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, June 10, 2021

9:00AM -1:30PM (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/j7ph92dc
**link is for members of the public only*

JOIN VIA WEBEX ON YOUR PHONE:

1-415-655-0001 US Toll   Access Code: 145 506 2482

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

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

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, June 10, 2021 | 9:00 AM – 1:30 PM

To Register/Join by Computer: https://tinyurl.com/j7ph92dc
**link is for members of the public*
To Join by Telephone: 1-415-655-0001 Access code: 145 506 2482

AGENDA POSTED: June 3, 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 – 9:05 AM

1. **ADMINISTRATIVE MATTERS**
   A. Approval of Agenda — **MOTION #1** — 9:05 AM – 9:07 AM
   B. Approval of Meeting Minutes — **MOTION #2** — 9:07 AM – 9:10 AM

2. **WELCOME, INTRODUCTIONS AND VIRTUAL MEETING GUIDELINES** — 9:10 AM – 9:15 AM

3. **REPORTS - I**
   A. Executive Director/Staff Report — 9:15 AM – 9:20 AM
      (1) Commission/County Operational Updates
   B. Co-Chairs' Report — 9:20 AM – 9:45 AM
      (1) Meeting Management | UPDATES
      (2) Reading Activity Goals, Objectives, and Process
      (3) Revisiting STD Response and Appeal to the Board of Supervisors
      (4) Methods and Leading Practices for Advancing Equity and Support for Underserved Communities Through Government | Request for Information (RFI) Due July 6, 2021
      (5) Ryan White Program 75/25 Waiver Proposed Rule Change
      (6) Ending the HIV Epidemic (EHE) Steering Committee COH Liaison Report
   C. California Office of AIDS (OA) Report — 9:45 AM – 9:55 AM
      (1) California HIV Planning Group (CPG) Update
   D. LA County Department of Public Health Report — 9:55 AM – 10:15 AM
      (1) Division of HIV/STD Programs (DHSP) Updates
         (a) Programmatic and Fiscal Updates
            - Ryan White Parts A & B
         (b) Ending the HIV Epidemic (EHE) Activities & Updates
   E. Housing Opportunities for People Living with AIDS (HOPWA) Report — 10:15 AM – 10:20 AM
   F. Ryan White Program Parts C, D, and F Report — 10:20 AM – 10:25 AM
   G. Cities, Health Districts, Service Planning Area (SPA) Reports — 10:25 PM –10:30 AM

4. **BREAK** — 10:30 AM – 10:40 AM

5. REPORTS – II

F. Standing Committee Reports 10:40 AM – 11:20 AM

(1) Operations Committee

(a) Membership Management

- New Member Application: Rene Vega | Alternate #22 **MOTION #3**
- New Member Application: Damone Thomas | Alternate #19 **MOTION #4**

(b) 2021 Renewal Membership Slate Process + Update

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

(a) Ryan White Program Year 31 (FY 2021) Revised Allocation **MOTION #5**

(b) Prevention Planning Work Group | UPDATES

(3) Standards and Best Practices (SBP) Committee

(a) Childcare Service Standards

(b) Substance Use and Residential Treatment Standards Review | UPDATES

(4) Public Policy Committee

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

- 2021 Legislative Docket

(b) County, State, and Federal Budget

G. Caucus, Task Force and Work Group Report 11:20 AM – 11:40 AM

(1) Aging Task Force | June 6, 2021 @ 1-3pm

(2) Black/African American Community (BAAC) Task Force | June 28, 2021 @ 1-3pm

(3) Consumer Caucus | June 10, 2021 @ 3-4:30pm

(4) Prevention Planning Workgroup | June 23, 2021 @ 5:30-7PM

(5) Transgender Caucus | June 22, 2021 @ 10am-12pm

(6) Women's Caucus | June 21, 2021 @ 2-4pm

6. TRAINING

A. Implicit Bias Training | Los Angeles County Human Relations Commission 11:40 AM – 1:15 PM

7. MISCELLANEOUS

A. Public Comment 1:15 PM – 1:20 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.

B. Commission New Business Items 1:20 PM – 1:25 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.

8. MISCELLANEOUS (cont'd)

C. Announcements 1:25 PM – 1:30 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 1:30 PM

Adjournment for the meeting of June 10, 2021.

PROPOSED MOTION(s)/ACTION(s):	
MOTION #1:	Approve the Agenda Order, as presented or revised.
MOTION #2:	Approve the Executive Committee minutes, as presented or revised.
MOTION #3:	Approve recommendation for New Member Applicant, Rene Vega, to occupy Alternate (#22) seat, and forward to the full body for approval, as presented or revised.
MOTION #4:	Approve recommendation for New Member Applicant, Damone Thomas, to occupy Alternate (#19) seat, and forward to the full body, as presented or revised.
MOTION #5:	Approve Ryan White Program Year 31 (FY 2021) Revised Allocations, as presented or revised, and provide DHSP the authority to make adjustments of 10% greater or lesser than the approved allocations amount, as expenditure categories dictate, without returning to this body

COMMISSION ON HIV MEMBERS:			
Bridget Gordon, Co-Chair	David P. Lee, MPH, LCSW Co-Chair	Miguel Alvarez	Everardo Alvizo, LCSW
Al Ballesteros, MBA	Alasdair Burton (*Alternate)	Danielle Campbell, MPH	Mikhaela Cielo, MD
Pamela Coffey (Reba Stevens, **Alternate)	Michele Daniels (*Alternate)	Erika Davies	Kevin Donnelly
Felipe Findley, PA-C, MPAS, AAHIVS	Alexander Luckie Fuller	Gerald Garth, MS	Jerry D. Gates, PhD
Grissel Granados, MSW	Joseph Green	Thomas Green	Felipe Gonzalez
Damontae Hack (*Alternate)	Karl Halfman, MA	(Kayla Walker-Heltzel, **Alternate)	Nestor Kamurigi
William King, MD, JD, AAHIVS (LoA)	Lee Kochems, MA	Anthony Mills, MD	Carlos Moreno
Derek Murray	Dr. Paul Nash, CPsychol, AFBPsS FHEA	Katja Nelson, MPP	Frankie Darling-Palacios
Mario J. Pérez, MPH	Juan Preciado	Joshua Ray, RN (Eduardo Martinez, **Alternate)	Mallery Robinson
Harold Glenn San Agustin, MD	Martin Sattah, MD	Tony Spears (*Alternate)	LaShonda Spencer, MD
Isabella Rodriguez, MA (*Alternate)	Ricky Rosales	Kevin Stalter	Maribel Ulloa
Guadalupe Velazquez	Justin Valero, MPA	Ernest Walker, MPH	Amiya Wilson (*Alternate)
MEMBERS:	**46**		
QUORUM:	**24**		

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
#STOPAAPIHATE

The Los Angeles County Commission on HIV condemns all forms of hate and violence. We stand in solidarity with Asian American and Pacific Islander (AAPI) communities and condemn the attacks on our AAPI brothers and sisters across the Country. Acts of hate against AAPI communities have risen during the COVID-19 pandemic. An attack on one community, is an attack on all of US.

The harmful rhetoric of the previous administration and the repeated use of the term "China virus" to refer to COVID-19 have fueled the senseless increase in violence we are seeing across the country. These hurtful words and demonization of a particular community followed the long American history of using diseases to justify anti-Asian xenophobia, one that dates to the 19th and 20th centuries, and has helped to shape perception of AAPIs as "perpetual foreigners."

Many scholars, historians, and activists have pointed out that racial violence against AAPIs often goes overlooked because of persistent stereotypes about the community. The pervasiveness of the model minority myth is a large contributing factor to the current climate. That false idea, constructed during the Civil Rights era to stymie racial justice movements, suggests that Asian Americans are more successful than other ethnic minorities because of hard work, education, and inherently law-abiding natures. Because the model minority myth suggests upward mobility, it creates a fallacy that Asian Americans don't experience struggle or racial discrimination and misogyny.

We applaud the Los Angeles County Board of Supervisors in their decision to immediately identify funding to expand the County's Anti-Hate program to combat hate against AAPIs. We call on all Angelenos to speak out against hateful and violent attacks on AAPI communities. Encourage those who experience or witness acts of hate toward the AAPIs communities to report an incident to 211 LA. Incidents can also be reported using the www.stopaapihate.org website. The STOP AAPI Hate reporting form is available in 11 languages.

The HIV movement knows too well that hateful language has real stigmatizing consequences. The hatred and violence we are witnessing perpetuated against AAPIs are rooted in the same form of racism, discrimination, and misogyny that continue to hinder our progress in ending HIV. Join us in stopping hate and support the AAPI communities.

In Solidarity,

Los Angeles County Commission on HIV

https://www.lavshate.org/
https://stopaapihate.org/

"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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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 Bi-Monthly	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
Prevention Planning Workgroup (PPW)	4th Wednesday of Each Month	5:30PM	-	7:00PM

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 06.07.21

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, 2020	June 30, 2022	
3	City of Long Beach representative	1	PP&A	Everardo Alvizo, LCSW	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, 2020	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, 2020	June 30, 2022	
7	Part B representative	1	PP&A	Karl Halfman, MA	California Department of Public Health, Office of AIDS	July 1, 2020	June 30, 2022	
8	Part C representative	1	PP&A|EXC	Frankie Darling Palacios	Los Angeles LGBT Center	July 1, 2020	June 30, 2022	
9	Part D representative	1	SBP	Mikhaela Cielo, MD	LAC + USC MCA Clinic, LA County Department of Health Services	July 1, 2019	June 30, 2021	
10	Part F representative	1	PP	Jerry D. Gates, PhD	Keck School of Medicine of USC	July 1, 2020	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, 2020	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, 2020	June 30, 2022	
15	Provider representative #5	1	SBP	Thomas Green	APAIT/Special Services for Groups (SSG)	July 1, 2019	June 30, 2021	
16	Provider representative #6	1	PP&A	Anthony Mills, MD	Men's Health Foundation	July 1, 2020	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, 2020	June 30, 2022	
19	Unaffiliated consumer, SPA 1			*Vacant*		July 1, 2019	June 30, 2021	
20	Unaffiliated consumer, SPA 2			*Vacant*		July 1, 2020	June 30, 2022	Amiya Wilson **(LOA)**
21	Unaffiliated consumer, SPA 3			*Vacant*		July 1, 2019	June 30, 2021	Alasdair Burton (PP)
22	Unaffiliated consumer, SPA 4	1	EXC|SBP	Kevin Stalter	*Unaffiliated Consumer*	July 1, 2020	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, 2020	June 30, 2022	Reba Stevns (SBP)
25	Unaffiliated consumer, SPA 7			*Vacant*		July 1, 2019	June 30, 2021	Mallery Robinson (SBP)
26	Unaffiliated consumer, SPA 8	1	PP&A	Kevin Donnelly	*Unaffiliated Consumer*	July 1, 2020	June 30, 2022	
27	Unaffiliated consumer, Supervisorial District 1			*Vacant*		July 1, 2019	June 30, 2021	Michele Daniels
28	Unaffiliated consumer, Supervisorial District 2	1	PP	Nestor Kamurigi (PP)	No affiliation	July 1, 2020	June 30, 2022	
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, 2020	June 30, 2022	Isabella Rodriguez (PP)
31	Unaffiliated consumer, Supervisorial District 5			*Vacant*		July 1, 2019	June 30, 2021	Kayla Walker-Heltzel (OPS)
32	Unaffiliated consumer, at-large #1	1	PP&A	Guadalupe Velazquez	*Unaffiliated Consumer*	July 1, 2020	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, 2020	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, 2020	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, 2020	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			*Vacant*		July 1, 2020	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, 2020	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, 2020	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, 2020	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	1	PP	Gerald Garth, MS	AMAAD Institue	July 1, 2020	June 30, 2022	
49	HIV stakeholder representative #6	1	OPS	Felipe Findley, PA-C, MPAS, AAHIVS	Watts Healthcare Corp	July 1, 2019	June 30, 2021	
50	HIV stakeholder representative #7	1	PP&A	William D. King, MD, JD, AAHIVS ***(LOA)***	W. King Health Care Group	July 1, 2020	June 30, 2022	
51	HIV stakeholder representative #8	1	OPS/SBP	Miguel Alvarez	No affiliation	July 1, 2020	June 30, 2022	
	TOTAL:	**40**						

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

LOA: Leave of Absence

Overall total: 50

Planning Council/Planning Body Reflectiveness (Updated 06.07.21)

(Use HIV/AIDS Prevalence data as reported FY 2020 Application)

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%	12	24.00%	5	45.45%
Black, not Hispanic	10,155	20.00%	15	30.00%	3	27.27%
Hispanic	22,766	44.84%	19	39.58	3	27.27%
Asian/Pacific Islander	1,886	3.71%	3	6.12%	0	0.00%
American Indian/Alaska Native	300	0.59%	1	2.04%	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%	50	100%	11	100%

Gender	Number	Percentage**	Number	Percentage**	Number	Percentage**
Male	44,292	87.23%	32	65.31%	7	63.64%
Female	5,631	11.09%	14	28.00%	4	36.36%
Transgender	854	1.68%	4	8.00%	0	0.00%
Unknown	0	0.00%	0	0.00%	0	0.00%
Total	50,777	100%	50	100%	11	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	4.08%	1	9.09%
30-39 years	9,943	19.58%	20	40.82%	2	18.18%
40-49 years	11,723	23.09%	12	24.49%	1	9.09%
50-59 years	15,601	30.72%	8	16.67%	6	54.55%
60+ years	8,973	17.67%	7	14.29%	1	9.09%
Other	0	0.00%	0	0.00%	0	0.00%
Total	50,777	99.99%	*49	100%	11	99.99%

Percentages may not equal 100% due to rounding.
(Includes alternates)
*Does not include M. Cielo

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 6/07/21

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
CIELO	**Mikhaela**	LAC& USC MCA Clinic	Ambulatory Outpatient Medical (AOM)
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
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
FINDLEY	**Felipe**	Watts Healthcare Corporation	Transportation Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Oral Health Care Services
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment
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
GARTH	**Gerald**	AMAAD Institute	No Ryan White or Prevention Contracts
GATES	**Jerry**	AETC	Part F Grantee

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
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
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
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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
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
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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
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
ROBINSON	**Mallery**	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
RODRIGUEZ	**Isabella**	No Affiliation	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**	Oasis Clinic (Charles R. Drew University/Drew CARES)	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Medical Care Coordination (MCC)
SPEARS	**Tony**	Capitol Drugs	No Ryan White or prevention contracts
STALTER	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
STEVENS	**Reba**	No Affiliation	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

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: June 07, 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= 11 | Number of Quorum= 6		
COMMITTEE MEMBER	**MEMBER CATEGORY**	**AFFILIATION**
Bridget Gordon	**Co-Chair, Comm./Exec.***	**Commissioner**
David Lee, MPH, LCSW	**Co-Chair, Comm./Exec.***	**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= 9 | Number of Quorum= 5		
COMMITTEE MEMBER	**MEMBER CATEGORY**	**AFFILIATION**
Carlos Moreno	**Committee Co-Chair***	**Commissioner**
Juan Preciado	**Committee Co-Chair***	**Commissioner**
Miguel Alvarez	*	Commissioner
Danielle Campbell, MPH	*	Commissioner
Michele Daniels	*	Alternate
Felipe Findley, MPAS, PA-C, AAHIVS	*	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= 16 | Number of Quorum= 9		
COMMITTEE MEMBER	**MEMBER CATEGORY**	**AFFILIATION**
Frankie-Darling Palacios	**Committee Co-Chair***	Commissioner
VACANT	**Committee Co-Chair***	Commissioner
Everardo Alvizo, LCSW	*	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 *(LOA)*	*	Commissioner
Miguel Martinez, MPH	**	Committee Member
Anthony Mills, MD	*	Commissioner
Derek Murray	*	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= 11 | Number of Quorum= 6		
COMMITTEE MEMBER	**MEMBER CATEGORY**	**AFFILIATION**
Lee Kochems, MA	**Committee Co-Chair***	Commissioner
Katja Nelson, MPP	**Committee Co-Chair***	Commissioner
Alasdair Burton	*	Alternate
Gerald Garth, MS	*	Commissioner
Jerry Gates, PhD	*	Commissioner
Eduardo Martinez	**	Alternate
Nestor Kamurigi	*	Alternate
Isabella Rodriguez	*	Commissioner
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: 10:00AM-12:00 PM
Number of Voting Members = 15 | Number of Quorum = 8

COMMITTEE MEMBER	MEMBER CATEGORY	AFFILIATION
Kevin Stalter	**Committee Co-Chair***	**Commissioner**
Erika Davies	**Committee Co-Chair***	**Commissioner**
Mikhaela Cielo, MD	*	Commissioner
Pamela Coffey (Reba Stevens, Alternate)	*	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
Mallery Robinson	*	Alternate
Harold Glenn San Agustin, MD	*	Commissioner
Justin Valero, MA	*	Commissioner
Ernest Walker	*	Commissioner
Amiya Wilson *(LOA)*	*	Commissioner
Wendy Garland, MPH	DHSP staff	DHSP

CONSUMER CAUCUS

Regular meeting day/time: 2nd Thursday of Each Month; Immediately Following Commission Meeting
Co-Chairs: Alasdair Burton & Jayda Arrington
Open membership to consumers of HIV prevention and care services

AGING TASK FORCE (ATF)

Regular meeting day/time: 1st Tuesday of Each Month @ 1pm-3pm
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 Every Other Month @ 10am-12pm
C0-Chairs: Frankie Darling-Palacios & Luckie Fuller
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

PREVENTION PLANNING WORKGROUP

Regular meeting day/time: 4th Wednesday of Each Month @ 5:30pm-7:00pm
Co-Chairs: Maribel Ulloa, Miguel Martinez, and Luckie Fuller
Open membership

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
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.

COMMISSION ON HIV VIRTUAL MEETING MINUTES
May 13, 2021

COMMISSION MEMBERS P=Present | A=Absent									
Miguel Alvarez	P	Kevin Donnelly	P	Karl Halfman, MA	P	Mario Peréz, MPH	P	Maribel Ulloa	A
Everardo Alvizo, MSW	P	Felipe Findley, PA-C, MPAS, AAHIVS	P	Kayla Heltzel-Walker (*Alt*)	P	Juan Preciado	P	Guadalupe Velasquez	A
Al Ballesteros, MBA	P	Alexander Luckie Fuller	P	Nestor Kamurigi	A	Joshua Ray, RN	A	Justin Valero, MPA	P
Alasdair Burton (*Alt*)	P	Gerald Garth	P	William King, MD, JD, AAHIVS (LoA)	A	Ricky Rosales	P	Ernest Walker	P
Danielle Campbell, MPH	P	Jerry Gates, PhD	P	Lee Kochems	P	Isabella Rodriguez (*Alt*)	P	Amiya Wilson (*Alt*) (LoA)	A
Raquel Cataldo	A	Felipe Gonzalez	P	Eduardo Martinez (*Alt*)	P	H. Glenn San Agustin, MD	P	*Bridget Gordon*	P
Pamela Coffey	P	Grissel Granados, MSW	P	Anthony Mills, MD	P	Tony Spears (*Alt*)	A	*David Lee, MPH, LCSW*	P
Michele Daniels (*Alt*)	A	Joseph Green	P	Carlos Moreno	P	LaShonda Spencer, MD	P		
Frankie Darling-Palacios	P	Thomas Green	P	Derek Murray	P	Kevin Stalter	P		
Erika Davies	A	Damontae Hack (*Alt*)	A	Dr. Paul Nash, CPsychol, AFBPsS, FHEA	P	Reba Stevens (*Alt*)	P		

COMMISSION STAFF & CONSULTANTS
Cheryl Barrit, MPIA, Executive Director; Carolyn Echols-Watson, MPA; Dawn Mc Clendon; and Sonja Wright, BA, MSOM, LAc,Dipl.OM, PES Jim Stewart, Parliamentarian
Robert Sowell and April Johnson, MA (LAC Human Relations Commission) Eve Kelly and Axum Taylor (HealthHIV)
DIVISION OF HIV AND STD PROGRAMS (DHSP) STAFF
Jane Bowers Rhodes, MPH; Maggie Esquivel; Andrea Kim, PhD; Pamela Ogata, MPH; Sophia Rumanes, MPH; Victor Scott, Julie Tolentino, MPH, and Paulina Zamudio, MPH

**Commission members and Members of the public may confirm their attendance by contacting Commission staff at hivcomm@lachiv.org*
***Meeting minutes may be corrected up to one year from the date of Commission approval.*

Meeting agenda and materials can be found on the Commission's website at:
http://hiv.lacounty.gov/Portals/HIV/Commission%20Meetings/2021/Packet/Pkt_COHMtg_051321_final.pdf?ver=69mKSH1vXU6c_QbsBwx7zw%3d%3d

CALL TO ORDER AND ROLL CALL: David Lee, LCSW, MPH, Co-Chair, opened the meeting at 9:03am and James Stewart, Parliamentarian, took the roll.
ROLL CALL (**PRESENT**): M. Alvarez, E. Alvizo, A. Ballesteros, A. Burton, P. Coffey, F. Darling-Palacios, K. Donnelly, F. Findley, A. Luckie Fuller, G. Garth, J. Gates, G. Granados, J. Green, K. Halfman, L. Kochems, C. Moreno, D. Murray, P. Nash, J. Preciado, T. Green, R. Rosales, H. San Agustin, M. Sattah, K. Stalter, R. Stevens, I. Rodriguez, E. Walker, D. Lee, and B. Gordon

1. ADMINISTRATIVE MATTERS

A. APPROVAL OF AGENDA
MOTION #1: Approve the Agenda Order, as presented ***(Passed by Consensus)***.

B. APPROVAL OF MEETING MINUTES
MOTION #2: Approve the April 8, 2021 Commission on HIV Meeting Minutes, as presented ***(Passed by Consensus)***.

2. WELCOME, INTRODUCTIONS, AND VIRTUAL MEETING GUIDELINES

- Bridget Gordon welcomed all attendees, recited the Commission's Code of Conduct, and provided the following reminders and meeting guidelines:
  - Please refer to the messages in the Chat from staff regarding virtual meeting etiquette. Please mute yourself when not speaking.
  - Commissioners are limited to 3 minutes per Commissioner and one comment per agenda item. After all Commissioners who wish to speak have done so, Commissioners who wish to speak a second time on the same topic may do so. To speak a third time, a Commissioner must move to suspend the rules, which requires a second and a two-thirds vote. This rule does not apply to those giving reports or invited speakers.
  - Public comments are limited to 2 minutes per person. Any person may speak for one two-minute period in non-agenda Public Comment and one two-minute period on any agenda topic at the time the topic comes to the floor.

3. REPORTS - I

A. EXECUTIVE DIRECTOR/STAFF REPORT

(1) Commission and County Operational Updates

- Chery Barrit, MPIA, Executive Director, reported that the County is conducting an emergency readiness assessment of each department, keeping employee health and safety at the forefront of their phased-in approach.
- C. Barrit continues to work with the Executive Office on its reopening efforts as it relates to the Commission and staff and will continue to keep the Commission updated on reopening efforts.

(2) 2021 Commission Work Plan and Activities

- C. Barrit referenced item #2 in the workplan – HealthHIV's assessment of the Commission's effectiveness and noted that the findings will be presented by HealthHIV later in the agenda. Staff and leadership will review the findings and work with the appropriate committees to determine next steps and implementation.
- C. Barrit also noted item #1 and shared that the Los Angeles County Human Relations Commission (HRC) will continue their training series followed by a 90-minute Implicit Bias (IB) training at the June COH meeting. C. Barrit reminded the members that the IB training was requested by members and noted that IB training is required for all County staff. C. Barrit encouraged members to provide feedback on the training series to determine how to better meet the needs of the Commission in addressing difficult conversations around race.

4. PRESENTATION

A. HealthHIV/COH Assessment of Effectiveness | FINAL RESULTS & REPORT

- HealthHIV presented an overview of their findings on the assessment of the Commission's effectiveness; see PowerPoint (PPT) slides in meeting packet.
- Feedback on the findings will be used to build out the final report which will be made available to the Commission. Feedback from the members included, but are not limited to:
  - Convene Commission meetings in areas most impacted, i.e. South Los Angeles. May change direction and dynamic of conversations which would be a good starting point.
  - Conduct more outreach to bring visibility and awareness of the Commission and its work:
    - Connect with academic institutions, community clinics, pediatric providers, and non-Ryan White Program (RWP) providers
    - Connect with LGBTQ+ groups and clubs at local colleges
    - Amp up social media promotion
    - Stream COH meetings at provider clinics
  - Support schools in incorporating HIV history in their sexual education curriculum
  - Determine how to reach young people and help them stay engaged and active on the Commission

DRAFT

5. DISCUSSION

A. "So You Want to Talk About Race" by Ijeoma Oluo Reading Activity.

- Kevin Donnelly, Commission member, read excerpts of Chapter 4-5.

B. Los Angeles County Human Relations Commission Guided Discussion & Training: Words Matter

- Robert Sowell and April Johnson, Los Angeles County Human Relations Commission (HRC), led the group in training and related exercises on Words Matter; see PPT slides in meeting packet.
- B. Gordon expressed that she is aware members are concerned about the lack of discussion following the reading activity and announced that a brief discussion period will open following future readings. It was important to ensure that members were equipped with the appropriate tools provided via the HRC training series to engage in constructive conversations around race before opening discussion.

6. REPORTS - II

A. CO-CHAIR REPORT

(1) Ending the HIV Epidemic (EHE) Plan & Commission Involvement

- B. Gordon reported that at the April 22 Executive Committee meeting, a discussion was held around opportunities for the Commission to be more engaged with Ending the HIV Epidemic efforts, clarify roles for the Commission and the DHSP EHE Steering Committee, how to best support each other and ensure that the activities between the 2 groups are complementary, and identify Commission liaisons to the DHSP EHE Steering Committee. The Committee determined:
  - B. Gordon will serve as Commission liaison to the DHSP EHE Steering Committee, with Katja Nelson, Kevin Stalter, and Felipe Findley serving as backup. The liaison team represents a diverse set of perspectives and community experience.
  - The liaisons will work as a team and serve as conduit of information and collaborative opportunities between the Commission and Steering Committee. In addition, the liaisons will also facilitate EHE-focused conversations at Commission, Committee, and subgroup meetings to identify specific activities that the COH can implement within its charge as the planning council for Los Angeles County.
  - The liaisons will engage Commissioners in thinking of broader ways the Commission can end the HIV epidemic in Los Angeles County.
  - Commissioners and the community are expected to engage in these important conversations on ending HIV, with a particular lens on eliminating health and social disparities.
  - The liaisons will share what we hear from you and the community with the DHSP EHE Steering Committee to leverage their action-oriented purpose and seek ways that we can amplify our strengths.
  - Commission liaisons will report back at monthly meetings and at Committee meetings.
  - Welcome DHSP EHE Steering Committee members to attend our meetings.
- B. Gordon thanked Al Ballesteros for serving as the Commission liaison since its inception and for providing guidance.
- D. Lee referenced the National Minority AIDS Council (NMAC) recent email referencing the Request for Information (RFI) soliciting feedback around barriers to care within federally funded systems. D. Lee and B. Gordon encouraged members to submit comments in response to the RFI and to attend the next Executive Committee meeting where there will be a fuller discussion around a coordinated response.

B. California Office of AIDS (OA) Report

- Karl Halfman, MA, referenced the May OA Voice and highlighted innovative interventions implemented by EHE initiative counties – San Bernardino and Riverside; see OA Voice for more information.
- OA is working on the renewal process for the Medicare Waiver program. Waiver renewal applications will be submitted to centers for Medicare and Medicaid at end of August. Public comment will be accepted through June 7, 2021. Instructions for submitting public comment can be found in the May OA Voice.
- Sharisse Kemp, Chief, ADAP Branch, reported that the PrEP Assistance Program currently has 192 enrollment sites that cover 156 clinics that make up the PrEP provider network – refer to the May OA Voice for data on enrollment. Additionally, refer to page 6 in the May OA Voice for data on the ADAP insurance assistance programs.
- K. Halfman reported that Kaiser – Romaine site – is now ADAP approved and thanked Commissioners and Mario J. Peréz, MPH, Director (DHSP) for bringing this issue to OA's attention. K. Stalter reported that the job bulletin for the site's enrollment worker has yet to be posted; S. Kemp indicated OA will follow up.
- It was reported that the Kaiser – South LA/Baldwin Hills – is not an ADAP approved pharmacy and clients must travel to the Cadillac site to access ADAP. K. Halfman noted that each pharmacy must apply to become an ADAP approved site.

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- B. Gordon requested that an assessment be conducted in South Los Angeles (SPA 6/Supervisorial District 2) to determine gaps in PLWH accessing ADAP sites. M. Peréz, shared that SPA 4 has the largest number of people living with HIV (PLWH), followed by SPA 8 and SPA 2 and offered a more equitable approach to conduct a County-wide assessment on where ADAP sites are in relation to highly impacted areas of PLWH should be requested versus requesting data for any one targeted area.
- S. Kemp noted that they are starting to see an uptick in clients seeing providers and picking up their prescriptions; starting to see things get back to normal.
- ➲ OA to provide the most recent list of ADAP pharmacy sites and their respective enrollment numbers in Los Angeles County and DHSP to superimpose data of where PLWH live; both agencies will work together to ensure there are accessible ADAP pharmacy sites in areas highly impacted and in areas where there are gaps in ADAP services.
- ➲ OA to provide a list of pharmacies who do not accept ADAP; will send GIS link to DHSP as a starting point.
- ➲ OA will also provide a list of PrEP enrollment sites and enrollment numbers for each site.

(1) California HIV Planning Group (CPG) Update

- K. Halfman reported that the CPG spring meeting is now occurring virtually over the course of four days. The remaining two meetings are May 14 and May 17 and are open to the public. More information can be found in the May OA Voice.

B. LOS ANGELES COUNTY (LAC) DEPARTMENT OF PUBLIC HEALTH (DPH) REPORT

(1) Division of HIV/STD Programs (DHSP) Updates

(a) Programmatic and Fiscal Updates

- 2020 HIV/STD Surveillance Data | PRESENTATON. Dr. Andrea Kim, PhD, MPH, Chief, HIV and STD Surveillance, (DHSP) presented on the update on HIV and STD surveillance in Los Angeles County; see PPT slides in meeting packet.
  - Discussion ensued around using the surveillance data to collaborate with the BOS, County partners and federally qualified health centers to coordinate a more holistic and broader menu of services and interventions.
  - A. Ballesteros recommended partnering with Louise McCarthy @ Community Clinic Association of Los Angeles to promote FQHC's services and offered his assistance.
  - DHSP continues to appeal for staffing relief to address the STD crisis and other priorities.
  - ➲ K. Stalter recommended that the COH submit a letter to the BOS to support return of DHSP staffing. C. Barrit suggested that this item be discussed at the next Executive Committee meeting.
- Child Care and Translation Services Provider + Client Survey | UPDATES
  - Paulina Zamudio, MPH, Chief, provided an overview of the Child Care and Interpretation/Translation Services survey; see PPT slides in meeting packet.
  - DHSP is currently going through the solicitation process to procure a Language Services vendor and is working with the COH to address the need for childcare services.
- M. Perez reported that DHSP is working with DPH and BOS to proclaim June 5, 2021 in recognition of the 40th anniversary of the first CDC reported HIV case and commit to ending the HIV epidemic.
- To date, 180 applications for Emergency Financial Assistance (EFA) have been received – 116 have been approved. Regarding submitting W9s, the rule is if the assistance goes directly to the renter, the cap of coverage is 25%. However, if the landlord receives the payment directly, the cap increases significantly to 80%. M. Peréz noted that DHSP will be developing a fact sheet for landlords to help promote the EFA.
- The Health and Human Services (HHS) has released a $1.3 billion solicitation to support disease intervention specialists to help with addressing COVID and other public health matters. M. Peréz announced that LA County will be applying.
- ➲ COH staff to send out EFA fact sheets.

(b) Ending the HIV Epidemic (EHE) Activities and Updates

- J. Tolentino, MPH, EHE Program Coordinator, thanked the COH liaisons and A. Ballesteros for their partnership and noted that C. Barrit created a log to memorialize feedback during EHE discussions at COH-related meetings. The feedback will be used as a guiding document for the COH liaisons to facilitate conversations around the EHE. Much of the feedback compiled to date include spreading the word about the EHE, ensuring RWP services are accessible and friendly and the need for new and innovative ideas.
- J. Tolentino reported that one of the EHE initiative activities included working on supporting HIV testing events and distribution of HIV self-test kits in June in commemoration of 40th anniversary of the first CDC reported HIV

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case and in honor of National HIV Testing Day. J. Tolentino thanked Derrick Murray and Mayor Lindsey P. Horvath of West Hollywood for their assistance in promoting HIV testing activities in West Hollywood. The EHE Steering Committee is working to identify additional locations in Los Angeles County to distribute HIV self-test kits.

- The Rapid Linkage to Care program launched at end of April in partnership with one HIV provider JWCH Institute/Wesley and two HIV testing providers – LACADA and REACH LA. Additional sites are being identified.
- Additional EHE activities include but are not limited to:
  - a work order solicitation in process to bring on an entire EHE team,
  - identifying an evaluator to conduct a landscape analysis of mental health services in Los Angeles County,
  - discussions with the LAC Department of Mental Health (DMH) to conduct rapid HIV testing in their clinics
  - develop a Memorandum of Understanding (MOU) to increase mental health services in three DMH sites
  - collaboration with the Substance Abuse and Prevention Services program to discuss support of syringe access and harm reduction programs under EHE.

➲ J. Tolentino will provide a more comprehensive report on EHE activities at an upcoming COH meeting.

C. HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS (HOPWA) REPORT No report provided.

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

- Part C No report provided
- Part D No report provided
- Part F/AETC Report on the demographics of the HIV fellows provided in the packet. J. Gates will go over the information at the June meeting.

E. CITIES, HEALTH DISTRICTS, SERVICE PLANNING AREA (SPA) REPORTS

- City of Pasadena. No updates.
- City of West Hollywood. No updates.
- City of Long Beach.
  - Everardo Alvizo, LSCW, reported that the City has developed a mental health awareness campaign for the month of May; flyers are available in English, Spanish and Kamai. The campaign presents an opportunity to correlate mental health and substance abuse around risk factors related to HIV transmission.
  - City's health department HIV CARE center and its sexual health clinic are working together to incorporate best practices for providing Post-Exposure Prophylaxis (PEP) services.
  - The LGBT Center, Long Beach, recently welcomed its new Executive Director – Carlos Torres, MPH. E. Alvizo will be meeting with C. Torres to inform him of the HIV strategy and to ensure he is a part of the EHE conversations moving forward.
- City of Los Angeles:
  - Ricky Rosales, AIDS Coordinator, reported that the City conducted its budget hearing and approved to restore all funding cut from this budget year.
  - City will fill an extra position dedicated to outreach in homeless encampments; waiting for final report from the CLA.
  - City completed the review process for the Request for Proposal (RFP) and will be meeting with the organizations and submitting recommendations to the City Council for approval.

F. STANDING COMMITTEE REPORTS

(1) Standards and Best Practices (SBP) Committee (Next Meeting June 1, 2021 @ 10am-12pm)

- Committee reviewed a Committee only membership application from Dr. Mark Mintline; Committee will approve application at the June SBP meeting.
- Next meeting: June 1 @ 10 am to 12 noon

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(a) Child Care Services Standard of Care (SOC) | UPDATE

- Committee approved the childcare service standards and it is set to go to Executive Committee on May 27 and the Commission on June 10 for approval.

(b) 2021 Standards of Care Review | UPDATE

- SBP Co-Chairs are working with consultant and HRSA technical assistance provider, Emily Gantz-McKay, to develop a training on service standards. This training is slated for the July SBP meeting and will be open to all Commissioners and members of the public.
- Wendy Garland, PhD, Chief Epidemiologist, (DHSP), provided an overview of the Ryan White Program (RWP) HIV Substance Use Disorder Residential Housing Services. Dr. Garland's overview covered how the implementation of Drug Medi-Cal in 2017 shifted the primary funding for substance outpatient treatment services under Substance Abuse and Prevention Control (SAPC); DSHP funds substance use residential services to complement and supplement substance use disorder services covered by Drug Medi-Cal. Dr. Garland also provided key service utilization data from Program Year 29. The service overview information will help guide the SBP Committee in updating the substance use service standards.
- Committee began reviewing the Substance Use Treatment service standards with initial changes for clarity, format, and alignment with relevant Drug Medi-Cal requirements.
- K. Stalter, Co-Chair, provided a personal testimony around his experience with barriers to care; see COH staff for copy.

(2) Operations Committee (Next Meeting June 24, 2021 @ 10am-12pm)

(a) <u>Membership Management</u>

- New Member Application: Mikhaela Cielo, MD, | Part D Representative Seat **MOTION #3**
  - Approve Recommendation for New Member Applicant Mikhaela Cielo, MD., to occupy the Part D seat, as presented or revised, and elevate to Board of Supervisors for appointment. (✓Passed by Roll Call Majority Vote)
- New Member Application: Mallery Robinson | Alternate #25 Seat **MOTION #4**
  - Approve Recommendation for New Member Applicant Mallery Robinson, to occupy the Alternate (#25) seat, as presented or revised, and elevate to Board of Supervisors for appointment. (✓Passed by Roll Call Majority Vote)
- Operations conducted an applicant interview that will be placed on its agenda for approval at the next committee meeting
- Approximately half of the seats are set to expire at the end of June 2021. Commissioners up for renewal should expect to receive an email from staff for next steps for those who wish to renew membership.

(b) <u>Membership Application Redevelopment | UPDATE</u>

- The revised membership application was approved at the Operations and Executive Committees and has been forwarded to County Counsel for review and approval. Once County Counsel has completed their review, the revised membership application will be placed on the Commission's agenda as a motion for approval by the full body.

(c) <u>Engagement + Retention Strategies</u>

- Operations continues its engagement and retention strategies and the Commission has documents readily available for commissioners who would like to make presentations at CAB and community events regarding who the Commission on HIV is and what we do.

(3) Planning, Priorities and Allocations (PP&A) Committee (Next Meeting May 18, 2021 @ 1-3PM)

- Committee discussed and agreed to modify the readability of Paradigm and Operating Values used in the planning, priority, and allocation decision-making process.
- Committee agreed to increase Consumer Caucus participation in the planning process by obtaining Consumer Caucus ongoing feedback on Paradigms and Operating Values, service prioritizations, multi-year allocations and DHSP Directives.
- Committee agreed to engage the Caucus in ongoing planning, priority, and allocation training efforts.
- Next meeting will focus on review and discussion on DHSP directives, discuss Special Projects of National Significance grant (SPNS) (Offered through the Department of Housing and Urban Development (HUD))
- Next Meeting is Tuesday, May 18, 2021 from 1-3PM.

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(a) Prevention Planning Workgroup (PPW) | UPDATES (Next Meeting May 26, 2021 @ 5:30-7pm)

- Last meeting was Wednesday, April 28, 2021 and DHSP presented fiscal and programmatic prevention data . The next meeting will provide an opportunity for workgroup participants to ask questions of DHSP; PPT slides are in meeting packet.
- The next PPW meeting will include discussions on the data presented by DHSP, and if time permits, innovation around testing and expanding store fronts as well as a review of approved prevention standards.

(4) Public Policy Committee (Next Meeting June 7, 2021 @ 1-3pm)

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

- Committee approved the 2021 legislative docket which will be on the May Executive Committee meeting. If approved, the docket will be on the June 2021 Commission agenda.
- Committee began a discussion on prioritizing the policy priorities approved by the Commission.
- End of the Epidemic Week of Action (May 3 – 6th) – which includes advocacy training and a racial justice workshop.

(b) County, State, and Federal Budget

- Waiting for federal appropriations to determine how much funding will be allocated to EHE efforts and HOPWA; budget to be approved in June 2021.
- Governor Gavin Newsom has released his May Revise; state legislature will meet on June 15, 2021 to vote.
- PPC will discuss the Commission's/County's response to the STD crisis at its next meeting.

B. CAUCUS, TASK FORCE, AND WORK GROUP REPORTS

(1) Aging Task Force (ATF): Next Meeting June 1, 2021 @ 1-3pm

- ATF had a robust discussion with Dr. Michael Green regarding the DHSP's response to the ATF recommendations. The ATF will redefine and/or clarify specific areas that DHSP was unclear on, including ways to operationalize some of the recommendations.
- Dr. Garland (DHSP) reported that she met with Dr. Paul Nash to brainstorm on strategies to gather data and provided an overview of ways to move forward in the examination of unmet psychosocial needs for the aging populations as follows:
- The group will look at quality programs for aging, inclusive of depression screening, mental health assessments.
- The ATF will continue looking at HIV geriatric care models such as the Golden Compass program from San Francisco to understand specific assessments, service modalities, and funding streams used, to develop a similar program in Los Angeles County.
- ATF will also review the RFP from NY on HIV and Aging services using HRSA Ending the HIV Epidemic funds.

(2) Black/African American Community (BAAC) Task Force: Next Meeting May 24, 2021 @ 1-3pm

- BAAC met on April 26 and welcomed DHSP for ongoing discussions on how to address recommendations within their scope.
- DHSP provided its final version of the comprehensive Implicit Bias webinar training slides which will be incorporated into its training curriculum for all contracted providers.
- DHSP also presented samples of existing social media PrEP marketing campaigns targeting the Black/AA community from other jurisdictions for the task force to consider. BAAC will discuss whether it will opt to use existing PrEP campaigns at its next meeting.
- BAAC and DHSP leadership will be meeting every couple of weeks until June 2021 to address key recommendations. The first of these meetings took place Monday, May 10th. The next small group meeting will follow the main BAAC meeting on May 24.
- BAAC leadership will be making its rounds to all Committees, Caucuses and Task Forces to engage in discussions and provide guidance on how to best address the recommendations.

(3) Consumer Caucus: Next Meeting May 13, 2021 @ 3-4:30pm

- Consumer Caucus met on April 8 and discussed the following:
  - Parliamentarian Training: How We Run Our Meetings: Jim Stewart delivered a training with a more focused question and answer period for the consumers.
  - Ending the HIV Epidemic (EHE) Plan Overview Refresher: Julie Tolentino, MPH, EHE Program Coordinator (DHSP), provided a refresher of the EHE Plan and engaged the Caucus in how they can participate in EHE activities.
  - The National Minority AIDS Council (NMAC) Building Leaders of Color (BLOC) virtual training for consumers in Los Angeles has been rescheduled to September 2021. The Caucus will discuss logistics and hopefully finalize training dates at its meeting this afternoon.

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- Caucus will be meeting following the Commission meeting and will discuss the following:
  - Continue parliamentary procedure training with Jim Stewart.
  - Laurie Aronoff, Project Coordinator, AIDS Legal Services Project, Los Angeles Bar Association, will provide a 10-minute presentation on its legal need's assessment project with the goal to recruit as many consumers as possible to participate.
  - Caucus will review the Planning, Priorities & Allocations (PP&A) Committee prioritizing services and resource allocation (PSRA) process, materials, and data for continued capacity and skill building training.
  - Caucus will discuss a potential presentation on social determinants of health for a future meeting

(4) Prevention Planning Workgroup: Next Meeting April 28, 2021 @ 5:30pm-7pm
Refer to the PP&A Committee Report.

(5) Transgender Caucus (TG): Next Meeting May 25, 2021 @ 10am-12pm

- TG will hold its next bi-monthly meeting on May 25th, 2021 from 10AM to 12 noon and will discuss the following:
  - Continued discussion of workplan which includes ongoing training about the Commission, how decisions are made, understanding Ryan White service categories, housing systems and funding streams, and other topics that are aimed at fostering leadership and active engagement of transgender individuals in the work of the Commission.
  - The monitoring of the EHE plan as a standing agenda item to capture ongoing feedback from the transgender community.
  - Continued discussions of SB 225 (Bodily Autonomy, Dignity, and Choice Act) and supporting community advocacy efforts to secure $15M for the Transgender Wellness Fund (AB2218); as well as continued collaboration with the Public Policy Committee to review bills that impact transgender health and welfare.
  - The Transgender Caucus is anticipating the BAAC Task Force to present an overview of its recommendations at the next meeting.

(6) Women's Caucus: Next Meeting June 21, 2021 @ 2-4pm

- Caucus met April 19, 2021 and Paulina Zamudio, MPH, Chief, (DHSP), presented on the results of the Child Care and Language Services provider survey; PPT slides in meeting packet.
- Caucus also welcomed an abridged presentation by our very own Danielle Campbell on Cis-gender women and PrEP from her presentations at the recent NMAC Biomedical Summit and CROI.
- Caucus confirmed a virtual lunch & learn event for May 26, 2021 at 12pm-1:30pm around Women Living with HIV and Mental Health & Wellness in commemoration of Mental Health Awareness Month.
- The May 17th Caucus meeting will be cancelled in lieu of the May 26 VLL; next meeting will be June 21 @ 2-4pm

7. <u>MISCELLANEOUS</u>

A. <u>PUBLIC COMMENT</u>: OPORTUNITY TO ADDRESS COMMISSION ON ITEMS OF INTEREST WITHIN COMMISSION JURISDICTION (To provide live public comment, register and join WebEx via computer or smartphone. Those joining via telephone cannot provide live public comment, but may submit written comments or materials via email to hivcomm@lachiv.org.)

B. <u>COMMISSION NEW BUSINESS ITEMS</u>: OPPORTUNITY FOR COMMISSION MEMBERS TO RECOMMEND NEW BUSINESS ITEMS FOR FULL BODY OR COMMITTEE DISCUSSION ON FUTURE AGENDAS, OR MATTERS REQUIRING IMMEDIATE ACTION DUE TO AN EMERGENCY, OR WHERE NEED TO TAKE ACTION AROSE SUBSEQUENT TO POSTING THE AGENDA:

- Justin Valero, Commission member, recommended that the Commission explore reorganizing its meeting agenda so there is sufficient time to thoroughly discuss standing reports and COH business, i.e. move standing reports up on the agenda, reconsider the amount of time allocated to the reading activity, etc.

C. <u>ANNOUNCEMENTS</u>: REGARDING COMMUNITY EVENTS, WORKSHOPS, TRAININGS, AND OTHER RELATED ACTIVITIES (Provision of announcements will follow the same protocol as that listed for public comments above.):

- Laurie Aronoff, Project Director, LACBA AIDS Legal Services Project, announced that the Los Angeles County Bar Association in partnership with the Inner-City Law Project is conducting a Legal Needs Assessment for PLWH and will be recruiting consumers to participate in their Community Advisory Committee (CAC). If interested, please contact L. Aronoff at laronoff@lacba.org.

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ADJOURNMENT AND ROLL CALL: The meeting adjourned at or around 2:20pm
Roll Call (Present): E. Alvizo, A. Ballesteros, A. Burton, D. Campbell, K. Donnelly, A. Luckie Fuller, G. Garth, F. Gonzalez, G. Granados, J. Green, K. Halfman, L. Kochems, C. Moreno, D. Murray, K. Nelson, T. Green, M. Peréz, J. Preciado, R. Rosales, H. San Agustin, I. Rodriguez, D. Lee, and B. Gordon

MOTION AND VOTING SUMMARY		
MOTION 1: Approve the Agenda Order, as presented.	***Passed by Consensus***	**MOTION PASSED**
MOTION 2: Approve the March 8, 2021 Commission on HIV Meeting Minutes, as presented.	***Passed by Consensus***	**MOTION PASSED**
MOTION 3: Approve Recommendation for New Member Applicant Mikhaela Cielo, MD., to occupy the Part D seat, as presented or revised, and elevate to Board of Supervisors for appointment	***Ayes:*** Alvarez, Alvizo, Ballesteros, Burton, Campbell, Coffey, Donnelly, Findley, Fuller, Granados, Gonzalez, Heltzel-Walker, Kochems, Moreno, Murray, Nash, Nelson, Green (Thomas), Pérez, Preciado, Martinez, Rosales, San Agustin, Sattah, Rodriguez, Valero, and Gordon ***Opposed***: None ***Abstentions***: None	**MOTION PASSED** **Ayes**: 27 **Opposed:** 0 **Abstentions**: 0
MOTION 4: Approve Recommendation for New Member Applicant Mallery Robinson, to occupy the Alternate (#25) seat, as presented or revised, and elevate to Board of Supervisors for appointment	***Ayes:*** Alvarez, Alvizo, Ballesteros, Burton, Campbell, Coffey, Donnelly, Findley, Fuller, Granados, Gonzalez, Heltzel-Walker, Kochems, Moreno, Murray, Nash, Nelson, Green (Thomas), Pérez, Preciado, Martinez, Rosales, San Agustin, Sattah, Rodriguez, Valero, and Gordon ***Opposed***: None ***Abstentions***: None	**MOTION PASSED** **Ayes**: 27 **Opposed:** 0 **Abstentions**: 0

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LOS ANGELES COUNTY COMMISSION ON HIV (COH) 2021 MASTER WORK PLAN
(Updated 5.25.21)

****Subject to change and does not include ongoing activities for Committees and subgroups.****

Co-Chairs: Bridget Gordon & David Lee	**Revision Dates: 1/5/21; 3/31/21; 5/5/21; 5/25/21**

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/STATUS
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 STARTED/IN PROGRESS
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 STARTED/IN PROGRESS
3	Support implementation of local EHE Plan within duties of the COH as defined in its ordinance. • Bridget Gordon, Co-Chair, will serve as the primary Commission liaison to the DHSP EHE Steering Committee, with Katja Nelson, Kevin Stalter, and Felipe Findley serving as backups. The liaison team represents a diverse set of perspectives and community experience. • The liaisons will work as a team and serve as conduit of information and collaborative opportunities between the Commission and Steering Committee. • In addition, the liaisons will also facilitate EHE-focused conversations at Commission, Committee, and subgroup meetings to identify specific activities that the COH can implement within its charge as the planning council for Los Angeles County. • The liaisons will engage Commissioners in thinking of broader ways the Commission can end the HIV epidemic in Los Angeles County.	ONGOING
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 STARTED/IN PROGRESS
5	Implement National Minority AIDS Council (NMAC) BLOC training for consumers • Customized training aimed at supporting consumer leadership development.	September 13-17 PLANNING IN PROGRESS
6	Implement activities aimed at integrated prevention and care planning, priority setting and resource allocation.	Start Jan/Ongoing STARTED/IN PROGRESS
7	Review BAAC and ATF charge and implement recommendations best aligned with the purpose and capacity of the Commission	Start Jan/Ongoing STARTED/IN PROGRESS

services for individuals with HIV identified and eligible under the statute, after reserving statutory permissible amounts for administrative and clinical quality management costs. The RWHAP statute also grants the Secretary authority to waive this requirement for RWHAP Parts A, B, or C recipients if a number of requirements are met and a waiver request is submitted to HRSA for approval. RWHAP Part A, B, and C core medical services waiver requests—if approved—are effective for a 1-year budget period, and apply to funds awarded under the Minority AIDS Initiative.

Currently, for a core medical services waiver request to be approved, (1) core medical services must be available and accessible to all individuals identified and eligible for the RWHAP in the recipient's service area within 30 days, without regard to payer source; (2) there cannot be any AIDS Drug Assistance Program waiting lists in the recipient's service area; and (3) a public process to obtain input on the waiver request from impacted communities, including clients and RWHAP-funded core medical services providers, on the availability of core medical services and the decision to request the waiver must have occurred. The public process may be a part of the same one used to seek input on community needs as part of the annual priority setting and resource allocation, comprehensive planning, statewide coordinated statement of need (SCSN), public planning, and/or needs assessment processes.

HRSA is proposing to simplify the waiver request process for RWHAP Parts A, B, and C recipients by revising Policy Number 13–07: Uniform Standard for Waiver of Core Medical Services Requirement for Grantees Under Part, A, B, and C. The proposed changes would reduce the administrative burden for recipients by lessening the documentation they must submit to HRSA when requesting a waiver. Under the proposed policy, recipients would be required to submit a one-page ''HRSA RWHAP Core Medical Services Waiver Request Attestation Form'' to HRSA in lieu of the multiple documents currently required to submit a waiver request. Waiver request submission deadlines would also be revised. When finalized, the policy would replace HAB Policy Number 13–07 effective October 1, 2021, and would be named ''Waiver of the Ryan White HIV/AIDS Program Core Medical Services Expenditure Requirement.'' HRSA is inviting comments on the proposed policy change under a separate policy notice titled, *Updates to Uniform Standard for Waiver of the Ryan White HIV/AIDS Program Core Medical Services Expenditure Requirement.*

Need and Proposed Use of the Information: HRSA uses the documentation submitted in core medical services waiver requests to determine if the grant applicant or recipient meets the statutory requirements for waiver eligibility outlined in Sections 2604(c), 2612(b), and 2651(c) of the Public Health Service Act.

Likely Respondents: HRSA expects responses from RWHAP Parts A, B, and C grant applicants and recipients. The number of grant recipients requesting waivers has fluctuated annually and has ranged from 15 to up to 22 per year since the Program's implementation in FY 2007. Given the changes in the health care environment, HRSA anticipates receiving possibly up to 22 applications in a given year.

Burden Statement: Burden in this context means the time expended by persons to generate, maintain, retain, disclose or provide the information requested. This includes the time needed to review instructions; to develop, acquire, install and utilize technology and systems for the purpose of collecting, validating and verifying information, processing and maintaining information, and disclosing and providing information; to train personnel and to be able to respond to a collection of information; to search data sources; to complete and review the collection of information; and to transmit or otherwise disclose the information. Public reporting burden for this collection of information is estimated to average four hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. The total annual burden hours estimated for this ICR are summarized in the table below.

TOTAL ESTIMATED ANNUALIZED BURDEN HOURS

Form name	Number of respondents	Number of responses per respondent	Total responses	Average burden per response (in hours)	Total burden hours
Waiver Request	22	1	22	4	88
Total	22		22		88

HRSA specifically requests comments on (1) the necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

Maria G. Button,

Director, Executive Secretariat.

[FR Doc. 2021–08017 Filed 4–19–21; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Updates to Uniform Standard for Waiver of the Ryan White HIV/AIDS Program Core Medical Services Expenditure

AGENCY: Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS).

ACTION: Request for public comment on updates to uniform standard for waiver of the Ryan White HIV/AIDS Program

core medical services expenditure requirement.

SUMMARY: The Ryan White HIV/AIDS Program (RWHAP) statute of the Public Health Services Act requires that RWHAP Part A, B, and C recipients expend 75 percent of Parts A, B, and C grant funds on core medical services for individuals with HIV/AIDS identified and eligible under the statute, after reserving statutory permissible amounts for administrative and clinical quality management costs. The statute also grants the Secretary authority to waive this requirement if certain requirements are met. HRSA is proposing to simplify the process for RWHAP Part A, B, and C recipients to request a waiver of the core medical services expenditure amount requirement by replacing HRSA Policy Number 13–07, ''Uniform Standard for Waiver of Core Medical Services Requirement for Grantees Under Parts, A, B, and C'' (accessible at the following link) *https://hab.hrsa.gov/sites/default/files/hab/Global/13-07waiver.pdf.* This notice seeks to make public the proposed policy and provide an opportunity for public comment before its implementation. In a separate notice entitled, *Updates to Uniform Standard for Waiver of the Ryan White HIV/AIDS Program Core Medical Services Expenditure Requirement, OMB No. 0906–XXXX–NEW,* HRSA is inviting comments on the data collection changes associated with this proposed policy change.

DATES: Submit comments no later than June 21, 2021. The policy will become effective on October 1, 2021.

ADDRESSES: Electronic comments on this policy should be sent to *RyanWhiteComments@hrsa.gov* by June 21, 2021.

FOR FURTHER INFORMATION CONTACT: Lieutenant Commander Emeka Egwim, U.S. Public Health Service, Senior Policy Analyst, Division of Policy & Data, HRSA, HIV/AIDS Bureau, 5600 Fishers Lane, Rockville, MD 20857, Phone: (301) 945–9637 or by emailing *RyanWhiteComments@hrsa.gov.*

SUPPLEMENTARY INFORMATION: The RWHAP statute grants the Secretary authority to waive this requirement for RWHAP Parts A, B, or C recipients if a number of requirements are met and a waiver request is submitted to HRSA for approval. RWHAP Part A, B, and C core medical services waiver requests—if approved—are effective for a 1-year budget period, and apply to funds awarded under the Minority AIDS Initiative.

Currently, for a core medical services waiver request to be approved, (1) core medical services must be available and accessible to all individuals identified and eligible for the RWHAP in the recipient's service area within 30 days, without regard to payer source; (2) there cannot be any AIDS Drug Assistance Program (ADAP) waiting lists in the recipient's service area; and (3) a public process to obtain input on the waiver request from impacted communities, including clients and RWHAP-funded core medical services providers, on the availability of core medical services and the decision to request the waiver must have occurred. The public process may be a part of the same one used to seek input on community needs as part of the annual priority setting and resource allocation, comprehensive planning, statewide coordinated statement of need, public planning, and/or needs assessment processes.

The proposed changes would reduce the administrative burden for recipients by lessening the documentation they must submit to HRSA when requesting a waiver. Under the proposed policy, recipients would be required to submit a one-page ''HRSA RWHAP Core Medical Services Waiver Request Attestation Form'' to HRSA in lieu of the multiple documents currently required to submit a waiver request. Waiver request submission deadlines would also be revised. When finalized, the policy would replace HIV/AIDS Bureau (HAB) Policy Number 13–07 effective October 1, 2021, and would be named ''Waiver of the Ryan White HIV/AIDS Program Core Medical Services Expenditure Requirement.''

Summary of Proposed Changes: Currently, all waiver requests must be signed by the Chief Elected Official or the project director, and include several documents, regardless of when they are submitted relative to the grant application. The documents required under the current waiver request process outlined in HAB Policy Number 13–07 are: (1) A letter signed by the Director of the RWHAP Part B state/territory recipient indicating that there is no current or anticipated ADAP services waiting list in the state/territory; (2) evidence that all core medical services listed in the statute are available and accessible within 30 days for all identified and eligible individuals with HIV in the service area; (3) evidence of a public process; and (4) a narrative of up to 10 pages.

HRSA has determined that some of this required information is duplicative of information recipients already submit as part of recipients' grant applications or other reporting requirements. The current documentation for preparing and submitting waiver requests requires a substantial amount of time for recipients. Likewise, HRSA requires a substantial amount of time to review and process them. Therefore, HRSA is proposing that recipients submit the proposed ''HRSA RWHAP Core Medical Services Waiver Request Attestation Form'' in lieu of the supporting documentation required per HAB Policy Number 13–07. HRSA may request additional information or supporting documentation upon request.

Availability of Core Medical Services

Currently, consistent with HAB Policy Number 13–07, recipients requesting core medical services waivers must provide evidence that all core medical services listed in the RWHAP statute are available for all identified and eligible individuals with HIV/AIDS in the service area without regard to the source of funding. However, as part of their grant application, RWHAP Part A, B, and C recipients provide sufficient information to satisfy this requirement. RWHAP Part A recipients describe the comprehensive system of care in the entire eligible metropolitan area or transitional grant area. This description includes the available core medical and support services funded by RWHAP Part A and other funding sources (including Minority AIDS Initiative funds), where those services are located, and how clients may access those services. Similarly, RWHAP Part B recipients provide a general description of the HIV service delivery system in the state/territory, including what services are available, where those services are located, and how clients may access those services. RWHAP Part C recipients also provide a description of services available to people with HIV in the entire designated service area; a map showing locations of all current and proposed local providers of HIV outpatient primary health care services, including the recipient's organization; and a list of all public and private organizations that provide HIV outpatient primary health care services to people with HIV in the entire designated service area. Therefore, it is duplicative to require additional documentation of this information separately as part of the core medical services waiver application.

ADAP Waiting Lists

Consistent with the current requirements outlined in HAB Policy Number 13–07, recipients requesting core medical services waivers are required to submit a letter from the director of the RWHAP Part B state/territory recipient indicating there are no current or anticipated ADAP services

waiting lists in the service area. All RWHAP Part B recipients already indicate in their grant applications whether there are ADAP waiting lists in their state or territory, and whether the recipient anticipates implementing one. Under the proposed changes, RWHAP Part A, B, and C recipients must still attest that there are no ADAP waiting lists in the RWHAP Part B program on the RWHAP Core Medical Services Waiver Request Attestation Form to HRSA.

Evidence of a Public Process

Currently, recipients submitting waiver requests also submit letters from the Planning Council Chair(s) and the state HIV/AIDS director describing the public process that occurred in the jurisdiction related to the availability of core medical services and the decision to request a waiver. RWHAP program recipients describe how they engaged affected communities regarding the availability of core medical services as part of their grant applications, and include evidence describing the community input process and how it informs the priority setting and resource allocation process for the jurisdiction. Specifically, the community input process described in RWHAP Part A grant applications addresses how data were used in the priority setting and allocation processes to increase access to core medical services. RWHAP Part B recipients' grant applications include needs assessments that in part, describes the Public Advisory Planning Process models to ensure inclusion of people with HIV, other RWHAP recipients, other HIV related programs, other general and local stakeholders, and community leaders. Similarly, RWHAP Part C recipients' grant applications include documentation on the process used to obtain community input on the design and implementation of activities related to the grant.

HRSA notes that these public processes are not done in the context of RWHAP Part A, B, or C recipients requesting waivers of the RWHAP core medical services expenditure requirements. Therefore, consistent with the requirements outlined in the statute, RWHAP Parts A, B, and C recipients should ensure the completion of a public process to obtain input on their desire to request a core medical services waiver prior to submitting the HRSA RWHAP Core Medical Services Waiver Request Attestation Form.

In addition to the three requirements outlined above and in HAB Policy Number 13–07, HRSA currently requires recipients to submit a narrative of up to 10 pages describing how their proposed percentage allocation will allow for services to be provided if the waiver is granted. These narratives also include any underlying local or state issues that influenced the decision to request a waiver, a proposed resource allocation table, as well as a description of the general healthcare landscape in the service area and how it may have changed over time. Given that recipients provide this information as part of the narrative in their grant applications or other submitted documentation, when a recipient submits a core medical services waiver application under the proposed policy, HRSA would be able to refer to that information or could request additional information from the recipient if needed.

For the reasons outlined above, HRSA has determined that these duplicative requirements outlined in HAB Policy Number 13–07 are administratively burdensome and can be reduced with a more streamlined process. The proposed policy would replace waiver requests with a one-page ''HRSA RWHAP Core Medical Services Waiver Request Attestation Form (see below).'' The Chief Elected Official, Chief Executive Officer, or a designee of either, would complete and submit the HRSA RWHAP Core Medical Services Waiver Request Attestation Form to HRSA certifying that the recipient has met the requirements outlined in the RWHAP statute and the new policy notice. This attestation form would be included as the last page of HAB Policy Notice 21–01, and would consist of the following:

1. Instructions stating the form is to be completed by the Chief Elected Official, Chief Executive Officer, or a designee of either, and the person completing it should initial the included checkboxes to attest to meeting each requirement after reading and understanding its explanation.

2. A field in which the recipient can fill in its name.

3. Checkboxes with which the recipient can indicate the following:

a. If they are a RWHAP Part A, B, or C recipient
b. Whether the request is an initial request or renewal request
c. The year the waiver is being requested

4. Checkboxes with which the recipient attests to meeting the following requirements:

a. Not having an ADAP waiting list
b. Availability of and accessibility to core medical services to all eligible individuals within the service area within 30 days
c. Evidence of having conducted a public process

5. Fields for the following details of the official completing the form:

a. Signature
b. Printed name
c. Title

6. The date the form was signed

HRSA Ryan White HIV/AIDS Program (RWHAP) Core Medical Services Waiver Request Attestation Form

This form is to be completed by the Chief Elected Official, Chief Executive Officer, or a designee of either.

Please initial to attest to meeting each requirement after reading and understanding the explanation.

Name of recipient ____________________

☐ **RWHAP Part A recipient** ☐ **RWHAP Part B recipient** ☐ **RWHAP Part C recipient**

☐ **Initial request** ☐ **Renewal request**

Year of request ____________________

REQUIREMENT	EXPLANATION
No ADAP waiting lists	By initialing here and signing this document, you attest there are no AIDS Drug Assistance Program (ADAP) waiting lists in the service area. ☐
Availability of, and accessibility to core medical services to all eligible individuals	By initialing here and signing this document, you attest to the availability of and access to core medical services for all HRSA RWHAP eligible individuals in the service area within 30 days. Such access is without regard to funding source, and without the need to spend on these services, at least 75 percent of funds remaining from your RWHAP award after reserving statutory permissible amounts for administrative and clinical quality management. You also agree to provide HRSA HAB supportive evidence of meeting this requirement upon request. ☐
Evidence of a public process	By initialing here and signing this document, you attest to having had a public process during which input related to the availability of core medical services and the decision to request this waiver was sought from impacted communities, including clients and RWHAP funded core medical services providers. You also agree to provide supportive evidence of such process to HRSA HAB upon request. ☐

____

SIGNATURE OF CHIEF ELECTED OFFICIAL OR CHIEF EXECUTIVE OFFICER (OR DESIGNEE)

____

PRINT NAME

____

TITLE

____

DATE

Although the proposed policy's purpose is to reduce administrative burden for recipients, if finalized, it would not change the underlying requirements necessary to obtain a waiver, *i.e.,* ensuring that: (1) All core medical services are available and accessible within 30 days in the jurisdiction or service area, (2) the state ADAP has no waiting lists, and (3) the recipient has used a public process to determine the need for a waiver. The HRSA RWHAP Core Medical Services Waiver Request Attestation Form provides recipients applying for waivers the ability to attest to having satisfied these requirements. Notwithstanding, recipients may still be required to provide further information to HRSA upon request.

Submission Deadlines

In addition to reducing the volume of documentation, HRSA is proposing to change the deadlines for submitting waiver requests.

Currently, consistent with the process outlined in HAB Policy Number 13–07, RWHAP Parts A, B, and C recipients may choose to submit a waiver request at any time prior to submission of the annual grant application, with the annual grant application, or up to 4 months after the start of the grant year for which the waiver is being requested.

To facilitate a more efficient review of waiver requests, the proposed changes would require waiver requests to be submitted by specific programmatic deadlines. A RWHAP Part A recipient would submit their waiver request as an attachment with the annual grant application or non-competing continuation (NCC) progress report. Because RWHAP Part B recipients submit their final budget 90 days after receiving their Notice of Award, the need for a waiver may not be identified until the final budget is approved. Therefore, a RWHAP Part B recipient would submit their waiver request either in advance of the grant application, with the grant application,

with the mandatory NCC progress report, or up to 4 months into the grant award budget period for which the waiver is being requested. A RWHAP Part C recipient would submit their request for a waiver as an attachment with the grant application or the mandatory NCC progress report. These proposed changes are intended to better align waiver requests with programmatic processes, thereby allowing HRSA to better manage the review and processing of waiver requests.

The proposed policy maintains that applicants submit their waiver requests with their grant applications through *www.grants.gov.* Recipients submit their waiver requests with the mandatory NCC progress report through the Electronic Handbooks (EHB). For waiver requests that are not submitted with grant applications or the mandatory NCC progress report, the proposed policy would require a recipient to notify its HRSA project officer (PO) of its intention to request a waiver in order to initiate a request for information in the EHB.

In the current process, HRSA reviews requests and notifies recipients of waiver approval or denial no later than the date of issuance of the Notices of Award. In the proposed process, HRSA would notify recipients of waiver approval or denial within 4 weeks of receipt of the request, thereby saving weeks when compared to the current process. As with the current process, approved core medical services waivers will be effective for the 1-year budget period for which they are approved; recipients must submit a new request for each budget period. Also as with the current process, a recipient would not be required to implement an approved waiver should it no longer be needed.

Waiver of the Ryan White HIV/AIDS Program Core Medical Services Expenditure Requirement

HAB Policy Notice 21–01
Replaces HAB Policy Number 13–07

Scope of Coverage

HRSA HIV/AIDS Bureau RWHAP Parts A, B, and C.

Purpose of Policy Notice

This HRSA policy notice replaces HAB Policy Number 13–07 Uniform Standard for Waiver of Core Medical Services Requirement for Grantees Under Parts, A, B, and C. It provides modified processes and requirements for HRSA RWHAP Parts A, B, and C recipients to request waivers of the statutory requirement regarding expenditure amounts for core medical services.

Requirements

A RWHAP Part A, B, or C recipient must meet a number of requirements, and submit a waiver request to HRSA to receive a waiver of the core medical services expenditure requirement.

1. Core medical services must be available and accessible to all individuals identified and eligible for the RWHAP in the recipient's service area within 30 days. This access must be:

a. Without regard to payer source, and

b. without the need to spend at least 75 percent of funds remaining from the recipient's RWHAP award after statutory permissible amounts for administrative and clinical quality management costs are reserved.

2. The recipient must ensure there are no ADAP waiting lists in its service area.

3. A public process to obtain input on the waiver request must have occurred.

a. This process must seek input from impacted communities including clients and RWHAP-funded core medical services providers on the availability of core medical services, and the decision to request the waiver.

b. The public process may be a part of the same one used to seek input on community needs as part of the annual priority setting and resource allocation, comprehensive planning, statewide coordinated statement of need, public planning, and/or needs assessment processes.

Requesting a Waiver

To request a waiver, the Chief Elected Official, Chief Executive Officer, or a designee of either must complete and submit the HRSA RWHAP Core Medical Services Waiver Request Attestation Form (appended below) to HRSA. The form should be submitted according to the applicable deadlines and methods for submission outlined below. By completing and submitting this form, the Chief Elected Official, Chief Executive Officer, or a designee of either attests to meeting the requirements outlined above and agrees to provide supportive evidence to HRSA upon request. No other documentation is required to be submitted with the HRSA RWHAP Core Medical Services Waiver Request Attestation Form, although recipients may be required to submit additional documentation to HRSA upon request.

Deadlines for Submitting Waiver Requests

RWHAP Part A Waiver Requests

A HRSA RWHAP Part A recipient should submit their request for a waiver as an attachment with the grant application or the mandatory NCC progress report, if applicable. In each case, waiver requests do not count towards the submission page limit. Do not submit requests for waivers prior to the grant application or mandatory NCC progress report, nor after the start of the grant award budget period for which the waiver is being requested.

RWHAP Part B Waiver Requests

A HRSA RWHAP Part B recipient may submit their request for a waiver either in advance of the grant application, as an attachment to the grant application, with the mandatory NCC progress report, or up to 4 months into the grant award budget period for which the waiver is being requested.

RWHAP Part C Waiver Requests

A HRSA RWHAP Part C recipient should submit their request for a waiver as an attachment to the grant application or the mandatory NCC progress report. Do not submit requests for waivers prior to the grant application or mandatory NCC progress report, nor after the start of the grant award budget period for which the waiver is being requested.

Methods for Submitting Waiver Requests

Applicants must submit their waiver requests with their grant applications through *www.grants.gov.* Recipients must submit their waiver requests with the mandatory NCC progress report through the Electronic Handbooks (EHB). Recipients who do not submit their waiver requests with their grant applications, or with their mandatory NCC progress reports must notify its HRSA PO of its intention to request a waiver. The PO will initiate a Request for Information in the EHB. The recipient must respond to the EHB task consistent with the deadlines for submitting waiver requests outlined above.

Waiver Review and Notification Process

HRSA will review requests and notify recipients of waiver approval or denial within 4 weeks of receipt of the request.

Approved core medical services waivers will be effective for the 1-year budget period for which it is approved; recipients must submit a new request for each budget period. A recipient

approved for a core medical services waiver is not required to implement the waiver if it is no longer needed.

Diana Espinosa,

Acting Administrator.

[FR Doc. 2021–08016 Filed 4–19–21; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended, notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: Center for Scientific Review Special Emphasis Panel; Special Topics: Vision Imaging, Bioengineering and Low Vision Technology Development.

Date: May 20–21, 2021.

Time: 8:00 a.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Susan Gillmor, Ph.D., Scientific Review Officer, National Institutes of Health, Center for Scientific Review, 6701 Rockledge Drive, Bethesda, MD 20892, 240–762–3076, *susan.gillmor@nih.gov.*

Name of Committee: Healthcare Delivery and Methodologies Integrated Review Group; Community Influences on Health Behavior Study Section.

Date: June 2–3, 2021.

Time: 10:00 a.m. to 7:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Tasmeen Weik, DRPH, MPH, Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 3141, Bethesda, MD 20892, 301–827–6480, *weikts@mail.nih.gov.*

Name of Committee: Infectious Diseases and Immunology A Integrated Review Group; Virology—B Study Section.

Date: June 9–10, 2021.

Time: 9:30 a.m. to 7:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Neerja Kaushik-Basu, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 3198, MSC 7808, Bethesda, MD 20892, (301) 435–1742, *kaushikbasun@csr.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Member Conflict: Bioengineering Science and Technology.

Date: June 21, 2021.

Time: 8:30 a.m. to 5:30 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Nitsa Rosenzweig, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4152, MSC 7760, Bethesda, MD 20892, (301) 404–7419, *rosenzweign@csr.nih.gov.*

Name of Committee: Digestive, Kidney and Urological Systems Integrated Review Group; Digestive System Host Defense, Microbial Interactions and Immune and Inflammatory Disease Study Section.

Date: June 24–25, 2021.

Time: 9:00 a.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Aiping Zhao, MD, Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 2188, Bethesda, MD 20892–7818, (301) 435–0682, *zhaoa2@csr.nih.gov.*

Name of Committee: Infectious Diseases and Immunology A Integrated Review Group; Cellular and Molecular Immunology—B Study Section.

Date: June 24–25, 2021.

Time: 9:00 a.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Liying Guo, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4198, MSC 7812, Bethesda, MD 20892, (301) 827–7728, *lguo@mail.nih.gov.*

Name of Committee: Infectious Diseases and Immunology A Integrated Review Group; Virology—A Study Section.

Date: June 24–25, 2021.

Time: 9:30 a.m. to 7:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Kenneth M. Izumi, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 3204, MSC 7808, Bethesda, MD 20892, 301–496–6980, *izumikm@csr.nih.gov.*

Name of Committee: Infectious Diseases and Immunology B Integrated Review Group; Host Interactions with Bacterial Pathogens Study Section.

Date: June 24–25, 2021.

Time: 9:45 a.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Fouad A. El-Zaatari, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 3186, MSC 7808, Bethesda, MD 20892, (301) 435–1149, *elzaataf@csr.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Biomedical Data Repositories and Knowledgebases.

Date: June 24, 2021.

Time: 10:00 a.m. to 7:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Joseph Thomas Peterson, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4118, MSC 7814, Bethesda, MD 20892, 301–408–9694, *petersonjt@csr.nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.306, Comparative Medicine; 93.333, Clinical Research, 93.306, 93.333, 93.337, 93.393–93.396, 93.837–93.844, 93.846–93.878, 93.892, 93.893, National Institutes of Health, HHS)

Dated: April 15, 2021.

Melanie J. Pantoja,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2021–08083 Filed 4–19–21; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

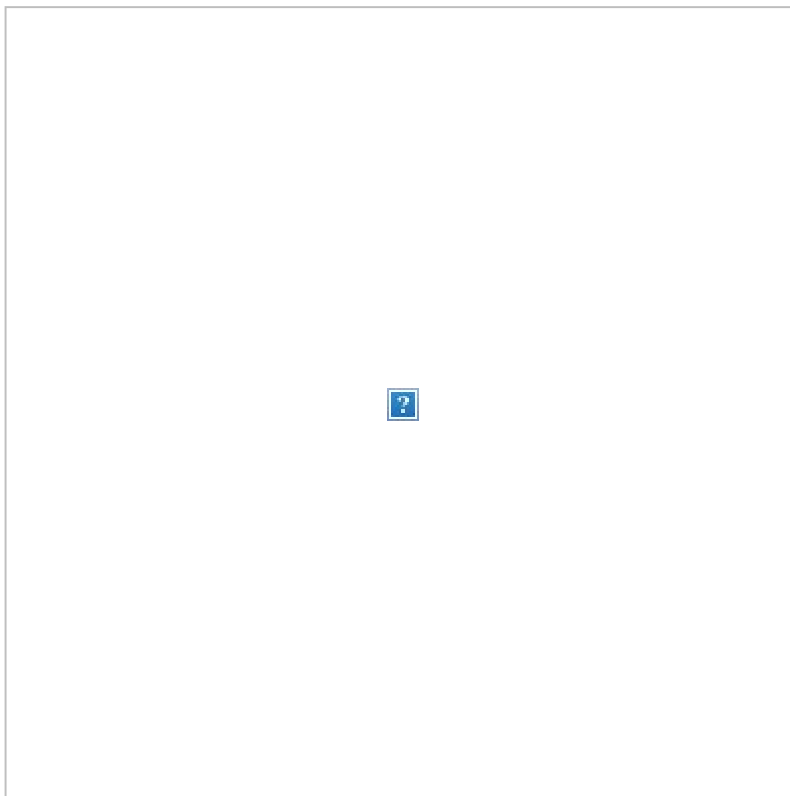
National Institutes of Health

Center for Scientific Review; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended, notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant

From:	Positive Women"s Network - USA
To:	Barrit, Cheryl
Subject:	Thanks for submitting a comment!
Date:	Friday, June 4, 2021 6:05:49 PM



Cheryl,

Thanks for submitting a comment in support of the proposed 75/25 Ryan White waiver!

Now, can you spread the word to keep up our momentum?

Click here to share this letter campaign on Facebook.

Click here to share this letter campaign on Twitter.

Or you can send your friends this link: https://www.pwn-usa.org/action-alert/?source=direct_link&

Or copy and paste the email below.

Thanks!

Positive Women's Network - USA

Copy and paste this email to friends to spread the word:

Subject: Send a letter: Show Your Support for the Ryan White 75/25 Waiver!

Body:

Friend,

I submitted a comment to HRSA in support of the Ryan White 75/25 waiver to make it faster to approve wraparound services for people living with HIV.

What is the 75/25 Waiver?
The Ryan White HIV/AIDS Program requires Part A, Part B, and Part C grant recipients to allocate and spend at least 75% of service funds on core medical services.

Core medical services are AIDS Drug Assistance Program (ADAP), 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; and substance abuse outpatient care.

Recipients are only permitted to spend 25% of their grant money on support services linked to medical outcomes. These support services can include child care while attending medical appointments, medical transportation, language services, referrals for health care and other support services, non-medical case management (like assisting with housing or legal issues), and substance abuse residential services.

Grant recipients can request a waiver so they do not have to adhere to this 75% spending requirement if:

The recipient is funded by Ryan White HIV/AIDS Program Parts A, B, or C;

There is no current or anticipated ADAP waiting list;

Core medical services are available to all eligible individuals in the applicant’s state, jurisdiction, or service area; and

There is evidence of a public process (meaning community input)

Grant recipients have to file a large amount of paperwork and documentation to ensure these requirements for the waiver are complied with. However, a lot of this information is duplicative, because recipients already provide sufficient information as part of their grant application.

This rule change would simply the process for Ryan White Part A, B, and C recipients to request a waiver of the core medical services expenditure amount requirement by replacing the current waiver forms with a one-page form to reduce the duplicative information.

This would not change the requirements of the process but would reduce the substantial amount of time it takes to request a waiver and have the government review and process that request. It means communities that meet the requirements will be able to start providing supportive services more quickly than in the past.

Can you join me and write a letter? Click here: https://actionnetwork.org/letters/show-your-support-for-the-ryan-white-7525-waiver?source=email&

Thanks!

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information collection, unless the OMB approves it and displays a currently valid OMB Control Number. In addition, notwithstanding any other provisions of law, no person shall generally be subject to penalty for failing to comply with a collection of information that does not display a valid OMB Control Number. *See* 5 CFR 1320.5(a) and 1320.6.

DOL seeks PRA authorization for this information collection for three (3) years. OMB authorization for an ICR cannot be for more than three (3) years without renewal. The DOL notes that information collection requirements submitted to the OMB for existing ICRs receive a month-to-month extension while they undergo review.

Agency: DOL–ETA.

Title of Collection: DOL-Only Performance Accountability, Information, and Reporting System.

OMB Control Number: 1205–0521.

Affected Public: Individuals or Households; State, Local, and Tribal Governments; Private Sector—Businesses or other for-profits and not-for-profit institutions.

Total Estimated Number of Respondents: 17,583,750.

Total Estimated Number of Responses: 41,064,037.

Total Estimated Annual Time Burden: 10,459,627 hours.

Total Estimated Annual Other Costs Burden: $9,491,287.

Authority: 44 U.S.C. 3507(a)(1)(D).

Dated: April 28, 2021.

Mara Blumenthal,

Senior PRA Analyst.

[FR Doc. 2021–09471 Filed 5–4–21; 8:45 am]

BILLING CODE 4510–FM–P

OFFICE OF MANAGEMENT AND BUDGET

Methods and Leading Practices for Advancing Equity and Support for Underserved Communities Through Government

AGENCY: Office of Management and Budget, Executive Office of the President.

ACTION: Request for Information (RFI).

SUMMARY: Recent Executive Orders have charged the Office of Management and Budget (OMB), in partnership with the heads of agencies, to identify, by July 2021, effective methods for assessing whether agency policies and actions (*e.g.,* programs, services, processes, and operations) equitably serve all eligible individuals and communities, particularly those that are currently and historically underserved. As part of this effort, agencies are directed to consult with members of communities that have been historically underrepresented in the Federal Government and underserved by, or subject to discrimination in, Federal policies and programs, and to evaluate opportunities, as allowable, to increase coordination, communication, and engagement with community-based and civil rights organizations. Through this request for information (RFI), OMB seeks input, information, and recommendations from a broad array of stakeholders in the public, private, advocacy, not-for-profit, and philanthropic sectors, including State, local, Tribal, and territorial areas, on available methods, approaches, and tools that could assist in this effort. OMB will consider the usability, applicability, and rigor of submissions in response to this RFI as OMB gathers resources to support agencies as they conduct internal assessments on the state of equity in their policies, programs, services, processes, and operations. OMB will also use what it learns from responses to this RFI as OMB works to expand use of equity-assessment methods and approaches across the Federal Government, as agencies develop agency Equity Action Plans (due to the Domestic Policy Council by January 19, 2022) outlining steps they will take to address identified gaps in equity.

DATES: Responses to this RFI should be received by July 6, 2021.

ADDRESSES: You should submit comments via the Federal eRulemaking Portal at *https://www.regulations.gov/.* Follow the instructions for submitting comments. All public comments received are subject to the Freedom of Information Act and will be posted in their entirety at *https://www.regulations.gov/*, including any personal and/or business confidential information provided. Do not include any information you would not like to be made publicly available.

Written responses should not exceed 20 pages, inclusive of a 1-page cover page as described below. Attachments or linked resources or documents are not included in the 20-page limit. Please respond concisely, in plain language, and in narrative format. You may respond to some or all of the questions listed in the RFI. Please ensure it is clear which question you are responding to. You may also include links to online material or interactive presentations but please ensure all links are publicly available. Each response should include:

- The name of the individual(s) and/or organization responding.
- The Area section(s) (1, 2, 3, 4 and/or 5) that your submission and materials support.
- A brief description of the responding individual(s) or organization's mission and/or areas of expertise, including any public-private partnerships with Federal, State, tribal, territorial, or local governments within the past three years that are relevant to this RFI.
- A contact for questions or other follow-up on your response.

By responding to the RFI, each participant (individual, team, or legal entity) warrants that they are the sole author or owner of, or has the right to use, any copyrightable works that the Submission comprises, that the works are wholly original (or is an improved version of an existing work that the participant has sufficient rights to use and improve), and that the Submission does not infringe any copyright or any other rights of any third party of which participant is aware.

By responding to the RFI, each participant (individual, team, or legal entity) consents to the contents of their submission being made available to all Federal agencies and their employees on an internal-to-government website accessible only to agency staffpersons.

Participants will not be required to transfer their intellectual property rights to OMB, but Participants must grant to the Federal government a nonexclusive license to apply, share, and use the materials that are included in the Submission. To participate in the RFI, each participant must warrant that there are no legal obstacles to providing the above-referenced nonexclusive licenses of participant rights to the Federal government.

Interested parties who respond to this RFI may be contacted for a follow-on strategic agency assessment dialogue, discussion, event, crowdsource campaign, or competition.

FOR FURTHER INFORMATION CONTACT: Issues regarding submission or questions on this RFI can be sent to Amira Boland at 202–395–5222 or to *equityRFI@omb.eop.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

E.O. 13985 states: ''*Equal opportunity is the bedrock of American democracy, and our diversity is one of our country's greatest strengths. But for too many, the American Dream remains out of reach. Entrenched disparities in our laws and public policies, and in our public and private institutions, have often denied that equal opportunity to individuals and communities. Our country faces*

converging economic, health, and climate crises that have exposed and exacerbated inequities, while a historic movement for justice has highlighted the unbearable human costs of systemic racism. Our Nation deserves an ambitious whole-of-government equity agenda that matches the scale of the opportunities and challenges that we face.

It is therefore the policy of my Administration that the Federal Government should pursue a comprehensive approach to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Affirmatively advancing equity, civil rights, racial justice, and equal opportunity is the responsibility of the whole of our Government. Because advancing equity requires a systematic approach to embedding fairness in decision-making processes, executive departments and agencies (agencies) must recognize and work to redress inequities in their policies and programs that serve as barriers to equal opportunity.''

Within 200 days of the date of the E.O. (by August 8, 2021), agencies must submit to the Assistant to the President for Domestic Policy an assessment of the state of equity for underserved communities and individuals, including on the following points, for example:

• Barriers that underserved communities and individuals may face to enrollment in and access to benefits and services in Federal programs;

• Barriers that underserved communities and individuals may face in participation in agency procurement and contracting opportunities;

• Barriers that underserved communities and individuals may face in participation in agency grant programs and other forms of financial assistance;

• Opportunities in current agency policies, regulations, and guidance to address affirmatively and equitably the underlying causes of systemic inequities in society;

• Opportunities in agency community engagement processes to engage with and empower marginalized, vulnerable, or underserved communities more directly to advance equitable policymaking; and

• The operational status and level of institutional resources available to agency offices or divisions responsible for advancing civil rights or required to serve underrepresented or disadvantaged communities.

Within one year of the date of E.O. 13985 (by January 19, 2022), the head of each agency will develop a plan for addressing any barriers to full and equal participation in programs and procurement opportunities identified in its assessment. Such a plan could include establishing ongoing routines to assess and rectify gaps in full and equal participation in programs and procurement opportunities.

E.O. 13985 uses the following definitions, which OMB adopts for purposes of this RFI.

The term ''equity'' means the consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as women and girls; Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; persons facing discrimination or barriers on account of gender identity; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.

The term ''underserved communities'' refers to populations sharing a particular characteristic, as well as geographic communities, that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life, as exemplified by the list in the preceding definition of ''equity.''

Information and Key Questions

OMB seeks input in the following areas:

1. Equity Assessments and Strategies. Approaches and methods for holistic and program- or policy-specific assessments of equity for public sector entities, including but not limited to the development of public policy strategies that advance equity and the use of data to inform equitable public policy strategies.

2. Barrier and Burden Reduction. Approaches and methods for assessing and remedying barriers, burden, and inequities in public service delivery and access.

3. Procurement and Contracting. Approaches and methods for assessing equity in agency procurement and contracting processes.

4. Financial Assistance. Approaches and methods for assessing equity in the administration of agency grant programs and other forms of financial assistance.

5. Stakeholder and Community Engagement. Approaches and methods for accessible and meaningful agency engagement with underserved communities.

The descriptions below represent a non-exhaustive accounting of issues that may fall under each topic area. These may assist in the formulation of comments. The list is not intended to restrict submissions. For all prompts, OMB requests that commenters incorporate examples, data, and, in particular, research or academic literature whenever possible.

For Area 1 on equity assessments and strategies:

The work of advancing equity requires a holistic assessment of agency practices and policies. Some Federal agencies will need to implement new approaches to assess whether future proposed policies, budgets, regulations, grants, or programs will be effective in advancing equity. OMB welcomes submissions that provide resources, tools, and examples of how agencies might conduct effective equity assessments, with the goal of embedding equity throughout agency practices and policies. Submissions might consider questions such as:

• What are some promising methods and strategies for assessing equity in internal agency practices and policies? What knowledge, skills, or supports do practitioners need to use such tools effectively?

• What are some promising methods and strategies for identifying systemic inequities to be addressed by agency policy?

• Jurisdictions at the State, local, Tribal, and territorial level have implemented equity assessment tools to inform their policymaking, budgetary, or regulatory processes. What are the lessons these jurisdictions have learned from implementing or interacting with those tools?

• What are some promising methods and strategies for advancing equity on urgent or immediate agency priorities?

• What types of equity assessment tools are especially useful for agencies with national security, foreign policy or law enforcement missions?

• How might agencies collect data and build evidence in appropriate and protected ways to reflect underserved individuals and communities and support greater attention to equity in future policymaking?

• How might agencies build capacity and provide training and support for teams conducting this work?

• How can community engagement or feedback from underserved individuals with lived expertise on a given policy problem be integrated meaningfully in an agency's use of equity assessment methods?

For Area 2 on barrier and burden reduction:

Members of underserved communities may experience a variety of external factors that may disproportionately affect their access to information about programs or program eligibility, applying for benefits, conducting post-award reporting, and recertification of eligibility. These barriers may include, but are not limited to: Non-traditional or inflexible work hours, childcare needs, housing insecurity, limited transportation access, limited proficiency in English, disability, low literacy, income or other resource constraints, stigma in accessing public programs, and limited access to technology.

Other barriers are internal to the administration of programs. While certain program rules may ensure that benefits are awarded to eligible individuals or are otherwise required by law, others are not necessary for ensuring benefits are awarded to eligible individuals and may be remedied via administrative or regulatory changes. The latter category of program rules may include: Unnecessary questions or requirements to produce documentation; complex eligibility formulas; forms or web applications that are confusingly designed; complicated instructions; long delays between application and adjudication; the need for third-party (*e.g.,* advocacy organization, legal counsel) support or consultation; frequent recertification of eligibility; processes that require multiple forms or touch-points; and duplicative or similar information collections by multiple agencies.

Responses should include, but not be limited to, information on any or all of the following points:

- How can agencies address known burdens or barriers to accessing benefits programs in their assessments of benefits delivery?
- What data, tools, or evidence are available to show how particular underserved communities or populations disproportionately encounter these barriers? Which underserved communities experience multiple, cumulative barriers and are disproportionately burdened by specific administrative processes or requirements?
- Are there specific requirements or processes (*e.g.,* in-person visits, frequency of recertification of eligibility) that have been shown in rigorous research to cause program drop-off or churn by underserved individuals and communities? Similarly, is there rigorous evidence available that certain requirements or processes have little actual effect on program integrity?
- How could agencies incorporate considerations of the psychological costs of qualifying or applying for Federal benefits programs into their assessments of equitable service delivery?
- What kinds of equity assessment tools are more useful for addressing urgent agency priorities versus making systemic change?
- What types of overarching metrics (*e.g.,* program uptake, over- or under-payments) might an agency use to measure a benefit program's outcomes [or whether it is implemented as intended?]?
- How might an agency assess or balance prioritization of potentially competing values associated with program administration, such as program uptake, program integrity, privacy protection, and resource constraints, in the context of addressing equity for underserved individuals and communities?
- How might agencies assess if specific barriers (*e.g.,* specific questions on forms or requirements such as in-person interviews) are achieving their intended purpose?
- How might agencies incorporate into their equity assessments barriers or duplicative burdens a participant is likely to experience when seeking services from multiple agencies?
- How can agencies best balance collecting demographic information about program applicants and participants with the potential effect on program participation that these questions may cause? What does rigorous research show about the effect of demographic questions on program participation?

For Area 3, on procurement and contracting:

The Federal Government is the world's largest purchaser of goods and services, with acquisitions totaling over $650 billion per year. As the Federal Government's purchasing power is used to fight COVID–19, increase domestic productivity, combat climate change, and address other Administration priorities, agencies will need to assess opportunities to invest in underserved individuals and communities by promoting business diversity (including, but not limited to, professional services, financial services, and technology) and resiliency. Agencies will need to assess opportunities to direct more procurement and contracting dollars to underserved individuals and communities so that a broad cross-section of American businesses can share in the jobs and opportunities created by Federal buying activities. Economic research shows that investing in underserved communities and closing racial wealth gaps yields economic growth and job creation that benefits all Americans.

OMB welcomes submissions that address questions such as:

- How do we achieve equity in a procurement system that must balance competing economic and social goals, including the need to conduct procurements in a streamlined and rapid manner?
- What kinds of equity assessment tools might agencies use to identify inequity in their standard practices throughout the acquisition lifecycle, including, but not limited to, the development of requirements, market research (including outreach to businesses), selection of contract type, availability of financing, incentive structure, negotiation and evaluation of interested sources, debriefings of unsuccessful offerors, management of contracts, evaluation of contractor performance, and use of past performance in selection of sources?
- What kinds of tools might agencies use to determine when there is inequity in the award of subcontracts under prime contracts and the cause of such?
- How might agencies identify opportunities to engage with business owners and entrepreneurs who are members of underserved communities to promote doing business with the Federal Government? What kinds of training and capacity building within agency teams would support equitable procurement and contracting efforts?
- What kinds of benchmarks and assessment techniques might support equitable procurement and contracting efforts?
- What kinds of data should agencies collect and use to assess equity in their procurement practices?

For Area 4, financial assistance:

Federal agencies run financial assistance programs, including grant opportunities, that have the potential, and in many cases, a stated intent, to channel resources to underserved communities. OMB welcomes submissions that address questions such as:

- How might agencies identify opportunities to adjust current practices in grants and other financial assistance programs to expand access for underserved communities and to achieve equity-oriented results? What are some promising approaches to the award and administration of Federal awards (including, for example, the integration of program planning and design) that should be considered?

• What are promising practices for equitable grantmaking and the administration of financial assistance programs that agencies should consider in the course of their equity assessments?

• How might agencies engage in outreach and stakeholder engagement to identify opportunities to make Federal grants and other financial assistance processes more accessible?

• What kinds of training and capacity building within agencies would support equitable grantmaking and financial assistance efforts?

• What kinds of benchmarks and assessment techniques would support equitable grantmaking and financial assistance efforts?

• What kinds of data should agencies collect and use to assess equity in their grantmaking and financial assistance practices?

For Area 5, on stakeholder and community engagement:

Section 8 of E.O. 13985 instructs agencies to expand their use of stakeholder and community engagement in carrying out the Order. OMB seeks specific approaches to stakeholder and community engagement with underserved communities that others have successfully used and that Federal agencies could adapt or apply.

Accordingly, OMB welcomes submissions that address questions such as:

• What processes should agencies have in place to engage proactively with the underserved individuals and communities that will be most affected by agency programs, policies, rules, processes, or operations? How can agencies design and implement community engagement practices that are accessible to underserved communities? How might affected communities be engaged pro-actively and early to shape agency policy priorities and strategies?

• What tools and best practices might agencies deploy to establish advisory boards, task forces, and commissions that are inclusive of underserved communities?

• How can an agency assess the accessibility of the agency's rulemaking and policymaking commenting and engagement processes, including for individuals that experience barriers to participation? Examples of barriers may include limited language access assistance, online-only engagement, and minimal proactive notification of opportunities to provide comment.

• Do feedback mechanisms for customers, beneficiaries, and communities affected by Government programs exist to inform policy research and evaluation processes? If so, are these feedback mechanisms accessible to underserved communities? If not, what are best practices that agencies should consider?

• What tools could agencies develop for expanding stakeholder input into programmatic and regulatory changes to minimize barriers and burden? How may existing processes (*e.g.,* notice and comment on information collections) be enhanced to improve accessibility by stakeholders?

• What tools can agency offices, including communications, civic engagement, enforcement, and policymaking offices, use to better engage or reach underserved communities?

• What are some of the barriers or factors that challenge underserved communities' interactions with Federal agencies and programs?

• What practices should agencies put in place to reach underserved communities in rural areas or underserved communities that otherwise are not able to visit Washington, DC, to engage with policymakers?

Shalanda Young,

Acting Director, Office of Management and Budget.

[FR Doc. 2021–09109 Filed 5–4–21; 8:45 am]

BILLING CODE 3110–01–P

NATIONAL FOUNDATION ON THE ARTS AND THE HUMANITIES

30-Day Notice for the "NEA Panelist Profile Data"

AGENCY: National Endowment for the Arts.

ACTION: Notice of proposed collection; comment request.

SUMMARY: The National Endowment for the Arts (NEA), as part of its continuing effort to reduce paperwork and respondent burden, conducts a preclearance consultation program to provide the general public and Federal agencies with an opportunity to comment on proposed and/or continuing collections of information in accordance with the Paperwork Reduction Act of 1995. This program helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed. Currently, the NEA is soliciting comments concerning the proposed information collection for the NEA Panelist Profile Data. Copies of this ICR, with applicable supporting documentation, may be obtained by visiting *www.Reginfo.gov.*

DATES: Interested persons are invited to submit comments within 30 days from the date of this publication in the **Federal Register**.

ADDRESSES: Comments should be sent to the Office of Information and Regulatory Affairs, Attn: OMB Desk Officer for the National Endowment for the Arts, Office of Management and Budget, Room 10235, Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: The Office of Information and Regulatory Affairs, Attn: OMB Desk Officer for the National Endowment for the Arts, Office of Management and Budget, Room 10235, Washington, DC 20503, (T) 202–395–7316.

SUPPLEMENTARY INFORMATION: The Office of Management and Budget (OMB) is particularly interested in comments which: (1) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (2) Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information including the validity of the methodology and assumptions used; (3) Enhance the quality, utility, and clarity of the information to be collected; and (4) Could help minimize the burden of the collection of information on those who are to respond, including through the use of electronic submission of responses through *Grants.gov.*

Agency: National Endowment for the Arts.

Title: NEA Panelist Profile Data Collection.

OMB Number: 3135–0098.

Frequency: Annually.

Affected Public: Individuals.

Estimated Number of Respondents: 600.

Total burden hours: 100 hours.

Total annualized capital/startup costs: 0.

Total annual costs (operating/maintaining systems or purchasing services): 0.

The NEA's mission is "to strengthen the creative capacity of our communities by providing all Americans with diverse opportunities for arts participation." With the advice of the National Council on the Arts and advisory panels, the Chairman establishes eligibility requirements and criteria for the review of applications for funding. Section 959(c) of the NEA's enabling legislation, as amended, directs

the OA Voice
Issue: June 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.

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- Strategy N

Office Highlight:

June 5th is the **40th Anniversary** of the national public health surveillance system identification of five cases of rare illnesses among gay men, initiating awareness of what became the HIV/AIDS pandemic. Forty years later there are still new HIV infections, and more than 1.2 million people in the United States, including 137,785 in California, are living with HIV. Nationally, one out of seven have HIV infection but are unaware—testing is still vital. HIV medication suppresses the virus to undetectable levels, and those who are undetectable cannot transmit the virus to others. Virally suppression maintains optimal health but only 56 percent of people living with HIV (PLWH) in the United States are currently virally suppressed—access to ongoing health care and medication is still vital. Gay men and men who have sexual contact with men have always led the U.S. epidemic, and currently young gay men 13 to 24 years of age are infected more than any other group—removing stigma and homophobia is still vital. The transformation from a largely fatal disease to a chronic infection that can be managed by medication was due to the scientists and researchers, healthcare professionals, and most importantly by those living with and who died from HIV and AIDS, together they achieved the ability to sustain health and thrive with HIV.

June 5th is also recognized as **HIV Long-term Survivors Day**, with admiration of those who have been living with HIV for decades, many from before HIV medications achieved the effectiveness and simplicity compared to the days of severe side-effects and challenging medication regimes requiring many medications taken throughout the day and night. They not only survived the virus, but the discrimination, loss of family and friends due to fear and ignorance, and the grief of losing their lovers and peers. HIV Long-term Survivors also include those who remained HIV negative throughout the epidemic but were present with those living with HIV, fighting for healthcare provided with dignity and respect.

Ways you can recognize the 40th anniversary and HIV Long-Term Survivors day includes taking an HIV test if you never had or if it has been awhile since your last test. Talk with long-term survivors and listen to their stories. Help people you know who are living with HIV but are not virally suppressed to stay in HIV medical care, encourage them to take HIV medications as prescribed, and celebrate when they achieve viral suppression, are undetectable AND untransmittable. Remind people, especially the young gay men who are currently being infected at the greatest rate, that HIV is preventable, especially by using Pre-Exposure Prophylaxis (PrEP), medication that prevents HIV infection. At the 50th anniversary, may we add to these achievements: no new HIV infections. It's viable, if we all work together.

HIV Awareness:

OA is recognizing and celebrating **Pride Month**. Gay pride or LGBTQ+ pride commemorates the LGBTQ+ movement against discrimination and violence toward lesbian, gay, bisexual, transgender and queer (LGBTQ+) people, remembering the beginning of the movement with the Stonewall Riots in 1969. Various events are held during this month to promote self-affirmation, dignity, equal rights, and the increased visibility as a social group. Pride builds community and celebrates sexual and gender diversity. Pride counters the shame and social stigma still present throughout the world, and Pride celebrations strengthens the LGBTQ+ rights movements globally.

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.

Collaborating with syringe services programs (SSPs) for vaccine distribution is one way to increase access to COVID-19 vaccines among people who use drugs and others underserved by traditional healthcare systems. The National Association released *COVID-19 Vaccine: Guidance for Syringe Services Programs, Health Departments, and People Who Use Drugs*. This resource provides strategies and considerations for potential collaboration between SSPs and health departments in COVID-19 vaccine distribution and can be found at https://www.nastad.org/resource/covid-19-vaccine-guidance-syringe-services-programs-health-departments-and-people-who-use-0.

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 OA Racial and Health Equity workgroup gathered in May to review progress of annual goals and deliverables. A review of microagressions was discussed including strategies to address and eliminate microagressive language.

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 (EtHE) 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 **Alameda County**. All six county plans have been described over the last months, starting in

February. Several of the interventions will impact multiple Integrated Plan strategies.

The California Consortium Ending the HIV Epidemic Plan will be accessible on the Office of AIDS website once the ADA adaptation has been complete. If you want a non-ADA accessible version sent to you, please request that from ETE@cdph.ca.gov. Four-page summaries of each county plan are now accessible on the OA website at https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_div_EtE.aspx.

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

Alameda County's plan for Ending the HIV Epidemic includes initiating Same-Day PrEP, which appreciates the longer time and more referrals between deciding one wants PrEP and actually having the medication, the more likely people will give up and not get the medication. Same-Day PrEP will be focused to Black/African American and Latinx Gay and other men who have sex with men (MSM), young gay/MSM of color, the transgender community, sexual and drug using partners of people living with HIV, and women at high risk of HIV exposure.

In addition, Alameda County is enhancing its use of surveillance data to reach newly identified people living with HIV to link to HIV care and medication, as well as to reach Gay/ MSM diagnosed with syphilis or STDs to link to PrEP. The enhanced surveillance work will also support expansion of partner services (Strategy C, Improved Linkage to Care (Strategy D), and Improved Retention in Care (Strategy E).

PrEP-Assistance Program (AP):

As of June 1, 2021, there are 192 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 table below and at the top of page four.

Strategy B: Increase and Improve HIV Testing

The Ending the HIV Epidemic five-year plan in Alameda will increase HIV testing through self-collection HIV and STD screening, additional focused testing for gay/MSM, especially men of color, and expanding routine opt-out testing to additional clinical settings.

Two agencies, AIDS Healthcare Foundation and Sutter East Bay Hospitals (East Bay AIDS Center), were granted funding to increase focused testing among Black/African American and Latinx Gay/MSM, including emphasis

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	272	6%	---	---	---	---	93	2%	365	8%
25 - 34	1,290	29%	---	---	1	0%	627	14%	1,918	42%
35 - 44	945	21%	---	---	4	0%	335	7%	1,284	28%
45 - 64	536	12%	1	0%	23	1%	213	5%	773	17%
65+	26	1%	---	---	136	3%	11	0%	173	4%
TOTAL	3,069	68%	1	0%	164	4%	1,279	28%	4,513	100%

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

Current Age	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	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
18 - 24	172	4%	104	2%	33	1%	34	1%	---	---	3	0%	4	0%	15	0%	365	8%
25 - 34	942	21%	537	12%	126	3%	202	4%	6	0%	4	0%	19	0%	82	2%	1,918	42%
35 - 44	787	17%	285	6%	69	2%	84	2%	2	0%	1	0%	6	0%	50	1%	1,284	28%
45 - 64	461	10%	226	5%	28	1%	39	1%	2	0%	2	0%	2	0%	13	0%	773	17%
65+	35	1%	132	3%	2	0%	3	0%	---	---	---	---	1	0%	---	---	173	4%
TOTAL	**2,397**	**53%**	**1,284**	**28%**	**258**	**6%**	**362**	**8%**	**10**	**0%**	**10**	**0%**	**32**	**1%**	**160**	**4%**	**4,513**	**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: 5/31/2021 at 12:00:41 AM Data source: ADAP Enrollment System. Site assignments are based on the site that submitted the most recent application.

on young gay/MSM. In addition, Bay Area Community Health was awarded funding to conduct routine opt-out testing with the transgender community. An innovative approach is including job readiness assistance to the transgender community as an incentive to knowing their HIV status.

OA's 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 8 months, between September 1, 2020 and April 30, 2021, 1390 tests were distributed, including 142 tests distributed in April. Of those ordering a test in April, 46.5% reported never before receiving an HIV test, 68.3% were 18 to 29 years of age. Of those reporting ethnicity, 42.5% were Hispanic/Latinx, and 57.0% of those reporting sexual history indicated 3 or more partners in the past 12 months. To date, 205 recipients have filled out an anonymous follow up survey, with 93.7% indicating that they would recommend TakeMeHome HIV test kits to a friend.

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

Alameda County will increase STI screening through the BHOC free HIV and STI screening program. Individuals can go on-line and order self-collection kits that will include HIV testing, testing for oral and anal chlamydia, gonorrhea and syphilis, as well as creatinine if using PrEP, Hepatitis C screening if indicated, and pregnancy testing to ensure women who are pregnant get treatment if infected with syphilis to avoid transmission to the baby.

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

ADAP's Insurance Assistance Programs:

As of June 1, 2021, the number of ADAP clients enrolled in each respective ADAP Insurance Program are shown in the chart found at the top page five.

ADAP Insurance Assistance Program	Number of Clients Enrolled	Percentage Change from April
Employer Based Health Insurance Premium Payment (EB-HIPP) Program	593	-2.30%
Office of AIDS Health Insurance Premium Payment (OA-HIPP) Program	6,658	+0.25%
Medicare Part D Premium Payment (MDPP) Program	2,051	+0.58%
Total	**9,302**	**+0.16%**

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

This month, CDC launched a new drug overdose website in Spanish. The new website, found at https://www.cdc.gov/drugoverdose/spanish/index.html?ACSTrackingID=USCDC_1026-DM58289&ACSTrackingLabel=May%20 2021%20Drug%20Overdose%20Updates%20 %28Revised%29&deliveryName=USCDC_1026-DM58289, includes fact sheets and informational materials to increase awareness of the overdose crisis and provide resources to prevent overdose and death. Please share this resource far and wide to increase access to much needed overdose education for Spanish-speaking communities.

Registration is open for the 10th Annual National Native Harm Reduction Summit, and can be found at https://web.cvent.com/event/2c21f3df-5e76-4805-a462-7cb06982d63a/summary?emci=68c8deee-75ba-eb11-a7ad-501ac57b8fa7&emdi=486da9ed-a4bc-eb11-a7ad-501ac57b8fa7&ceid=9301331. The virtual conference will highlight the intersection of racial equity, health equity, and social justice, as they relate to hepatitis C, HIV, and drug use in Tribal, urban Indian, and rural communities. Tribal and allied health care and behavioral health care providers, social services providers, community allies and public health officials are encouraged to attend. Please share widely with service providers working directly or indirectly with native communities.

The National Harm Reduction Coalition will host a free virtual harm reduction convening for people from Monterey, San Benito, San Luis Obispo and Santa Barbara counties. The multi-day sessions include a training on harm reduction basics and a facilitated discussion to identify strategies to reduce HIV, hepatitis C and overdose. The event is open to services providers and community members. Registration information can be found at https://secure.everyaction.com/e2j1GgbOp02gvbu-el_pgQ2.

Strategy N: Enhance Collaborations and Community Involvement

California Planning Group (CPG):

The California Planning Group (CPG) and OA hosted a four-day virtual CPG meeting on May 7, 10, 14, and 17. The first day was open to CPG members only, as we hosted our third CPG Leadership Academy, which focused on skills and capacity building for our CPG members. The meeting was comprised of four separate Zoom sessions (three hours each day, 1:00 – 4:00 pm). There was a 10-minute public-comment period on May 10, 14, and 17. The May 10 meeting featured a community presentation by Dr. Kristopher Lyon, MD titled “Routine Opt-Out

Testing in Kern County", and May 17 featured an OA presentation on "COVID-19 and HIV Update" by Dr. Phillip Peters, MD. CPG members elected two new Community Co-Chairs, Natalie Sanchez (1 year) and Robyn Learned (2 years)! OA extends our appreciation and thank you to outgoing co-chairs, Edd Cockrell, Evelyn Alvarez, and Jax Kelly, for your leadership, service, and passionate commitment and dedication to community and CPG, especially during this challenging time of COVID-19. Congratulations to newly elected HIV & Aging Committee Co-Chair Keith Sellons! Thank you to outgoing committee co-chair Michael Weiss for your leadership and commitment. The meeting was productive and engaging and OA would like to thank the members of the public who attended. Meeting recordings can be accessed on the OACPG webpage at https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_CPG.aspx.

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

Keck School of Medicine of USC

HIV Clinical Leadership Program in Los Angeles

An intensive fellowship training for primary care physicians committed to leadership and service through caring for people living with HIV in underserved communities

The two-year Fellowship is based at the Rand Schrader Clinic, LAC+USC Medical Center and is a partnership with the LAC Department of Health Services, the Los Angeles Area Pacific AIDS Education and Training Center (PAETC) based in the Family Medicine Department, Keck Medical School of USC, and ViiV Healthcare. The program is highly competitive with applicates from all over the United States. Each class has 2-3 participants.

Program Goals: The goal of the fellowship is to train primary care physicians who are:

1. committed to providing high quality HIV care and prevention to all patients disproportionately impacted and vulnerable communities,
2. skilled in understanding the importance of health services research that benefits patients and communities affected by HIV/AIDS, and
3. dedicated to being leaders in healthcare, medical education, and patient advocacy.

In 2016 DHS received a grant from ViiV Healthcare, an HIV Specialist company to establish a HIV fellowship program in Los Angeles and that year DHS and the PAETC partnered to offer a two-year fellowship. ViiV Healthcare is a global specialist HIV company established in November 2009 by GlaxoSmithKline and Pfizer dedicated to delivering advances in treatment and care for people living with HIV. The company's aim is to take a deeper and broader interest in HIV/AIDS than any company has done before and take a new approach to deliver effective and new HIV

The HIV Clinical Leadership Program is managed by the Los Angeles County Department of Health Services (DHS). The mission of DHS is to ensure access to high-quality, patient-centered, cost-effective health care for Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

The Pacific AIDS Education and Training Center at USC (PAETC) is housed in the Department of Family Medicine at the Keck School of Medicine at USC. In 2000, recognizing an increasing need for well-trained HIV providers, PAETC at USC developed one of the first HIV fellowships in the United States. This one-year fellowship accepted recent graduates from family and internal medicine residencies who had a passion for HIV medicine, primary care, and a desire to practice in underserved communities hardest hit by the HIV epidemic. This LAC+USC Medical Center based HIV clinical fellowship was unique in that it also included experiences in several community and academic settings. In 2010, the only HIV Corrections fellowship in the United States was established, in partnership with the LA County Sheriff's Department.

Former and current fellows

To date 28 physicians have successfully completed the program with 2 currently in training and 3 to start July 2021. The listing below shows characteristics of our former and current fellows.

Women	15
Men	15

Ethnicity:

White non-Hispanic	15
Asian	11
Hispanic	4
African-American	1
South Asian	1

Residency training (18 California, 12 other states)

Family Medicine	23
Internal Medicine	4
Med-Peds	3

Current practice locations of former fellows

California (Southern)	19
California (Northern)	3
Southeast	3
Southwest	2
Midwest	1

Current employment of former fellows

Federally Qualified Health Center (FQHC)	12
Medical School/Residency Programs	7
Corrections	4
Kaiser	3
Public Health	3
Private Practice	2
Doctors without Boarders	2

LOS ANGELES COUNTY
COMMISSION ON HIV

René Vega, MPH

Membership Application on File with the Commission Office

LOS ANGELES COUNTY
COMMISSION ON HIV

Damone Thomas

Membership Application on File with the Commission Office

LOS ANGELES COUNTY COMMISSION ON HIV
RYAN WHITE PY 31 (FY 2021) REVISED ALLOCATION -MOTION #5

	RW Service Allocation Descriptions	FY 2021 PY 31 Approved 09/10/2020		Revised Allocation PY 31 (FY 2021) (1)	
PY 31 Priority #	Service Category	Part A %	MAI %	Part A %	MAI %
2	Outpatient/Ambulatory Health Services (AOM)	26.38%	0.00%	27.21%	0.00%
NP	AIDS Drug Assistance Program (ADAP) Treatments	0.00%	0.00%	0.00%	0.00%
26	AIDS Pharmaceutical Assistance (local)	0.00%	0.00%	0.00%	0.00%
12	Oral Health	15.10%	0.00%	13.04%	0.00%
9	Early Intervention Services	0.00%	0.00%	0.59%	0.00%
21	Health Insurance Premium & Cost Sharing Assistance	0.00%	0.00%	0.00%	0.00%
19	Home Health Care	0.00%	0.00%	0.00%	0.00%
18	Home and Community Based Health Services	7.67%	0.00%	6.70%	0.00%
27	Hospice Services	0.00%	0.00%	0.00%	0.00%
7	Mental Health Services	0.75%	0.00%	0.60%	0.00%
23	Medical Nutritional Therapy	0.0%	0.00%	0.0%	0.00%
6	Medical Case Management (MCC)	34.69%	0.00%	29.83%	0.00%
18	Substance Abuse Services Outpatient	0.0%	0.00%	0.0%	0.00%
3	Case Management (Non-Medical) BSS/TCM	3.81%	9.25%	5.91%	10.53%
13	Child Care Services	0.00%	0.00%	1.00%	0.00%
4	Emergency Financial Assistance	0.00%	0.00%	0.00%	0.00%
11	Food Bank/Home-delivered Meals	7.95%	0.00%	5.94%	0.00%

LOS ANGELES COUNTY COMMISSION ON HIV
RYAN WHITE PY 31 (FY 2021) REVISED ALLOCATION -MOTION #5

		FY 2021 PY 31 Approved 09/10/2020		Revised Allocation PY 31 (FY 2021)	
PY 31 Priority #	**Service Category**	**Part A %**	**MAI %**	**Part A %**	**MAI %**
17	Health Education/Risk Reduction	0.00%	0.00%	0.00%	0.00%
1	Housing Services RCFCI/TRCF/Rental Subsidies with CM	1.15%	90.75%	1.56%	89.47%
14	Legal Services	0.25%	0.00%	0.16%	0.00%
22	Linguistic Services	0.00%	0.00%	0.00%	0.00%
8	Medical Transportation	2.25%	0.00%	1.89%	0.00%
10	Outreach Services (LRP)	0.00%	0.00%	5.56%	0.00%
5	Psychosocial Support Services	0.00%	0.00%	0.00%	0.00%
20	Referral	0.00%	0.00%	0.00%	0.00%
24	Rehabilitation	0.00%	0.00%	0.00%	0.00%
25	Respite Care	0.00%	0.00%	0.00%	0.00%
16	Substance Abuse Residential	0.00%	0.00%	0.00%	0.00%
	Overall Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Footnote:

1 - Recommended revision approved by the Planning, Priorities and Allocations Committee on 5/18/2021.

LOS ANGELES COUNTY

COMMISSION ON HIV

CHILDCARE

STANDARDS OF CARE

FINAL—UPDATED 12/14/20

APPROVED BY SBP 5/4/21

FOR EXECUTIVE COMMITTEE APPROVAL ~~5/27/21~~ ~~6-24-21~~

CHILDCARE SERVICES
STANDARDS OF CARE

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

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

CHILDCARE SERVICES OVERVIEW: ALLOWABLE USE OF FUNDS

HRSA allows the use of Ryan White Part A funding for childcare services for the children of clients living with HIV, provided intermittently, **only while** the client attends in person, telehealth, or other appointments and/or Ryan White HIV/AIDS Program-related meetings, groups, or training sessions. Part A funded childcare services cannot be used while the patient is at school or work. Only Ryan White Part A community advisory board meetings and Part A funded support groups are covered in these standards. The goal of childcare services is to reduce barriers for clients in accessing, maintaining and adhering to primary health care and related support services. Childcare services are to be made available for all clients using Ryan White Part A medical and support services. "**Licensed**" means childcare providers who are

licensed by the State of California and are required to maintain minimum standards related to physical size of the facility, safety features, cleanliness, staff qualifications, and staff-to-child ratios.

Childcare services may include recreational and social activities for the child/children, if provided in a licensed childcare setting including drop-in centers in primary care or satellite facilities. However, funds may not be used for off-premise social/recreational activities or gym membership. Existing Federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services.

All service providers receiving funds to provide childcare services are required to adhere to the following standards.

Table 1. CHILDCARE SERVICE REQUIREMENTS

SERVICE COMPONENT	STANDARD	DOCUMENTATION
Eligibility and Need	Eligibility for Ryan White and need for childcare service are identified at intake and assessments by agencies providing licensed childcare.	Documentation of eligibility and in the client's primary record must reflect the appointment and/or meeting/group/training session attended.
Licensed Child Care Centers and Family Child Care Homes	Licensed childcare facilities must carry a valid active license as a childcare provider in the State of California. Services must be delivered according to California State and local childcare licensing requirements which can be found on the California Department of Social Services, Community Care Licensing Division website.[1]	a. Appropriate liability release forms are obtained that protect the client, provider, and the Ryan White program b. Providers must develop policies, procedures, and signed agreements with clients for childcare services. c. Documentation that no cash payments are being made to clients or primary care givers
Training	Agencies providing childcare are responsible for ensuring childcare providers are trained	Record of trainings on file at provider agency.

[1] https://cdss.ca.gov/inforesources/child-care-licensing

	appropriately for their responsibilities. In addition to State-required training for licensed childcare providers, childcare staff must complete the following training: • Domestic violence • HIPAA and confidentiality • Cultural diversity • HIV stigma reduction • LGBTQ 101 • Ryan White programs and service referral	
Language	Whenever possible, childcare should be delivered in the language most familiar to the child or language preferred by the patient. If this is not possible, interpretation services must be available in cases of emergency.	Appropriate language noted in client or program file.
Confidentiality	Agencies coordinating and providing childcare services must ensure client confidentiality will always be maintained. HIV status shall never be disclosed to anyone.	Written confidentiality and HIPAA policy in place. Documentation of notice of privacy and confidentiality practices provided to clients and/or family members before the start of service. Signed confidentiality policy and agreements for all employees on file and reviewed during new hire orientation and annually.
Service Promotion	Agencies coordinating licensed childcare services are expected to promote the availability of childcare to potential clients, external partners, and other DHSP-funded Ryan White service providers.	Program flyers, emails, or website documenting that childcare services was promoted to clients and HIV service providers.

Referrals	Programs coordinating childcare services will provide referrals and information about other available resources to adults living with HIV who have the primary responsibility for the care of children. Special consideration should be given to helping clients find longer term or additional childcare options and resources.[2] Whenever appropriate, program staff will provide linked referrals demonstrating that clients, once referred, have accessed services. Staff are required to coordinate across Ryan White funded and non-funded programs to ensure clients' needs are met.	Documentation of referral efforts will be maintained on file by coordinating agency. Description of staff efforts of coordinating across systems in client file (e.g. referrals to housing case management services, etc.).

[2] Los Angeles County Department of Public Health, Office for the Advancement of or Early Care and Education: https://childcare.lacounty.gov/resources-for-families-and-communities/

<table>
<tr><td></td><td>Follow up with client in 30 days to track referrals related to care coordination.</td><td>Documentation of follow up in client file.</td></tr>
<tr><td>Transportation</td><td colspan="2">Clients who demonstrate a need for transportation to and from the childcare site, must be provided transportation support. Agencies must follow transportation programmatic guidance and requirements from DHSP. Childcare must be provided in a manner that is more accessible and convenient for the client.</td></tr>
<tr><td>Physical Environment</td><td colspan="2">The design and layout of the physical environment have a profound impact on children's safety, learning, behavior and on the client’s ability to focus on their medical and support services appointments.

Childcare environments must have:

• Internet access and computers for children to use to complete schoolwork or participate in virtual classes if the parent/caregiver Ryan White appointment occurs during school hours
• Age-appropriate educational supplies
• Healthy food/snacks
• Masks and personal protective equipment (PPEs) especially designed for children
• A variety of inviting equipment and play materials accessible to children
• Kid-friendly and visually appealing space with sufficient and uncluttered space for active play with an additional cozy space set aside for individual and quiet play
• Kid-friendly videos available to watch
• Available 5 days a week</td></tr>
</table>

Appendix A: Examples of Childcare Resources

California Department of Social Services, Childcare Licensing
https://www.cdss.ca.gov/inforesources/child-care-licensing
The State of California requires licensed childcare providers to complete trainings in First Aid/CPR; fire and electrical safety; child development; waste disposal procedures; child abuse (includes sexual abuse); Health Insurance Portability and Accountability Act of 1996 (**HIPAA**) and confidentiality; infection control and preventative health measures; and the American Disabilities Act (ADA). Visit the website for additional information on childcare licensing rules and regulations.

Child Care Alliance Los Angeles offers voucher-based services for low income families.
https://www.ccala.net/

Los Angeles County Department of Public Health, Office for the Advancement of or Early Care and Education: https://childcare.lacounty.gov/resources-for-families-and-communities/

Los Angeles Education Partnership
www.laep.org
LAEP offers childcare for parent workshops, meetings, conferences, and other activities on a fee-for-service basis. LAEP brings all the necessary materials and supplies, including snacks.

LOS ANGELES COUNTY
COMMISSION ON HIV

STANDARDS OF CARE FOR SUBSTANCE USE OUTPATIENT CARE AND RESIDENTIAL SERVICES

Last Approved by the Commission on HIV on 4/13/2017
Draft Revisions as of 6/3/21

SUBSTANCE USE SERVICES STANDARDS OF CARE

IMPORTANT: The service standards for Substance Use Outpatient Care and Residential Services adhere to requirements and restrictions from the federal agency, Health Resources and Services Administration (HRSA). The key documents used in developing standards are as follows:
Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18)

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

Service Standards: Ryan White HIV/AIDS Programs

INTRODUCTION

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

The Los Angeles County Commission on HIV developed the Substance Use Outpatient Care and Residential Service standards to establish the minimum services necessary to support clients through treatment and counseling services for drug or alcohol use disorders and promote engagement in medical care and treatment adherence to achieve viral load suppression.

The development of the standards includes guidance from service providers, people living with HIV, the Los Angeles County Department of Public Health, Division of HIV and STD Programs (DHSP), members of the Los Angeles County Commission on HIV, Standards & Best Practices Committee, caucuses, and the public-at-large.

HRSA Definitions and Program Guidance

Substance Use Outpatient Care	Substance Use Residential Services
Per HRSA Policy Guidance, Substance Use Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Activities under Substance Use Outpatient Care service category include: • Screening	Per HRSA Policy Guidance, Substance Use Residential Services is the provision of services for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. This

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Assessment
Diagnosis, and/or treatment of substance use disorder, including:

Pretreatment/recovery readiness programs
Harm reduction
Behavioral health counseling associated with substance use disorder
Outpatient drug-free treatment and counseling
Medication-assisted therapy (MAT)
Neuro-psychiatric pharmaceuticals
Relapse prevention

Program Guidance: Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the HRSA RWHAP, it is included in a documented plan. Syringe access services are allowable, to the extent that they comport with current appropriations law and applicable HHS guidance, including HRSA- or HIV/AIDS Bureau (HAB)-specific guidance.
</td>
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service includes:

Pretreatment/recovery readiness programs
Harm reduction
Behavioral health counseling associated with substance use disorder
Medication-assisted therapy (MAT)
Neuro-psychiatric pharmaceuticals
Relapse prevention
Detoxification, if offered in a separate licensed residential setting (including a separately licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital)

Program Guidance: Substance Use Residential Services is permitted only when the client has received a written referral from the clinical provider as part of a substance use disorder treatment program funded under the HRSA Ryan white HIV/AIDS Program (RWHAP). Acupuncture therapy may be an allowable cost under this service category only when it is included in a documented plan as part of a substance use disorder treatment program funded under the HRSA RWHAP. HRSA RWHAP funds may not be used for inpatient detoxification in a hospital setting, unless the detoxification facility has a separate license.

Substance Use Residential Services seek to provide interim housing with supportive services for up to one (1) year exclusively designated and targeted for homeless or unstably housed persons living with HIV/AIDS in various stages of recovery from substance use disorder. The purpose of the service is to facilitate continued recovery from substance abuse and movement toward more traditional, permanent housing through assessment of the individual's needs,
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	counseling, and case management.

All contractors must meet the Universal Standards of Care in addition to the following Substance Use Outpatient Care and Residential Services service standards.[1]

Service Components	Standard	Documentation
1a. Activities Based on client needs and assessment, providers must provide the following service activities: • Intake • Individual counseling • Group counseling • Patient education • Family therapy • Safeguard medications • Medication services • Collateral services • Crisis intervention services • Treatment planning • Discharge services	Agencies must maintain complete and thorough documentation of services provided to client.	Agencies maintain documentation based on Los Angeles County, Substance Abuse and Mental Health Services Administration (SAMHSA), and American Society of Addiction Medicine (ASAM) guidelines. Progress notes are thorough, dated, and verified by a licensed supervisor.
1b. Agency Licensing and Policies	**Outpatient Services:** Agency is licensed and accredited by appropriate state and local agency to provide substance use outpatient care services. **Residential Services:** Agencies must operate as a licensed adult residential facility, a transitional housing facility or a congregate living facility.	Current license(s) on file.

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

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Service Components	Standard	Documentation
1c. Client Assessment and Reassessment	Assessments will be completed at the initiation of services and at minimum should assess whether the client is in care. Reassessments must be completed every 6 months.	Completed assessment in client chart signed and dated by Case Manager.
	Appropriate medical evaluation must be performed prior to initiating residential treatment services, including physical examinations when deemed necessary.	Medical record of physical examinations and medical evaluation by a licensed medical provider.
	Use the Medical Care Coordination (MCC) Assessment tool to determine acuity level and eligibility for MCC services.	Documentation of use MCC assessment tool as deemed appropriate by staff.
	Screen and assess clients for the presence of co-occurring mental disorders and use the information obtained from the screening and assessment to develop appropriate treatment approaches for the persons identified as having co-occurring disorders.	Documentation of assessment in client file.
1d. Staff Competencies	Staff members are licensed or certified, as necessary, to provide substance use outpatient care and residential services and have experience and skills appropriate to the specified substance needed by the client. Bachelor's degree in a related field preferred and/or lived experience preferred.	Current license and résumé on file.
	Providers are responsible to provide culturally competent services. Services must be embedded in the organizational structure and upheld in day-to-day operations.	Agencies must have in place policies, procedures and practices that are consistent with the principles outlined in the National Standards for Culturally and Linguistically

		Appropriate Services in Health Care (CLAS).
	Use a trauma-informed approach following SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach (http://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-aTrauma-Informed-Approach/SMA14-4884).	Training documentation in personnel and program files.
1e. Integrated Behavioral and Medical Care	All Ryan White funded substance use outpatient care and residential services must provide integrated services of behavioral health treatment and HIV medical care. An integrated behavioral health and HIV medical care program addresses alcohol, marijuana, cocaine, heroin, injection drug use (IDU), and prescription drug misuse; mental disorder treatment and HIV/viral hepatitis services, including HIV and hepatitis B and C testing; and use evidence-based interventions defined by the Substance Use and Mental Health Services Administration (SAMHSA).	A comprehensive written program service delivery protocol outlining how staff will deliver all service components based on Los Angeles County, SAMHSA, and ASAM guidelines.
	Agencies must have procedures for linkage/integration of Medication-Assisted Treatment (MAT) for patients to ensure adequate access to core components of substance use disorder (SUD) treatment.	Established protocols for MAT following prescribing standards from ASAM and SAMHSA.
	Agencies must use Evidence-Based Practices such as Motivational Interviewing and Cognitive Behavioral Therapy, relapse prevention, trauma-informed treatment, and psychoeducation.	Written evidence-based program protocol.

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	Case management will assist patients in navigating and accessing mental health, physical health, and social service delivery systems.	Case notes must show that the initiating provider provided case management services and communicated with the next provider along the continuum of care to ensure smooth transitions between levels of care. If the client is referred to a different agency, case notes must show that the client has been successfully admitted for services with the new treating provider.
	Providers must deliver recovery support services to clients to sustain engagement and long-term retention in recovery, and re-engagement in SUD treatment and other services and supports as needed.	Written recovery support services protocol. MOUs with agencies for ensuring coordination of care.
	All clients who are considered to be at risk for viral hepatitis (B and C), as specified by the United States Preventive Services Task Force (USPSTF) recommendations for hepatitis B and hepatitis C screening, must be tested for viral hepatitis (B and C) in accordance with state and local requirements, either onsite or through referral.	Documentation of hepatitis screening and treatment described in client file.
1f. Individual Treatment Plan	Individual Treatment Plans (ITPs) will be developed collaboratively between the client and Case Manager within 7 calendar days (or as soon as possible) of completing the assessment or reassessment and, at minimum, should include: • Description of client goals and desired outcomes	Completed ITP in client chart, dated and signed by client and Case Manager.

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	• Action steps to be taken and individuals responsible for the activity • Anticipated time for each action step and goal • Status of each goal as it is met, changed or determined to be unattainable	
1g. Linkage and Referral	Link clients and partners to appropriate community-based behavioral health services/systems including primary HIV care and antiretroviral treatment (ART), HIV pre-exposure prophylaxis (PrEP), viral hepatitis B and C, primary health care, and other recovery support services.	Documentation of linkage and referrals, follow-up care and treatment for in client case files.
	Ensure that patients who need trauma-related services have access to these services through case management and referral to certified trauma providers.	Documentation of linkage and referrals in client case files.
1h. Discharge Planning	Client Discharge Plan should be developed for every client, regardless of reason for discharge. At minimum, the Discharge Plan should include: • Reason for client discharge from services (i.e., treatment goals achieved, client requested termination of services, client left facility, client deceased, etc.) • Referrals to ongoing outpatient substance use treatment service • Identification of housing options and address at which client is expected to reside	Client record documentation contains signed and dated Discharge Plan with required Elements.

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	• Identification of medical care provider from whom client is expected to receive treatment • Identification of case manager/care coordinator from whom client is expected to receive services • Source of client's HIV medications upon discharge	
	Client Discharge Plan should be provided to client.	Client record signed and dated progress notes reflect provision of Discharge Plan to client.

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APPENDIX A: DEFINITIONS
Source: Substance Use Disorder Treatment Services Provider Manual, Version 5.0, Last Updated July 2020. Los Angeles County Department of Public Health, Substance Abuse Prevention and Control.

Collateral Services
Collateral Services are sessions between significant persons in the life of the patient (i.e., personal, not official or professional relationship with patient) and SUD counselors or Licenses Practitioner of the Healing Arts (LPHA) are used to obtain useful information regarding the patient to support the patient's recovery. The focus of Collateral Services is on better addressing the treatment needs of the patient.

Crisis Intervention Services
Crisis Intervention services include direct communication and dialogue between the staff and patient and are conducted when: 1) A threat to the physical and/or emotional health and well-being of the patient arises that is perceived as intolerable and beyond the patient's immediately available resources and coping mechanisms; or 2) An unforeseen event or circumstance occurs that results in or presents an imminent threat of serious relapse. These sessions are immediate and short-term encounters that focus on (1) stabilization and immediate management of the crisis, often by strengthening coping mechanisms and (2) alleviating a patient's biopsychosocial functioning and well-being after a crisis.

Discharge Services
Discharge services or discharge planning is the process of preparing the patient for referral into another level of care, post-treatment return, or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services. Discharge planning should identify a description of the patient's triggers, a plan to avoid relapse for each of these triggers and an overall support plan.

Family Therapy
Family therapy is a form of psychotherapy that involves both patients and their family members and uses specific techniques and evidence-based approaches (e.g. family systems theory, structural therapy, etc.) to improve the psychosocial impact of substance use and the dynamics of a social/family unit.

Field-based Services (FBS)
Field-based Services (FBS) are a method of mobile service delivery for SUD outpatient services case, management, and recovery support services (RSS) for patients with established medical necessity. FBS provide an opportunity for SUD network providers to address patient challenges to accessing traditional treatment settings, such as physical limitations, employment conflicts, transportation limitations, or restrictive housing requirements (e.g., registered sex offenders).

Group Counseling
Group counseling sessions are designed to support discussion among patients, with guidance from the facilitator to support understanding and encourage participation, on psychosocial issues related to substance use.

Individual Counseling
Individual Counseling sessions are designed to support direct communication and dialogue between the staff and patient and focus on psychosocial issues related to substance use and goals outlined in the patient's individualized Treatment Plan.

Intake
Intake involves completing a series of administrative processes that are designed to ensure/verify eligibility, discuss program offerings, consent forms and other relevant documents. The intake process is a critical first step in establishing trust between the provider and the client and sets the stage for supporting the client in their treatment process.

Medication-assisted Treatment/Therapy (MAT)
Medication-assisted treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Medications used in MAT are approved by the Food and Drug Administration (FDA) and MAT programs are clinically driven and tailored to meet each patient's needs.

Medication Services and Safeguarding Medications
Medication services and safeguarding medications include the prescription, administration, or supervised self-administration (in residential settings) of medication related to SUD treatment services or other necessary medications. Medication services may also include assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services and/or order laboratory testing within their scope of practice or licensure.

Patient Education
Patient education sessions are designed to enable the facilitator to teach participants and encourage discussion among patients on research-based educational topics such as addiction, treatment, recovery, and associated health consequences with the goal of minimizing the harms of SUDs, lowering the risk of overdose and dependence, and minimizing adverse consequences related to substance use.

Treatment Plan/Planning
A treatment plan is an electronic or paper document that describes the patient's individualized diagnosis, strengths, needs, long-range goals, short-term goals, treatment and supportive interventions, and treatment providers.

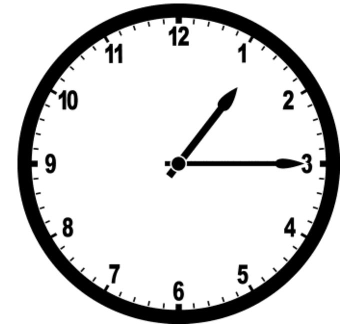
DRAFT

LA County Commission on HIV

Implicit Bias

County of Los Angeles Department of Workforce Development, Aging, and Community Services
Commission on Human Relations
April Johnson, AJohnson@wdacs.lacounty.gov **Robert Sowell,** RSowell@wdacs.lacounty.gov

Today



You will know

what implicit bias is,
how it works, and
why it's important

Arno and Pradeep video

Interaction Agreements

Engage Fully – avoid distractions

Represent Yourself – don't claim to speak for others

Share the Space – give room for others to speak

Receive Generously – don't attribute motives

Assume Alliance – we may disagree on issues, but we don't attack people

Protect Confidentiality – take learning with you, leave stories behind

Look at and remember this list

Ant

Spider

Fly

Crawl

Bite

Bug

Fright

Bee

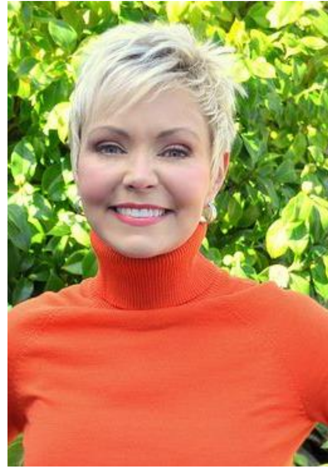
Sting

Small

Creepy

Who's Who?

purple


orange

black

brown

attorney in Cheyenne, Wyoming
meteorologist in Atlanta, Georgia
chef in Sydney, Australia
physician in Boston, Massachusetts

LOS ANGELES COUNTY COMMISSION ON HIV

Who's Who?

respond at pollev.com/robertsowell759
OR
text 'robertsowell759' to 37607

When poll is active, respond at **pollev.com/robertsowell759**

Text **ROBERTSOWELL759** to **37607** once to join

Who's the attorney in Cheyenne, Wyoming?

- purple
- orange
- black
- brown
- none of the above

Start the presentation to see live content. For screen share software, share the entire screen. Get help at **pollev.com/app**

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Text **ROBERTSOWELL759** to **37607** once to join

Who's the chef in Sydney, Australia

purple

orange

black

brown

none of the above

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When poll is active, respond at **pollev.com/robertsowell759**

Text **ROBERTSOWELL759** to **37607** once to join

Who's the physician in Boston, Massachusetts?

purple

orange

black

brown

none of the above

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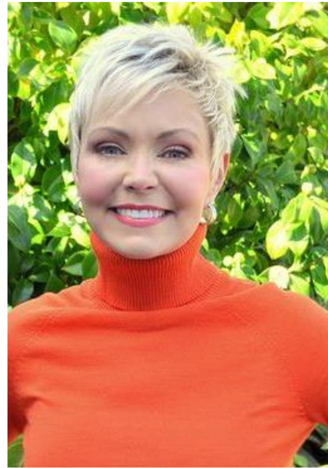
Who's Who?

purple

attorney in Cheyenne, Wyoming



orange

meteorologist in Atlanta, Georgia

black

chef in Sydney, Australia

brown

physician in Boston, Massachusetts

Which words were not on the previous list?

Maple Ant Fly Stem Berry Small Birch
Sting Bug Oak Leaves Bite Fright
Tree Roots Acorn Insect Bee Willow
Spider Crawl Pine Creepy

Which words were not on the previous list?

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Thinking about our thinking

Implicit Bias

stereotypes that affect our attitudes, understanding, actions, and decisions in an unconscious manner

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stereotypes that affect our attitudes, understanding, actions, and decisions in an unconscious manner

What are common stereotypes you've seen or heard?

Start the presentation to see live content. For screen share software, share the entire screen. Get help at **pollev.com/app**

Peanut butter and jelly video

LOS ANGELES COUNTY
COMMISSION ON HIV

Thinking about our thinking

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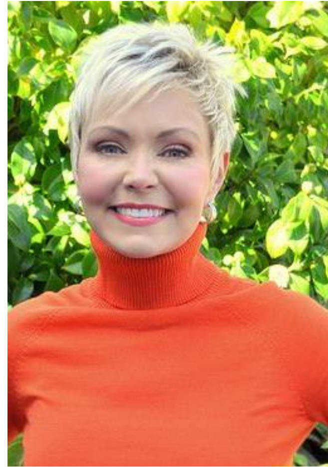

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black

chef in Sydney, Australia

brown

physician in Boston, Massachusetts

Implicit Bias

stereotypes that affect our attitudes, understanding, actions, and decisions in an unconscious manner

LOS ANGELES COUNTY
COMMISSION ON HIV

Harro, B, “The Cycle of Socialization.” In M. Adams, W. Blumenfeld, R. Castañeda, H. Hackman, M. Peters, and X. Zúñiga, eds, *Readings for Diversity and Social Justice: An Anthology on Racism, Antisemitism, Sexism, Heterosexism, Ableism, and Classism,* 2000, Routledge.

First Socialization

Socialized
Taught on a Personal Level by Parents, Relatives, Teachers, People We Love and Trust:
Shapers of Expectations, Norms, Values, Roles, Rules, Models of Ways to Be, Sources of Dreams

The Beginning

Born into World with Mechanics in Place
No Blame, No Consciousness, No Guilt, No Choice
Limited Information
No Information
Misinformation
Biases
Stereotypes
Prejudices
History
Habit
Tradition

Institutional and Cultural Socialization

Reinforced/ Bombarded with Messages from

Institutions
Churches
Schools
Television
Legal System
Mental Health
Medicine
Business

Culture
Practices
Song Lyrics
Language
Media
Patterns of Thought

On Conscious and Unconscious Levels

Core
Fear
Ignorance
Confusion
Insecurity

Enforced
Sanctioned
Stigmatized
Rewards and Punishments
Privilege
Persecution
Discrimination
Empowerment

Enforcements

Resulting in

Dissonance, Silence, Anger, Dehumanization, Guilt, Collusion, Ignorance, Self-Hatred, Stress, Lack of Reality, Horizontal Violence, Inconsistency, Violence, Crime, Internalization of Patterns of Power

Results

Do Nothing
Don't Make Waves
Promote Status Quo

Actions

Change
Raise Consciousness
Interrupt
Educate
Take a Stand
Question
Reframe

Direction for Change

Choose a number from 1 to 10.

Multiply the number by 9.

Add the two digits of the new number.

Subtract 5 from the sum.

Choose the letter in the alphabet that corresponds to the result of subtracting 5.

Think of a country in the world that begins with that letter.

Think of an animal that begins with the last letter in the name of the country.

Think of a fruit that begins with the last letter in the name of the animal.

Denmark, Kangaroo, Orange

Implicit Bias

stereotypes that affect our attitudes, understanding, actions, and decisions in an unconscious manner

Our implicit biases can become mental habits.

RED	BLUE	GREEN	BROWN	PURPLE
BROWN	PURPLE	BLUE	GREEN	
GREEN	RED	BROWN	PURPLE	BLUE
PURPLE	GREEN	RED	BROWN	
BLUE	BROWN	PURPLE	GREEN	RED

LOS ANGELES COUNTY
COMMISSION ON HIV

Prejudicial Bias

Structural

Institutional /Systemic

policies, practices, and processes that advantage one or some groups and disadvantage others

Individual

bias/discrimination by an individual against another person or group

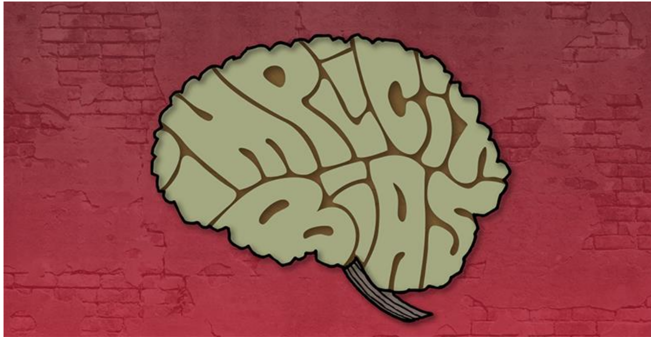
LOS ANGELES COUNTY COMMISSION ON HIV

wdacs

workforce development
aging & community services

Los Angeles County
Commission on Human Relations

2019 HATE CRIME REPORT



You're waiting in line to buy coffee and two people in front of you are talking with each other. You notice that one of them seems to have an accent that sounds more British than what is most common in the United States. Suddenly the person behind you in line leans forward and interrupts the two people in conversation in front of you and says, "Excuse me, but may I just say that I love the way you talk? I think people that talk like you are so intelligent and in charge!"

What biases might be being expressed in this situation?

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You are participating in a meeting as a member of a team planning a large 3-day conference. In this meeting the team is discussing a large number of possible speakers all of whom have earned PhDs or MDs. After about 20 minutes you notice what you think is a pattern and begin to pay closer attention. After a few more minutes you confirm that the potential speakers who are white males are almost always referred to by their degree title (i.e. “Dr”) and last name while the potential speakers who are not white or not male are almost always referred to by their first name.

What biases might be being expressed in this situation?

Start the presentation to see live content. For screen share software, share the entire screen. Get help at **pollev.com/app**

In future sessions

How we can manage our own biases effectively and respond to the biases of others constructively

30-minute sessions in monthly Commission meetings: presentation of skill and practice/application

Self-Management

Empathy

Inquiry

Listening without Judging

Disclosing, Part 1 - affirming Shared Views

Disclosing, Part 2 - presenting Different Facts or Perspective

Disclosing, Part 3 - requesting Different Behavior

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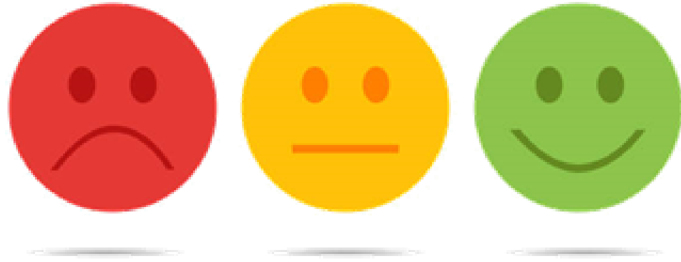
Feedback



We value your Feedback!

There is a link in the Chat to a brief online survey.

Zak Ebrahim video

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