LOS ANGELES COUNTY
COMMISSION ON HIV

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

EXECUTIVE COMMITTEE

Meeting

Tuesday, December 12, 2023
11:00AM-12:00PM (PST)
510 S. Vermont Ave
9th Floor, Terrace Conference Room, Los Angeles, CA 90020
Validated Parking Available at 523 Shatto Place, LA 90020

Agenda and meeting materials will be posted on our website at https://hiv.lacounty.gov/executive-committee

As a building security protocol, attendees entering the building must notify the parking attendant and security personnel that they are attending a Commission on HIV meeting in order to access the Terrace Conference Room (9th flr) where our meetings are held

For Members of the Public Who Wish to Join Virtually, Register Here:
https://lacountyboardofsupervisors.webex.com/weblink/register/rb7688be424d2c6af46e3f1fc61b9f545
To Join by Telephone: 1-213-306-3065
Password: EXECUTIVE Access Code: 2536 002 9429

Scan QR code to download an electronic copy of the meeting agenda and packet on your smart device. Please note that hard copies of materials will not be made available during meetings unless otherwise determined by staff in alignment with the County's green initiative to recycle and reduce waste. **If meeting packet is not yet available, check back 2-3 days prior to meeting; meeting packet subject to change. Agendas will be posted 72 hours prior to meeting per Brown Act.*

LIKE WHAT WE DO?

Apply to become a Commission Member at:
https://www.surveymonkey.com/r/2023CommissiononHIVMemberApplication
For application assistance call (213) 738-2816 or email hivcomm@lachiv.org

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave., 14th Floor, Los Angeles CA 90020
MAIN: 213.738.2816 EML: hivcomm@lachiv.org WEBSITE: https://hiv.lacounty.gov

AGENDA FOR THE SPECIAL MEETING OF THE LOS ANGELES COUNTY COMMISSION ON HIV

EXECUTIVE COMMITTEE

THURSDAY, DECEMBER 12, 2023 | 11:00AM-12:00PM

510 S. Vermont Ave
Terrace Level Conference Room A
Los Angeles, CA 90020
Validated Parking: 523 Shatto Place, Los Angeles 90020
**As a building security protocol, attendees entering the building must notify the parking attendant and security personnel that they are attending a Commission on HIV meeting in order to access the Terrace Conference Room (9th flr) where our meetings are held.*

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EXECUTIVE COMMITTEE MEMBERS			
Luckie Fuller, Co-Chair (LOA)	*Bridget Gordon, Co-Chair*	*Joseph Green, Co-Chair Pro Tem*	Miguel Alvarez (Executive At-Large)
Al Ballesteros, MBA	Danielle Campbell, MPH (Executive At-Large)	Erika Davies	Kevin Donnelly
Lee Kochems, MA	Katja Nelson, MPP	Mario J. Peréz, MPH	Kevin Stalter
Justin Valero, MPA			
QUORUM: 7			

AGENDA POSTED: November 21, 2023

SUPPORTING DOCUMENTATION: Supporting documentation can be obtained via the Commission on HIV Website at: http://hiv.lacounty.gov or in person. The Commission Offices are located at 510 S. Vermont Ave., 14th Floor Los Angeles, 90020. Validated parking is available at 523 Shatto Place, Los Angeles 90020. **Hard copies of materials will not be made available during meetings unless otherwise determined by staff in alignment with the County's green initiative to recycle and reduce waste.*

PUBLIC COMMENT: Public Comment is an opportunity for members of the public to comment on an agenda item, or any item of interest to the public, before or during the Commission's consideration of the item, that is within the subject matter jurisdiction of the Commission. To submit Public Comment, you may submit in person, email to hivcomm@lachiv.org , or submit electronically here. All Public Comments will be made part of the official record.

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 (213) 738-2816 or via email at HIVComm@lachiv.org.

Los servicios de interpretación para personas con impedimento auditivo y traducción para personas que no hablan Inglés están disponibles sin costo. Para pedir estos servicios, póngase en contacto con Oficina de la Comisión al (213) 738-2816 (teléfono), o por correo electrónico á HIVComm@lachiv.org, por lo menos setenta y dos horas antes de la junta.

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.

I. ADMINISTRATIVE MATTERS

1.	Call to Order & Meeting Guidelines/Reminders		11:00 AM – 11:03 AM
2.	Introductions, Roll Call, & Conflict of Interest Statements		11:03 AM – 11:05 AM
3.	Approval of Agenda	**MOTION #1**	11:05 AM – 11:07 AM
4.	Approval of Meeting Minutes	**MOTION #2**	11:07 AM – 11:10 AM

II. PUBLIC COMMENT 11:10 AM – 11:13 AM

5. Opportunity for members of the public to address the Committee of items of interest that are within the jurisdiction of the Committee. For those who wish to provide public comment may do so in person, electronically by clicking here, or by emailing hivcomm@lachiv.org.

III. COMMITTEE NEW BUSINESS ITEMS 11:13 AM – 11:15 AM

6. 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.

IV. REPORTS

7. Executive Director/Staff Report 11:15 AM – 11:20 AM

A. Commission (COH)/County Operational Updates

(1) 2023 Annual Report Planning

8. Co-Chair Report 11:20 AM – 11:35 AM

A. 2023 Annual Conference| FOLLOW UP & FEEDBACK

9. Division of HIV and STD Programs (DHSP) Report 11:35 AM – 11:40 AM

A. Fiscal, Programmatic and Procurement Updates

(1) Ryan White Program (RWP) Part A & MAI

(2) Fiscal

(3) Mpox | UPDATES

10. Standing Committee Report 11:40 AM – 11:50 AM

A. Operations Committee

(1) Proposed Updates to Bylaws

B. Standards and Best Practices (SBP) Committee

(1) Universal Service Standards & Patient Bill of Rights | **MOTION #3**

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

D. Public Policy Committee (PPC)

12. Caucus, Task Force, and Work Group Reports: 11:50 AM – 11:55 AM

A. Aging Caucus

B. Black/AA Caucus

C. Consumer Caucus

(1) SAVE THE DATE: 2023 Consumer Caucus Retreat: December 14 @ 11AM-2PM (Vermont Corridor)

D. Transgender Caucus

E. Women's Caucus

F. Bylaws Review Taskforce

H. Prevention Planning Workgroup

V. NEXT STEPS 11:55 AM – 11:57 AM

13. Task/Assignments Recap

14. Agenda development for the next meeting

VI. ANNOUNCEMENTS 11:57 AM – 12:00 PM

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

VII. ADJOURNMENT 12:00 PM

Adjournment for the meeting of December 12, 2023.

PROPOSED MOTIONS	
MOTION #1	Approve the Agenda Order as presented or revised.
MOTION #2	Approve the meeting minutes, as presented or revised.
MOTION #3	Approve Universal Service Standards and Patient Bill of Rights as presented or revised.

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave 14th Floor • Los Angeles, CA 90020 • TEL (213) 738-2816 • FAX (213) 637-6748
HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov

Approved by COH 6/8/23

CODE OF CONDUCT

The Commission on HIV welcomes commissioners, guests, and the public into a space where people of all opinions and backgrounds are able to contribute. In this space, we challenge ourselves to be self-reflective and committed to an ongoing understanding of each other and the complex intersectionality of the lives we live. We create a safe environment where we celebrate differences while striving for consensus in the fights against our common enemies: HIV and STDs. We build trust in each other by having honest, respectful, and productive conversations. 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 approach all our interactions with compassion, respect, and transparency.**
2) **We respect others' time by starting and ending meetings on time, being punctual, and staying present.**
3) **We listen with intent, avoid interrupting others, and elevate each other's voices.**
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) **Be flexible, open-minded, and solution-focused.**
7) **We give and accept respectful and constructive feedback.**
8) **We keep all issues on the table (no "hidden agendas"), avoid monopolizing discussions and minimize side conversations.**
9) **We have no place in our deliberations for racist, sexist, homophobic, transphobic, and other discriminatory statements, and "-isms" including misogyny, ableism, and ageism.**
10) **We give ourselves permission to learn from our mistakes.**

In response to violation of the Code of Conduct which results in meeting disruption, Include provisions of SB 1100 which states in part, ". . . authorize the presiding member of the legislative body conducting a meeting or their designee to remove, or cause the removal of, an individual for disrupting the meeting . . . . Removal to be preceded by a warning to the individual by the presiding member of the legislative body or their designee that the individual's behavior is disrupting the meeting and that the individual's failure to cease their behavior may result in their removal." Complaints related to internal Commission matters such as alleged violation of the Code of Conduct or other disputes among members are addressed and resolved in adherence to Policy/Procedure #08.3302." (Commission Bylaws, Article VII, Section 4.)

2023 MEMBERSHIP ROSTER| UPDATED 11.20.23

SEAT NO.	MEMBERSHIP SEAT	Commissioners Seated	Committee Assignment	COMMISSIONER	AFFILIATION (IF ANY)	TERM BEGIN	TERM ENDS	ALTERNATE
1	Medi-Cal representative			***Vacant***		July 1, 2023	June 30, 2025	
2	City of Pasadena representative	1	EXC|SBP	Erika Davies	City of Pasadena Department of Public Health	July 1, 2022	June 30, 2024	
3	City of Long Beach representative			***Vacant***	Long Beach Health & Human Services	July 1, 2023	June 30, 2025	
4	City of Los Angeles representative	1	PP	Ricky Rosales	AIDS Coordinator's Office, City of Los Angeles	July 1, 2022	June 30, 2024	
5	City of West Hollywood representative	1	PP&A	Derek Murray	City of West Hollywood	July 1, 2023	June 30, 2025	
6	Director, DHSP **Non Voting*	1	EXC	Mario Pérez, MPH	DHSP, LA County Department of Public Health	July 1, 2022	June 30, 2024	
7	Part B representative	1	PP&A	Karl Halfman, MA	California Department of Public Health, Office of AIDS	July 1, 2022	June 30, 2024	
8	Part C representative	1	PP	Leon Maultsby, MHA	Charles R. Drew University	July 1, 2022	June 30, 2024	
9	Part D representative	1	SBP	Mikhaela Cielo, MD	LAC + USC MCA Clinic, LA County Department of Health Services	July 1, 2023	June 30, 2025	
10	Part F representative	1	PP	Sandra Cuevas	Pacific AIDS Education and Training - Los Angeles Area	July 1, 2022	June 30, 2024	
11	Provider representative #1	1	OPS	Jose Magana	The Wall Las Memorias	July 1, 2023	June 30, 2025	
12	Provider representative #2	1	SBP	Andre Molette	Men's Health Foundation	July 1, 2022	June 30, 2024	
13	Provider representative #3	1	PP&A	Harold Glenn San Agustin, MD	JWCH Institute, Inc.	July 1, 2023	June 30, 2025	
14	Provider representative #4	1	PP&A	LaShonda Spencer, MD	Charles Drew University	July 1, 2022	June 30, 2024	
15	Provider representative #5	1	SBP	Byron Patel, RN, ACRN	Los Angeles LGBT Center	July 1, 2023	June 30, 2025	
16	Provider representative #6	1	PP&A	Anthony Mills, MD	Men's Health Foundation	July 1, 2022	June 30, 2024	
17	Provider representative #7	1	EXC	Alexander Luckie Fuller ***(LOA)***	Invisible Men	July 1, 2023	June 30, 2025	
18	Provider representative #8	1	SBP	Martin Sattah, MD	Rand Shrader Clinic, LA County Department of Health Services	July 1, 2022	June 30, 2024	
19	Unaffiliated consumer, SPA 1			***Vacant***		July 1, 2023	June 30, 2025	
20	Unaffiliated consumer, SPA 2	1	SBP	Russell Ybarra	*Unaffiliated Consumer*	July 1, 2022	June 30, 2024	
21	Unaffiliated consumer, SPA 3	1	PP&A	Ish Herrera	*Unaffiliated Consumer*	July 1, 2023	June 30, 2025	
22	Unaffiliated consumer, SPA 4			***Vacant***		July 1, 2022	June 30, 2024	Lambert Talley (PP&A)
23	Unaffiliated consumer, SPA 5	1	EXC|SBP	Kevin Stalter	*Unaffiliated Consumer*	July 1, 2023	June 30, 2025	
24	Unaffiliated consumer, SPA 6	1	OPS	Jayda Arrington	*Unaffiliated Consumer*	July 1, 2022	June 30, 2024	
25	Unaffiliated consumer, SPA 7			***Vacant***		July 1, 2023	June 30, 2025	Ronnie Osorio (PP)
26	Unaffiliated consumer, SPA 8	1	EXC|PP&A	Kevin Donnelly	*Unaffiliated Consumer*	July 1, 2022	June 30, 2024	
27	Unaffiliated consumer, Supervisorial District 1			***Vacant***		July 1, 2023	June 30, 2025	Dechelle Richardson (PP&A)
28	Unaffiliated consumer, Supervisorial District 2	1	EXC	Bridget Gordon	*Unaffiliated Consumer*	July 1, 2022	June 30, 2024	
29	Unaffiliated consumer, Supervisorial District 3	1	SBP	Arlene Frames	*Unaffiliated Consumer*	July 1, 2023	June 30, 2025	
30	Unaffiliated consumer, Supervisorial District 4			***Vacant***		July 1, 2022	June 30, 2024	Juan Solis (SBP)
31	Unaffiliated consumer, Supervisorial District 5	1	PP&A	Felipe Gonzalez	*Unaffiliated Consumer*	July 1, 2023	June 30, 2025	
32	Unaffiliated consumer, at-large #1	1	PP&A	Lilieth Conolly	*Unaffiliated Consumer*	July 1, 2022	June 30, 2024	
33	Unaffiliated consumer, at-large #2			***Vacant***		July 1, 2023	June 30, 2025	Erica Robinson (OPS)
34	Unaffiliated consumer, at-large #3			***Vacant***		July 1, 2022	June 30, 2024	David Hardy (SBP)
35	Unaffiliated consumer, at-large #4	1	EXEC	Joseph Green	*Unaffiliated Consumer*	July 1, 2023	June 30, 2025	
36	Representative, Board Office 1	1	EXC|PP&A	Al Ballesteros, MBA	JWCH Institute, Inc.	July 1, 2022	June 30, 2024	
37	Representative, Board Office 2	1	EXC|OPS	Danielle Campbell, MPH	T.H.E Clinic, Inc. (THE)	July 1, 2023	June 30, 2025	
38	Representative, Board Office 3	1	EXC|PP	Katja Nelson, MPP	APLA	July 1, 2022	June 30, 2024	
39	Representative, Board Office 4	1	EXC|OPS	Justin Valero, MA	No affiliation	July 1, 2023	June 30, 2025	
40	Representative, Board Office 5	1	PP&A	Jonathan Weedman	ViaCare Community Health	July 1, 2022	June 30, 2024	
41	Representative, HOPWA	1	PP&A	Jesus Orozco	City of Los Angeles, HOPWA	July 1, 2023	June 30, 2025	
42	Behavioral/social scientist	1	EXC|PP	Lee Kochems, MA	*Unaffiliated Consumer*	July 1, 2022	June 30, 2024	
43	Local health/hospital planning agency representative			***Vacant***		July 1, 2023	June 30, 2025	
44	HIV stakeholder representative #1	1	PP	Alasdair Burton	No affiliation	July 1, 2022	June 30, 2024	
45	HIV stakeholder representative #2	1	PP	Paul Nash, CPsychol AFBPsS FHEA	University of Southern California	July 1, 2023	June 30, 2025	
46	HIV stakeholder representative #3	1	PP	Pearl Doan	No affiliation	July 1, 2022	June 30, 2024	
47	HIV stakeholder representative #4	1	PP&A	Redeem Robinson ***(LOA)***	No affiliation	July 1, 2023	June 30, 2025	
48	HIV stakeholder representative #5	1	PP	Mary Cummings	Bartz-Altadonna Community Health Center	July 1, 2022	June 30, 2024	
49	HIV stakeholder representative #6	1	PP	Felipe Findley, PA-C, MPAS, AAHIVS	Watts Healthcare Corp	July 1, 2023	June 30, 2025	
50	HIV stakeholder representative #7	1	PP&A	William D. King, MD, JD, AAHIVS	W. King Health Care Group	July 1, 2022	June 30, 2024	
51	HIV stakeholder representative #8	1	EXC|OPS	Miguel Alvarez	No affiliation	July 1, 2022	June 30, 2024	
	TOTAL:	**41**						

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: 47

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 11/20/23

In accordance with the Ryan White Program (RWP), conflict of interest is defined as any financial interest in, board membership, current or past employment, or contractual agreement with an organization, partnership, or any other entity, whether public or private, that receives funds from the Ryan White Part A program. These provisions also extend to direct ascendants and descendants, siblings, spouses, and domestic partners of Commission members and non-Commission Committee-only members. Based on the RWP legislation, HRSA guidance, and Commission policy, it is mandatory for Commission members to state all conflicts of interest regarding their RWP Part A/B and/or CDC HIV prevention-funded service contracts prior to discussions involving priority-setting, allocation, and other fiscal matters related to the local HIV continuum. Furthermore, Commission members must recuse themselves from voting on any specific RWP Part A service category(ies) for which their organization hold contracts.***An asterisk next to member's name denotes affiliation with a County subcontracted agency listed on the addendum.***

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ALVAREZ	**Miguel**	No Affiliation	No Ryan White or prevention contracts
ARRINGTON	**Jayda**	Unaffiliated consumer	No Ryan White or prevention contracts
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**	T.H.E. Clinic, Inc.	See attached subcontractor's list
CIELO	**Mikhaela**	LAC & USC MCA Clinic	Biomedical HIV Prevention
CUEVAS	**Sandra**	Pacific AIDS Education and Training - Los Angeles	No Ryan White or prevention contracts
CUMMINGS	**Mary**	Bartz-Altadonna Community Health Center	No Ryan White or prevention contracts
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DOAN	**Pearl**	No Affiliation	No Ryan White or prevention contracts
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
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
FRAMES	**Arlene**	Unaffiliated consumer	No Ryan White or prevention contracts
FULLER	**Luckie**	No Affiliation	No Ryan White or prevention contracts
GONZALEZ	**Felipe**	Unaffiliated consumer	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated consumer	No Ryan White or prevention contracts
GREEN	**Joseph**	Unaffiliated consumer	No Ryan White or prevention contracts
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
HARDY	**David**	LAC-USC Rand Schrader Clinic	No Ryan White or prevention contracts
HERRERA	**Ish**	Unaffiliated consumer	No Ryan White or prevention contracts
KOCHEMS	**Lee**	Unaffiliated consumer	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
MAGANA	**Jose**	The Wall Las Memorias, Inc.	HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MARTINEZ (PP&A Member)	**Miguel**	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
			Promoting Healthcare Engagement Among Vulnerable Populations
MAULTSBY	**Leon**	Charles R. Drew University	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences (No Affiliation)	No Ryan White or prevention contracts
MOLLETTE	**Andre**	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
MURRAY	**Derek**	City of West Hollywood	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention
NELSON	**Katja**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			Nutrition Support
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			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
OROZCO	**Jesus ("Chuy")**	HOPWA-City of Los Angeles	No Ryan White or prevention contracts
OSORIO	**Ronnie**	Center For Health Justice (CHJ)	Transitional Case Management - Jails
			Promoting Healthcare Engagement Among Vulnerable Populations

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
PATEL	**Byron**	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
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
RICHARDSON	**Dechelle**	AMAAD Institute	Community Engagement/EHE
ROBINSON	**Erica**	Health Matters Clinic	No Ryan White or prevention contracts
ROBINSON	**Mallery**	No Affiliation	No Ryan White or prevention contracts
ROBINSON	**Redeem**	All Souls Movement (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	No Ryan White or prevention contracts
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
SOLIS *	**Juan**	UCLA Labor Center	See attached subcontractor's list
SPENCER	**LaShonda**	Oasis Clinic (Charles R. Drew University/Drew CARES)	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
STALTER	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
TALLEY	**Lambert**	Grace Center for Health & Healing (No Affiliation)	No Ryan White or prevention contracts
VALERO	**Justin**	No Affiliation	No Ryan White or prevention contracts
WEEDMAN	**Jonathan**	ViaCare Community Health	Biomedical HIV Prevention
YBARRA	**Russell**	Capitol Drugs	No Ryan White or prevention contracts

The following list and addendum present the conflicts of interest for Commission members who represent agencies with Part A/B and/or CDC HIV Prevention-funded service contracts and/or subcontracts with the County of Los Angeles. For a list of County-contracted agencies and subcontractors, please defer to Conflict of Interest & Affiliation Disclosure Form.

Division of HIV and STD Programs Contracted Community Services		
ORGANIZATION	**SERVICE CATEGORY**	**SUBCONTRACTOR**
AIDS Healthcare Foundation (AHF)	Mental Health	
	Medical Specialty	
	Oral Health	
APLA Health & Wellness (AHW)	Ambulatory Outpatient Medical (AOM)	
	Case Management Home-Based	Libertana Home Health, Caring Choice, The Wright Home Care, Cambrian, Care Connection, Envoy
	Nutrition Support (Food Bank/Pantry Service	AIDS Food Store, Foothill AIDS Project, JWCH, Project Angel
	Oral Health	Dostal Laboratories
	STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)	
	STD-Ex.C	
	Biomedical HIV Prevention Services	
AltaMed Health Services	Case Management Home-Based	Envoy, Caring Choice, Health Talent Strategies, Hope International
	Mental Health	
	Vulnerable Populations (YMSM)	TWLMP
Bienestar Human Services (BEN)	Nutrition Support (Food Bank/Pantry Service)	
	Vulnerable Populations (Trans)	CHLA, SJW
Black AIDS Institute	HTS - Storefront	LabLinc Mobile Testing Unit Contract
Center for Health Justice (CHJ)	Transitional Case Management (Jails)	
	Vulnerable Populations (YMSM)	
Childrens Hospital Los Angeles (CHL)	AOM	
	Vulnerable Populations (YMSM)	APAIT
	HTS - Storefront	AMAAD, Center for Health Justice, Sunrise Community Counceling Center
Coachman Moore and Associates	STD Prevention	
East Los Angeles Womens Center	HERR	
East Valley Community Health Center (EVC)	AOM	
Essential Access Health (formerly California Family Health Council)	STD Infertility Prevention and District 2	
Friends Research Institute	HERR	
Greater Los Angeles Agency on Deafness, Inc. (GLAD)	HERR	LIFESIGNS, Inc., Sign Language Interpreter Services
Heluna Health	Linkage to Care Service forr Persons Living with HIV	EHE Mini Grants (MHF; Kavich-Reynolds; SJW; CDU; Kedren Comm Health Ctr; RLA; SCC; EHE Priority Populations (BEN; ELW; LGBT; SJW; SMM; WLM; UCLA LAFANN; Spanish Telehealth Mental Health Services; Translation/Transcription Services; Public Health Detailing; HIV Workforce Development
In the Meantime Men's Group	Vulnerable Populations (YMSM)	Resilient Solutions Agency
JWCH Institute, Inc. (JWCH)	Mental Health	Bienestar
	Oral Health	USC School of Dentistry
	Biomedical HIV Prevention Services	
LAC University of Southern California Medical Center Foundation, Inc.	Community Engagement and Related Services	AMAAD, Program Evaluation Services, Community Partner Agencies
LAC-DHS Housing for Health (DHS)	Housing Assistance Services	Heluna Health
Los Angeles LGBT Center (LGBT)	AOM	Barton & Associates
	Vulnerable Populations (YMSM)	Bienestar, CHLA, The Walls Las Memorias, Black AIDS Institute
	Vulnerable Populations (Trans)	Special Services for Groups, Translatin@ Coalition, CHLA, Friends

Men's Health Foundation (Anthony Martin Mills, MD)	AOM	AMMD (Medical Services)
	Biomedical HIV Prevention Services	
	Vulnerable Poplulations (YMSM)	
	Sexual Health Express Clinics (SHEx-C)	AMMD - Contracted Medical Services
Minority AIDS Project (MAP)	Case Management Home-Based	Caring Choice, Envoy
Northeast Valley Health Corporation (NEV)	AOM	
	Mental Health	
	STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)	
Project New Hope (PNH)	Residential Facility For the Chronically Ill (RCFCI)	
Public Health Foundation Enterprises (PHF)	Transitional Case Management (Jails)	
St. John's Well Child and Family Center (SJW)	HTS - Social and Sexual Networks	Black AIDS Institute
St. Mary Medical Center (SMM)	AOM	
	Case Management Home-Based	Envoy, Cambrian, Caring Choice
	Oral Health	Dental Laboratory
T.H.E. Clinic, Inc. (THE)	AOM	
The Wall Las Memorias Project	HTS - Storefront	
	HTS - Social and Sexual Networks	
Tarzana Treatment Center (TTC)	AOM	New Health Consultant
	Case Management Home-Based	Always Right Home, Envoy
	Mental Health	
The Regents of the University of California (UCLA)	Oral Health-Endo	
	Oral Health-Gen.	
University of Southern California School of Dentistry (USC-Ostrow)	Oral Health-Endo	Patient Lab - Burbank Dental Lab, DenTech; Biopsies - Pacific Oral Pathology
	Oral Health-Gen.	Patient Lab Services
Venice Family Clinic (VFC)	AOM	UCLA
	Benefit Specialty	UCLA
	Medical Care Coordination	UCLA
Watts Healthcare Corporation (WHC)	Oral Health	

Commission on HIV 2023 Annual Conference Feedback Survey

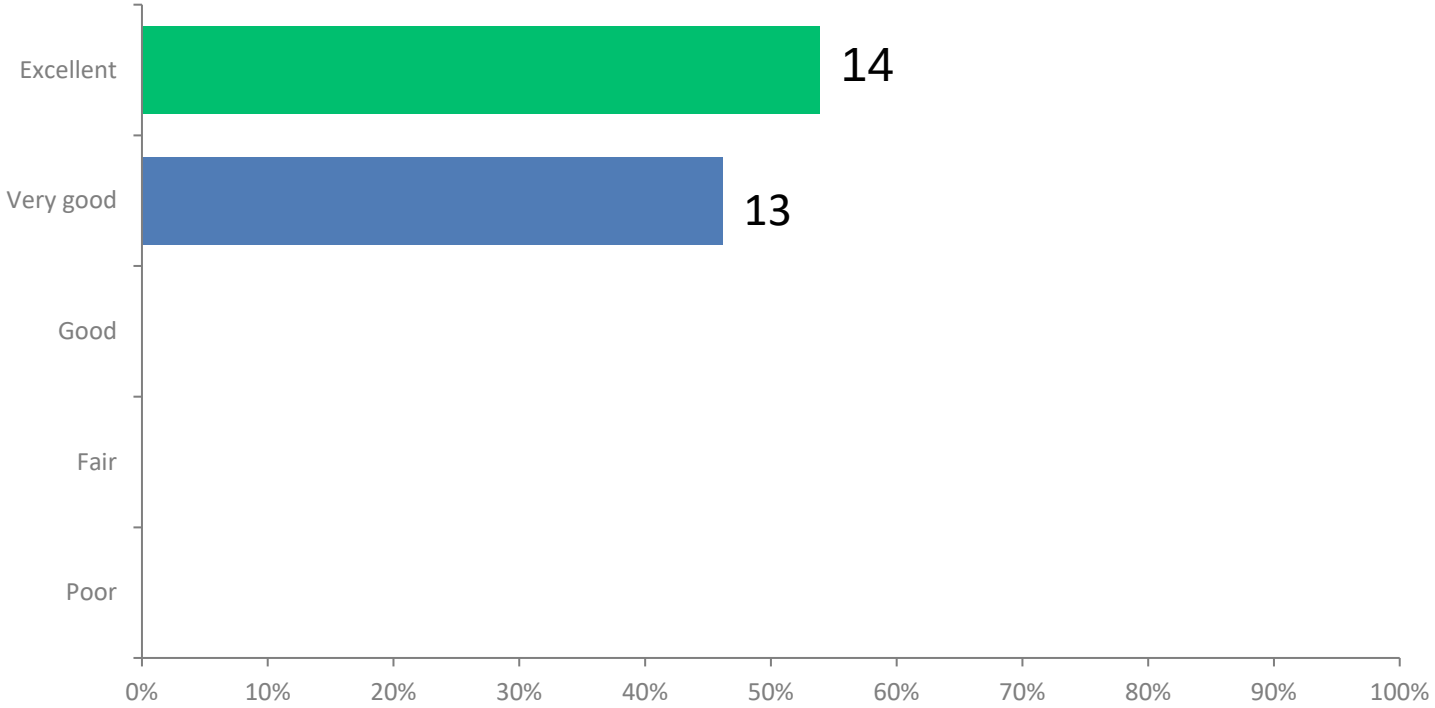
December 12, 2023

- 58 in-person attendees
- 30 via livestreaming
- 100% rated the event “Excellent” or “Very Good” (N=27)
- “The collegial aspect of the conference. People had time to talk with each other and spend time doing so. This was a healing opportunity for our community after the years of Covid.”
- “Very interactive. The topics were relevant to what is happening in our communities.”
- “Well-organized, very good presentations and discussions.”

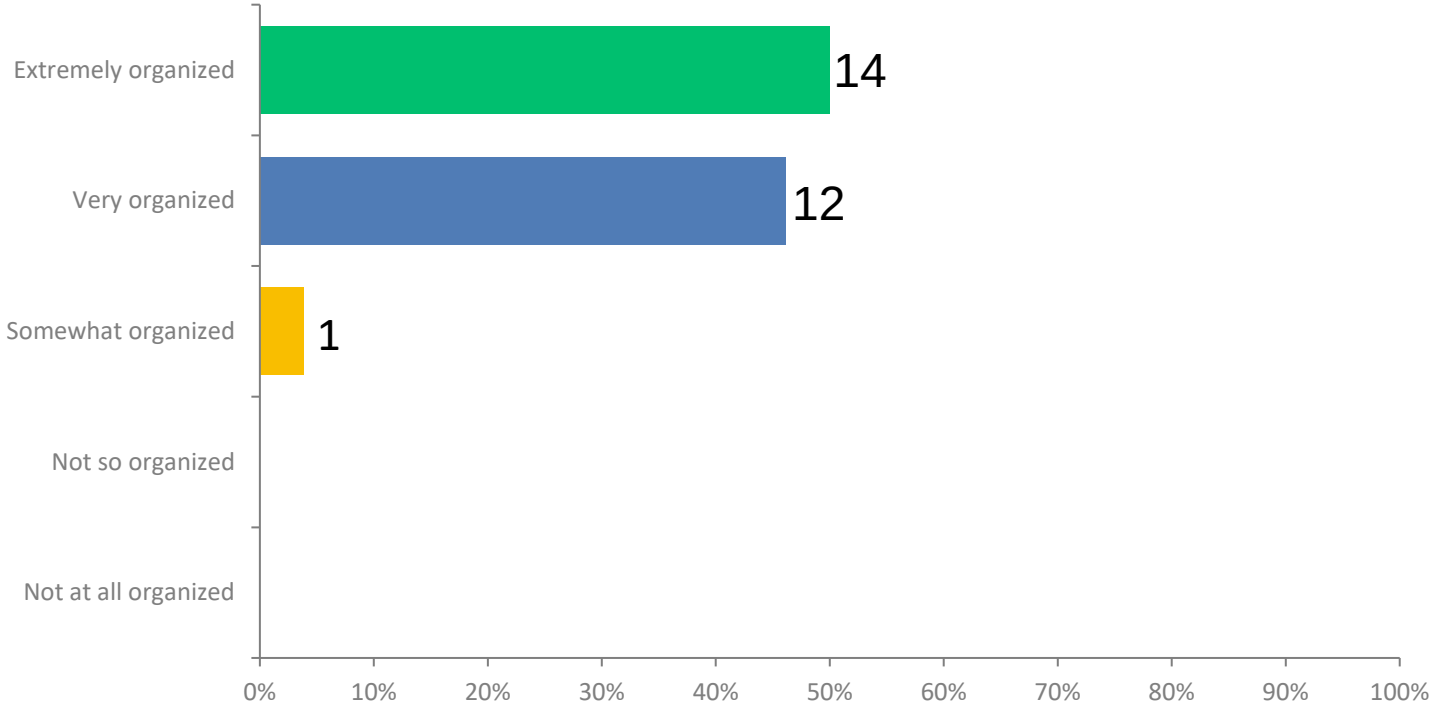
Nov 9 at 2:55 PM ·

@hivcommla Annual Conference.
Thank you for a great informative program. Let’s end this epidemic.

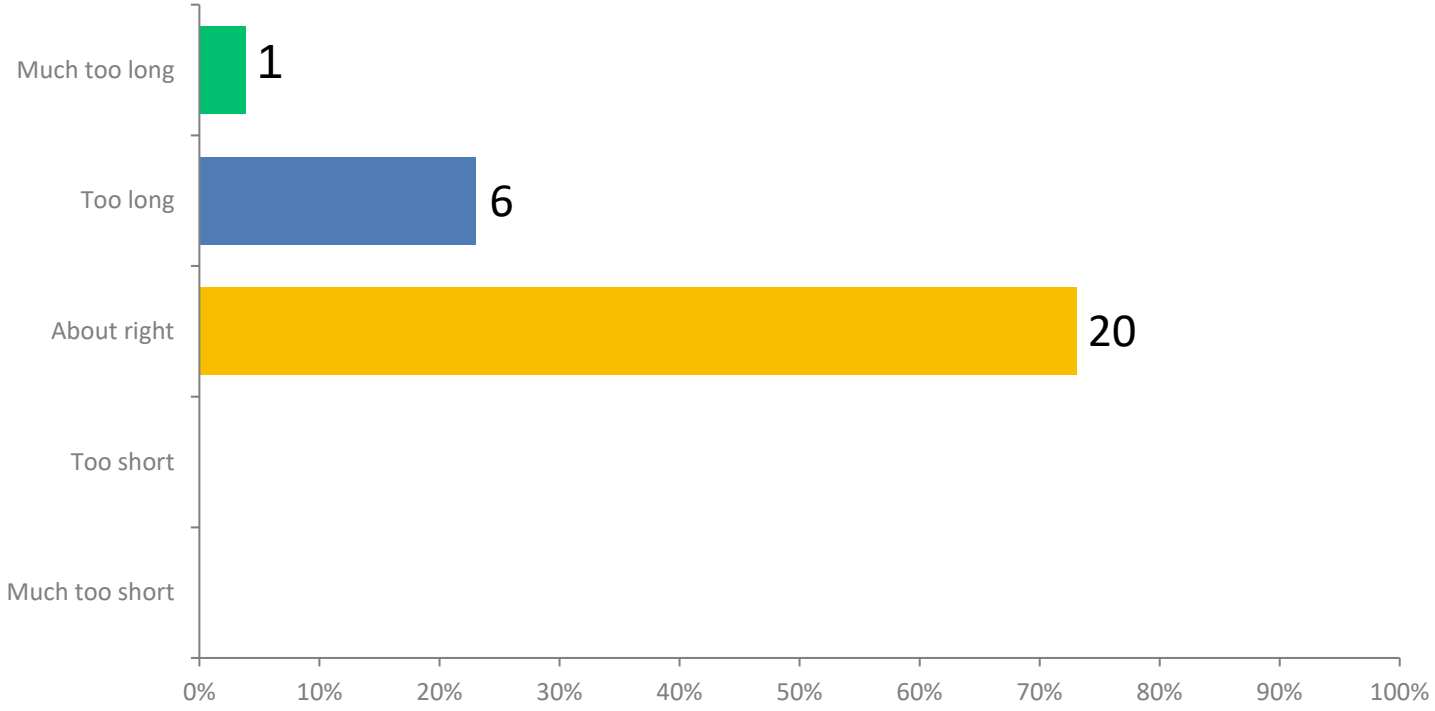
Q1: Overall, how would you rate the event?



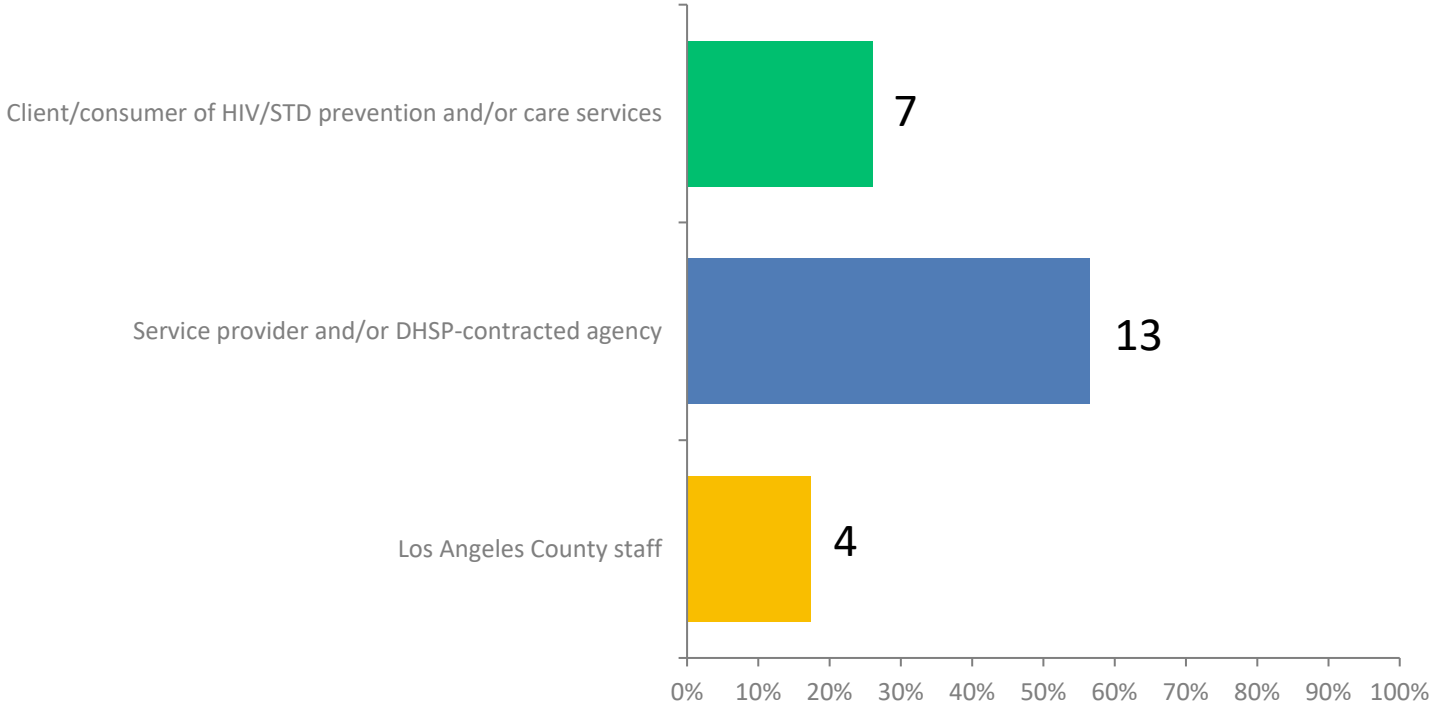
Q4: How organized was the event?



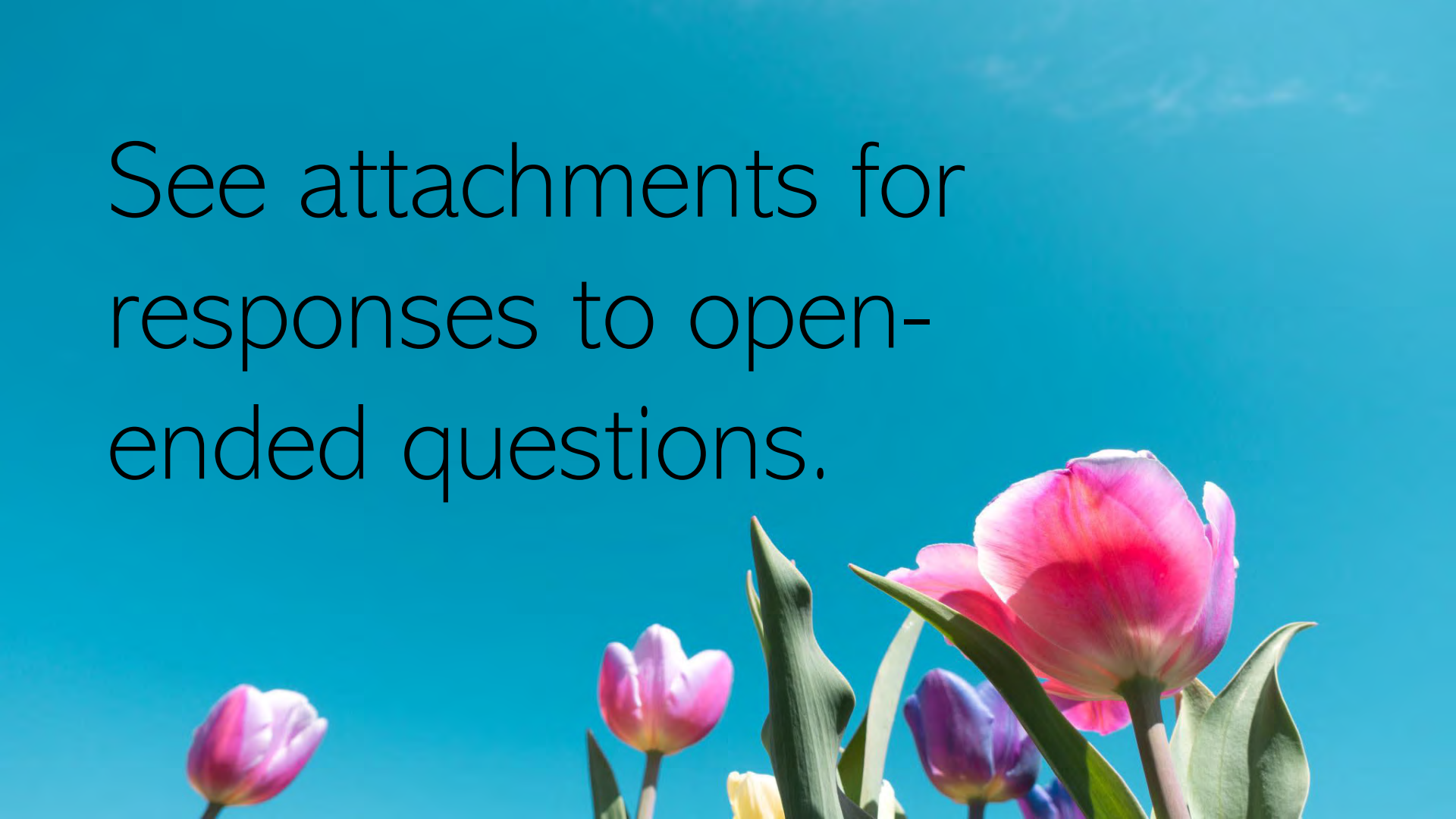
Q5: Was the event length too long, too short or about right?



Q7: Which of the following categories best describes you. Please select one.



See attachments for responses to open-ended questions.



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2023 ANNUAL CONFERENCE EVALUATION
RESPONSES TO OPEN-ENDED QUESTIONS

What did you like about the event?

1. The presenters and content were great. The fellowship of all that attended was very nice.
2. The issues relating to the generational divide.
3. The event flowed well, was informative and thought-provoking, and sometimes entertaining ...
4. Great presentations (except for the Mental Health presenter - that was not engaging and it felt patronizing tbh)
5. Love all the speakers.
6. The information about PrEP and implementation of EHE
7. The location!
8. Presentation and group participation. Information presented.
9. Very well-spoken speakers and great information shared.
10. The collegial aspect of the conference. People had time to talk with each other and spend time doing so. This was a healing opportunity for our community after the years of Covid
11. Very interactive. The topics were relevant to what is happening in our communities.
12. The data about PrEP
13. I enjoyed the intergenerational conversation.
14. I liked all the various topics discussed in the conference!
15. Well-organized, very good presentations and discussions.
16. Various updates on services in LA County
17. Great camaraderie, speakers, and food.
18. People interacting with each other.
19. I enjoyed the presentations, particularly the Harm Reduction, Increasing Access Among Priority Populations, and the Intergenerational conversations.
20. Presentations & Participation
21. The variety of information that was presented. Everyone was excellent.
22. All the presenters were informative and knowledgeable
23. It was super informative. I enjoyed the different speakers and how the problems were being addressed.
24. The EHE session and Doxy PEP sessions were very informative
25. Let's me know where my computer programming outputs find their use.
26. I learned stuff.

What did you dislike about the event?

1. The location of the language interpreters. They were located in the very center of the room, 3 tables back. It was extremely distracting for me, and at times hard to follow the speakers/presenters because the voices of the interpreters were competing with the voices of the speakers/presenters. I think the interpreters could have been located in the very back corners of the room. This way the interpreters could still see and hear everything in order to provide interpretation services, but they would be much less distracting for those of us not needing interpretation services.
2. Should've had more folks in attendance from some of our long-time colleagues,
3. Not so much disliked, as I look forward to when we can have attendance back up at the pre-COVID levels ...
4. Food could have been better and more substantial. The raffle of prizes at the end felt haphazard and the way it was given was a bit unfair - it was a question that was posed and even before the question was asked, Katya raised her hand and then she was given the question, and when she got it right, she got two prizes. It was unfair and I think it was just poor planning because that raffle should have been done appropriately and included everyone who submitted a raffle ticket, not just a raise of hand.
5. Everything was great! Would have liked to hear more from those with lived experiences. Consider panel discussions highlighting some of the populations and opportunities for interaction among attendees and presenters.
6. Everything was good
7. The food
8. N/A
9. Too many audience questions and comments unrelated to the subject.
10. I wish the Housing and Intergenerational segments had been more structured. There was space for improvisation. We could have asked more challenging questions of ourselves.
11. none
12. I personally do not like the breakdown groups.
13. Nothing
14. n/a
15. The slides had to be rotated each time. It was distracting and annoying.
16. Food
17. More information on what the COH has accomplished
18. Went a little too long. Had to rush out and did not get to enjoy the meet and greet after the meeting. Many people left half way through the event.
19. The event could use more opportunities to the be actively engaged. The presentations were amazing but sometimes felt a little being lectured to for hours.
20. N\A
21. Misinformation about 988 mental health crisis hotline.
22. Nothing
23. I was unaware until the morning of.
24. Nothing. The more awareness, the better. If I have to come up with something, it was not a programming seminar.
25. Missed in depth conversations.

Please share other comments you have.

1. Invited to afternoon cookies/snacks, didn't arrive until the closing statements
2. CoH staff continues to set themselves a high standard for subsequent years ...
3. Should end at 2pm
4. I don't have any comments at this time
5. it is nice to meet and learn the new updates!
6. N/A
7. Dr. Moe is a dynamic presenter. People around me were nodding their heads in agreement with her observations. Would the Commission or DHSP sponsor an event with Drs. King, Moe, Hardy and Gottlieb? I was struck by the through line of HIV care and knowledge in these doctors training.
8. n/a
9. I like to see HIV efforts merge with DMH. And DMH do more HIV education.
10. Lovely event, just too long
11. More integrated discussions amongst the larger group, such as the intergenerational activity, would be welcome.
12. I would like to see more Mediterranean meals because cold high carb foods, I was told to stay away from. While there many hours those on medical have restrictions.
13. Just looking forward to seeing if the providers listened and are willing to help their clients more. Also, a little bit more compassionate towards the issues we face daily as PLWHIV

LOS ANGELES COUNTY COMMISSION ON HIV

together.
WE CAN END HIV IN OUR COMMUNITIES ONCE & FOR ALL

2023 ANNUAL CONFERENCE CALL TO ACTION RESPONSES

Los Angeles County State of HIV/STDs/ Updates | Division of HIV and STD Programs (DHSP)	
EDUCATION AND OUTREACH/COMMUNITY ENGAGEMENT AND EMPOWERMENT	• Obtain data on the impact of DoxyPEP on county-wide reductions on STIs. • Secure leadership support from agencies to strengthen community by prioritizing and supporting staff to connect with other agencies. • Increase opportunities for staff to participate in SPA meetings, Commission, Task Forces, etc. Require this for all funded agencies. • Public assistance participants must attend sexual health class/classes to learn about syphilis, gonorrhea, HIV, DoxyPEP. • Visit day care centers and offer workshops for parent on sexual health. • Learn more about working with schools, street medicine, buddy programs, and grants for innovative outreach. • Increase unaffiliated consumer representation on CABs, Commission and other planning efforts. Providers should promote client participation in the Consumer Caucus. Consider opening up the DHSP training for frontline staff to unaffiliated consumers.
PROGRAM AND SERVICE DELIVERY IMPROVEMENTS	• Implement and support programs that reach vulnerable priority populations effectively. • Employ contingency management for staying in care and maintaining viral suppression. • Expand public health detailing program to more clinics. • Clarify if street medicine includes mental health medication. • Expand the availability of and access to women's condoms. • Equip LGBT+ bars with home test kits. • Simplify the application process for the Emergency Financial Assistance program. • Bulk HIV/STD test kits to distribute like COVID tests in pharmacies, clinics, community centers, etc. Incentivize HIV+ clients with SUD and meth to be virologically controlled, similar to contingency management model. DoxyPEP without prescription needed; given through pharmacy. • Start focusing on herpes on MSM. Please use independent pharmacies.

	• Implement HIV testing at commonly utilized, public non-medical service centers (e.g., DMV). This has worked well in D.C. • Take national advocacy action to make benzathine penicillin more available to better treat syphilis and stop transmission. • Advance street medicine programs to deliver injectable ART and PrEP on the street. • Explore how staff and agencies can obtain harm reduction medicine cabinet kits. • Establish (or support and expand) support groups for domestic violence/sexual assault survivors living with HIV specifically women of color {trauma-informed}. Continuous support services (ongoing). • Watts Health Center has a mobile unit currently unused (for most part). It is paid for – but we need funding to use this unit as a street medicine van as well as for full staffing- clinician, nurse, case worker, etc. We have applied for grants with CHIPTS and AMAAD but pending—could this be a joint DHSP endeavor? (FF)
PARTNERSHIPS	Partner with schools to educate and provide care. Compel private health groups and insurers have more skin in the game with comes to STI prevention.

The County's Response to the Intersection of HIV and Substance Use | Harm Reduction and Other Services, DPH, Substance Abuse Prevention and Control (SAPC) | Dr. Sid Puri, Associate Medical Director, SAPC	
EDUCATION AND OUTREACH/COMMUNITY ENGAGEMENT AND EMPOWERMENT	• Establish regular meetings with appropriate commissioners. • Educate community-at-large about the role of safe injection/consumption sites to promote acceptance.
PROGRAM AND SERVICE DELIVERY IMPROVEMENTS	• Clarify federal and local rules and regulations about the ability of FQHCs to serve as a syringe exchange programs. • There is a need for provider detailing and harm reduction strategies around GHB (a.k.a., Liquid Ecstasy, G, Georgia homeboy, cups).

	• Support and expand safe sites/overdose sites. • Create and support users union. • Reduce costs for medication. • Promote women's condoms for harm reduction. • Use harm reduction techniques as a form of prevention instead of gateway to stigma and misinformed calls to action. Reduce stigma so more people come forward and are able to voice their experience as a building block to make these services more accessible or at the very least bring more awareness to services offered. • Establish and use of safe use spaces to engage with PWIDs, offer through OD-protective services, build trust, and begin discussion about harm reduction, recovery and a new way of life. Increase use of harm reduction services as a beginning.
PARTNERSHIPS	• Use independent pharmacies.

PrEP, Long-acting PrEP, DoxyPEP | Strategies for Increasing Access and Utilization among Priority Populations | Dr. Ardis Moe	
EDUCATION AND OUTREACH/COMMUNITY ENGAGEMENT AND EMPOWERMENT	• Inform providers and community about PrEP failures for both oral and long-acting injectables. Educate the community about the costs, uptake and what the reality/complexity is around PrEP failures. • Consider using the messaging, "Health pill" not the "pill to prevent HIV." • Train doctors to prescribe PrEP in emergency departments. • Educate providers and the community about rules and regulations about access to PrEP for minors. • Educate the community about PrEP and DoxyPEP options for cisgender women.
PROGRAM AND SERVICE DELIVERY IMPROVEMENTS	• Operationalize home testing kits for routine PrEP labs to further decrease barrier and increase PrEP persistence. • Support the EHE initiative around pharmacy PrEP Centers of Excellence and share a list of participating pharmacies that can dispense PrEP and PEP and this list disseminated to the

	community. • Promote conversations with providers, especially those who receive those government funds, about making the conversation around PrEP something as easy as asking for general medical care. It would be nice to see Hold providers accountable to having those conversations and prescribing PrEP. Patients shouldn't have to educate their providers. "We are all having sex. But no one is talking about it." • Consider DPH-initiated injectable PrEP with directly observed therapy approach to administer at home. PrEP and DoxyPEP through pharmacy or clinical pharmacist.

Housing and HIV | Community Reflections on Coordinated Planning	
GENERAL REFLECTIONS	• Bridge the huge disconnect between what we discuss at the Commission meetings, the HOPWA reports, and the actual lived experience of patients. Doctors feel helpless when their patients need housing and they are not able to offer help even if their agency has a housing case manager, or funded to provide housing, or serves primarily people experiencing homelessness. • Who do we need to engage to identify a true coordinated entry system? i.e., centralized document repository. How can we create a low barrier entry system? What does a coordinated case management system look like? How can we successfully house persons experiencing mental illness? How can COH and participants contribute to the housing solution other than allocating RWP funding? What training is available on the housing system/partner/ stakeholders in LAC? Need to understand the foundation/context to be able to participate in conversations. What homeless prevention services/programs can we provide? • The homeless point in time count underestimates the severity of homelessness. The unsheltered PIT count in LA was 52,307. The annualized estimate is 87,526. This should be the number used as a denominator for population-based coverage, especially if we

	are following people indoors, which we should be. The unsheltered count is approximately a 30% *underestimate* due to only counting the visible homeless population. This would put us well over 100k. The PIT count *excludes* those in hospitals, jail, and people who are "doubled up." This may result in a disproportionate undercounting of racial and ethnic minorities who are overrepresented in incarcerated populations. A published study did an expanded count to include those in jails, which increased the count by 57%.
PROGRAM AND SERVICE DELIVERY IMPROVEMENTS	• PLWH seniors and disabled for permanent housing as aged are priced out. Create communities of PLWH and other allies for services. Seniors on fixed income are not able to keep up with rising cost of rent. • People need help every step of the way from how to start an application and through maintaining housing. Keep seniors in housing and provide ongoing assistance. • Listings on CHIRPLA does not necessarily mean that an individual will qualify for these units. It is important to prevent eviction. • Reduce caseloads- there is not enough time for case managers to adequately help clients given the huge caseloads. Case managers themselves are barely able to make ends meet and pay their rent. They too need a decent source of income. • Unit set asides for affordable housing are not necessarily affordable. The application fee is too high for many and they need help filling out the application form. • There is lack of housing for seniors; some do not know how to fill out the paper work or collect the required documentation. • HOPWA needs to do just more than “site audits”- talk to consumers. Cover application fees. Increase salary for staff. Smaller caseloads. Housing specialists need to hold their clients through the process. Hire and train more HOPWA and LAHSA staff. • Assist people with subsidized housing stay housed and pay their bills. Train case managers to hold client’s hands throughout their housing needs.

	• Educate the community about entities and resources to maintain the habitability (maintenance and upkeep) of their housing. • More effort is needed to create more housing specialists. More compassion and not just a check. Would be nice to bring more housing organizations to the table. We see the need and how underserved this service is so why isn't the conversation happening to be able to implement on a higher scale. Cross training utilization is lacking when that could potentially bridge the gap in not only, accessing out receiving services. • Address stigma in PLWH and homelessness in order to increase retention in medical care and adhere to ART. Develop strategies specially in cisgender women. • Develop built-in accountability to spend funds that are earmarked in a timely manner. Get passionate/effective/ productive navigators to help clients throughout the process of accessing funds/resources. Have their salaries contingent on a certain level of productivity and incentivize higher pay with helping more clients. • Conduct an asset mapping and work with different housing players to understand different housing options/services available in different geographic areas; have all housing providers come together quarterly to provide report and share inventory of available housing. • A coordinated application process is needed. • Housing for cisgender women is an even bigger issue; some cannot get housing because they have a partner. We need to illustrate housing funding and resources by populations; people need help paying their bills on a regular basis because its too expensive. • Bring housing as part of the status neutral approach. Providers are learning a lot of barriers for clients (such as EFA cannot pay for transitional housing assistance). Staff need additional support for coordination.
PARTNERSHIPS	• It is critical to have HOPWA and LAHSA representatives and leaders present at housing

	conversations. Have a staff from CHIRP LA at Commission meetings. How do we get housing funders to talk to us? • Develop a sustainable housing plan. Consider how much we can actually impact. • Accountability of a timeline for and goals reached (# of homeless persons housed) to ensure prompt and productive use of appropriated funds from each funded source. Integration of mental health, substance use, more building/rehabilitation, life skills building services with housing. • Consider awarding contracts to other and new entities to have a new approach. Maybe giving contracts to community members with a fresh plan. • Work with housing funders to host RFP informational sessions.

Then & Now: Where We Were & Where We Are Now **Facilitated Community Discussion | Intergenerational Perspectives on Community Building and Resilience**	
EDUCATION AND OUTREACH/COMMUNITY ENGAGEMENT AND EMPOWERMENT	• Consider how staff/client/patient generational differences impact positively or negatively healthcare outcomes. Provide education about the different generations; mentorship and reverse mentorship; allyship; storytelling; technology comfort – opportunities to end HIV. • Ongoing training on cultural humility. • Work together. Share experience and wisdom. Start/end with any 1 process/person. Promote relatability and allyship. Stigma still here. Use status-neutral language. Use language that promote unity rather than division. Address lack of trust. Promote diversity equity, shared values, shared goals and things in common. Consider information accessibility across generations. • It is important to involve the communities that one is conducting research, care, outreach, and programs for in the decisions that affect them, particularly in youth. Have voting members of every generation ensures that there is an active voice in the decisions being made for them. For instance, if you have a department that serves ages 12-24, you

	should have a member of that age range with equal voting power helping to make decisions for them. • More fun space intergenerational, like a game night where we learn old and new games.

Enhancing Access to Mental Health Services for PLWH | Dr. Curley Bonds, Chief Medical Officer, Los Angeles County Department of Mental Health	
EDUCATION AND OUTREACH/COMMUNITY ENGAGEMENT AND EMPOWERMENT	• Address or bridge the disconnect with what is actually experienced by patients and services offered in the community. Consider a patient and DMH panel to continue this important conversation. • Increase promotion of 988. Consider working with a coalition or workgroup that meet monthly or whatever it may be to offer services across the board to organizations which may need these extended services or services they do not directly offer.
PROGRAM AND SERVICE DELIVERY IMPROVEMENTS	• Work with DMH to collect HIV status data for all clients. How and what training do MH clinicians need to address HIV and LGBTQ+ issues?
PARTNERSHIPS	• Foster more connection with LAC DMH and the Commission.

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PROPOSED VISION AND MISSION STATEMENTS COMMUNITY REACTIONS

Part I VISION STATEMENTS

1	**(CURRENT)** 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. • Strongly agree 12 • Agree 5 • Neutral 3
2	An equitable system of HIV prevention and care that is comprehensive, sustainable, and accessible empowering and educating all communities to make informed decisions about their sexual health needs to maximize life expectancy and optimize quality of life. • Strongly agree 9 • Agree 8 • Neutral 2
3	To eliminate HIV transmission in Los Angeles County and maximize life expectancy and optimize quality of life for those living with HIV and those at high risk. • Strongly agree 11 • Agree 5 • Neutral 4 • Strongly disagree 2
4	• Education/training; long term survivors • More innovative ideas and resolution in how we access virtually for those who are technically challenged or cannot attend meeting in person due to their diagnosis of HIV/AIDS. • Promotion of sexual health is my preference, however it ignores the fact that HIV is transmitted by other means. • I hope it's really comprehensive because is causing a disconnect between resources and community because a lot of linkage systems are not comprehensive. I would have liked to see some language about whole person care.

Part II MISSION STATEMENTS

1	**(CURRENT)** 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). • Strongly agree 9 • Agree 5 • Neutral 5

2	To plan, promote, and advocate for equitable policies, programs, and services that address the HIV epidemic in Los Angeles County. The Commission works to ensure that Los Angeles residents have access to quality sexual healthcare, including HIV prevention, testing, treatment, and support services. The Commission strives to eliminate stigma and discrimination associated with all sexually-transmitted diseases and to promote sexual health awareness and education to the public, particularly in underserved communities. Utilizing an approach that addresses both the mental and physical health of the whole person as well as social determinants of health, the Commission collaborates with and seeks input from people with lived experience, planners, and stakeholders to coordinate efforts and leverage resources to ensure that its work is responsive to the needs of those impacted by the epidemic, regardless of socioeconomic status. • Strongly agree 12 • Agree 6 • Disagree 2
3	To work with local stakeholders to plan for programs and services to end HIV transmission, improve and optimize quality of life for those living with HIV through community engagement and advocacy and to ensure a system of care that is responsive to community needs. • Strongly agree 8 • Agree 8 • Neutral 1
4	Other suggestions or comments: None provided.

12/12/23 OPS/EXEC
INITIAL/FIRST REVIEW

TRACKED CHANGES

POLICY/PROCEDURE #06.1000	Bylaws of the Los Angeles County Commission on HIV	Page 1 of 24

SUBJECT: **The Bylaws of the Los Angeles County Commission on HIV.**

PURPOSE: **To define the governance, structural, operational, and functional responsibilities and requirements of the Los Angeles County Commission on HIV.**

BACKGROUND:

- **Health Resources and Services Administration (HRSA) Guidance**: "Planning Councils must set up planning council operations to help the planning council to operate smoothly and fairly. This includes such features as bylaws, open meetings, grievance procedures, and conflict of interest standards." [Ryan White HIV/AIDS Program Part A Manual, VI (Planning Council Operations), 1. Planning Council Duties, C. Fulfilling Planning Council Duties, Planning Council Operations].

- **Centers for Disease Control and Prevention (CDC) Guidance: "**The HIV Planning Group (HPG) is the official HIV planning body that follows the *HIV Planning Guidance* to inform the development or update of the health department's Jurisdictional HIV Prevention Plan, which depicts how HIV infection will be reduced in the jurisdiction."

- **Los Angeles County Code, Title 3—Chapter 3.29.070 (Procedures)**: "The Commission shall adopt bylaws which may include provisions relating to the time and place of holding meetings, election and terms of its co-chairs and other officers, and such other rules and procedures necessary for its operation."

POLICY:

1) **Consistency with the Los Angeles County Code:** The Commission's Bylaws are developed in accordance with the Los Angeles County Code, Title 3—Chapter 29 ("Ordinance"), the authority which establishes and governs the administration and operations of the Los Angeles County Commission on HIV. These Bylaws serve as the Commission's administrative, operational, and functional rules and requirements.

2) RWHAPRWHAPRWHAPRWHAPRWHAP**Commission Bylaws Review and Approval**: The Commission conducts an annual administrative review of these Bylaws to ensure ongoing compliance, relevance, and adaptability to changes in both the external environment and internal structure.

A. Prior to approval by its members, the Commission will request that the Ryan White HIV/AIDS Program (RWHAP) Part A project officer review the draft Bylaws to ensure compliance and alignment with HRSA requirements.

B. Amendments to the Bylaws will be promptly considered, with any necessary adjustments made in alignment with amendments to the Ordinance.

C. Approval of amendments or revisions requires a two-thirds vote from Commission members present at the meeting. To facilitate a thorough and informed decision-making process, proposed changes must be formally noticed for consideration and review at least ten days prior to the scheduled meeting (refer to Article XVI). Additionally, a 30-day public comment period will open, allowing the public to provide input on the proposed amendments for further transparency and inclusivity.

ARTICLES:

I. NAME AND LEGAL AUTHORITY:

Section 1. Name. The name of this Commission is the Los Angeles County Commission on HIV.

Section 2. Created. This Commission was created by an act of the Los Angeles County Board of Supervisors ("BOS"), codified in sections 3.29.010 – 3.29.120, Title 3—Chapter 29 of the Los Angeles County Code.

Section 3. Organizational Structure. The Commission on HIV is housed as an independent commission within the Executive Office of the BOS in the organizational structure of the County of Los Angeles.

Section 4. Duties and Responsibilities. As defined in Los Angeles County Code 3.29.090 (*Duties*), and consistent with Section 2602(b)(4) (42 U.S.C § 300ff-12) of the Ryan White HIV/AIDS Program legislation, HRSA guidance, and requirements of the CDC HIV Planning Guidance, the Commission is charged with and authorized to:

A. Develop a comprehensive HIV plan that is based on assessment of service needs and gaps and that includes a defined continuum of HIV services; monitor the implementation of that plan; assess its effectiveness; and collaborate with the Division of HIV and STD Programs ("DHSP")/Department of Public Health ("DPH") to update the plan on a regular basis.

B. Develop standards of care for the organization and delivery of HIV care, treatment, and prevention services.

C. Establish priorities and allocations of RWHAP Part A and B and CDC prevention funding in percentage and/or dollar amounts to various services; review the grantee's allocation and expenditure of these funds by service category or type of activity for consistency with the Commission's established priorities, allocations, and comprehensive HIV plan, without the review of individual contracts; provide and monitor directives to the grantee on how to best meet the need and other factors that further instruct service delivery planning and implementation; and provide assurances to the BOS and HRSA verifying that service category allocations and expenditures are consistent with the Commission's established priorities, allocations and comprehensive HIV plan.

D. Evaluate service effectiveness and assess the efficiency of the administrative mechanism, with particular attention to outcome evaluation, cost effectiveness, rapid disbursement of funds, compliance with Commission priorities and allocations, and other factors relevant to the effective and efficient operation of the local Eligible Metropolitan Area's ("EMA") delivery of HIV services.

E. Plan and develop HIV and public health service responses to address the frequency of HIV infection concurrent with STDs and other co-morbidities; plan the deployment of those best practices and innovative models in the County's STD clinics and related health centers; and strategize mechanisms for adapting those models to non-HIV-specific platforms for an expanded STD and co-morbidity response.

F. Study, advise, and recommend to the BOS, the grantee and other departments policies and other actions/decisions on matters related to HIV.

G. Inform, educate, and disseminate information to consumers, specified target populations, providers, the public, and HIV and health service policy makers to build knowledge and capacity for HIV prevention, care, and treatment, and actively engage individuals and entities concerned about HIV.

H. Provide a report to the BOS annually describing Los Angeles County's progress in ending HIV as a threat to the health and welfare of Los Angeles County residents with indicators to be determined by the Commission in collaboration with DHSP; make other reports as necessary to the BOS, the grantee, and other departments on HIV-related matters referred for review by the BOS, the grantee, or other departments.

I. Act as the planning body for all HIV programs in DPH or funded by the County; and

J. Make recommendations to the BOS, the grantee and other departments concerning the allocation and expenditure of funding other than Ryan White Program Part A and B and CDC prevention funds expended by the grantee and the County for the provision of HIV-related services.

Section 5. Federal and Local Compliance. These Bylaws ensure that the Commission meets all RWHAP, HRSA, and CDC requirements and adheres to the Commission's governing Los Angeles County Code, Title 3—Chapter 29.

Section 6. Service Area. In accordance with Los Angeles County Code and funding designations from HRSA and the CDC, the Commission executes its duties and responsibilities for the entire County.

A. The geographic boundaries of Los Angeles County match the funding. designations from both the CDC and HRSA, which calls the Part A funding area an Eligible Metropolitan Area ("EMA").

II. MEMBERS:

Section 1. Definition. A member of this Commission is any person who has been duly appointed by the BOS as a Commissioner, Alternate or a Committee-only member.

A. Commissioners are appointed by the BOS as full voting members to execute the duties and responsibilities of the Commission.

B. Alternates are appointed by the BOS to serve in place of an Unaffiliated Consumer member when the Unaffiliated Consumer members cannot fulfill their Commission duties and responsibilities.

C. Committee-only members are appointed by the BOS to serve as voting members on the Commission's standing committees, according to the committees' processes for selecting Committee-only members.

Section 2. Composition. As defined by Los Angeles County Code 3.29.030 (*Membership*), all members of the Commission shall serve at the pleasure of the BOS. The membership shall consist of fifty (50) voting members and one (1) non-voting member. Voting members are nominated by the Commission and appointed by the BOS. Non-voting members do not count toward quorum.

Consistent with the Open Nominations Process, the following recommending entities shall forward candidates to the Commission for membership consideration:

A. Five (5) members who are recommended by the following governmental, health and social service institutions, among whom shall be individuals with epidemiology skills or experience and knowledge of Hepatitis B, C and STDs:
   1. Medi-Cal, State of California,
   2. City of Pasadena,
   3. City of Long Beach,
   4. City of Los Angeles,
   5. City of West Hollywood

B. One (1) non-voting member representative from the Los Angeles County Department of Public Health, Division of HIV and STD Programs (DHSP) - the RWPRWHAP Recipient/Part A Grantee.

C. Four (4) members who are recommended by RWHAP grantees as specified below or by representative groups of RWHAP grant recipients in the County, one from each of the following:
   1. Part B (State Office of AIDS),
   2. Part C (Part C grantees),
   3. Part D (Part D grantees),
   4. Part F [Part F grantees serving the County, such as the AIDS Education and Training Centers (AETCs), or local providers receiving Part F dental reimbursements].

D. Eight (8) provider representatives who are recommended by the following types of organizations in the County and selected to ensure geographic diversity and who reflect the epicenters of the epidemic, including:
   1. An HIV specialty physician from an HIV medical provider,
   2. A Community Health Center/Federally Qualified Health Center ("CHC"/ "FQHC") representative,
   3. A mental health provider,
   4. A substance abuse treatment provider,
   5. A housing provider,
   6. A provider of homeless services,
   7. A representative of an AIDS Services Organization ("ASO") offering federally funded HIV prevention services,
   8. A representative of an ASO offering HIV care and treatment services.

E. Seventeen (17) unaffiliated consumers of Part A services, to include:
   1. Eight (8) consumers, each representing a different Service Planning Area ("SPA") and who are recommended by consumers and/or organizations in the SPA,

2. Five (5) consumers, each representing a supervisorial district, who are recommended by consumers and/or organizations in the district,
3. Four (4) consumers serving in an at-large capacity, who are recommended by consumers and/or organizations in the County.

F. Five (5) representatives, with one (1) recommended by each of the five (5) supervisorial offices.

G. One (1) provider or administrative representative from the Housing Opportunities for Persons with AIDS (HOPWA) program, recommended by the City of Los Angeles Housing Department.

H. One (1) representative of a health or hospital planning agency.

I. One (1) behavioral or social scientist who promotes and presents behavioral research regarding HIV/AIDS and STIs and the people it impacts/affects. .

J. Eight (8) representatives of HIV stakeholder communities, each of whom may represent one or more of the following categories. The Commission may choose to nominate several people from the same category or to identify a different stakeholder category, depending on identified issues and needs:
1. Faith-based entities engaged in HIV prevention and care,
2. Local education agencies at the elementary or secondary level,
3. The business community,
4. Union and/or labor,
5. Youth or youth-serving agencies,
6. Other federally funded HIV programs,
7. Organizations or individuals engaged in HIV-related research,
8. Organizations providing harm reduction services,
9. Providers of employment and training services, and
10. HIV-negative individuals from identified high-risk or special populations.

Section 3. Term of Office. Consistent with the Los Angeles County Code 3.29.050 (*Term of Service*), all members serve two-year terms.

A. Commissioners and Alternates serve two-year staggered terms as reflected on the Membership Roster.

B. A Committee-only member's term begins with the date of appointment and serves a one-year term.

C. Members are limited to three consecutive terms and are eligible to reapply following a one-year break in service.

Section 4. Consumer Membership. In accordance with RWHAP Part A legislative requirements outlined in Section 2602(b)(2): REPRESENTATION, the Commission shall ensure that 33% of its members are consumers of RWHAP Part A services who are not aligned or affiliated with RWHAP Part A-funded providers as employees, consultants, or Board members.

Additionally, at least one (1) consumer member must be co-infected with Hepatitis B or C; andat least one (1) consumer member must be a person who was incarcerated in a Federal, state, or local facility within the past three (3) years and who has a HIV diagnosis as of the date of release or is a representative of the recently incarcerated described as such.**Section 5. Reflectiveness**. In accordance with RWHAP Part A legislative requirements [Section 2602(b)(1)], the Commission shall ensure that its full membership and the subset of unaffiliated consumer members proportionately reflect the ethnic, racial and gender characteristics of HIV disease prevalence in the EMA.

Section 6. Representation. In accordance with RWHAP Part A legislative requirements [Section 2602(b)(2)], the Commission shall ensure that all appropriate specific membership categories designated in the legislation are represented among the membership of Commission.

A. Commission membership shall include individuals from areas with high HIV and STD incidence and prevalence.

Section 7. Parity, Inclusion, and Representation (PIR). In accordance with CDC's *HIV Planning Guidance,* the planning process must ensure the parity and inclusion of the members.

A. "'Parity' is the ability of HIV planning group members to equally participate and carry out planning tasks or duties in the planning process. To achieve parity, representatives should be provided with opportunities for orientation and skills-building to participate in the planning process and have an equal voice in voting and other decision-making activities."

B. "'Inclusion' is the meaningful involvement of members in the process with an active role in making decisions. An inclusive process assures that the views, perspectives, and needs of affected communities, care providers, and key partners are actively included."

A. "Representation" means that "members should be representative of varying races and ethnicities, genders, sexual orientations, ages, and other characteristics such as varying educational backgrounds, professions, and expertise."

Section 8. HIV and Target Population Inclusion. In all categories when not specifically required, recommending entities and the Commission are strongly encouraged to nominate candidates living with HIV and individuals who are members of populations at disproportionate risk for HIV.

Section 9. Accountability. Members are expected to convey two-way information and communication between their represented organization/constituency and the Commission. Members are expected to provide the perspective of their organization/constituency and the Commission to other, relevant organizations regardless of the member's personal viewpoint. Members may, at times, represent multiple constituencies.

Section 10. Alternates. In accordance with Los Angeles County Code 3.29.040 (*Alternate members*), any Commission member who has disclosed that they are living with HIV is entitled to an Alternate who shall serve in the place of the Commissioner when necessary.

A. Alternates submit the same application and are evaluated and scored by the same nomination process as Commissioner candidates.

Section 11. Committee-only Members. Consistent with the Los Angeles County Code 3.29.060 D (*Meetings and committees*), the Commission's standing committees may elect to nominate Committee-only members for appointment by the BOS to serve as voting members on the respective committees to provide professional expertise, as a means of further engaging community participation in the planning process.

Section 12. DHSP Role & Responsibility. DHSP, despite being a non-voting member, plays a pivotal role in the Commission's work. As the RWHAP Grantee and Part A representative for the Los Angeles County EMA, DHSP provides essential epidemiological and surveillance data to guide the Commission's decision-making. DHSP plays a central role in carrying out needs assessments, conducting comprehensive planning, overseeing contracting and procurement of providers, evaluating service effectiveness, and performing quality management. Collaborating closely with DHSP, the Commission ensures effective coordination and implementation of its integrated comprehensive HIV plan. The Commission heavily relies on this partnership to ensure the optimal use of RWHAP funds and

adherence to legislative and regulatory requirements, ensuring the highest standard of HIV services in Los Angeles County.

III. MEMBER REQUIREMENTS:

Section 1. Attendance. Commissioners and/or their Alternates are expected to attend all regularly scheduled Commission meetings, primary committee meetings, priority- and allocation-setting meetings, orientation, and training meetings, and the Annual Conference.

A. In accordance with Los Angeles County Code 3.29.060 (*Meetings and committees*), the BOS shall be notified of member attendance on a semi-annual basis.

Section 2. Committee Assignments. Commissioners are required to be a member of at least one standing committee, known as the member's "primary committee assignment," and adhere to attendance requirements of that committee.

A. Commissioners who live and work outside of Los Angeles County as necessary to meet expectations of their specific seats on the Commission are exempted from the requirement of a primary committee assignment, i.e., State Office of AIDS/Part B Representative and State Medi-Cal Representative

B. Commissioners and Alternates are allowed to voluntarily request or accept "secondary committee assignments" upon agreement of the Co-Chairs.

Section 3. Conflict of Interest. Consistent with the Los Angeles County Code 3.29.046 (*Conflict of Interest*), Commission members are required to abide by the Conflict of Interest and Disclosure requirements of the Commission, the County of Los Angeles, the State of California (including Government Code Sections 87100, 87103, and 1090, et seq.), the RWHAP, as outlined in HRSA and relevant CDC guidance.

A. As specified in Section 2602(b)(5) (42 U.S.C § 300ff-12) of the RWHAP legislation, the Commission shall not be involved directly or in an advisory capacity in the administration of RWHAP funds and shall not designate or otherwise be involved in the selection of entities as recipients of those grant funds. While not addressed in the Ryan White legislation, the Commission shall adhere to the same rules for CDC and other funding.

B. Section 2602(b)(5)(B) continues that a planning council member who has a financial interest in, is employed by, or is a member of a public or private entity seeking local RWHAP funds as a provider of specific services is precluded from participating in—directly or in an advisory capacity—the process of selecting contracted providers for those services.

C. Further, in accordance with HRSA guidance, Commission Policy #08.3108: Ryan White Conflict of Interest Requirements, dictates that all members must declare conflicts of interest involving RWHAP-funded agencies and their services, and the member is required to recuse themselves from discussion and/or voting concerning that area of conflict, or funding for those services and/or to those agencies.

Section 4. Code of Conduct. All Commission members and members of the public are expected to adhere to the Commission's approved Code of Conduct at Commission and sponsored meetings and events. Those in violation of the Code of Conduct will be subject to the Commission's Policy #08.3302 Intra-Commission Grievance and Sanctions Procedures.

Section 5. Comprehensive Training. Commissioners and Alternates are required to fulfill all mandatory County and Commission training requirements.

Section 6. Removal/Replacement. A Commissioner or Alternate may be removed or replaced by the BOS for failing to meet attendance requirements, and/or other reasons determined by the BOS.

A. The Commission, via its Operations and Executive Committees, may recommend vacating a member's seat if egregious or unresolved violations of the Code of Conduct occur, after three months of consecutive absences, if the member's term is expired, or during the term if a member has moved out of the jurisdiction and/or no longer meets the qualifications for the seat.

IV. NOMINATION PROCESS:

Section 1. Open Nominations Process. Application, evaluation, nomination and appointment of Commission members shall follow "...an open process (in which) candidates shall be selected based on locally delineated and publicized criteria," as described in Section 2602(b)(1) of the RWHAP legislation and "develop and apply criteria for selecting HPG members, placing special emphasis on identifying representatives of at-risk, persons living with HIV/AIDS, and socio-economically marginalized populations," as required by the CDC *HIV Planning Guidance.*

A. The Commission's Open Nominations Process is defined in Policy/ Procedure #09.4205 (*Commission Membership Evaluation and Nominations Process*) and related policies and procedures.

B. Nomination of candidates that are forwarded to the BOS for appointment shall be made according to the policy and criteria adopted by the Commission.

Section 2. Application. Application for Commission membership shall be made on forms as approved by the Commission.

A. All candidates for first-time Commission membership shall be interviewed by

the Operations Committee. Renewing members must complete an application and may be subject to an interview as determined by the Operations Committee.

B. Any candidate may apply individually or through recommendation of other stakeholders or entities.

C. Candidates cannot be recommended to the Commission or nominated to the BOS without completing the appropriate Commission-approved application, BOS Statement of Qualifications, and being evaluated and scored by the Operations Committee.

Section 3. Appointments. All Commission members (Commissioners, Alternates and Committee-only members) must be appointed by the BOS.

V. MEETINGS:

Section 1. Public Meetings. The Commission adheres to federal open meeting regulations outlined in Section 2602(b)(7)(B) of the RWHAP legislation, accompanying HRSA guidance, and California's Ralph M. Brown Act (Brown Act).

A. According to the RWHAP legislation, Council meetings must be open to the public with adequate notice. HRSA guidance extends these rules to Commission and committee meetings.

B. The Brown Act mandates that any meeting involving a quorum of the Commission or committee must be publicly open and noticed.

C. Specific public meeting requirements for Commission working units are detailed in Commission Policy #08.1102: Subordinate Commission Working Units.

Section 2. Public Noticing. Advance public notice of meetings shall comply with HRSA's open meeting and Brown Act public noticing requirements, and all other applicable laws and regulations.

Section 3. Meeting Minutes/Summaries. Meeting summaries and minutes are produced in accordance with HRSA's open meeting requirements, the Brown Act, Commission policies and procedures, and all other applicable laws and regulations.

A. Meeting minutes are posted to the Commission's website at https://hiv.lacounty.gov/ following their approval by the respective body.

Section 4. Public Comment. In accordance with Brown Act requirements, public comment on agendized and non-agendized items are allowed at all Commission meetings open to the public. The Commission is allowed to limit the time of public comment consistent with Los Angeles County rules and regulations and must adhere to all other County and Brown Act rules and requirements regarding public comment.

Section 5. Regular meetings. In accordance with Los Angeles County Code 3.29.060 (*Meetings and committees*), the Commission shall meet at least ten (10) times per year. Commission meetings are held monthly, unless cancelled, at a time and place to be designated by the Co-Chairs or the Executive Committee.

A. The Commission's Annual Conference will replace one of the regularly scheduled monthly meetings.

Section 6. Special Meetings. In accordance with the Brown Act, special meetings may be called as necessary by the Co-Chairs, the Executive Committee, or a majority of the members of the Commission.

Section 7. Executive Sessions. In accordance with the Brown Act, the Commission or its committees may convene executive sessions closed to the public to address pending litigation or personnel issues. An executive session will be posted as such.

Section 8. Robert's Rules of Order. All meetings of the Commission shall be conducted according to the current edition of "*Robert's Rules of Order, Newly Revised*," except where superseded by the Commission's Bylaws, policies/procedures, and/or applicable laws.

Section 9. Quorum. In accordance with Los Angeles County Code 3.29.070 (*Procedures*), the quorum for any regular or special Commission or committee meeting shall be a majority of voting, seated Commission or committee members.

A. A quorum for any committee meeting shall be a majority of Board-appointed, voting members or their Alternates assigned to the committee.

Non-voting members, i.e., DHSP, do not count toward quorum.

VI. RESOURCES:

Section 1. Fiscal Year. The Commission's Fiscal Year (FY) and programmatic year coincide with the County's fiscal year, from July 1 through June 30 of any given year.

Section 2. Operational Budgeting and Support. Operational support for the Commission is principally derived from RWHAP Part A and CDC prevention funds, and Net County Costs ("NCC")—all from grant and County funding managed by DHSP. Additional support may be obtained from alternate sources, as needed and available, for specific Commission activities.

A. The total amount of each year's operational budget is negotiated annually with DHSP, in accordance with County budgeting guidelines, and approved by the DHSP Director and the Commission's Executive Committee.
B. Projected Commission operational expenditures are allocated from RWHAP Part A administrative, CDC prevention, and NCC funding in compliance with relevant guidance and allowable expenses for each funding stream. As the administrative agent of those funds, DHSP is charged with oversight of the funds to ensure that their use for Commission operational activities is compliant with relevant funder program regulations and the terms and conditions of the award/funding.
C. Costs and expenditures are enabled through a Departmental Service Order (DSO) between DHSP/DPH and the Executive Office of the BOS, the Commission's fiscal and administrative agent.
D. Expenditures for staffing or other costs covered by various funding sources will be prorated in the Commission's annual budget according to their respective budget cycles and the Commission's/County's fiscal year.

Section 3. Other Support. Activities beyond the scope of RWHAP Part A planning councils and CDC HPGs, as defined by HRSA and CDC guidance, are supported by other sources, including NCC, as appropriate.

Section 4. Additional Revenues. The Commission may receive other grants and/or revenues for projects/activities within the scope of its duties and responsibilities, as defined in these Bylaws Article I, Section 4. The Commission will follow County-approved procedures for allocating project-/activity-related costs and resources in the execution of those grants and/or fulfillment of revenue requirements.

Section 5. Commission Member Compensation. In accordance with Los Angeles County Code 3.29.080 (*Compensation*), RWHAP Part A planning council requirements, CDC guidance, and/or other relevant grant restrictions, Commission members, or designated subsets of Commission members, may be compensated for their service on the Commission contingent upon the establishment of policies and procedures governing Commission member compensation practices.

Section 6. Staffing. The Executive Director serves as the Commission's lead staff person and manages all personnel, budgetary and operational activities of the Commission.

A. The Co-Chairs and the Executive Committee are responsible for overseeing the Executive Director's performance and management of Commission operations and activities consistent with Commission decisions, actions, and directives.

B. Within Los Angeles County's organizational structure, the County's Executive Officer and/or his/her delegated representative serve as the supervising authority of the Executive Director.

VII. POLICIES AND PROCEDURES:

Section 1. Policy/Procedure Manual. The Commission develops and adopts policies and procedures consistent with RWHAP, HRSA, and CDC requirements, Los Ange-les County Code, Title 3—Chapter 29, these Bylaws, and other relevant governing rules and requirements to operationalize Commission functions, work, and activities. The policy/procedure index and accompanying adopted policies/procedures are incorporated by reference into these Bylaws.

Section 2. HRSA Approval(s). DMHAP/HAB at HRSA requires RWHAP Part A planning councils to submit their grievance and conflict of interest policies for review by the RWHAP Part A project officer.

A. Although it is not required, it is the Commission's practice to submit proposed drafts of its Bylaws for review to ensure compliance with HRSA requirements.

Section 3. Grievance Procedures. The Commission's *Grievance Process* is incorporated by reference into these Bylaws. The Commission's grievance procedures must comply with RWHAP, HRSA, CDC, and Los Angeles County requirements, and will be amended from time to time, as needed, accordingly.

Section 4. Complaints Procedures. Complaints related to internal Commission matters such as alleged violations of the Code of Conduct or other disputes among members are addressed and resolved in adherence to Commission's Policy #08.3302: Intra-Commission Grievance and Sanctions Procedure.

Section 5. Conflict of Interest Procedures. The Commission's conflict of interest procedures must comply with the RWHAP legislation, HRSA guidance, CDC, State of California and Los Angeles County requirements, and will be amended from time to time, as needed, accordingly. These policies/procedures are incorporated by reference into these Bylaws.

VIII. LEADERSHIP:

Section 1. Commission Co-Chairs. The officers of the Commission shall be two (2) Commission Co-Chairs ("Co-Chairs").

A. One of the Co-Chairs must be person living with HIV/AIDS. Best efforts shall be made to have the Co-Chairs reflect the diversity of the HIV epidemic in Los Angeles County.

B. The Co-Chairs' terms of office are two years, which shall be staggered. In the event of a vacancy, a new Co-Chair shall be elected to complete the term.

C. The Co-Chairs are elected by a majority vote of Commissioners or Alternates present at a regularly scheduled Commission meeting at least four months prior to the start date of their term, after nominations periods opened at the prior regularly scheduled meeting. The term of office begins at the start of the calendar year. When a new Co-Chair is elected, this individual shall be identified as the Co-Chair-Elect and will have four months of mentoring and preparation for the Co-Chair role.

D. As reflected in the Commission Co-Chair Duty Statement, one or both Co-Chairs shall preside at all regular or special meetings of the Commission and at the Executive Committee. In addition, the Co-Chairs shall:

1. Assign the members of the Commission to committees.
2. Approve committee co-chairs, in consultation with the Executive Committee.
3. Represent the Commission at functions, events, and other public activities, as necessary.
4. Call special meetings, as necessary, to ensure that the Commission fulfills its duties.
5. Consult with and advise the Executive Director regularly, and the RWHAP Part A and CDC project officers, as needed.
6. Conduct the performance evaluation of the Executive Director, in consultation with the Executive Committee and the Executive Office of the BOS.
7. Chair or co-chair committee meetings in the absence of both committee co-chairs.
8. Serve as voting members on all committees when attending those meetings.
9. Are empowered to act on behalf of the Commission or Executive Committee on emergency matters; and
10. Attend to such other duties and responsibilities as assigned by the BOS or the Commission.

Section 2. Committee Co-Chairs: Each committee shall have two co-chairs.

A. Committee co-chairs' terms of office are for one year and may be re-elected by the committee membership. In the event of a vacancy, a new co-chair shall be elected by the respective committee to complete the term.
B. Committee co-chairs are elected by a majority vote of the members of the respective committees present at regularly scheduled meetings at the
C. beginning of the calendar year, following the open nomination period at the prior regularly scheduled meetings of the committees. As detailed in the Commission Co-Chair Duty Statement, one or both co-chairs shall preside at all regular or special meetings of their respective committee. Committee co-chairs shall have the following additional duties:
    1. Serve as members of the Executive Committee.
    2. Develop annual work plans for their respective committees in consultation with the Executive Director, subject to approval of the Executive Committee and/or Commission.
    3. Manage the work of their committees, including ensuring that work plan tasks are completed; and
    4. Present the work of their committee and any recommendations for action to the Executive Committee and the Commission.

IX. COMMISSION WORK STRUCTURES:

Section 1. Committees and Working Units. The Commission completes much of its work through a strong committee and working unit structure outlined in Commission Policy #08.1102: Subordinate Commission Working Units.

Section 2. Commission Decision-Making. Committee work and decisions are forwarded to the full Commission for further consideration and approval through the Executive Committee, unless that work, or decision has been specifically delegated to a committee. All final decisions and work presented to the Commission must be approved by at least a majority of the quorum of the Commission.

Section 3. Standing Committees. The Commission has established five standing committees: Executive; Operations; Planning, Priorities and Allocations (PP&A); Public Policy (PPC); and Standards and Best Practices (SBP).

Section 4. Committee Membership. Only Commissioners or Alternates assigned to the committees by the Commission Co-Chairs, the Commission Co-Chairs themselves, and Committee-only members nominated by the committee and appointed by the BOS shall serve as voting members of the committees.

Section 5. **Meetings.** All committee meetings are open to the public, and the public is welcome to attend and participate, but without voting privileges**.**

Section 6. Other Working Units. The Commission and its committees may create other working units such as subcommittees, ad-hoc committees, caucuses, task forces, or work groups, as they deem necessary and appropriate.

A. The Commission is empowered to create caucuses of subsets of Commission members who are members of "key or priority populations" or "populations of interest" as identified in the comprehensive HIV plan, such as consumers. Caucuses are ongoing for as long as they are needed.
B. Task forces are established to address a specific issue or need and may be ongoingor time limited.

X. EXECUTIVE COMMITTEE:

Section 1. Membership. The voting membership of the Executive Committee shall comprise of the Commission Co-Chairs, the committee co-chairs, three (3) Executive Committee At-Large members who are elected by the Commission, and DHSP as a non-voting member.

Section 2. Co-Chairs. The Commission Co-Chairs shall serve as the co-chairs of the Executive Committee, and one or both shall preside over its meetings.

Section 3. Responsibilities. The Executive Committee is charged with the following responsibilities:

A. Overseeing all Commission and planning council operational and administrative activities.
B. Serving as the clearinghouse to review and forward items for discussion, approval and action to the Commission and its various working groups and units.
C. Acting on an emergency basis on behalf of the Commission, as necessary, between regular meetings of the Commission.
D. Approving the agendas for the Commission's regular, Annual, and special meetings.
E. Determining the annual Commission work plan and functional calendar of activities, in consultation with the committees and subordinate working units.
F. Conducting strategic planning activities for the Commission.

G. Adopting a Memorandum of Understanding ("MOU") with DHSP, if needed, and monitoring ongoing compliance with the MOU.

H. Resolving potential grievances or internal complaints informally when possible and standing as a hearing committee for grievances and internal complaints.

I.

J. Addressing matters related to Commission office staffing, personnel, and operations, when needed.

K. Developing and adopting the Commission's annual operational budget.

L. Overseeing and monitoring Commission expenditures and fiscal activities; and

M. Carrying out other duties and responsibilities, as assigned by the BOS or the Commission.

Section 4. At-Large Member Duties. As reflected in *Executive Committee At-Large Members Duty Statement*, the At-Large members shall serve as members of both the Executive and Operations Committees.

XI. OPERATIONS COMMITTEE:

Section 1. Voting Membership. The voting membership of the Operations Committee shall comprise of the Executive Committee At-Large members elected by the Commission membership, members assigned by the Commission Co-Chairs, Committee-only members nominated by the committee and appointed by the BOS, and the Commission Co-Chairs when attending. T

Section 2. Responsibilities. The Operations Committee is charged with the following responsibilities:

A. Ensuring that the Commission membership adheres to RWHAP reflectiveness and representation and CDC PIR requirements (*detailed in Article II, Sections 5, 6 and 7*), and all other membership composition requirements.

B. Recruiting, screening, scoring, and evaluating applications for Commission membership and recommending nominations to the Commission in Accordance with the Commission's established Open Nominations Process.

C. Developing, conducting, and overseeing ongoing, comprehensive training for the members of the Commission and public to educate them on matters and topics related to the Commission, HIV service delivery, skills building, leadership development, and providing opportunities for personal/professional growth.

D. Conducting regular orientation meetings for new Commission members and interested members of the public to acquaint them with the Commission's role, processes, and functions.

E. Developing and revising, as necessary, Commission member duty statements (job descriptions).

F. Recommending and nominating, as appropriate, candidates for committee, task force and other work group membership to the Commission.

G. Recommending amendments, as needed, to the Ordinance, which governs Commission operations.

H. Recommending amendments or revisions to the Bylaws consistent with Ordinance amendments and/or to reflect current and future goals, requirements and/or objectives.

I. Recommending, developing, and implementing Commission policies and procedures and maintenance of the Commission's Policy/Procedure Manual.

J. Coordinating on-going public awareness and information referral activities in cross-collaboration with other committees and subordinate working units to educate and engage the public about the Commission and promote the availability of HIV services.

K. Working with local stakeholders to ensure their representation and involvement in the Commission and in its activities.

L. Identifying, accessing, and expanding other financial resources to support the Commission's special initiatives and ongoing operational needs.

M. Conducting an annual assessment of the administrative mechanism, and overseeing implementation of the resulting, adopted recommendations; and

N. Carrying out other duties and responsibilities, as assigned by the Commission or the BOS.

XII. PLANNING, PRIORITIES AND ALLOCATIONS (PP&A) COMMITTEE:

Section 1. Voting Membership. The voting membership of the PP&A Committee shall comprise of members assigned by the Commission Co-Chairs, Committee-only members nominated by the committee and appointed by the BOS, the Commission Co-Chairs when attending, and DHSP as a non-voting member.

Section 2. Responsibilities. The PP&A Committee is charged with the following responsibilities:

A. Conducting continuous, ongoing needs assessment activities and related collection and review as the basis for decision-making, including gathering expressed need data from consumers on a regular basis, and reporting regularly to the Commission on consumer and service needs, gaps, and priorities.

B. Overseeing development and updating of the comprehensive HIV plan and monitoring implementation of the plan.
C. Recommending to the Commission annual priority rankings among service categories and types of activities and determining resource allocations for Part A, Part B, prevention, and other HIV and STD funding.
D. Ensuring that the priorities and implementation efforts are consistent with needs, the continuum of HIV services, and the service delivery system.
E. Monitoring the use of funds to ensure they are consistent with the Commission's allocations.
F. Recommending revised allocations for Commission approval, as necessary.
G. Coordinating planning, funding, and service delivery to ensure funds are used to fill gaps and do not duplicate services provided by other funding sources and/or health care delivery systems.
H. Developing strategies to identify, document, and address "unmet need" and to identify people living with HIV who are unaware of their status, make HIV testing available, and bring them into care.
I. Collaborating with DHSP to ensure the effective integration and implementation of the continuum of HIV services.
J. Reviewing monthly fiscal reporting data for HIV and STD expenditures by funding source, service category, service utilization and/or type of activity.
K. Monitoring, reporting, and making recommendations about unspent funds.
L. Identifying, accessing, and expanding other financial resources to meet Los Angeles County's HIV service needs; and
M. Carrying out other duties and responsibilities, as assigned by the Commission or the BOS.

XIII. PUBLIC POLICY COMMITTEE (PPC):

Section 1. Voting Membership.. The voting membership of the PPC shall comprise of members assigned by the Commission Co-Chairs, Committee-only members nominated by the committee and appointed by the BOS, and the Commission Co-Chairs when attending.

Section 2. Resources. Since some PPC activities may be construed as outside the purview of the RWHAP Part A or CDC planning bodies, resources other than federal funds will be used to cover staff costs or other expenses necessary to carry out activities.

Section 3. Responsibilities. The PPC is charged with the following responsibilities:

A. Advocating public policy issues at every level of government that impact Commission efforts to implement a continuum of HIV services or a service delivery system for Los Angeles County, consistent with the comprehensive HIV plan.

B. Initiating policy initiatives that advance HIV care, treatment and prevention services and related interests.

C. Providing education and access to public policy arenas for the Commission members, consumers, providers, and the public.

D. Facilitating communication between government and legislative officials and the Commission.

E. Recommending policy positions on governmental, administrative, and legislative action to the Commission, the BOS, other County departments, and other stakeholder constituencies, as appropriate.

F. Advocating specific public policy matters to the BOS, County departments, interests and bodies, and other stakeholder constituencies, as appropriate.

G. Researching and implementing public policy activities in accordance with the County's adopted legislative agendas.

H. Advancing specific Commission initiatives related to its work into the public policy arena; and

I. Carrying out other duties and responsibilities as assigned by the Commission or the BOS.

XIV. STANDARDS AND BEST PRACTICES (SBP) COMMITTEE:

Section 1. Voting Membership. The voting membership of the SBP Committee shall comprise of members assigned by the Commission Co-Chairs, Committee-only members as nominated by the committee and appointed by the BOS, the Commission Co-Chairs when attending, and DHSP as a non-voting member.

Section 2. Responsibilities. The SBP Committee is charged with the following responsibilities:

A. Working with the DHSP and other bodies to develop and implement a quality management plan and its subsequent operationalization.

B. Identifying, reviewing, developing, disseminating, and evaluating standards of care for HIV and STD services.

C. Reducing the transmission of HIV and other STDs, improving health outcomes, and optimizing quality of life and self-sufficiency for all people infected by HIV and their caregivers and families through the adoption and implementation of "best practices".

D. Recommending service system and delivery improvements to DHSP to ensure that the needs of people at risk for or living with HIV and/or other STDs are adequately met.

E. Developing and defining directives for implementation of services and service models;

F. Evaluating and designing systems to ensure that other service systems are sufficiently accessed.

G. Identifying and recommending solutions for service gaps.

H. Ensuring that the basic level of care and prevention services throughout Los Angeles County is consistent in both comprehensiveness and quality through the development, implementation, and use of outcome measures.

I. Reviewing aggregate service utilization, delivery and/or quality management information from DHSP, as appropriate.

J. Evaluating and assessing service effectiveness of HIV and STD service delivery in Los Angeles County, with particular attention to, among other factors, out-come evaluation, cost effectiveness, capacity, and best practices.

K. Verifying system compliance with standards by reviewing contract and RFP templates; and

L. Carrying out other duties and responsibilities, as assigned by the Commission or the BOS.

XV. OFFICIAL COMMUNICATIONS AND REPRESENTATIONS:

Section 1. Representation/Misrepresentation. No officer or member of the Commission shall commit any act or make any statement or communication under circumstances that might reasonably give rise to an inference that they are representing the Commission, including, but not limited to communications upon Commission stationery; public acts; statements; or communications in which they are identified as a member of the Commission, except only in the following:

A. Actions or communications that are clearly within the policies of the Commission and have been authorized in advance by the Commission.

B. Actions or communications by the officers that are necessary for and/or incidental to the discharge of duties imposed upon them by these Bylaws, policies/procedures and/or resolutions/decisions of the Commission.

C. Communications addressed to other members of the Commission or to its staff, within Brown Act rules and requirements.

XVI. AMENDMENTS: The Commission shall have the power to amend or revise these Bylaws at any meeting at which a quorum is present, providing that written notice of the proposed change(s) is given at least ten days prior to such meeting. In no event shall these Bylaws be changed in such a manner as to conflict with Los Angeles County Code, Title 3—Chapter 29 establishing the Commission and governing its activities and operations, or with CDC, RWHAP, and HRSA requirements.

NOTED AND APPROVED: Craig A. Vincent-Jones **EFFECTIVE DATE:** July 11, 2013

Originally Adopted: 3/15/1995 *Revision(s): 1/27/1998, 10/14/1999, 8/28/2002, 9/8/2005, 9/14/2006, 7/1/2007, 4/9/2009, 2/9/2012, 5/2/2013, 7/11/2013; 12/12/23*

REVISION HISTORY	
COH Approval Date	**Justification/Reason for Updates**
3.15.1995	Original Adoption
1.27.1998	Standard Review
10.14.1999	Standard Review
8.28.2002	Standard Review
9.8.2005	Standard Review
9.14.2006	Standard Review
7.1.2009	Standard Review
2.9.2012	Standard Review
5.2.2013	Integration of Prevention Planning Committee & COH
7.11.2013	Integration of Prevention Planning Committee & COH
12.12.23	First review by OPS/EXEC Committees. Proposed updates include HRSA findings compliance as determined by the Bylaws Review Taskforce (BRT).

12/12/23 OPS/EXEC
INITIAL/FIRST REVIEW

CLEAN VERSION

POLICY/PROCEDURE #06.1000	Bylaws of the Los Angeles County Commission on HIV	Page 1 of 22

SUBJECT: **The Bylaws of the Los Angeles County Commission on HIV.**

PURPOSE: **To define the governance, structural, operational, and functional responsibilities and requirements of the Los Angeles County Commission on HIV.**

BACKGROUND:

- **Health Resources and Services Administration (HRSA) Guidance**: "Planning Councils must set up planning council operations to help the planning council to operate smoothly and fairly. This includes such features as bylaws, open meetings, grievance procedures, and conflict of interest standards." [Ryan White HIV/AIDS Program Part A Manual, VI (Planning Council Operations), 1. Planning Council Duties, C. Fulfilling Planning Council Duties, Planning Council Operations].

- **Centers for Disease Control and Prevention (CDC) Guidance: "**The HIV Planning Group (HPG) is the official HIV planning body that follows the *HIV Planning Guidance* to inform the development or update of the health department's Jurisdictional HIV Prevention Plan, which depicts how HIV infection will be reduced in the jurisdiction."

- **Los Angeles County Code, Title 3—Chapter 3.29.070 (Procedures)**: "The Commission shall adopt bylaws which may include provisions relating to the time and place of holding meetings, election and terms of its co-chairs and other officers, and such other rules and procedures necessary for its operation."

POLICY:

1) **Consistency with the Los Angeles County Code:** The Commission's Bylaws are developed in accordance with the Los Angeles County Code, Title 3—Chapter 29 ("Ordinance"), the authority which establishes and governs the administration and operations of the Los Angeles County Commission on HIV. These Bylaws serve as the Commission's administrative, operational, and functional rules and requirements.

2) **Commission Bylaws Review and Approval**: The Commission conducts an annual administrative review of these Bylaws to ensure ongoing compliance, relevance, and adaptability to changes in both the external environment and internal structure.
   A. Prior to approval by its members, the Commission will request that the Ryan White HIV/AIDS Program (RWHAP) Part A project officer review the draft Bylaws to ensure compliance and alignment with HRSA requirements.
   B. Amendments to the Bylaws will be promptly considered, with any necessary adjustments made in alignment with amendments to the Ordinance.
   C. Approval of amendments or revisions requires a two-thirds vote from Commission members present at the meeting. To facilitate a thorough and informed decision-making process, proposed changes must be formally noticed for consideration and review at least ten days prior to the scheduled meeting (refer to Article XVI). Additionally, a 30-day public comment period will open, allowing the public to provide input on the proposed amendments for further transparency and inclusivity.

ARTICLES:

I. NAME AND LEGAL AUTHORITY:

Section 1. Name. The name of this Commission is the Los Angeles County Commission on HIV.

Section 2. Created. This Commission was created by an act of the Los Angeles County Board of Supervisors ("BOS"), codified in sections 3.29.010 – 3.29.120, Title 3—Chapter 29 of the Los Angeles County Code.

Section 3. Organizational Structure. The Commission on HIV is housed as an independent commission within the Executive Office of the BOS in the organizational structure of the County of Los Angeles.

Section 4. Duties and Responsibilities. As defined in Los Angeles County Code 3.29.090 (*Duties*), and consistent with Section 2602(b)(4) (42 U.S.C § 300ff-12) of the Ryan White HIV/AIDS Program legislation, HRSA guidance, and requirements of the CDC HIV Planning Guidance, the Commission is charged with and authorized to:

   A. Develop a comprehensive HIV plan that is based on assessment of service needs and gaps and that includes a defined continuum of HIV services; monitor the implementation of that plan; assess its effectiveness; and collaborate with the Division of HIV and STD Programs ("DHSP")/Department of Public Health ("DPH") to update the plan on a regular basis.
   B. Develop standards of care for the organization and delivery of HIV care, treatment, and prevention services.
   C. Establish priorities and allocations of RWHAP Part A and B and CDC prevention funding in percentage and/or dollar amounts to various services; review the grantee's allocation and expenditure of these funds by service category or type of activity for consistency with the Commission's established priorities, allocations, and comprehensive HIV plan, without the

review of individual contracts; provide and monitor directives to the grantee on how to best meet the need and other factors that further instruct service delivery planning and implementation; and provide assurances to the BOS and HRSA verifying that service category allocations and expenditures are consistent with the Commission's established priorities, allocations and comprehensive HIV plan.

D. Evaluate service effectiveness and assess the efficiency of the administrative mechanism, with particular attention to outcome evaluation, cost effectiveness, rapid disbursement of funds, compliance with Commission priorities and allocations, and other factors relevant to the effective and efficient operation of the local Eligible Metropolitan Area's ("EMA") delivery of HIV services.

E. Plan and develop HIV and public health service responses to address the frequency of HIV infection concurrent with STDs and other co-morbidities; plan the deployment of those best practices and innovative models in the County's STD clinics and related health centers; and strategize mechanisms for adapting those models to non-HIV-specific platforms for an expanded STD and co-morbidity response.

F. Study, advise, and recommend to the BOS, the grantee and other departments policies and other actions/decisions on matters related to HIV.

G. Inform, educate, and disseminate information to consumers, specified target populations, providers, the public, and HIV and health service policy makers to build knowledge and capacity for HIV prevention, care, and treatment, and actively engage individuals and entities concerned about HIV.

H. Provide a report to the BOS annually describing Los Angeles County's progress in ending HIV as a threat to the health and welfare of Los Angeles County residents with indicators to be determined by the Commission in collaboration with DHSP; make other reports as necessary to the BOS, the grantee, and other departments on HIV-related matters referred for review by the BOS, the grantee, or other departments.

I. Act as the planning body for all HIV programs in DPH or funded by the County; and

J. Make recommendations to the BOS, the grantee and other departments concerning the allocation and expenditure of funding other than Ryan White Program Part A and B and CDC prevention funds expended by the grantee and the County for the provision of HIV-related services.

Section 5. Federal and Local Compliance. These Bylaws ensure that the Commission meets all RWHAP, HRSA, and CDC requirements and adheres to the Commission's governing Los Angeles County Code, Title 3—Chapter 29.

Section 6. Service Area. In accordance with Los Angeles County Code and funding designations from HRSA and the CDC, the Commission executes its duties and responsibilities for the entire County.

A. The geographic boundaries of Los Angeles County match the funding. designations from both the CDC and HRSA, which calls the Part A funding area an Eligible Metropolitan Area ("EMA").

II. MEMBERS:

Section 1. Definition. A member of this Commission is any person who has been duly appointed by the BOS as a Commissioner, Alternate or a Committee-only member.

A. Commissioners are appointed by the BOS as full voting members to execute the duties and responsibilities of the Commission.

B. Alternates are appointed by the BOS to serve in place of an Unaffiliated Consumer member when the Unaffiliated Consumer members cannot fulfill their Commission duties and responsibilities.

C. Committee-only members are appointed by the BOS to serve as voting members on the Commission's standing committees, according to the committees' processes for selecting Committee-only members.

Section 2. Composition. As defined by Los Angeles County Code 3.29.030 (*Membership*), all members of the Commission shall serve at the pleasure of the BOS. The membership shall consist of fifty (50) voting members and one (1) non-voting member. Voting members are nominated by the Commission and appointed by the BOS. Non-voting members do not count toward quorum.

Consistent with the Open Nominations Process, the following recommending entities shall forward candidates to the Commission for membership consideration:

A. Five (5) members who are recommended by the following governmental, health and social service institutions, among whom shall be individuals with epidemiology skills or experience and knowledge of Hepatitis B, C and STDs:
   1. Medi-Cal, State of California,
   2. City of Pasadena,
   3. City of Long Beach,
   4. City of Los Angeles,
   5. City of West Hollywood

B. One (1) non-voting member representative from the Los Angeles County Department of Public Health, Division of HIV and STD Programs (DHSP) - the RWHAP Recipient/Part A Grantee.

C. Four (4) members who are recommended by RWHAP grantees as specified below or by representative groups of RWHAP grant recipients in the County, one from each of the following:
   1. Part B (State Office of AIDS),
   2. Part C (Part C grantees),
   3. Part D (Part D grantees),
   4. Part F [Part F grantees serving the County, such as the AIDS Education and Training Centers (AETCs), or local providers receiving Part F dental reimbursements].

D. Eight (8) provider representatives who are recommended by the following types of organizations in the County and selected to ensure geographic diversity and who reflect the epicenters of the epidemic, including:
   1. An HIV specialty physician from an HIV medical provider,
   2. A Community Health Center/Federally Qualified Health Center ("CHC"/ "FQHC") representative,
   3. A mental health provider,
   4. A substance abuse treatment provider,
   5. A housing provider,
   6. A provider of homeless services,
   7. A representative of an AIDS Services Organization ("ASO") offering federally funded HIV prevention services,
   8. A representative of an ASO offering HIV care and treatment services.

E. Seventeen (17) unaffiliated consumers of Part A services, to include:
   1. Eight (8) consumers, each representing a different Service Planning Area ("SPA") and who are recommended by consumers and/or organizations in the SPA,
   2. Five (5) consumers, each representing a supervisorial district, who are recommended by consumers and/or organizations in the district,
   3. Four (4) consumers serving in an at-large capacity, who are recommended by consumers and/or organizations in the County.

F. Five (5) representatives, with one (1) recommended by each of the five (5) supervisorial offices.

G. One (1) provider or administrative representative from the Housing Opportunities for Persons with AIDS (HOPWA) program, recommended by the City of Los Angeles Housing Department.

H. One (1) representative of a health or hospital planning agency.

I. One (1) behavioral or social scientist who promotes and presents behavioral research regarding HIV/AIDS and STIs and the people it impacts/affects.

J. Eight (8) representatives of HIV stakeholder communities, each of whom may represent one or more of the following categories. The Commission may choose to nominate several people from the same category or to identify a different stakeholder category, depending on identified issues and needs:

1. Faith-based entities engaged in HIV prevention and care,
2. Local education agencies at the elementary or secondary level,
3. The business community,
4. Union and/or labor,
5. Youth or youth-serving agencies,
6. Other federally funded HIV programs,
7. Organizations or individuals engaged in HIV-related research,
8. Organizations providing harm reduction services,
9. Providers of employment and training services, and
10. HIV-negative individuals from identified high-risk or special populations.

Section 3. Term of Office. Consistent with the Los Angeles County Code 3.29.050 (*Term of Service*), all members serve two-year terms.

A. Commissioners and Alternates serve two-year staggered terms as reflected on the Membership Roster.

B. A Committee-only member's term begins with the date of appointment and serves a one-year term.

C. Members are limited to three consecutive terms and are eligible to reapply following a one-year break in service.

Section 4. Consumer Membership. In accordance with RWHAP Part A legislative requirements outlined in Section 2602(b)(2): REPRESENTATION, the Commission shall ensure that 33% of its members are consumers of RWHAP Part A services who are not aligned or affiliated with RWHAP Part A-funded providers as employees, consultants, or Board members.

Additionally, at least one (1) consumer member must be co-infected with Hepatitis B or C; and at least one (1) consumer member must be a person who was incarcerated in a Federal, state, or local facility within the past three (3) years and who has a HIV diagnosis as of the date of release or is a representative of the recently incarcerated described as such.

Section 5. Reflectiveness. In accordance with RWHAP Part A legislative requirements [Section 2602(b)(1)], the Commission shall ensure that its full membership and the subset of unaffiliated consumer members proportionately reflect the ethnic, racial and gender characteristics of HIV disease prevalence in the EMA.

Section 6. Representation. In accordance with RWHAP Part A legislative requirements [Section 2602(b)(2)], the Commission shall ensure that all appropriate specific membership categories designated in the legislation are represented among the membership of Commission.

A. Commission membership shall include individuals from areas with high HIV and STD incidence and prevalence.

Section 7. Parity, Inclusion, and Representation (PIR). In accordance with CDC's *HIV Planning Guidance,* the planning process must ensure the parity and inclusion of the members.

A. "'Parity' is the ability of HIV planning group members to equally participate and carry out planning tasks or duties in the planning process. To achieve parity, representatives should be provided with opportunities for orientation and skills-building to participate in the planning process and have an equal voice in voting and other decision-making activities."

B. "'Inclusion' is the meaningful involvement of members in the process with an active role in making decisions. An inclusive process assures that the views, perspectives, and needs of affected communities, care providers, and key partners are actively included."

C. "Representation" means that "members should be representative of varying races and ethnicities, genders, sexual orientations, ages, and other characteristics such as varying educational backgrounds, professions, and expertise."

Section 8. HIV and Target Population Inclusion. In all categories when not specifically required, recommending entities and the Commission are strongly encouraged to nominate candidates living with HIV and individuals who are members of populations at disproportionate risk for HIV.

Section 9. Accountability. Members are expected to convey two-way information and communication between their represented organization/constituency and the Commission. Members are expected to provide the perspective of their organization/constituency and the Commission to other, relevant organizations regardless of the member's personal viewpoint. Members may, at times, represent multiple constituencies.

Section 10. Alternates. In accordance with Los Angeles County Code 3.29.040 (*Alternate members*), any Commission member who has disclosed that they are living with HIV is entitled to an Alternate who shall serve in the place of the Commissioner when necessary.

A. Alternates submit the same application and are evaluated and scored by the same nomination process as Commissioner candidates.

Section 11. Committee-only Members. Consistent with the Los Angeles County Code 3.29.060 D (*Meetings and committees*), the Commission's standing committees may elect to nominate Committee-only members for appointment by the BOS to serve as voting members on the respective committees to provide professional expertise, as a means of further engaging community participation in the planning process.

Section 12. DHSP Role & Responsibility. DHSP, despite being a non-voting member, plays a pivotal role in the Commission's work. As the RWHAP Grantee and Part A representative for the Los Angeles County EMA, DHSP provides essential epidemiological and surveillance data to guide the Commission's decision-making. DHSP plays a central role in carrying out needs assessments, conducting comprehensive planning, overseeing contracting and procurement of providers, evaluating service effectiveness, and performing quality management. Collaborating closely with DHSP, the Commission ensures effective coordination and implementation of its integrated comprehensive HIV plan. The Commission heavily relies on this partnership to ensure the optimal use of RWHAP funds and adherence to legislative and regulatory requirements, ensuring the highest standard of HIV services in Los Angeles County.

III. MEMBER REQUIREMENTS:

Section 1. Attendance. Commissioners and/or their Alternates are expected to attend all regularly scheduled Commission meetings, primary committee meetings, priority- and allocation-setting meetings, orientation, and training meetings, and the Annual Conference.

A. In accordance with Los Angeles County Code 3.29.060 (*Meetings and committees*), the BOS shall be notified of member attendance on a semi-annual basis.

Section 2. Committee Assignments. Commissioners are required to be a member of at least one standing committee, known as the member's "primary committee assignment," and adhere to attendance requirements of that committee.

A. Commissioners who live and work outside of Los Angeles County as necessary to meet expectations of their specific seats on the Commission are exempted from the requirement of a primary committee assignment, i.e., State Office of AIDS/Part B Representative and State Medi-Cal Representative.

B. Commissioners and Alternates are allowed to voluntarily request or accept "secondary committee assignments" upon agreement of the Co-Chairs.

Section 3. Conflict of Interest. Consistent with the Los Angeles County Code 3.29.046 (*Conflict of Interest*), Commission members are required to abide by the Conflict of Interest and Disclosure requirements of the Commission, the County of Los Angeles, the State of California (including Government Code Sections 87100, 87103, and 1090, et seq.), the RWHAP, as outlined in HRSA and relevant CDC guidance.

A. As specified in Section 2602(b)(5) of the RWHAP legislation, the Commission shall not be involved directly or in an advisory capacity in the administration of RWHAP funds and shall not designate or otherwise be involved in the selection of entities as recipients of those grant funds. While not addressed in the Ryan White legislation, the Commission shall adhere to the same rules for CDC and other funding.

B. Section 2602(b)(5)(B) continues that a planning council member who has a financial interest in, is employed by, or is a member of a public or private entity seeking local RWHAP funds as a provider of specific services is precluded from participating in—directly or in an advisory capacity—the process of selecting contracted providers for those services.

C. Further, in accordance with HRSA guidance, Commission Policy #08.3108: Ryan White Conflict of Interest Requirements, dictates that all members must declare conflicts of interest involving RWHAP-funded agencies and their services, and the member is required to recuse themselves from discussion and/or voting concerning that area of conflict, or funding for those services and/or to those agencies.

Section 4. Code of Conduct. All Commission members and members of the public are expected to adhere to the Commission's approved Code of Conduct at Commission and sponsored meetings and events. Those in violation of the Code of Conduct will be subject to the Commission's Policy #08.3302 Intra-Commission Grievance and Sanctions Procedures.

Section 5. Comprehensive Training. Commissioners and Alternates are required to fulfill all mandatory County and Commission training requirements.

Section 6. Removal/Replacement. A Commissioner or Alternate may be removed or replaced by the BOS for failing to meet attendance requirements, and/or other reasons determined by the BOS.

A. The Commission, via its Operations and Executive Committees, may recommend vacating a member's seat if egregious or unresolved violations of the Code of Conduct occur, after three months of consecutive absences, if the member's term is expired, or during the term if a member has moved out of the jurisdiction and/or no longer meets the qualifications for the seat.

IV. NOMINATION PROCESS:

Section 1. Open Nominations Process. Application, evaluation, nomination and appointment of Commission members shall follow "...an open process (in which) candidates shall be selected based on locally delineated and publicized criteria," as described in Section 2602(b)(1) of the RWHAP legislation and "develop and apply criteria for selecting HPG members, placing special emphasis on identifying representatives of at-risk, persons living with HIV/AIDS, and socio-economically marginalized populations," as required by the CDC *HIV Planning Guidance.*

A. The Commission's Open Nominations Process is defined in Policy/ Procedure #09.4205 (*Commission Membership Evaluation and Nominations Process*) and related policies and procedures.

B. Nomination of candidates that are forwarded to the BOS for appointment shall be made according to the policy and criteria adopted by the Commission.

Section 2. Application. Application for Commission membership shall be made on forms as approved by the Commission.

A. All candidates for first-time Commission membership shall be interviewed by the Operations Committee. Renewing members must complete an application and may be subject to an interview as determined by the Operations Committee.

B. Any candidate may apply individually or through recommendation of other stakeholders or entities.

C. Candidates cannot be recommended to the Commission or nominated to the BOS without completing the appropriate Commission-approved application, BOS Statement of Qualifications, and being evaluated and scored by the Operations Committee.

Section 3. Appointments. All Commission members (Commissioners, Alternates and Committee-only members) must be appointed by the BOS.

V. MEETINGS:

Section 1. Public Meetings. The Commission adheres to federal open meeting regulations outlined in Section 2602(b)(7)(B) of the RWHAP legislation, accompanying HRSA guidance, and California's Ralph M. Brown Act (Brown Act).

A. According to the RWHAP legislation, Council meetings must be open to the public with adequate notice. HRSA guidance extends these rules to Commission and committee meetings.

B. The Brown Act mandates that any meeting involving a quorum of the Commission or committee must be publicly open and noticed.

C. Specific public meeting requirements for Commission working units are detailed in Commission Policy #08.1102: Subordinate Commission Working Units.

Section 2. Public Noticing. Advance public notice of meetings shall comply with HRSA's open meeting and Brown Act public noticing requirements, and all other applicable laws and regulations.

Section 3. Meeting Minutes/Summaries. Meeting summaries and minutes are produced in accordance with HRSA's open meeting requirements, the Brown Act, Commission policies and procedures, and all other applicable laws and regulations.

A. Meeting minutes are posted to the Commission's website at https://hiv.lacounty.gov/ following their approval by the respective body.

Section 4. Public Comment. In accordance with Brown Act requirements, public comment on agendized and non-agendized items are allowed at all Commission meetings open to the public. The Commission is allowed to limit the time of public comment consistent with Los Angeles County rules and regulations and must adhere to all other County and Brown Act rules and requirements regarding public comment.

Section 5. Regular meetings. In accordance with Los Angeles County Code 3.29.060 (*Meetings and committees*), the Commission shall meet at least ten (10) times per year. Commission meetings are held monthly, unless cancelled, at a time and place to be designated by the Co-Chairs or the Executive Committee.

A. The Commission's Annual Conference will replace one of the regularly scheduled monthly meetings.

Section 6. Special Meetings. In accordance with the Brown Act, special meetings may be called as necessary by the Co-Chairs, the Executive Committee, or a majority of the members of the Commission.

Section 7. Executive Sessions. In accordance with the Brown Act, the Commission or its committees may convene executive sessions closed to the public to address pending litigation or personnel issues. An executive session will be posted as such.

Section 8. Robert's Rules of Order. All meetings of the Commission shall be conducted according to the current edition of "*Robert's Rules of Order, Newly Revised*," except where superseded by the Commission's Bylaws, policies/procedures, and/or applicable laws.

Section 9. Quorum. In accordance with Los Angeles County Code 3.29.070 (*Procedures*), the quorum for any regular or special Commission or committee meeting shall be a majority of voting, seated Commission or committee members.

A. A quorum for any committee meeting shall be a majority of Board-appointed, voting members or their Alternates assigned to the committee.
B. Non-voting members do not count toward quorum.

VI. RESOURCES:

Section 1. Fiscal Year. The Commission's Fiscal Year (FY) and programmatic year coincide with the County's fiscal year, from July 1 through June 30 of any given year.

Section 2. Operational Budgeting and Support. Operational support for the Commission is principally derived from RWHAP Part A and CDC prevention funds, and Net County Costs ("NCC")—all from grant and County funding managed by DHSP. Additional support may be obtained from alternate sources, as needed and available, for specific Commission activities.

A. The total amount of each year's operational budget is negotiated annually with DHSP, in accordance with County budgeting guidelines, and approved by the DHSP Director and the Commission's Executive Committee.
B. Projected Commission operational expenditures are allocated from RWHAP Part A administrative, CDC prevention, and NCC funding in compliance with relevant guidance and allowable expenses for each funding stream. As the administrative agent of those funds, DHSP is charged with oversight of the funds to ensure that their use for Commission operational activities is compliant with relevant funder program regulations and the terms and conditions of the award/funding.
C. Costs and expenditures are enabled through a Departmental Service Order (DSO) between DHSP/DPH and the Executive Office of the BOS, the Commission's fiscal and administrative agent.
D. Expenditures for staffing or other costs covered by various funding sources will be prorated in the Commission's annual budget according to their respective budget cycles and the Commission's/County's fiscal year.

Section 3. Other Support. Activities beyond the scope of RWHAP Part A planning councils and CDC HPGs, as defined by HRSA and CDC guidance, are supported by other sources, including NCC, as appropriate.

Section 4. Additional Revenues. The Commission may receive other grants and/or revenues for projects/activities within the scope of its duties and responsibilities, as defined in these Bylaws Article I, Section 4. The Commission will follow County-approved procedures for allocating project-/activity-related costs and resources in the execution of those grants and/or fulfillment of revenue requirements.

Section 5. Commission Member Compensation. In accordance with Los Angeles County Code 3.29.080 (*Compensation*), RWHAP Part A planning council requirements, CDC guidance, and/or other relevant grant restrictions, Commission members, or designated subsets of Commission members, may be compensated for their service on the Commission contingent upon the establishment of policies and procedures governing Commission member compensation practices.

Section 6. Staffing. The Executive Director serves as the Commission's lead staff person and manages all personnel, budgetary and operational activities of the Commission.

A. The Co-Chairs and the Executive Committee are responsible for overseeing the Executive Director's performance and management of Commission operations and activities consistent with Commission decisions, actions, and directives.

B. Within Los Angeles County's organizational structure, the County's Executive Officer and/or his/her delegated representative serve as the supervising authority of the Executive Director.

VII. POLICIES AND PROCEDURES:

Section 1. Policy/Procedure Manual. The Commission develops and adopts policies and procedures consistent with RWHAP, HRSA, and CDC requirements, Los Ange-les County Code, Title 3—Chapter 29, these Bylaws, and other relevant governing rules and requirements to operationalize Commission functions, work, and activities. The policy/procedure index and accompanying adopted policies/procedures are incorporated by reference into these Bylaws.

Section 2. HRSA Approval(s). DMHAP/HAB at HRSA requires RWHAP Part A planning councils to submit their grievance and conflict of interest policies for review by the RWHAP Part A project officer.

A. Although it is not required, it is the Commission's practice to submit proposed drafts of its Bylaws for review to ensure compliance with HRSA requirements.

Section 3. Grievance Procedures. The Commission's *Grievance Process* is incorporated by reference into these Bylaws. The Commission's grievance procedures must comply with RWHAP, HRSA, CDC, and Los Angeles County requirements, and will be amended from time to time, as needed, accordingly.

Section 4. Complaints Procedures. Complaints related to internal Commission matters such as alleged violations of the Code of Conduct or other disputes among members are addressed and resolved in adherence to Commission's Policy #08.3302: Intra-Commission Grievance and Sanctions Procedure.

Section 5. Conflict of Interest Procedures. The Commission's conflict of interest procedures must comply with the RWHAP legislation, HRSA guidance, CDC, State of California and Los Angeles County requirements, and will be amended from time to time, as needed, accordingly. These policies/procedures are incorporated by reference into these Bylaws.

VIII. LEADERSHIP:

Section 1. Commission Co-Chairs. The officers of the Commission shall be two (2) Commission Co-Chairs ("Co-Chairs").

A. One of the Co-Chairs must be person living with HIV/AIDS. Best efforts shall be made to have the Co-Chairs reflect the diversity of the HIV epidemic in Los Angeles County.

B. The Co-Chairs' terms of office are two years, which shall be staggered. In the event of a vacancy, a new Co-Chair shall be elected to complete the term.

C. The Co-Chairs are elected by a majority vote of Commissioners or Alternates present at a regularly scheduled Commission meeting at least four months prior to the start date of their term, after nominations periods opened at the prior regularly scheduled meeting. The term of office begins at the start of the calendar year. When a new Co-Chair is elected, this individual shall be identified as the Co-Chair-Elect and will have four months of mentoring and preparation for the Co-Chair role.

D. As reflected in the Commission Co-Chair Duty Statement, one or both Co-Chairs shall preside at all regular or special meetings of the Commission and at the Executive Committee. In addition, the Co-Chairs shall:

1. Assign the members of the Commission to committees.
2. Approve committee co-chairs, in consultation with the Executive Committee.
3. Represent the Commission at functions, events, and other public activities, as necessary.
4. Call special meetings, as necessary, to ensure that the Commission fulfills its duties.
5. Consult with and advise the Executive Director regularly, and the RWHAP Part A and CDC project officers, as needed.
6. Conduct the performance evaluation of the Executive Director, in consultation with the Executive Committee and the Executive Office of the BOS.
7. Chair or co-chair committee meetings in the absence of both committee co-chairs.
8. Serve as voting members on all committees when attending those meetings.
9. Are empowered to act on behalf of the Commission or Executive Committee on emergency matters; and
10. Attend to such other duties and responsibilities as assigned by the BOS or the Commission.

Section 2. Committee Co-Chairs: Each committee shall have two co-chairs.

A. Committee co-chairs' terms of office are for one year and may be re-elected by the committee membership. In the event of a vacancy, a new co-chair shall be elected by the respective committee to complete the term.
B. Committee co-chairs are elected by a majority vote of the members of the respective committees present at regularly scheduled meetings at the
C. beginning of the calendar year, following the open nomination period at the prior regularly scheduled meetings of the committees. As detailed in the Commission Co-Chair Duty Statement, one or both co-chairs shall preside at all regular or special meetings of their respective committee. Committee co-chairs shall have the following additional duties:
    1. Serve as members of the Executive Committee.
    2. Develop annual work plans for their respective committees in consultation with the Executive Director, subject to approval of the Executive Committee and/or Commission.
    3. Manage the work of their committees, including ensuring that work plan tasks are completed; and
    4. Present the work of their committee and any recommendations for action to the Executive Committee and the Commission.

IX. COMMISSION WORK STRUCTURES:

Section 1. Committees and Working Units. The Commission completes much of its work through a strong committee and working unit structure outlined in Commission Policy #08.1102: Subordinate Commission Working Units.

Section 2. Commission Decision-Making. Committee work and decisions are forwarded to the full Commission for further consideration and approval through the Executive Committee, unless that work, or decision has been specifically delegated to a committee. All final decisions and work presented to the Commission must be approved by at least a majority of the quorum of the Commission.

Section 3. Standing Committees. The Commission has established five standing committees: Executive; Operations; Planning, Priorities and Allocations (PP&A); Public Policy (PPC); and Standards and Best Practices (SBP).

Section 4. Committee Membership. Only Commissioners or Alternates assigned to the committees by the Commission Co-Chairs, the Commission Co-Chairs themselves, and Committee-only members nominated by the committee and appointed by the BOS shall serve as voting members of the committees.

Section 5. **Meetings.** All committee meetings are open to the public, and the public is welcome to attend and participate, but without voting privileges**.**

Section 6. Other Working Units. The Commission and its committees may create other working units such as subcommittees, ad-hoc committees, caucuses, task forces, or work groups, as they deem necessary and appropriate.

A. The Commission is empowered to create caucuses of subsets of Commission members who are members of "key or priority populations" or "populations of interest" as identified in the comprehensive HIV plan, such as consumers. Caucuses are ongoing for as long as they are needed.

B. Task forces are established to address a specific issue or need and may be ongoing or time limited.

X. EXECUTIVE COMMITTEE:

Section 1. Membership. The voting membership of the Executive Committee shall comprise of the Commission Co-Chairs, the committees co-chairs, three (3) Executive Committee At-Large members who are elected by the Commission, and DHSP as a non-voting member.

Section 2. Co-Chairs. The Commission Co-Chairs shall serve as the co-chairs of the Executive Committee, and one or both shall preside over its meetings.

Section 3. Responsibilities. The Executive Committee is charged with the following responsibilities:

A. Overseeing all Commission and planning council operational and administrative activities.

B. Serving as the clearinghouse to review and forward items for discussion, approval and action to the Commission and its various working groups and units.

C. Acting on an emergency basis on behalf of the Commission, as necessary, between regular meetings of the Commission.

D. Approving the agendas for the Commission's regular, Annual, and special meetings.

E. Determining the annual Commission work plan and functional calendar of activities, in consultation with the committees and subordinate working units.

F. Conducting strategic planning activities for the Commission.

G. Adopting a Memorandum of Understanding ("MOU") with DHSP, if needed, and monitoring ongoing compliance with the MOU.

H. Resolving potential grievances or internal complaints informally when possible and standing as a hearing committee for grievances and internal complaints.

I. Addressing matters related to Commission office staffing, personnel, and operations, when needed.

J. Developing and adopting the Commission's annual operational budget.

K. Overseeing and monitoring Commission expenditures and fiscal activities; and

L. Carrying out other duties and responsibilities, as assigned by the BOS or the Commission.

Section 4. At-Large Member Duties. As reflected in *Executive Committee At-Large Members Duty Statement*, the At-Large members shall serve as members of both the Executive and Operations Committees.

XI. OPERATIONS COMMITTEE:

Section 1. Voting Membership. The voting membership of the Operations Committee shall comprise of the Executive Committee At-Large members elected by the Commission membership, members assigned by the Commission Co-Chairs, Committee-only members nominated by the committee and appointed by the BOS, and the Commission Co-Chairs when attending.

Section 2. Responsibilities. The Operations Committee is charged with the following responsibilities:

A. Ensuring that the Commission membership adheres to RWHAP reflectiveness and representation and CDC PIR requirements (*detailed in Article II, Sections 5, 6 and 7*), and all other membership composition requirements.
B. Recruiting, screening, scoring, and evaluating applications for Commission membership and recommending nominations to the Commission in Accordance with the Commission's established Open Nominations Process.
C. Developing, conducting, and overseeing ongoing, comprehensive training for the members of the Commission and public to educate them on matters and topics related to the Commission, HIV service delivery, skills building, leadership development, and providing opportunities for personal/professional growth.
D. Conducting regular orientation meetings for new Commission members and interested members of the public to acquaint them with the Commission's role, processes, and functions.
E. Developing and revising, as necessary, Commission member duty statements (job descriptions).
F. Recommending and nominating, as appropriate, candidates for committee, task force and other work group membership to the Commission.
G. Recommending amendments, as needed, to the Ordinance, which governs Commission operations.
H. Recommending amendments or revisions to the Bylaws consistent with Ordinance amendments and/or to reflect current and future goals, requirements and/or objectives.
I. Recommending, developing, and implementing Commission policies and procedures and maintenance of the Commission's Policy/Procedure Manual.

J. Coordinating on-going public awareness and information referral activities in cross-collaboration with other committees and subordinate working units to educate and engage the public about the Commission and promote the availability of HIV services.

K. Working with local stakeholders to ensure their representation and involvement in the Commission and in its activities.

L. Identifying, accessing, and expanding other financial resources to support the Commission's special initiatives and ongoing operational needs.

M. Conducting an annual assessment of the administrative mechanism, and overseeing implementation of the resulting, adopted recommendations; and

N. Carrying out other duties and responsibilities, as assigned by the Commission or the BOS.

XII. PLANNING, PRIORITIES AND ALLOCATIONS (PP&A) COMMITTEE:

Section 1. Voting Membership. The voting membership of the PP&A Committee shall comprise of members assigned by the Commission Co-Chairs, Committee-only members nominated by the committee and appointed by the BOS, the Commission Co-Chairs when attending, and DHSP as a non-voting member.

Section 2. Responsibilities. The PP&A Committee is charged with the following responsibilities:

A. Conducting continuous, ongoing needs assessment activities and related collection and review as the basis for decision-making, including gathering expressed need data from consumers on a regular basis, and reporting regularly to the Commission on consumer and service needs, gaps, and priorities.

B. Overseeing development and updating of the comprehensive HIV plan and monitoring implementation of the plan.

C. Recommending to the Commission annual priority rankings among service categories and types of activities and determining resource allocations for Part A, Part B, prevention, and other HIV and STD funding.

D. Ensuring that the priorities and implementation efforts are consistent with needs, the continuum of HIV services, and the service delivery system.

E. Monitoring the use of funds to ensure they are consistent with the Commission's allocations.

F. Recommending revised allocations for Commission approval, as necessary.

G. Coordinating planning, funding, and service delivery to ensure funds are used to fill gaps and do not duplicate services provided by other funding sources and/or health care delivery systems.

H. Developing strategies to identify, document, and address "unmet need" and to identify people living with HIV who are unaware of their status, make HIV testing available, and bring them into care.

I. Collaborating with DHSP to ensure the effective integration and implementation of the continuum of HIV services.

J. Reviewing monthly fiscal reporting data for HIV and STD expenditures by funding source, service category, service utilization and/or type of activity.

K. Monitoring, reporting, and making recommendations about unspent funds.

L. Identifying, accessing, and expanding other financial resources to meet Los Angeles County's HIV service needs; and

M. Carrying out other duties and responsibilities, as assigned by the Commission or the BOS.

XIII. PUBLIC POLICY COMMITTEE (PPC):

Section 1. Voting Membership.. The voting membership of the PPC shall comprise of members assigned by the Commission Co-Chairs, Committee-only members nominated by the committee and appointed by the BOS, and the Commission Co-Chairs when attending.

Section 2. Resources. Since some PPC activities may be construed as outside the purview of the RWHAP Part A or CDC planning bodies, resources other than federal funds will be used to cover staff costs or other expenses necessary to carry out activities.

Section 3. Responsibilities. The PPC is charged with the following responsibilities:

A. Advocating public policy issues at every level of government that impact Commission efforts to implement a continuum of HIV services or a service delivery system for Los Angeles County, consistent with the comprehensive HIV plan.

B. Initiating policy initiatives that advance HIV care, treatment and prevention services and related interests.

C. Providing education and access to public policy arenas for the Commission members, consumers, providers, and the public.

D. Facilitating communication between government and legislative officials and the Commission.

E. Recommending policy positions on governmental, administrative, and legislative action to the Commission, the BOS, other County departments, and other stakeholder constituencies, as appropriate.

F. Advocating specific public policy matters to the BOS, County departments, interests and bodies, and other stakeholder constituencies, as appropriate.

G. Researching and implementing public policy activities in accordance with the County's adopted legislative agendas.

H. Advancing specific Commission initiatives related to its work into the public policy arena; and

I. Carrying out other duties and responsibilities as assigned by the Commission or the BOS.

XIV. STANDARDS AND BEST PRACTICES (SBP) COMMITTEE:

Section 1. Voting Membership. The voting membership of the SBP Committee shall comprise of members assigned by the Commission Co-Chairs, Committee-only members as nominated by the committee and appointed by the BOS, the Commission Co-Chairs when attending, and DHSP as a non-voting member.

Section 2. Responsibilities. The SBP Committee is charged with the following responsibilities:

A. Working with the DHSP and other bodies to develop and implement a quality management plan and its subsequent operationalization.

B. Identifying, reviewing, developing, disseminating, and evaluating standards of care for HIV and STD services.

C. Reducing the transmission of HIV and other STDs, improving health outcomes, and optimizing quality of life and self-sufficiency for all people infected by HIV and their caregivers and families through the adoption and implementation of "best practices".

D. Recommending service system and delivery improvements to DHSP to ensure that the needs of people at risk for or living with HIV and/or other STDs are adequately met.

E. Developing and defining directives for implementation of services and service models;

F. Evaluating and designing systems to ensure that other service systems are sufficiently accessed.

G. Identifying and recommending solutions for service gaps.

H. Ensuring that the basic level of care and prevention services throughout Los Angeles County is consistent in both comprehensiveness and quality through the development, implementation, and use of outcome measures.

I. Reviewing aggregate service utilization, delivery and/or quality management information from DHSP, as appropriate.

J. Evaluating and assessing service effectiveness of HIV and STD service delivery in Los Angeles County, with particular attention to, among other factors, out-come evaluation, cost effectiveness, capacity, and best practices.

K. Verifying system compliance with standards by reviewing contract and RFP templates; and

L. Carrying out other duties and responsibilities, as assigned by the Commission or the BOS.

XV. OFFICIAL COMMUNICATIONS AND REPRESENTATIONS:

Section 1. Representation/Misrepresentation. No officer or member of the Commission shall commit any act or make any statement or communication under circumstances that might reasonably give rise to an inference that they are representing the Commission, including, but not limited to communications upon Commission stationery; public acts; statements; or communications in which they are identified as a member of the Commission, except only in the following:

A. Actions or communications that are clearly within the policies of the Commission and have been authorized in advance by the Commission.

B. Actions or communications by the officers that are necessary for and/or incidental to the discharge of duties imposed upon them by these Bylaws, policies/procedures and/or resolutions/decisions of the Commission.

C. Communications addressed to other members of the Commission or to its staff, within Brown Act rules and requirements.

XVI. AMENDMENTS: The Commission shall have the power to amend or revise these Bylaws at any meeting at which a quorum is present, providing that written notice of the proposed change(s) is given at least ten days prior to such meeting. In no event shall these Bylaws be changed in such a manner as to conflict with Los Angeles County Code, Title 3—Chapter 29 establishing the Commission and governing its activities and operations, or with CDC, RWHAP, and HRSA requirements.

NOTED AND APPROVED: Craig A. Vincent-Jones **EFFECTIVE DATE:** July 11, 2013

Originally Adopted: 3/15/1995 *Revision(s): 1/27/1998, 10/14/1999, 8/28/2002, 9/8/2005, 9/14/2006, 7/1/2007, 4/9/2009, 2/9/2012, 5/2/2013, 7/11/2013; 12/12/23*

REVISION HISTORY	
COH Approval Date	**Justification/Reason for Updates**
3.15.1995	Original Adoption
1.27.1998	Standard Review
10.14.1999	Standard Review
8.28.2002	Standard Review
9.8.2005	Standard Review
9.14.2006	Standard Review
7.1.2009	Standard Review
2.9.2012	Standard Review
5.2.2013	Integration of Prevention Planning Committee & COH
7.11.2013	Integration of Prevention Planning Committee & COH
12.12.23	First review by OPS/EXEC Committees. Proposed updates include HRSA findings compliance as determined by the Bylaws Review Taskforce (BRT).

RYAN WHITE PROGRAM
UNIVERSAL STANDARDS OF CARE

Los Angeles County Commission on HIV

LOS ANGELES COUNTY
COMMISSION ON HIV

Table of Contents

IMPORTANT: Service standards must adhere to requirements and restrictions from the federal agency, Health Resources and Services Administration (HRSA). The key documents used in developing standards are as follows:

- Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18)
- HIV/AIDS Bureau, Division of Metropolitan HIV/AIDS Programs National Monitoring Standards for Ryan White Part A Grantees: Program – Part A
- Service Standards: Ryan White HIV/AIDS Programs

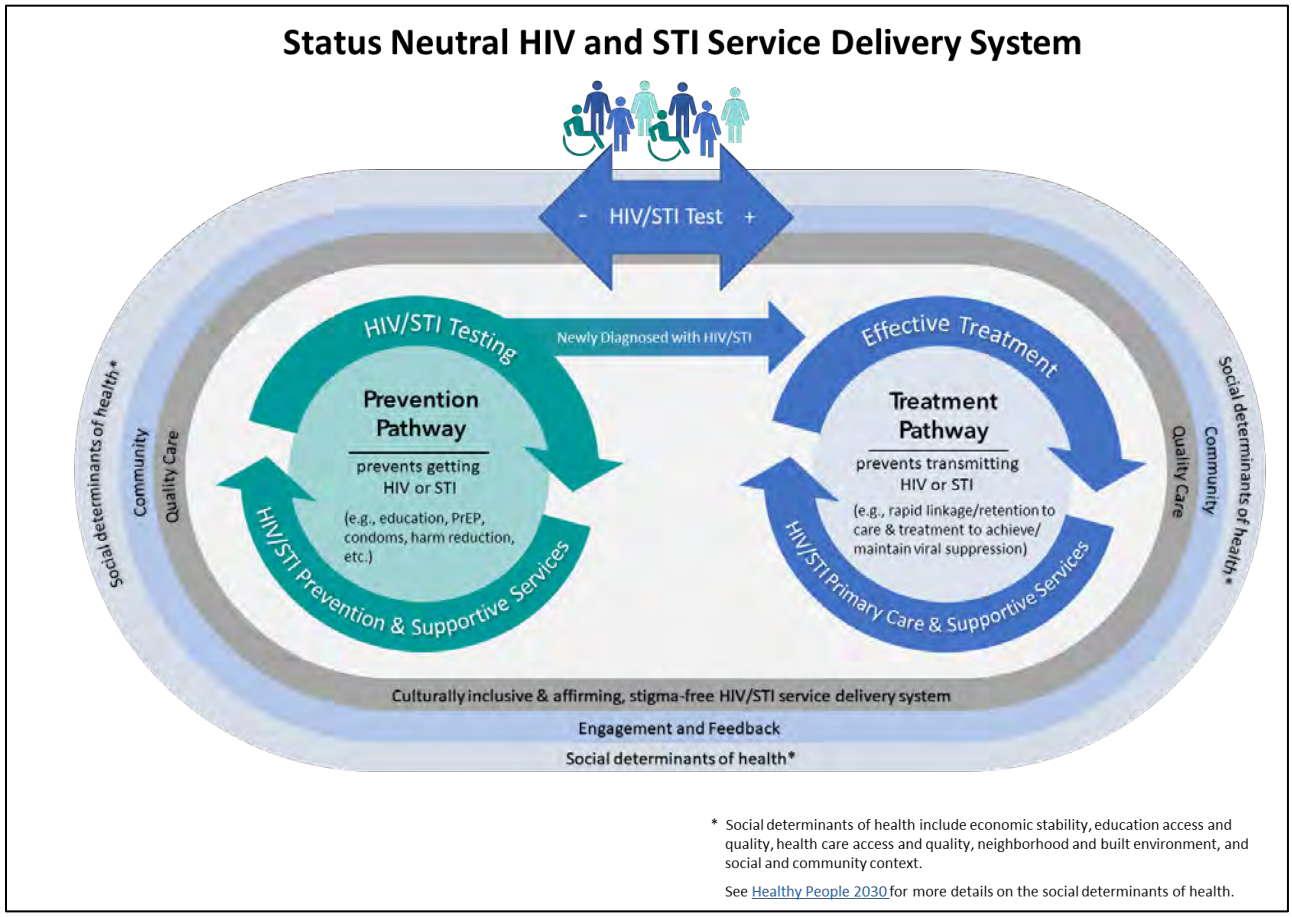
Introduction

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

The Los Angeles County Commission on HIV (COH) developed the Universal Standards of Care to reflect current guidelines from federal and national agencies on HIV care and treatment, and to establish the minimum standards of care necessary to achieve optimal health among people living with HIV (PLWH), regardless of where services are received in Los Angeles County (LAC). The development of the standards includes guidance from service providers, consumers, members of the COH and the Standards and Best Practices (SBP) Committee.

Additionally, providers are encouraged to adopt the "Status Neutral HIV and STI Service Delivery System Framework," that addresses both HIV care and prevention and is responsive to the unique needs of their clients (see **Figure 1**). The framework functions to provide comprehensive support and care to address the social determinants of health that create HIV and STI disparities. A status-neutral approach means that all people are treated in the same way and are linked to preventive care, medical care, and supportive services, regardless of HIV or STI status. When done effectively, rapidly linking newly diagnosed people to HIV treatment and those who test negative to ongoing prevention services will decrease new HIV infections, support positive people to thrive with and beyond HIV, and works to reduce health disparities.

Figure 1 - Status Neutral HIV and STI Service Delivery System Framework
(Adapted from the Centers for Disease Control and Prevention Status Neutral HIV Prevention and Care Framework)



Further information on the "Status Neutral HIV and STI Service Delivery System Framework," and standards related to prevention can be found at https://hiv.lacounty.gov/service-standards.

Universal Standards Overview

The objectives of the Universal Standards are to ensure agencies:

- Provide services that are accessible and non-discriminatory to all PLWH in LAC.
- Educate staff and clients on the importance of receiving care, treatment as prevention, and how maintaining an undetectable viral load will result in little to no risk of HIV transmission.
- Protect client rights and ensure quality of care.
- Provide client-centered, age appropriate, culturally, and linguistically competent care.
- Provide high quality services through experienced and trained staff.
- Meet federal, state, and county requirements and guidelines regarding safety, sanitation, access, and public health.
- Guarantee client confidentiality, protect client autonomy, and ensure a fair process of addressing grievances.
- Prevent information technology security risks and protect patient information and records.
- Inform clients of services, establish eligibility, and collect information through an intake process.
- Effectively assess client needs and encourage informed and active participation.
- Address client needs through coordination of care and referrals to needed services.
- Ensure that the quality of service and materials given to patients during telehealth encounter is similar with in-person visits.

Section 1.0—General Agency Policies

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

1.0 GENERAL AGENCY POLICIES		
	STANDARD	DOCUMENTATION
1.1	Agency develops or utilizes an existing client confidentiality policy in accordance with state and federal laws to assure protection of client HIV status, behavioral risk factors, and/or use of services.	Written client confidentiality policy on file with specific information technology safeguards for confidentiality and patient information if using telehealth service modality.
1.2	Agency is responsible for informing the patient that they have the right to obtain copies of their medical and other health records maintained by the agency.	Written policy for informing the patient of their rights to receive a copy of their medical records. The policy should contain a description of the process for obtaining records, such as a verbal or written request and a reasonable timeframe for patients to receive the information.
1.3	Client determines what information of theirs can be released and with whom it can be	Completed *Release of Information Form* on file including: • Name of agency/individual

	shared. Services using telehealth modality are subject to consent by the patient.	with whom information will be shared • Information to be shared • Duration of the release consent • Client signature For agencies and information covered by the Health Insurance Portability and Accountability Act (HIPAA), form must be HIPAA disclosure authorization compliant. The form must also be compliant with the CA Medi-Cal telehealth policy.[1]
1.4	Agency develops or utilizes an existing grievance procedure to ensure clients have recourse if they feel they are being treated in an unfair manner or feel they are not receiving quality services.	Written grievance procedure on file that includes, at minimum: • Client process to file a grievance • Information on the Los Angeles County Department of Public Health, Division of HIV & STD Programs (DHSP) Customer Support Program2 1-800-260-8787. DHSP Customer Support Program information is posted in a visible location on site or provided to the patient at the beginning of a telehealth encounter.
1.5	Agency provides eligibility requirements for services available upon request. Eligibility requirements must follow guidance from Division of HIV & STD Programs (DHSP) and HRSA under Policy Clarification Notice #16-023	Written eligibility requirements on file.
1.6	All client files are stored in a secure and confidential location, and electronic client files are protected from unauthorized use. Protection of client files and information must cover use of electronic medical records, phones, text messages, email, and telehealth modalities.	Client files must be locked and/or password protected with access provided only to appropriate personnel. Agencies must establish written procedures and IT policies for message encryption and restrictions on staff access to protect client information.
1.7	Agency maintains progress notes of all communication between provider and client.	Legible progress notes maintained in individual client files that include, at minimum: • Date of communication or service • Service(s) provided Recommended referrals linking clients to needed services (See Section 6: Referrals and Case Closure)
1.8	Agency develops or utilizes an existing crisis management policy.	Written crisis management policy on file that includes, at minimum: • Mental health crises Dangerous behavior by clients or staff

1.9	Agency develops a policy on utilization of Universal Precaution Procedures[4,5]. Staff members are trained in universal precautions.	Written policy or procedure on file. Documentation of staff training in personnel file.
1.10	Agency ensures compliance with Americans with Disabilities Act[6] (ADA) criteria for programmatic accessibility (e.g. building and design accessibility, parking, etc.). For agencies with multiple sites, all sites must comply with the ADA requirements.	ADA criteria on file at all sites.
1.11	Agency complies with all applicable state and federal workplace and safety laws and regulations, including fire safety.	Signed confirmation of compliance with applicable regulations on file.

Section 2.0—Client Rights and Responsibilities

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

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

		emailed to patient and/or posted on the agency website. The document should contain at least the following information: • Instructions on how to use telehealth tools (i.e., phone, laptop, tablets, etc.) in plain language and available in the patient's preferred language. • Telephone number for technical support or trouble shooting available before, during and after the telehealth appointment.
2.4	Agency ensures that clients retain the right to accept or decline a telehealth visit. The ultimate decision on the mode of service delivery, whether in- person or telehealth, must be determined by the client first before an appointment is made.	Written procedures and telehealth acceptance or denial form completed by patients prior to the appointment.
2.5	Agency provides each client a copy of the *Patient & Client Bill of Rights & Responsibilities (Appendix B)* document that informs them of the following: • Confidentiality policy • Expectations and responsibilities of the client when seeking services • Client right to file a grievance • Client right to receive no-cost interpreter services • Client right to access their file (if psychotherapy notes cannot be released per clinician guidance, agency should provide a summary to client within 30 days) • Reasons for which a client may be removed from services and the process that occurs during involuntary removal	*Patient and Client Bill of Rights* document is signed by client and kept on file.

Section 3.0—Staff Requirements and Qualifications

Staff must be well qualified and, if necessary, hold all required licenses, registration, and/or degrees in accordance with applicable State and federal regulations as well as requirements of the Los Angeles County Department of Public Health, Division of HIV & STD Programs. At minimum, all staff will be able to provide timely, linguistically, and culturally competent care to people living with HIV. Staff will complete orientation through their respective hiring agency, including a review of established

programmatic guidelines, and supplemental trainings as required by the Los Angeles County Department of Public Health, Division of HIV and STD Programs. The AIDS Education Training Center (AETC)7 offers a variety of training for the HIV workforce.

3.0 STAFF REQUIREMENTS AND QUALIFICATIONS		
	STANDARD	**DOCUMENTATION**
3.1	Staff members meet the minimum qualifications for their job position and have the knowledge, skills, and ability to effectively fulfill their role and the communities served. Employment is an essential part of leading an independent, self-directed life for all people, including those living with HIV/AIDS. Agencies should develop policies that strive to hire PLWH in all facets of service delivery, whenever appropriate.	Hiring policy and staff resumes on file.
3.2	If a position requires licensed staff, staff must be licensed to provide services.	Copy of current license on file.
3.3	Staff will participate in trainings appropriate to their job description and program a. Required education on how a client achieving and maintaining an undetectable viral load for a minimum of six months will not sexually transmit HIV. Continuing to take HIV medications as directed is imperative to stay undetectable. b. Staff should have experience in or participate in trainings on: • LGBTQ+/Transgender community and HIV Navigation Services (HNS)[8] provided by Centers for Disease Control and Prevention (CDC). • Trauma informed care • Providing care for older adults Mental Health First Aid	Documentation of completed trainings on file -
3.4	New staff will participate in trainings to increase capacity for fulfilling the responsibilities of their position. a. Required completion of an agency-level orientation within 6 weeks of hire b. Training within 3 months of being hired appropriate to the	Documentation of completed trainings on file

	job description. c. Additional trainings appropriate to the job description and Ryan White service category.	
3.5	Staff are required to coordinate across Ryan White funded and non-funded programs to ensure clients' needs are met.	Documentation of staff efforts of coordinating across systems for the client on file (e.g. housing case management services, etc.).

Section 4.0—Cultural and Linguistic Competence

Ryan White funded agencies must provide services that are culturally and linguistically competent based on the National Standards for Culturally and Linguistically Appropriate Services9 (CLAS) in Health and Health Care. As noted in the CLAS Standards10, ensuring culturally and linguistically appropriate services advances health equity, improves quality, and helps eliminate health care disparities by establishing a blueprint for health and health care organizations. For the purpose of these standards, culture is defined as the integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics. The standards below are adapted directly from the National CLAS Standards.

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

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

Federal and State language access laws require health care facilities that receive federal or state funding to provide competent interpretation services to limited English proficiency patients at no cost, to ensure equal and meaningful access to health care services. Interpretation refers to verbal

communication where speech is translated from a speaker to a receiver in a language that the receiver can understand. Translation refers to the conversion of written material from one language to another.

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

Section 5.0—Intake and Eligibility

All clients who request or are referred to HIV services will participate in an intake process conducted by appropriately trained staff. The intake worker will review client rights and responsibilities, explain

available services, the confidentiality and grievance policy, assess immediate service needs, and secure permission to release information.

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

Section 6.0—Referrals and Case Closure

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

6.0 REFERRALS AND CASE CLOSURE

	STANDARD	DOCUMENTATION
6.1	Agency will maintain a comprehensive list of providers for full spectrum HIV-related and other service referrals a. Staff will provide referrals to link clients to services based on assessments and reassessments	Identified resources for referrals at provider agency (e.g. lists on file, access to websites) Written documentation of recommended referrals in client file
6.2	If needed, staff will engage additional providers for specific support services (e.g. behavioral health, substance use, housing).	Agency establishes partnerships with agencies for referrals as needed. Memoranda of Understanding (MOU) on file.
6.3	For clients with missed appointments or pending case closure, staff will attempt to contact client. a. Cases may be closed if the client: • Relocates out of the service area • Is no longer eligible for the service • Discontinues the service • No longer needs the service • Puts the agency, service provider, or other clients at risk • Uses the service improperly or has not complied with the services agreement • Is deceased • Has had no direct agency contact, after repeated attempts, for a period of 12 months.	Attempts to contact client and mode of communication documented in file. Justification for case closure documented in client file
6.4	Agency has a transition procedure in place that is implemented for clients leaving services to ensure a smooth transition.	Completed transition summary in file, signed by client and supervisor (if possible). Summary should include reason for case closure; and a plan for transition to other services, if applicable, with confirmation of communication between referring and referral agencies, or between client and agency.
6.5	Agency develops or utilizes existing due process policy for involuntary removal of clients from services; policy includes a series of verbal and written warnings before final notice and case closure.	Due process policy on file as part of transition, and case closure policy described in the *Patient & Client Bill of Rights and Responsibilities* document. (Refer to Appendix B).

APPENDIX A—Ryan White Part A Service Categories

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

CORE MEDICAL SERVICES	DESCRIPTION
Ambulatory Outpatient Medical (AOM) Services	HIV medical care access through a medical provider.
Home-based Case Management	Specialized home care for homebound clients.
Medical Care Coordination (MCC)	HIV care coordination through a team of health providers to improve quality of life.
Medical Specialty Services	Medical care referrals for complex and specialized cases.
Mental Health Services	Psychiatry, psychotherapy, and specialized cases.
Oral Health Services (General & Specialty)	General and specialty dental care services.

SUPPORTIVE SERVICES	DESCRIPTION
Benefits Specialty Services	Assistance navigating public and/or private benefits and programs (health, disability, etc.).
Language Translation Services	Translation services for non-English speakers and deaf and/or hard of hearing individuals.
Legal Services	Legal information, advice, and services.
Nutrition Support Services	Home-delivered meals, food banks, and pantry services.
Residential Care Facility for the Chronically Ill (RCFCI)	Home-like housing that provides 24-hour care.
Substance Use Disorder Transitional Housing (SUDTH)	Housing services for clients in recovery form drug or alcohol use disorders.
Transitional Case Management	Support for incarcerated individuals transitioning from County jails back to the community.
Transitional Residential Care Facility (TRCF)	Short-term housing that provides 24-hour assistance to clients with independent living skills.
Transportation Services	Ride services to medical and social services appointments.

APPENDIX B—Patient and Client Bill of Rights and Responsibilities

It is the provider's responsibility to provide clients a copy of the Patient & Client Bill of Rights and Responsibilities in all service settings, including telehealth. The purpose of this Patient and Client Bill of Rights is to help enable clients to act on their own behalf and in partnership with their providers to obtain the best possible HIV/AIDS care and treatment. This Bill of Rights and Responsibilities comes from the hearts of people living with HIV/AIDS in the diverse communities of Los Angeles County. As

someone newly entering or currently accessing care, treatment, or support services for HIV/AIDS, you have the right to:

A. Respectful Treatment and Preventative Services

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

B. Competent, High-Quality Care

1. Have your care provided by competent, qualified professionals who follow HIV treatment standards as set forth by the U.S. Department of Health and Human Services12 (HHS), the Centers for Disease Control and Prevention13 (CDC), the California Department of Health Services14, and the County of Los Angeles Department of Public Health15.
2. Have access to these professionals at convenient times and locations.
3. Receive appropriate referrals to other medical, mental health or care services.
4. Have their phone calls and/or emails answered with 1-5 business days based on the urgency of the matter.

C. Participate in the Decision-making Treatment Process

1. Receive complete and up-to-date information in words you understand about your diagnosis, treatment options, medications (including common side effects and complications) and prognosis that can reasonably be expected.
2. Participate actively with your provider(s) in discussions about choices and options available for your treatment.
3. Make the final decision about which treatment option is best for you after you have been given all relevant information about these choices and the clear recommendation of your provider.
4. Have access to patient-specific education resources and reliable information and training about patient self-management.
5. Refuse any and all treatments recommended and be told of the effect that not taking the treatment may have on your health, be told of any other potential consequences of your refusal and be assured that you have the right to change your mind later.

6. Be informed about and afforded the opportunity to participate in any appropriate clinical research studies for which you are eligible.
7. Refuse to participate in research without prejudice or penalty of any sort.
8. Refuse any offered services or end participation in any program without bias or impact on your care.
9. Be informed of the procedures at the agency for resolving misunderstandings, making complaints, or filing grievances.
10. Receive a response to a complaint or grievance within 30-45 days of filing it.
11. Be informed of independent ombudsman or advocacy services outside the agency to help you resolve problems or grievances (see number at bottom of this form), including how to access a federal complaint center within the Center for Medicare and Medicaid Services16 (CMS).

D. Confidentiality and Privacy

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

E. Billing Information and Assistance

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

F. Patient/Client Responsibilities

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

1. Participate in the development and implementation of your individual treatment or service plan to the extent that you are able.
2. Provide your providers, to the best of your knowledge, accurate and complete information about your current and past health and illness, medications and other treatment and services you are receiving, since all of these may affect your care. Communicate promptly any changes or new developments.
3. Communicate to your provider whenever you do not understand information you are provided.
4. Follow the treatment plan you have agreed to and understand the consequences of failing to adhere to the recommended course of treatment or of using alternative treatments.

5. Understand that cases may be closed if the client:
    i. Relocates out of the service area
    ii. Is no longer eligible for the service(s)
    iii. Discontinues the service(s)
    iv. No longer needs the service(s)
    v. Puts the agency, service provider, or other clients at risk
    vi. Uses the service(s) improperly or has not complied with the services agreement
    vii. Is deceased
    viii. Has had no direct agency contact, after repeated attempts, for a period of 12 months
6. Keep your appointments and commitments at this agency or inform the agency promptly if you cannot do so.
7. Keep your provider or main contact informed about how to reach you confidentially by phone, mail, or other means.
8. Follow the agency's rules and regulations concerning patient/client care and conduct.
9. Be considerate of your providers and fellow clients/patients and treat them with the respect you yourself expect.
10. Refrain from the use of profanity or abusive or hostile language; threats, violence, or intimidations; carrying weapons of any sort; theft or vandalism; sexual harassment and misconduct.
11. If you are a person living with a Substance Use Disorder, please be open and honest with your provider about your substance use so that any issues can be properly addressed.

For More Help or Information

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

Division of HIV and STD Programs | Customer Support Program (800) 260-8787 | 8:00 am – 5:00 Monday – Friday

APPENDIX C—Division on HIV/STD Programs Customer Support Program

The Division of HIV and STD Programs' (DHSP) Customer Support Program aims to assist consumers of HIV and STD services who have experienced difficulty accessing services from DHSP-funded providers throughout Los Angeles County. If you or someone you know is a consumer of HIV and STD services who have experienced difficulty accessing services from DHSP-funded providers throughout Los Angeles County, the Customer Support Program can assist with accessing HIV or STD services and addressing concerns about the quality of services received.

Please contact the Customer Support Program via email dhspsupport@ph.lacounty.gov , online http://publichealth.lacounty.gov/dhsp/QuestionServices.htm or by telephone at (800) 260-8787. By

contacting the Customer Support Program, you will **not** be denied services. Your name and personal information can be kept confidential.

APPENDIX D—Telehealth Resources

Federal and National Resources:

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

Telehealth Discretion During Coronavirus:

- AAFP Comprehensive Telehealth Toolkit: https://www.aafp.org/dam/AAFP/documents/practice_management/telehealth/2020-AAFP-Telehealth-Toolkit.pdf
- ACP Telehealth Guidance & Resources: https://www.acponline.org/practice-resources/business-resources/telehealth
- ACP Telemedicine Checklist: https://www.acponline.org/system/files/documents/practice-resources/health-information- technology/telehealth/video_visit_telemedicine_checklist_web.pdf
- AMA Telehealth Quick Guide:https://www.ama-assn.org/practice-management/digital/ama-telehealth-quick-guide
- CMS Flexibilities for Physicians: https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf
    - "Under the CARES Act, CMS is waiving the requirements of section 1834(m)(1) of the ACT and 42 CFR § 410.78(a)(3) for use of interactive telecommunications systems to furnish telehealth services, to the extent they require use of video technology, for certain services. This waiver allows the use of audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services, and behavioral health counseling and educational services."
- CMS Flexibilities for RHCs and FQHCs: https://www.cms.gov/files/document/covid-rural-health-clinics.pdf
    - "Medicare telehealth services generally require an interactive audio and video telecommunications system that permits real-time communication between the practitioner and the patient. (During the PHE, some telehealth services can be furnished using audio-only technology.)"
- CMS Fact Sheet on Virtual Services: https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
- Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency

ENDNOTES

[1] California Department of Health Care Services Telehealth Provider Manual can be accessed here https://files.medi- cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mednetele.pdf

[2] More information on the Customer Support Program can be found here: DHSP_CSP_CustomerSupportForm_Website- ENG-Final_12.2022.pdf (lacounty.gov)

[3] PCN 16-02 RWHAP Services Eligible Individuals and Allowables Uses of Funds (hrsa.gov)

[4] Bloodborne Infectious Diseases | NIOSH | CDC

[5] Bloodborne Pathogens - Worker protections against occupational exposure to infectious diseases | Occupational Safety and Health Administration (osha.gov)

[6] Laws, Regulations & Standards | ADA.gov

Welcome | AIDS Education and Training Centers National Coordinating Resource Center (AETC NCRC) (aidsetc.org)

[8] HIV Navigation Services | Treat | Effective Interventions | HIV/AIDS | CDC

[9] Culturally and Linguistically Appropriate Services - Think Cultural Health (hhs.gov)

[10] CLAS Standards - Think Cultural Health (hhs.gov)

[11] DHSP_CSP_CustomerSupportForm_Website-ENG-Final_12.2022.pdf (lacounty.gov)

[12] HIV Treatment Guidelines | NIH

[13] Guidelines and Recommendations | Clinicians | HIV | CDC

[14] HIV Care Program

[15] LA County Department of Public Health

[16] Home - Division of Appeals Policy (lmi.org)

2023 CONSUMER CAUCUS RETREAT

JOIN US AS WE REFLECT ON THE STRIDES AND CHALLENGES OF 2023, COLLECTIVELY SHARING OUR LIVED EXPERIENCES.

TOGETHER, LET'S ENVISION AND PLAN FOR AN IMPACTFUL 2024.

THURSDAY

12.14.23

11AM-2PM

510 S. Vermont Ave, 9th Floor (Press Room), LA 90020

Validated Parking @ 523 Shatto Pl, LA

Inform parking attendant/building security you are attending a Commission on HIV-sponsored meeting

****LUNCH & RAFFLES****

OPEN TO ALL CONSUMERS OF HIV PREVENTION & CARE SERVICES

LOS ANGELES COUNTY COMMISSION ON HIV

Contact Dawn Mc Clendon at dmcclendon@lachiv.org for more information

LOS ANGELES COUNTY
COMMISSION ON HIV

2023 CONSUMER CAUCUS RETREAT AGENDA

THURSDAY, DECEMBER 14 @ 11AM-2PM
510 S. VERMONT AVE, 9TH FLR (PRESS ROOM), LA 90020

Welcome & Introductions (11AM-11:15AM)
Damone Thomas & Alasdair Burton, Co-Chairs

Retreat Purpose & Objective (11:15AM-11:30AM)
Damone Thomas & Alasdair Burton, Co-Chairs

Consumer Caucus Mission, Purpose & Scope (11:30AM-11:45AM)
Damone Thomas & Alasdair Burton, Co-Chairs

2023 Reflections (11:45AM-12:15PM)
What positive changes or advantages do you hope to experience through your engagement in the Consumer Caucus, and what specific benefits would you like to see resulting from your participation?
Consumer Caucus Group Discussion

Building Management Security Updates (12:15:-12:30PM)
Vermont Corridor Capital Projects/Security Services

****LUNCH & RAFFLES****

2024 Planning Discussion (12:30-1:45PM)
- Meeting Management & Logistics (Standing time/days & location)
- Creating Safe Spaces (Non COH/DHSP/Provider Participants)
- Capacity Building & Training Opportunities
- Consumer Education & Empowerment
- 2024 Consumer Caucus Open Nominations & Elections

Recap, Call to Action & Adjournment (1:45PM-2:00PM)

All are welcomed to attend the Planning, Priorities & Allocations (PP&A) Committee immediately following the Caucus retreat.

the OA Voice
Issue: December 2023

This newsletter is currently organized to align 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.

INSIDE:

STAFF HIGHLIGHT

OA would like to congratulate **Mindy McFall** on her promotion to the Health Program Specialist I position in the Support Branch's Business Operations & Compliance Section. In this position she will serve as our CDC grant specialist.

Mindy has been with OA for two years working as a fiscal analyst in the Support Branch. During that time, she provided administrative support for invoice processing, reconciliation, federal fund drills, and encumbrances. She also initiated and implemented several process improvement efforts that streamlined the encumbrance management process, reports for the Center of Infectious Diseases (CID) briefings, enhancements to the invoice trackers, and the STD 215 revision process. Prior to working in OA, Mindy was a senior business analyst for Intel, and also owned and managed a fitness studio in Folsom. Mindy has over 15 years of analytics and business experience that has been used to improve the efficiency of Support Branch activities and processes.

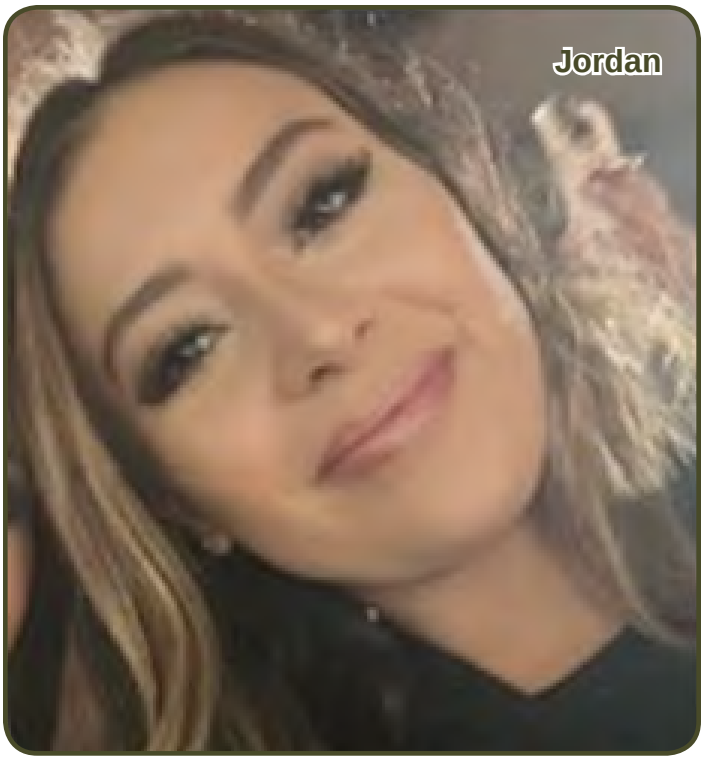
Outside of work, Mindy enjoys hanging with family, competing in endurance races, cheering-on the Sacramento Kings, and snuggling with her bearded dragon, Chili.

Additionally, please join us in congratulating **Jordan Folster**. She has been promoted within


Mindy

the OA Support Branch to the Staff Services Manager II (Section Chief) position overseeing the Business Operations and Compliance Section.

Jordan has over 9 years of experience as a Human Resources Manager. She is well trained and experienced in providing guidance related to the Family and Medical Leave Act, California Family Rights Act, Pregnancy Disability Leave, Workers' Compensation, Reasonable Accommodations, and more. Her knowledge and experience in human resources, project management, policy and procedure



development, benefits, leave, training, employee development, and payroll administration will be a valuable asset to our team. For the past year she has led the Personnel and Operations Unit in the Support Branch where she has worked with the Personnel Liaisons to facilitate the Request for Personnel Action (RPA) process and responded to inquiries from OA management regarding the hiring process, redirections, position tracking, reorganizations, and other RPA-related processes that pertain to OA's staffing needs in addition to providing direction related to memorandums, policies, and procedures from the Human Resources Division. Jordan has also assisted on multiple special projects and contributed to grant and audit activities.

We'd also like to congratulate **Matthew Brown**. Matthew accepted a promotion as Care Business Unit Chief in the Care Branch's Care Program Section.

Matthew joined the Care Business Unit three years ago as a Fiscal Analyst. He helped innovate many of the tools in the unit such as the budget/expenditure "Master Tracker," providing feedback to help build the new HIV Care Connect data system, and the personnel salary budget tool to assist our subrecipients build their budgets. Matthew is a Georgia native and spent most of his childhood growing up in Brunswick and Atlanta, Georgia. He attended Delaware State University and received a bachelor's degree in aviation management. He is currently pursuing a master's degree in video game development at the Academy of Art University based in San Francisco. He plans to open his own indie video game company and create Christian video games that teach people about salvation and the good news of Jesus Christ. He is an avid video gamer, he loves reading all types of books from fantasy to leadership development, and he enjoys traveling around the world. He is always down for a new food adventure, and a dream of his is to spend one year living in Japan.

HIV AWARENESS

***December 1st** marks the 35th commemoration of **World AIDS Day**, and this year's theme is, "Remember and Commit." It's a time to*

remember the early years when illness and death were common, as well as remember the amazing strides that transformed HIV infection to a chronic manageable disease when HIV medications are taken regularly, and the virus is suppressed to undetectable levels. Those living with HIV who are undetectable optimize their health and cannot infect others. Undetectable Equals Untransmittable. Of the 141,001 people living with diagnosed HIV infection in 2021, 73.0% were in HIV care and 64.4% achieved viral suppression. The Ending the HIV Epidemic in the United States goals are to increase linkage to care and viral suppression to 95% by 2025. New infections continue, and as of 2020, more than 14,000 individuals are infected with HIV but unaware of their status. HIV health disparities in California are decreasing but are still present, especially within the Latinx and African American communities. Therefore, we commit to continuing to address the syndemic of HIV, STIs, and HCV by confronting structural and systemic health disparities fueled by racism, homophobia and transphobia, sexism, ableism, xenophobia, social and economic inequality, homelessness, and identity-based discrimination and stigma. OA and the STD Control Branch are guided by an integrated Strategic Plan for California, which was created from extensive community input from people with lived experience, as well as input from state agencies, local health jurisdictions, and healthcare- and community-based organizations. Innovations have increased access to HIV, STI, and HCV screening through home collection kits available for free, telehealth has broadened the ability for people to interact with their health care and other support providers, and the PrEP Assistance Program removes the financial barrier to accessing PrEP. Guided by ongoing community input, the OA is committed to continuing on the path of decreased new infections, increase the percentage of people living with HIV who have sustained viral suppression, and coordinating with other resources to ensure those vulnerable to HIV infection obtain the services and resources needed to live healthy, dignity-filled lives free of stigma. Therefore, on this World AIDS Day we commit ourselves to working with you to work and eliminate health inequities among those most affected by HIV, HCV, and STIs in California. Co-create the California we want to live in together and we will make our work and continued progress the best way to honor those who we have lost.

– **Dr. Marisa Ramos, Chief, State Office of AIDS**

⪢ World AIDS Day Resources

- Visit the World AIDS Day webpage to review general resources for World AIDS Day.
- Share the HIV.gov theme announcement blog, which includes remarks from senior domestic and global leadership. Also, watch for the White House World AIDS Day proclamation.
- Watch and share Harold Phillips' FYI video, (Lead of the Office of National AIDS Policy) where he shares why we should pause and reflect on the day's importance.

ENDING THE EPIDEMICS STRATEGIC PLAN OA/STD

Implementation of the ***Ending the Epidemics Strategic Plan***, which replaces our *Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention, and Care Plan* (Integrated Plan), is continuing.

Thank you to the California Planning Group (CPG) for hosting a discussion about the ***Implementation Blueprint***, which is a supporting document to our *Ending the Epidemics Strategic Plan,* at their in-person meeting in November. The CPG and other Planning Councils, Commissions and Groups across California have been integral partners in the review, improvement, and implementation of our *Strategic Plan*.

The *Strategic Plan* has 30 strategies organized over six social determinants of health and our

Implementation Blueprint helps us drill-down into these strategies. Please continue to use and share these two documents.

CDPH has also made technical assistance available to counties that want to customize the *Implementation Blueprint* for their communities.

For technical assistance and more information about our ongoing community engagement, please visit Facente Consulting's webpage at https://facenteconsulting.com/cdph-technical-assistance-request-portal/.

GENERAL UPDATES

COVID-19

OA is committed to providing updated information related to COVID-19. We have disseminated a number of documents in an effort to keep our clients and stakeholders informed. Please refer to our OA website to stay informed.

Mpox

OA is committed to providing updated information related to mpox. We have partnered with the Division of Communicable Disease Control (DCDC), a program within the Center of Infectious Diseases and have disseminated a number of documents in an effort to keep our clients and stakeholders informed. Please refer to the DCDC website to stay informed.

Mpox digital assets are available for LHJs and CBOs.

Racial Justice and Health Equity

The Racial & Health Equity (RHE) workgroup aims to gain insight and understanding of racial and health equity efforts throughout CDPH and take next steps towards advancing RHE in our work. The workgroup has formed subcommittees

to address community stakeholder engagement challenges, improve OA policy and practices to support RHE and increasing OA knowledge and attitude on RHE among leadership and staff.

HIV/STD/HCV Integration

Now that the Emergency Declaration has ended and the COVID-19 response is winding down, we are reinitiating our integration discussions and moving forward with the necessary steps to integrate our HIV, STI, and HCV programs into a single new Division. We will continue to keep you apprised on our journey!

Ending the HIV Epidemic

The *Ending the HIV Epidemic (EHE) in the US Initiative* counties of Alameda, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco and Los Angeles have all completed another calendar year of work. Thank you for expanding services for HIV testing, PrEP and linkage to HIV medical care to EHE priority populations. More information about the EHE Initiative.

STRATEGY A

Improve Pre-Exposure Prophylaxis (PrEP) Utilization:

PrEP-Assistance Program (AP)

As of November 29, 2023, there are 217 PrEP-AP enrollment sites and 187 clinical provider sites that currently make up the PrEP-AP Provider network.

Data on active PrEP-AP clients can be found in the three tables displayed on page 7 of this newsletter.

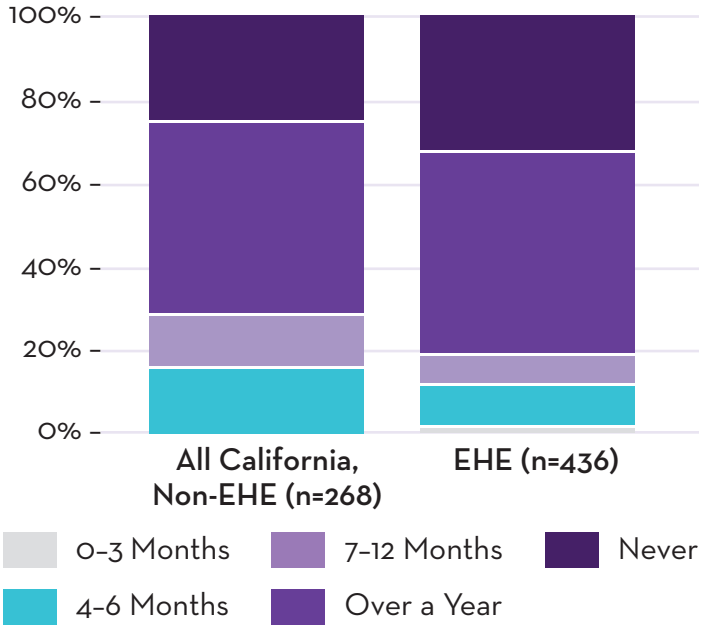
STRATEGY B

Increase and Improve HIV Testing:

OA continues to implement its Building Healthy Online Communities (BHOC) self-testing program to allow for rapid OraQuick test orders in all jurisdictions in California. The program, TakeMeHome®, (https://takemehome.org/) is advertised on gay dating apps, where users see an ad for home testing and are offered a free HIV-home test kit.

In October, 268 individuals in 31 counties ordered self-test kits, with 215 (80.2%) individuals ordering 2 tests. Additionally, OA's existing TakeMeHome Program continues in the six California Consortium Phase I Ending the HIV Epidemic in America counties. In the first 38 months, between September 1, 2020, and October 31, 2023, 7895 tests have been distributed. This month, mail-in lab tests (including dried blood spot tests for HIV, syphilis, and Hepatitis C, as well as 3-site tests for gonorrhea and chlamydia) accounted for 275 (63.1%) of the 436 total tests distributed in EHE counties.

HIV Test History Among Individuals Who Ordered TakeMeHome Kits, Oct. 2023



TAKEMEHOME

Additional Key Characteristics	EHE	All California, Non-EHE
Of those sharing their gender, were cisgender men	48.1%	62.7%
Of those sharing their race or ethnicity, identify as Hispanic or Latinx	37.3%	43.8%
Were 17-29 years old	50.7%	40.7%
Of those sharing their number of sex partners, reported 3 or more in the past year	49.7%	40.7%

Since September 2020, 890 test kit recipients have completed the anonymous follow up survey from EHE counties; there have been 281 responses from the California expansion since January 2023. Highlights from the survey results include:

	EHE	All California, Non-EHE
Would recommend TakeMeHome to a friend	94.5%	94.3%
Identify as a man who has sex with other men	60.7%	61.9%
Reported having been diagnosed with an STI in the past year	8.7%	9.6%

STRATEGY F

Improve Overall Quality of HIV-Related Care:

The Clinical Quality Management (CQM) Program is thrilled to announce the release of the 2023 CQM Program presentation on the OA CQM webpage. This comprehensive document outlines the goals and strategies of the CQM program, providing valuable insights into the program's mission to enhance quality care for people living with HIV (PLWH).

STRATEGY J

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

As of November 29, 2023, the number of ADAP clients enrolled in each respective ADAP Insurance Assistance Program are shown in the chart at the top of page 8.

STRATEGY K

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

The Federal Substance Abuse and Mental Health Services Agency (SAMHSA) has a new Housing and Homelessness Resource Center that issues a monthly newsletter with information, upcoming webinars, and more. This month's highlights include *Thinking About Starting a Supportive Housing Program? Recommendations and Considerations for the Planning Process*, a resource developed by the National Association of State and Territorial AIDS

(continued on page 8)

Active PrEP-AP Clients by Age and Insurance Coverage:

Current Age	PrEP-AP Only		PrEP-AP With Medi-Cal		PrEP-AP With Medicare		PrEP-AP With Private Insurance		TOTAL	
	N	%	N	%	N	%	N	%	N	%
18 - 24	390	11%	---	---	---	---	36	1%	426	12%
25 - 34	1,261	34%	1	0%	1	0%	204	6%	1,467	40%
35 - 44	889	24%	---	---	3	0%	157	4%	1,049	28%
45 - 64	388	11%	1	0%	19	1%	100	3%	508	14%
65+	22	1%	---	---	201	5%	8	0%	231	6%
TOTAL	**2,950**	**80%**	**2**	**0%**	**224**	**6%**	**505**	**14%**	**3,681**	**100%**

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

Current Age	Latinx		American Indian or Alaskan Native		Asian		Black or African American		Native Hawaiian/ Pacific Islander		White		More Than One Race Reported		Decline to Provide		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
18 - 24	235	6%	---	---	44	1%	21	1%	3	0%	78	2%	2	0%	43	1%	426	12%
25 - 34	877	24%	1	0%	129	4%	88	2%	9	0%	276	7%	10	0%	77	2%	1,467	40%
35 - 44	634	17%	4	0%	99	3%	43	1%	4	0%	208	6%	9	0%	48	1%	1,049	28%
45 - 64	291	8%	---	---	43	1%	19	1%	2	0%	131	4%	2	0%	20	1%	508	14%
65+	20	1%	---	---	3	0%	3	0%	---	---	198	5%	---	---	7	0%	231	6%
TOTAL	**2,057**	**56%**	**5**	**0%**	**318**	**9%**	**174**	**5%**	**18**	**0%**	**891**	**24%**	**23**	**1%**	**195**	**5%**	**3,681**	**100%**

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

Gender	Latinx		American Indian or Alaskan Native		Asian		Black or African American		Native Hawaiian/ Pacific Islander		White		More Than One Race Reported		Decline to Provide		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Female	71	2%	---	---	6	0%	10	0%	1	0%	20	1%	---	---	6	0%	114	3%
Male	1,788	49%	4	0%	291	8%	157	4%	17	0%	844	23%	23	1%	170	5%	3,294	89%
Trans	172	5%	---	---	17	0%	6	0%	---	---	14	0%	---	---	7	0%	216	6%
Unknown	26	1%	1	0%	4	0%	1	0%	---	---	13	0%	---	---	12	0%	57	2%
TOTAL	**2,057**	**56%**	**5**	**0%**	**318**	**9%**	**174**	**5%**	**18**	**0%**	**891**	**24%**	**23**	**1%**	**195**	**5%**	**3,681**	**100%**

All 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: 11/30/2023 at 12:02:18 AM Data source: ADAP Enrollment System. Site assignments are based on the site that submitted the most recent application.

ADAP Insurance Assistance Program	Number of Clients Enrolled	Percentage Change from October
Employer Based Health Insurance Premium Payment (EB-HIPP) Program	501	+ 0.02%
Office of AIDS Health Insurance Premium Payment (OA-HIPP) Program	5,240	- 0.26%
Medicare Part D Premium Payment (MDPP) Program	2,074	+ 1.02%
Total	**7,815**	**+ 0.10%**

Source: ADAP Enrollment System

Directors (NASTAD) along with other partners and informed by conversations with current housing and harm reduction service providers.

Sign up for the Housing and Homelessness Resource Center newsletter.

STRATEGY N

Enhance Collaborations and Community Involvement:

California Planning Group (CPG)

The Fall In-Person CPG Meeting was held in Sacramento from November 13 – 15, 2023. The theme of the meeting was *Adapting to a Changing Landscape - Advocacy in Community Engagement, Organization and Mobilization*. We want to thank all CPG members and community members for their attendance, active participation and engagement, personal perspectives, and help in creating a safe space for sharing and listening. We also want to thank all Steering Committee members who helped to plan the meeting, support the CPG members, and helped with setting up, running mics, cleaning up, and so much more. Also, much appreciation to the OA and STD Control Branch Committee Liaisons who continuously support CPG members throughout the monthly committee meetings leading up to and during this event. Without you all, this would not have been possible. We hope you found the meeting informative to our CPG and collective work.

Huge thank you to our facilitator, Eileen Jacobowitz, for her always stellar facilitation and OA Division Chief, Dr. Marisa Ramos, for taking time out of her busy schedule to attend and provide her candid open forum updates. Also, thank you to the OA and STD Control Branch Management Teams for attending the meeting and supporting CPG members. We also want to express a huge thanks to Community Co-Chairs Rafael Gonzalez and Yara Tapia for their ongoing work and support in helping to plan for this meeting. Additionally, a huge thank you to Kevin Ramos and Janet Scott from the CDC for their attendance and participation. And finally, a huge thank you to Rachel Kallett and CSUS for taking care of all our travel and hotel logistics!

Meeting Highlights

During this meeting, Tai Edward Few from the Denver Prevention Training Center hosted our fifth skills and capacity building CPG Leadership Academy on **Day 1**. The Academy was focused

on *Using Racial Equity and Anti-Racist Practices to Advance Community Advocacy*.

On **Day 2** we had presentations by Jax Kelly, President of Let's Kick ASS Palm Springs, with his impactful presentation on the *BEAM Wellness Grant*, and Kevin Sitter, who presented on *The Vital Role of People with Lived Experience in Ending the Syndemic of HIV, HCV, and STIs*.

On **Day 3** we held our first ever Planning Council Roundtable where each nominated member from local planning councils shared their personal work in their respective planning bodies. We also had Pike Long of the OA Harm Reduction Unit and Ale Del Pinal, Program Director, and Luka Zies with Punks with Lunch present on Harm Reduction in California and Punks with Lunch, Oakland. We thank them all for sharing their time, efforts, and expertise with CPG.

Overall, it was a successful and engaging meeting. We look forward to the next in-person meeting in Southern California in the Spring of 2024!

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