master of Arts, English Literature
Antioch University | Los Angeles, CA **06/2010 – 8/2012**

*The gap in unemployment is due to a Medical Emergency in 2015, and as a result of my disability I went back to school to pursue a Master of Arts.

Bachelor of Liberal Arts, Creative Writing Concentration

INTERNSHIPS
Research Intern for Talia Mae Bettcher, Ph. D. Professor of Philosophy at CSULA **06/2012 – 12 /2012**

LANGUAGES
Fluent in Spanish

SKILLS
Proficient in Microsoft Office; MS Word, MS Outlook, MS Excel, MS PowerPoint as well as proficiency in Macintosh Software, Internet Research Skills, above average computer literacy.

*The gap in unemployment is due to a Medical Emergency in 2015, and as a result of my disability I went back to school to pursue a Master of Arts.

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

PART II: MEMBERSHIP APPLICATION FORM
Section 1: Contact Information

1. Name: Reba Stevens
   (Please print name as you would like it to appear in communications)
2. Organization: (if applicable) Resident of Los Angeles, County of Los Angeles
3. Job Title: Community Advocate
4. Mailing Address: _____
5. City: _____ State: _____ Zip Code: _____
6. Provide address of office and where services are provided (if different from above):
   Mailing Address: _____
   City: _____ State: _____ Zip Code: _____

7. Tel.: _____ Fax: _____
8. Email: _____
   (Most Commission communications are conducted through email)
9. Mobile Phone #: (optional): _____

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

10/05/2020
Date

Signature: _____

Reba Stevens
Print Name

Section 2: Demographic Information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6b. **Age:**

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

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

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

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

Section 3: Experience/Knowledge

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

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

Bridget Gordon

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

Unaffiliated Stakeholder

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

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

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

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

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

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

Section 4: Biographical Information

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

As a community member and advocate who is a from a population identified as high-risk, living in SPA 6 which is a community that is highly impacted by HIV and STI's, I am very committed to ensuring systems are responsive and accessible to those who need them the most. I am active in the homeless count every year and have noted the rising numbers of HIV positive people who are unhoused and endure the fear, trauma and vulerablility associated with being homeless. My community has both the highest rates of homelessnes and also the highest rates of HIV and STI's in Los Angeles County.

I am a strong advocate, adept at analysing data and the results of our system, my goal is making sure policies and programs actually serve those who are living with HIV and especially those who are HIV and homeless.

Through dedicated service on key leadership bodies within the County of Los Angeles, I strive to make sure the voices of those who need help are authentically heard and taken seriously. I am often the only voice speaking from the perspective of "real life experience" and actual contact with key systems under review.

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

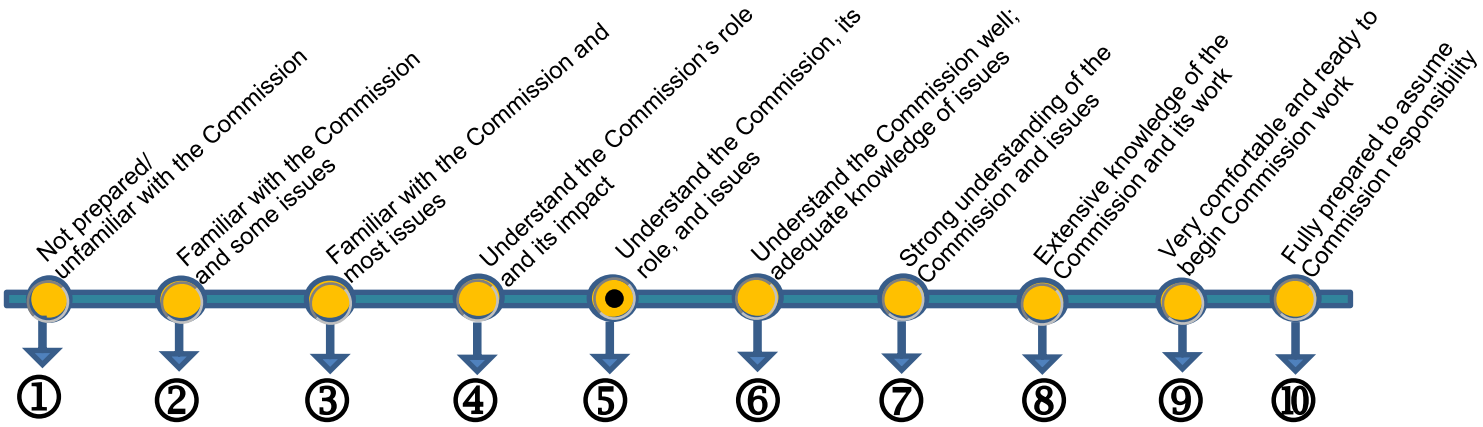
I am dedicated to using my real life experience to advocate for community members who are in dire need of effective support, solutions, care systems and programs that "give a hand up and educate" when dealing with system-wide programs that in many cases have failed them.
Prior to being diagnosed with a mental illness and starting my personal road to recovery & sobriety, I lived on and off the streets of Los Angeles for 21 years. The experience and feelings of overwelming stress, anxiety, feelings of shame, remorse, stigma and incomprehensible demoralization are a part of who I am, memories of those years give me the drive to collaborate and participate in forging solutions that uplift my own community and raise the standards in how we treat and support overlooked and underserved residents into opportunities for health, healing and growth.

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

NA

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

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



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

Currently I am a member of the LGBT Center South, Community Advisory Board from 2019 to present, I am learning about specific needs for people living with HIV and preventing HIV transmission in the surrounding communities.

Currently I am a member of the Los Angeles County Mental Health Commission, 2018 - present, it is critical to address the mental health needs and traumatic experiences of people living with, newly diagnosed and at risk for HIV and STI's.

My participation on Los Angeles County's Integration Advisory Board 2015 -2018, provided a broad view of how the county health systems operates, the need for "whole person" integrated health care and the importance of prioritizing the needs, quality and ease of access to county residents that are in most need of health and supportive services.

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

My greatest hurtle will be learning and understanding the complexities of this commission. It operates much differently than most commissions. I enjoy being an "A" student, studying to understand and asking alot of questions about the scope and limitations of the commission and how each of the standing committees relate to the objectives of the commission. I always work to understand the details and the underlying implications of how the decisions and policies impact the consumer and residents of Los Angeles County who utilize public health services.

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

Well, I am able to participate with a different perspective and mindset based on my varied experiences. I believe " new eyes" provide opportunities to uncover issues and/or solve challenges that may not otherwise be recongnized by those deeply immersed in the work.

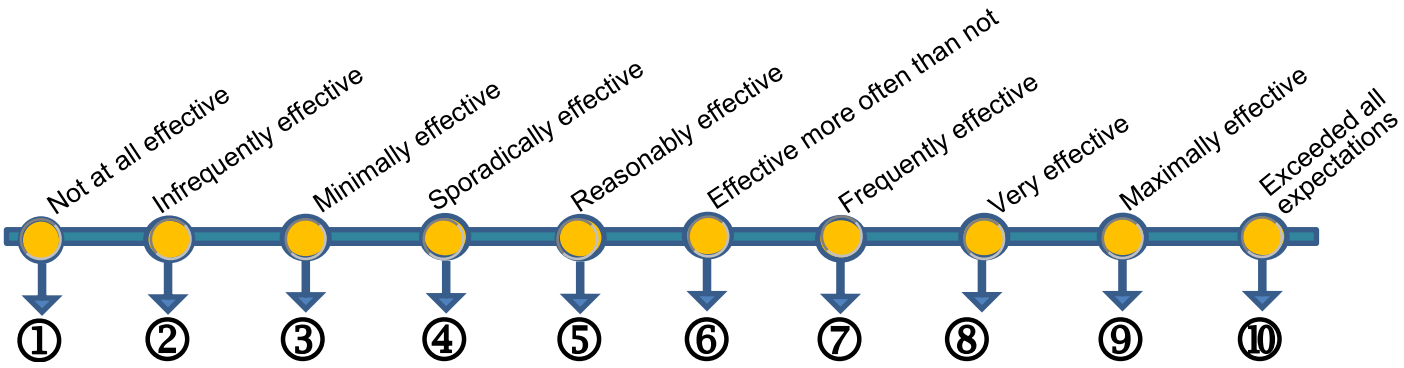
17. **Which of your strengths do you feel will enhance your Commission performance? What skills will you need to develop further for optimal Commission performance? Continue on an additional page if necessary.**

My attention to detail, my willingness to speak up and ask questions and my commitment to participate fully in the opportunities and obligations I am blessed to accept. Again, this is a more complex commission so I will need to study and understand how the commission works from the federal, state and local levels - and who is impacted by the decisions that come out of this commission.

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

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

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



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

NA

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

NA

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

NA

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

NA

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

Not at this time.

Reba Stevens
BIO

Reba Stevens is dedicated to using her real life experience to advocate for community members who are homeless, as well as for residents who need or use mental health services in Los Angeles County.

She is powerfully committed to ensuring systems are responsive and accessible to those who need them the most.

Prior to being diagnosed with mental illness and beginning her personal road to recovery, Ms. Stevens lived on and off the streets of Los Angeles for 21 years. She recalls the many fears and trauma associated with being homeless; overwhelming depression, stress, anxiety, feelings of shame, remorse and incomprehensible demoralization. Her understanding of the mental health system in L.A. County, together with her experience and deep knowledge and empathy for those who are homeless, deeply inform her unwavering conviction that solutions must be based on an individual's needs and experiences. Ms. Stevens pursues these solutions relentlessly.

Today Ms. Stevens is a fierce advocate, adept at analyzing the results of our system. Her goal is making sure policies and programs actually serve those who are homeless and/or in need of mental health services, and that they also address long neglected and now dire needs. Through dedicated service on key leadership bodies within the Los Angeles County, she makes sure the voices of those who need help are heard seriously and authentically. Often she is the only voice speaking from the perspective of "real life experience" and actual contact with the key systems under review.

Ms. Stevens is an appointee to the following governmental advisory bodies:

- Los Angeles County, Health Agency Integration Advisory board (IAB), 2015 - 2018
- Los Angeles Homeless Services Authority, (LAHSA) Homeless Advisory Board, 2015 - present
- Los Angeles Regional Homeless Advisory Council, (RHAC), 2017 - present
- Los Angeles County Department of Mental Health, Service Area, 6 Advisory Committee (SAAC), 2010 - present
- Los Angeles City, LA Door Housing Committee, 2017 - present
- Los Angeles City, Mayor's Homeless Cabinet, 2018 - present
- Los Angeles City & County Office of Diversion and Reentry Prop 47 Steering Committee, 2017 - present
- LAHSA Ad Hoc Committee on Black People Experiencing Homelessness, 2018 - present

- Los Angeles County, Department of Mental Health Commission, 2018 - present
- LGBT South Community Advisory Board, 2019 – present
- Project RoomKey - The 100 Day Challenge May 2020
- SPA 6 Homeless Coalition, 2015 – present

In 2017, Ms. Stevens served as an appointee to the Los Angeles County Measure H Revenue Planning Committee Process and design sessions. She has regularly testified at the Los Angeles County Board of Supervisors and LAHSA Board of Commissioners in support of ending homelessness.

Ms. Stevens has been a mental health consumer with the Los Angeles County Department of Mental Health (DMH) since 1999. Her keen insight, sharp and analysis and personal experience give her a deep understanding of opportunities for improving systems, structures and services for all.

Her advocacy has received coverage in print and broadcast media:

- Los Angeles Times
- Los Angeles Daily News
- Free Your Mind Projects Radio Show, KABC-AM (AM790)
- Hope On The Horizon MHSOAC News Publication
- LACDMH and Jackie Lacey Discuss Jail Diversion Program
- Making Sense of Measure H: Dr. Mitch Katz and Reba Stevens in conversation with Pat Prescott (94.7 The Wave)
- Unsheltered… New Possibilities Tedx Crenshaw (Ted Talk)
- Strategic Concepts in Organizing & Policy Education (SCOPE)
- Empowerment Congress Mental Health Committee
- Empowerment Congress Human Services Committee

Reba is a sought after public speaker.

Reba's motto is:

"Hope is the Application of Humanness where there is Hopelessness, that only a life lived for others is a life worthwhile".

LOS ANGELES COUNTY
COMMISSION ON HIV

PLANNING, PRIORITIES AND ALLOCATIONS (PP&A) COMMITTEE PARADIGMS AND OPERATIONG VALUES

(APPROVED by PP&A JANUARY 19, 2021)

PARADIGMS (Decision-Making)

Compassion: response to suffering of others that motivates a desire to help

Equity: The absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. (1)

OPERATING VALUES

Efficiency: accomplishing the desired operational outcomes with the least use of resources

Quality: the highest level of competence in the decision-making process

Advocacy: addressing the asymmetrical power relationships of stakeholders in the process

Representation: ensuring that all relevant stakeholders/constituencies are adequately represented in the decision-making process

Humility: Acknowledging that we do not know everything and being open to learning and listening carefully to others.

Footnote:
(1) the World Health Organization's (WHO) definition of equity.

Motion #9/COH 02.11.21

RYAN WHITE PROGRAM

UNIVERSAL SERVICE STANDARDS

Final for Commission on HIV Approval 2/11/21

Approved by SBP on 2/2/21

TABLE OF CONTENTS

IMPORTANT: Service standards must adhere to requirements and restrictions from the federal agency, Health Resources and Services Administration (HRSA). The key documents used in developing standards are as follows:
Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18)
HIV/AIDS Bureau, Division of Metropolitan HIV/AIDS Programs National Monitoring Standards for Ryan White Part A Grantees: Program – Part A
Service Standards: Ryan White HIV/AIDS Programs

INTRODUCTION

Standards of Care outline the elements and expectations a Ryan White service provider follows when implementing a specific service category. Standards of Care are available for each service category to set the minimum level of care Ryan White funded agencies should offer to clients. The Standards are intended to help Ryan White Part A funded agencies meet the needs of their clients. Providers are encouraged to exceed these standards.

The Los Angeles County Commission on HIV developed the Universal Standards of Care to reflect current guidelines from federal and national agencies on HIV care and treatment, and 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.

UNIVERSAL STANDARDS OVERVIEW

The objectives of the Universal Standards are to ensure agencies:

- Provide services that are accessible and non-discriminatory to all people living with HIV in Los Angeles County with a focus on highly impacted populations
- Educate staff and clients on the importance of receiving care, treatment as prevention, and how people who are completely, durably suppressed will not sexually transmit HIV.
- Protect client rights and ensure quality of care
- Provide client-centered, age appropriate, culturally and linguistically competent care
- Provide high quality services through experienced and trained staff
- Meet federal, state, and county requirements regarding safety, sanitation, access, and public health.
- Guarantee client confidentiality, protect client autonomy, and ensure a fair process of addressing grievances
- Prevent information technology security risks and protect patient information and records
- Inform clients of services, establish eligibility, and collect information through an intake process
- Effectively assess client needs and encourage informed and active participation

- Address client needs through coordination of care and referrals to needed services
- Ensure that the quality of service and materials given to patients during telehealth encounter is similar with in-person visits.

1. GENERAL AGENCY POLICIES

All agencies offering Ryan White services must have written policies that address client confidentiality, release of information, client grievance procedures, and eligibility. Agency policies and procedures facilitates service delivery as well as ensures safety and well-being of clients and staff. Agencies are encouraged to build their telehealth technology infrastructure and capacity to include videoconferencing to facilitate patient-provider connectivity and relationships.

1.0 GENERAL AGENCY POLICIES	
Standard	**Documentation**
1.1 Agency develops or utilizes an existing client confidentiality policy in accordance with state and federal laws to assure protection of client HIV status, behavioral risk factors, and/or use of services.	1.1 Written client confidentiality policy on file with specific information technology safeguards for confidentiality and patient information if using telehealth service modality.
1.2 Agency is responsible for informing the patient that they have the right to obtain copies of their medical and other health records maintained by the agency.	1.2 Written policy for informing the patient of their rights to receive a copy of their medical records. The policy should contain a description of the process for obtaining records, such as a verbal or written request and a reasonable timeframe for patients to receive the information.
1.3 Client determines what information of theirs can be released and with whom it can be shared. Services using telehealth modality are subject to consent by the	1.3 Completed *Release of Information Form* on file including: • Name of agency/individual with whom information will be shared • Information to be shared • Duration of the release consent • Client signature For agencies and information covered by the Health Insurance Portability and Accountability Act (HIPAA), form must be HIPAA disclosure authorization compliant. The form must also be compliant with the

patient.[1]	CA Medi-Cal telehealth policy.[2]
1.4 Agency develops or utilizes an existing grievance procedure to ensure clients have recourse if they feel they are being treated in an unfair manner or feel they are not receiving quality services.	1.4 Written grievance procedure on file that includes, at minimum: • Client process to file a grievance • Information on the Los Angeles County Department of Public Health, Division of HIV & STD Programs (DHSP) Grievance Line 1-800-260-8787. Additional ways to file grievances can be found at http://publichealth.lacounty.gov/dhsp/QuestionServices.htm DHSP Grievance Line is posted in a visible location on site or provided to the patient at the beginning of a telehealth encounter.

[1] https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthFAQ.aspx
[2] https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mednetele.pdf

Standard	Documentation
1.5 Agency provides eligibility requirements for services available upon request. Eligibility requirements must follow guidance from Division of HIV & STD Programs (DHSP) and HRSA under Policy Clarification Notice #16-02.[4]	1.5 Written eligibility requirements on file.
1.6 All client files are stored in a secure and confidential location, and electronic client files are protected from unauthorized use. Protection of client files and information must cover use of electronic medical records, phones, text messages, email, and telehealth modalities.	1.6 Client files must be locked and/or password protected with access provided only to appropriate personnel. Agencies must establish written procedures and IT policies for message encryption and restrictions on staff access to protect client information.
1.7 Agency maintains progress notes of all communication between provider and client.	1.7 Legible progress notes maintained in individual client files that include, at minimum: • Date of communication or service • Service(s) provided • Recommended referrals linking clients to needed services (See Section 6: Referrals and Case Closure)
1.8 Agency develops or utilizes an existing crisis management policy.	1.8 Written crisis management policy on file that includes, at minimum: • Mental health crises • Dangerous behavior by clients or staff
1.9 Agency develops a policy on utilization of Universal Precaution Procedures (https://www.cdc.gov/niosh/topics/bbp/universal.html). a. Staff members are trained in universal precautions.	1.9 Written policy or procedure on file. a. Documentation of staff training in personnel file.
1.10 Agency ensures compliance with Americans with Disabilities Act (ADA) criteria for programmatic accessibility (e.g. building and design accessibility, parking, etc.). For agencies with multiple sites, all sites must comply with the ADA requirements.	1.10 ADA criteria on file at all sites.

[4] https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

Standard	Documentation
1.11 Agency complies with all applicable state and federal workplace and safety laws and regulations, including fire safety.	1.11 Signed confirmation of compliance with applicable regulations on file.

2. CLIENT RIGHTS AND RESPONSIBILITIES

A key component of HIV/AIDS service delivery is the historic and continued involvement of people living with HIV in the design and evaluation of services. The quality of care and quality of life for people living with HIV/AIDS is maximized when people living with HIV are active participants in their own health care decisions with their providers. This can be facilitated by ensuring that clients are aware of and understand the importance of their input in the development of HIV programming.

2.0 CLIENT RIGHTS AND RESPONSIBILITIES	
Standard	**Documentation**
2.1 Agency ensures services are available to any individual who meets the eligibility requirements for the specific service category.	2.1 Written eligibility requirements on file. Client utilization data made available to funder.
2.2 Agency includes input from people living with HIV/AIDS in the design and evaluation of services to ensure care is client-centered.	2.2 Written documentation of how input was received to inform service planning and evaluation in regular reports. Lists may include: • Consumer Advisory Board meetings • Participation of people living with HIV in HIV program committees or other planning bodies • Needs assessments • Anonymous patient satisfaction surveys. Discreet drop off boxes should be available in various sites throughout the agency and/or anonymous electronic follow-up surveys emailed to patients after their appointment. • Focus groups

2.3 Agency ensures that clients receive information technology support and training on how to use telehealth services.	2.3 Written checklists and/or "how to" guides are provided to patients prior to their telehealth appointment. Materials may be emailed to patient and/or posted on the agency website. The document should contain at least the following information: • Instructions on how to use telehealth tools (i.e., phone, laptop, tablets, etc.) in plain language and available in the patient's preferred language. • Telephone number for technical support or trouble shooting available before, during and after the telehealth appointment.
2.4 Agency ensures that clients retain the right to accept or decline a telehealth visit. The ultimate decision on the mode of service delivery, whether in-person or telehealth, must be determined by the client first before an appointment is made.	2.4 Written procedures and telehealth acceptance or denial form completed by patients prior to the appointment.

Standard	Documentation
2.5 Agency provides each client a copy of the *Patient Bill of Rights & Responsibilities (Appendix B)* document that informs them of the following: • Confidentiality policy • Expectations and responsibilities of the client when seeking services • Client right to file a grievance • Client right to receive no-cost interpreter services • Client right to access their file (if psychotherapy notes cannot be released per clinician guidance, agency should provide a summary to client within 30 days) • Reasons for which a client may be removed from services and the process that occurs during involuntary removal	*2.5 Patient Bill of Rights* document is signed by client and kept on file.

3. STAFF REQUIREMENTS AND QUALIFICATIONS

Staff must be well qualified and, if necessary, hold all required licenses, registration, and/or degrees in accordance with applicable State and federal regulations as well as requirements of the Los Angeles County Department of Public Health, Division of HIV & STD Programs. At minimum, all staff will be able to provide timely, linguistically and culturally competent care to people living with HIV. Staff will complete orientation through their respective hiring agency, including a review of established programmatic guidelines, and supplemental trainings as required by the Los Angeles County Department of Public Health, Division of HIV and STD Programs. The AIDS Education Training Center (AETC) offers a variety of training for the HIV workforce.

3.0 STAFF REQUIREMENTS AND QUALIFICATIONS	
Standard	**Documentation**
3.1 Staff members meet the minimum qualifications for their job position and have the knowledge, skills, and ability to effectively fulfill their role and the communities served. Employment is an essential part of leading an independent, self-directed life for all people, including those living with HIV/AIDS. Agencies	3.1 Hiring policy and staff resumes on file.

should develop policies that strive to hire PLWH in all facets of service delivery, whenever appropriate.	
3.2 If a position requires licensed staff, staff must be licensed to provide services.	3.2 Copy of current license on file.
3.3 Staff will participate in trainings appropriate to their job description and program a. Required education on how a client achieving and maintaining an undetectable viral load for a minimum of six months will not sexually transmit HIV. b. Staff should have experience in or participate in trainings on: • LGBTQ+/Transgender community and • HIV Navigation Services (HNS) provided by Centers for Disease Control and Prevention (CDC). • Trauma informed care	3.3 Documentation of completed trainings on file
3.4 New staff will participate in trainings to increase capacity for fulfilling the responsibilities of their position. a. Required completion of an agency-based orientation within 6 weeks of hire b. Training within 3 months of being hired appropriate to the job description. c. Additional trainings appropriate to the job description and Ryan White service category.	3.4 Documentation of completed trainings on file
3.5 Staff are required to coordinate across Ryan White funded and non-funded programs to ensure clients' needs are met.	3.5 Documentation of staff efforts of coordinating across systems for the client on file (e.g. housing case management services, etc.).

4. CULTURAL AND LINGUISTIC COMPETENCE

Ryan White funded agencies must provide services that are culturally and linguistically competent based on the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. As noted in the CLAS Standards, ensuring culturally and linguistically appropriate services advances health equity, improves quality, and helps eliminate health care disparities by establishing a blueprint for health and health care organizations. For the purpose of these standards, culture is defined as the integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics (Source: National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice. Office of Minority Health, US Department of Health and Human Services. April 2013 https://www.thinkculturalhealth.hhs.gov/clas/standards). The standards below are adapted directly from the National CLAS Standards.

Agencies should also strive towards acknowledging implicit bias, how it plays a role in service delivery, and how it can be addressed and countered. Agencies must provide services that align with strategies to reduce implicit bias by the Institute for Healthcare Improvement.[7] For the purpose of the standards, implicit bias refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. These biases, which encompass both favorable and unfavorable assessments, are activated involuntarily and without an individual's awareness or intentional control. Residing deep in the subconscious, these biases are different from known biases that individuals may choose to conceal for the purposes of social and/or political correctness.[8]

Cultural competence and acknowledging implicit bias rely on behaviors, attitudes, and policies that come together in a system, agency, or among individuals that reduces stigma and enables effective delivery of services. Linguistic competence is the ability to communicate effectively with clients, including those whose preferred language is not the same as the provider's, those who have low literacy skills, and/or those with disabilities. Cultural and linguistic competence is a goal toward which all service providers must aspire, but one that may never be completely achieved given the diversity of languages and cultures throughout our communities, and understanding that culture is dynamic in nature, and individuals may identify with multiple cultures over the course of their lifetime. However, agencies should ensure staff are involved in a continual process of learning, personal growth, and training that increases cultural and linguistic competence, addresses implicit bias, decreases stigma and enhances the ability to provide appropriate services to all individuals living with HIV/AIDS.

Federal and State language access laws require health care facilities that receive federal or state funding to provide competent interpretation services to limited English proficiency patients at no cost, to ensure equal and meaningful access to health care services.[9] Interpretation refers to verbal communication where speech is translated from a speaker to a

receiver in a language that the receiver can understand. Translation refers to the conversion of written material from one language to another.

4.0 CULTURAL AND LINGUISTIC COMPETENCE	
Standard	**Documentation**
4.1 Recruit, promote, and support a culturally and linguistically diverse workforce that are responsive to the population served.	4.1 Documentation of how staff demographics reflect the demographics of clients served on file (e.g. race, gender identity, age, sexual orientation, etc.)

[7] http://www.ihi.org/communities/blogs/how-to-reduce-implicit-bias

[8] http://kirwaninstitute.osu.edu/research/understanding-implicit-bias/

[9] Title VI of the Civil Rights Act of 1964 and California's 1973 Dymally-Alatorre Bilingual Services Act

Standard	Documentation
4.2 Agency develops or utilizes existing culturally and linguistically appropriate policies and practices. a. Agency educates and trains workforce on culturally and linguistically appropriate practices on an ongoing basis.	4.2 Written policy and practices on file a. Documentation of completed trainings on file.
4.3 Provide resources onsite to facilitate communication for individuals who experience impairment due to a challenging medical condition or status (e.g. augmentative and alternative communication resources or auxiliary aids and services)	4.3 Resources on file b. Checklist of resources onsite that are available for client use. c. Type of accommodations provided documented in client file.
4.4 Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.	4.4 *Signed Patient Bill of Rights* document on file that includes notice of right to obtain no-cost interpreter services.
4.5 Ensure the competence of individuals providing language assistance a. Use of untrained individuals and/or minors as interpreters should be avoided b. Ensure quality of language skills of self-reported bilingual staff who use their non-English language skills during client encounters	4.5 Staff resumes and language certifications, if available, on file.
4.6 Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area in clinic points of entry (e.g. registration desks, front desks, reception, waiting rooms, etc.) and areas where work with client is performed (e.g. clinic rooms, meeting rooms, etc.)	4.6 Materials and signage in a visible location and/or on file for reference.

5. INTAKE AND ELIGIBILITY

All clients who request or are referred to HIV services will participate in an intake process conducted by appropriately trained staff. The intake worker will review client rights and responsibilities, explain available services, the confidentiality and grievance policy, assess immediate service needs, and secure permission to release information.

5.0 INTAKE AND ELIGIBILITY	
Standard	**Documentation**
5.1 Intake process begins within 5 days of initial contact and is completed within 30 days of initial contact with client.	5.1 Completed intake on file that includes, at minimum: • Client's legal name, name if different than legal name, and pronouns • Address, phone, and email (if available). A signed affidavit declaring homelessness should be kept on file for clients without an address. • Preferred method of communication (e.g., phone, email, or mail) • Emergency contact information • Preferred language of communication • Enrollment in other HIV/AIDS services; • Primary reason and need for seeking services at agency If client chooses not to complete the intake within 30 days of initial contact, document attempts to contact client and mode of communication in client file.
5.2 Agency determines client eligibility	5.2 Documentation includes: • Los Angeles County resident • Income equal to or below the required Federal Poverty Level (FPL) as determined by Division of HIV & STD Programs • Verification of HIV positive status

6. REFERRALS AND CASE CLOSURE

A client case may be closed through a systematic process that includes case closure justification and a transition plan to other services or other provider agencies, if applicable. Agencies should maintain a list of resources available for the client for referral purposes. If the client does not agree with the reason for case closure, they should follow the grievance policy at the provider agency and/or be referred to the Department of Public Health, Division of HIV and STD Programs Grievance Line.

6.0 REFERRALS AND CASE CLOSURE	
Standard	**Documentation**
6.1. Agency will maintain a comprehensive list of providers for full spectrum HIV-related and other service referrals a. Staff will provide referrals to link clients to services based on assessments and reassessments	6.1 Identified resources for referrals at provider agency (e.g. lists on file, access to websites) a. Written documentation of recommended referrals in client file
6.2 If needed, staff will engage additional providers for specific support services (e.g. behavioral health, substance abuse, housing)	6.2 Agency establishes partnerships with agencies for referrals as needed. Memoranda of Understanding (MOU) on file.
6.3 For clients with missed appointments or pending case closure, staff will attempt to contact client. a. Cases may be closed if the client: • Relocates out of the service area • Is no longer eligible for the service • Discontinues the service • No longer needs the service • Puts the agency, service provider, or other clients at risk • Uses the service improperly or has not complied with the services agreement • Is deceased • Has had no direct agency contact, after repeated attempts, for a period of 12 months.	6.3 Attempts to contact client and mode of communication documented in file. a. Justification for case closure documented in client file

Standard	Documentation
6.4 Agency has a transition procedure in place that is implemented for clients leaving services to ensure a smooth transition.	6.4 Completed transition summary in file, signed by client and supervisor (if possible). Summary should include reason for case closure; and a plan for transition to other services, if applicable, with confirmation of communication between referring and referral agencies, or between client and agency.
6.5 Agency develops or utilizes existing due process policy for involuntary removal of clients from services; policy includes a series of verbal and written warnings before final notice and case closure.	6.5 Due process policy on file as part of transition, and case closure policy described in the *Patient & Client Bill of Rights* document. (Refer to Appendix B).

Federal and National Resources:

HRSA's Ryan White HIV/AIDS Program Expanding HIV Care Through Telehealth CARE Action Newsletter October 2019:
https://hab.hrsa.gov/sites/default/files/hab/Publications/careactionnewsletter/telehealth.pdf

Telehealth Discretion During Coronavirus:

AAFP Comprehensive Telehealth Toolkit:
https://www.aafp.org/dam/AAFP/documents/practice_management/telehealth/2020-AAFP-Telehealth-Toolkit.pdf

ACP Telehealth Guidance & Resources: https://www.acponline.org/practice-resources/business-resources/telehealth

ACP Telemedicine Checklist: https://www.acponline.org/system/files/documents/practice-resources/health-information-technology/telehealth/video_visit_telemedicine_checklist_web.pdf

AMA Telehealth Quick Guide: https://www.ama-assn.org/practice-management/digital/ama-telehealth-quick-guide

CMS Flexibilities for Physicians: https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf - "Under the CARES Act, CMS is waiving the requirements of section 1834(m)(1) of the ACT and 42 CFR § 410.78(a)(3) for use of interactive telecommunications systems to furnish telehealth services, to the extent they require use of video technology, for certain services. This waiver allows the

use of audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services, and behavioral health counseling and educational services."

CMS Flexibilities for RHCs and FQHCs: https://www.cms.gov/files/document/covid-rural-health-clinics.pdf - "Medicare telehealth services generally require an interactive audio and video telecommunications system that permits real-time communication between the practitioner and the patient. (During the PHE, some telehealth services can be furnished using audio-only technology.)"

CMS Fact Sheet on Virtual Services: https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency

Using Telehealth to Expand Access to Essential Health Services during the COVID-19 Pandemic

7. APPENDICES

APPENDIX A: RYAN WHITE PART A SERVICE CATEGORIES

Ryan White HIV/AIDS Program Part A provides assistance to communities that are most severely impacted by the HIV epidemic. Part A funds must be used to provide core medical and support services for people living with HIV.

Core medical services include the following categories:

- AIDS Drug Assistance Program
- AIDS pharmaceutical assistance
- Early intervention services
- Health insurance premium and cost sharing assistance for low-income individuals
- Home and community-based health services
- Home health care
- Hospice services
- Medical case management, including treatment-adherence services
- Medical nutrition therapy
- Mental health services
- Oral health
- Outpatient and ambulatory medical care
- Substance abuse outpatient care

Support services include the following categories:

- Case Management (Non-Medical)
- Childcare Services
- Emergency Financial Assistance
- Food Bank/Home Delivered Meals
- Health Education/Risk Reduction
- Housing Services
- Legal Services
- Linguistic Services

- Medical Transportation
- Outreach Services
- Psychosocial Support Services
- Referral
- Rehabilitation
- Respite Care
- Substance Abuse Residential
- Treatment Adherence Counseling

APPENDIX B: PEOPLE WITH HIV/AIDS BILL OF RIGHTS AND RESPONSIBILITIES

It is the provider's responsibility to provide clients a copy of the Patient Bills of Rights and Responsibilities in all service settings, including telehealth.

The purpose of this Patient and Client Bill of Rights is to help enable clients to act on their own behalf and in partnership with their providers to obtain the best possible HIV/AIDS care and treatment. This Bill of Rights and Responsibilities comes from the hearts of people living with HIV/AIDS in the diverse communities of Los Angeles County. As someone newly entering or currently accessing care, treatment or support services for HIV/AIDS, you have the right to:

A. Respectful Treatment and Preventative Services

1. Receive considerate, respectful, professional, confidential and timely care and preventative services (such as screenings and vaccinations) in a safe client-centered, trauma-informed environment without bias.
2. Receive equal and unbiased care according to your age and needs in accordance with federal and State laws.
3. Receive information about the qualifications of your providers, particularly about their experience managing and treating HIV/AIDS or related services.
4. Be informed of the names and work phone numbers of the physicians, nurses and other staff members responsible for your care.
5. Receive safe accommodations for protection of personal property while receiving care services.
6. Receive services that are culturally and linguistically appropriate, including having a full explanation of all services and treatment options provided clearly in your own language and dialect.
7. Review your medical records and receive copies of them upon your request (reasonable agency policies including reasonable fee for photocopying may apply).

B. Competent, High-Quality Care

1. Have your care provided by competent, qualified professionals who follow HIV treatment standards as set forth by the Federal Public Health Service Guidelines, the Centers for Disease Control and Prevention (CDC), the California Department of Health Services, and the County of Los Angeles.
2. Have access to these professionals at convenient times and locations.
3. Receive appropriate referrals to other medical, mental health or care services.
4. Have their phone calls and/or emails answered with 3 days.

C. Participate in the Decision-making Treatment Process

1. Receive complete and up-to-date information in words you understand about your diagnosis, treatment options, medications (including common side effects and complications) and prognosis that can reasonably be expected.
2. Participate actively with your provider(s) in discussions about choices and options available for your treatment.
3. Make the final decision about which treatment option is best for you after you have been given all relevant information about these choices and the clear recommendation of your provider.
4. Have access to patient-specific education resources and reliable information and training about patient self-management.
5. Refuse any and all treatments recommended and be told of the effect that not taking the treatment may have on your health, be told of any other potential consequences of your refusal and be assured that you have the right to change your mind later.
6. Be informed about and afforded the opportunity to participate in any appropriate clinical research studies for which you are eligible.
7. Refuse to participate in research without prejudice or penalty of any sort.
8. Refuse any offered services or end participation in any program without bias or impact on your care.
9. Be informed of the procedures at the agency for resolving misunderstandings, making complaints or filing grievances.
10. Receive a response to a complaint or grievance within 30-45 days of filing it.
11. Be informed of independent ombudsman or advocacy services outside the agency to help you resolve problems or grievances (see number at bottom of this form), including how to access a federal complaint center within the Center for Medicare and Medicaid Services (CMS).

D. Confidentiality and Privacy

1. Receive a copy of your agency's Notice of Privacy Policies and Procedures. (Your agency will ask you to acknowledge receipt of this document.)
2. Keep your HIV status confidential. Have information explained to you about confidentiality policies and under what conditions, if any, information about HIV care services may be released.
3. Request restricted access to specific sections of your medical records.
4. Authorize or withdraw requests for your medical record from anyone else besides your health care providers and for billing purposes.
5. Question information in your medical chart and make a written request to change specific documented information. (Your physician has the right to accept or refuse your request with an explanation.)
6.

E. Billing Information and Assistance

1. Receive complete information and explanation in advance of all charges that may be incurred for receiving care, treatment and services as well as payment policies of your provider.
2. Receive information on any programs to help you pay and assistance in accessing such assistance and any other benefits for which you may be eligible.

F. Patient/Client Responsibilities

In order to help your provider give you the care to which you are entitled, you also have the responsibility to:

1. Participate in the development and implementation of your individual treatment or service plan to the extent that you are able.
2. Provide your providers, to the best of your knowledge, accurate and complete information about your current and past health and illness, medications and other treatment and services you are receiving, since all of these may affect your care. Communicate promptly any changes or new developments.
3. Communicate to your provider whenever you do not understand information you are given.
4. Follow the treatment plan you have agreed to and/or accept the consequences of failing to adhere to the recommended course of treatment or of using other treatments.
5. Keep your appointments and commitments at this agency or inform the agency promptly if you cannot do so.
6. Keep your provider or main contact informed about how to reach you confidentially by phone, mail or other means.
7. Follow the agency's rules and regulations concerning patient/client care and conduct.
8. Be considerate of your providers and fellow clients/patients and treat them with the respect you yourself expect.
9. Refrain from the use of profanity or abusive or hostile language; threats, violence or intimidations; carrying weapons of any sort; theft or vandalism; intoxication or use of illegal drugs; sexual harassment and misconduct.

For More Help or Information

Your first step in getting more information involving any complaints or grievances is to speak with your provider or a designated client services representative or patient or treatment advocate at the agency. If this does not resolve the problem in a reasonable time span, or if serious concerns or issues arise and you would like to speak with someone outside the agency, you may call the number below for confidential, independent information and assistance.

Division of HIV and STD Programs Client Grievance Line
(800) 260-8787 8:00 am – 5:00 Monday – Friday

LOS ANGELES COUNTY
COMMISSION ON HIV

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

BLACK AFRICAN AMERICAN COMMUNITY (BAAC) TASK FORCE

SOCIAL MEDIA TOOL KIT

PURPOSE

Bringing awareness to and calling for community participation in joining the efforts of the Los Angeles County Commission on HIV, Black African American Community (BAAC) Task Force in addressing HIV racial justice to improve HIV-related health outcomes for our Black/African American communities in Los Angeles County.

CALL TO ACTION

Please join us in mobilizing our efforts and share this Social Media Tool Kit far and wide in your communities.

#nothingaboutuswithoutus

Click links below to access resources

COMMITTMENT STATEMENT

STATEMENT OF SOLIDARITY

RECOMMENDATIONS

SOCIAL MEDIA POSTS

Sample #1
Sample #2
Sample #3
Sample #4
Sample #5

HASHTAGS

#nothingaboutuswithoutus
#BAAC
#BAACNBHAAD

INTEREST FORM

Should you encounter challenges accessing the resources in the Social Media Tool Kit, please contact Dawn McClendon at dmcclendon@lachiv.org.