LOS ANGELES COUNTY COMMISSION ON HIV
3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
http://hiv.lacounty.gov

COMMISSION ON HIV MEETING

Thursday, June 8, 2017
9:00 AM – 12:15 PM

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

Los Angeles County Commission on HIV

VISION

A comprehensive, sustainable, accessible system of prevention and care that empowers people at risk, living with or affected by HIV to make decisions and to maximize their lifespans and quality of life.

MISSION

The Los Angeles County Commission on HIV focuses on the local HIV/AIDS epidemic and responds to the changing needs of People Living With HIV/AIDS (PLWHA) within the communities of Los Angeles County.

The Commission on HIV provides an effective continuum of care that addresses consumer needs in a sensitive prevention and care/treatment model that is culturally and linguistically competent and is inclusive of all Service Planning Areas (SPAs).

LOS ANGELES COUNTY COMMISSION ON HIV

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GUIDELINES FOR CONDUCT

The Los Angeles County Commission on HIV has played an active role in shaping HIV services in this County and in the State for over a decade. The dedication to providing quality services to people with and at risk of HIV/AIDS by people who are members of this body, both past and present, is unparalleled.

In order to encourage the active participation of all members and to address the concerns of many Commissioners, consumers and other interested members of the community, it is important that meetings take place in a "safe" environment. A "safe" environment is one that recognizes differences, while striving for consensus and is characterized by consistent professional and respectful behavior. As a result, the Commission has adopted and is consistently committed to implementing the following Guidelines for Conduct for Commission, committee and associated meetings.

Similar meeting ground rules have been developed and successfully used in large group processes to tackle difficult issues. Their intent is not to discourage meaningful dialogue, but to recognize that differences and even conflict can result in highly creative solutions to problems when approached in a respectful and professional manner.

The following should be adhered to by all participants and stakeholders:

1) Be on Time for Meetings
2) Stay for the Entire Meeting
3) Show Respect to Invited Guests, Speakers and Presenters
4) Listen
5) Don't Interrupt
6) Focus on Issues, Not People
7) Don't just Disagree, Offer Alternatives
8) Give Respectful, Constructive Feedback
9) Don't Judge
10) Respect Others' Opinions
11) Keep an Open Mind to Others' Opinions
12) Allow Others to Speak
13) Respect Others' Time
14) Begin and End on Time
15) Have All the Issues on the Table and No "Hidden Agendas"
16) Minimize Side Conversations
17) Don't Monopolize the Discussion
18) Don't Repeat What Has Already Been Said
19) If Beepers or Cell Phones Must Be On, Keep Them on Silent or Vibrate

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

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2. APPROVAL OF AGENDA:

A Agenda
B Membership Roster
C Committee Assignments
D Commission Member Conflict of Interest
E Geographic Maps
F June - September 2017 Meeting Calendar

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Los Angeles County Commission on HIV (COH) MEETING AGENDA

Thursday, June 8, 2017
9:00am – 12:15pm
St. Anne's Conference Center
Foundation Conference Room
155 North Occidental Boulevard, Los Angeles, CA 90026

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

All Commission meetings will begin at their appointed times.
Participants should make every effort to be prompt and ready.

All agenda items are subject to action. Public comment will be invited for each item.

All "action" (non-procedural) motions are included on the consent calendar and are approved when the consent calendar is approved.
A motion can be "pulled" from the consent calendar if there are objections to it, or if it is to be presented or discussed later in the meeting.

Members/Visitors: Remember that the agenda order (and the scheduled times for items) can be changed or significantly delayed during and at a meeting.	**Motions**, public comment periods, dates/times/venues of future activities.	**Who** addresses the issue, reports on it, and/or who follows-up after that.	**Agenda Times** are best estimates, but are subject to change at any time.
AGENDA ORDER/AGENDA ITEMS	**MOTIONS/ACTIONS**	**PARTY(IES) RESPONSIBLE**	**SCHEDULED TIMES**
1. Call to Order		**B Land/R Rosales** Co-Chairs, COH	9:00 am — 9:03 am
A Roll Call			
2. Approval of Agenda	**MOTION #1**	**Commision**	9:03am — 9:05 am
3. Approval of Meeting Minutes	**MOTION #2**	**Commission**	9:05 am — 9:07 am
4. Executive Director's Report		**C Barrit, MPIA** Executive Director, COH	9:07am — 9:10am

AGENDA ORDER/AGENDA ITEMS	MOTIONS/ACTIONS, DATES and LOGISTICS	PARTY(IES) RESPONSIBLE	SCHEDULED TIMES
5. Co-Chairs Report		**B Land/R Rosales,** Co-Chairs, COH	9:10am — 9:15am
A Commissioner Welcome & Service Recognition **B** Meeting Management **C** 2017 Membership Cohort/Drive			
6. County's Health Department Integration Advisory Board (IAB) Report Report		**COH IAB Representatives**	9:15am — 9:18am
7. Housing Opportunities for People With AIDS (HOPWA) Report		**A Marquez** Housing + Community Investment Dept City of Los Angeles	9:18am — 9:35am
8. Immunization Program, Department of Public Health Report		**F Pratt, MD, MPHTM, FACEP** Medical Director, Immunization Program Dept of Public Health	9:35am — 9:45am
9. Division of HIV and STD Programs (DHSP), Department of Public Health		**M Peréz, MPH,** Director, DHSP	9:45am — 10:05am
10. California Office of AIDS (OA) Report		**State Office of AIDS**	10:05am — 10:20am
A OA Work/Information		**M Arnold, MS-HAS,** Chief, Care Branch, OA	
11. Break			10:20am — 10:35am
12. Standing Committee Reports			10:35am — 11:35am

A Standards and Best Practices (SBP) Committee — **J Cadden, MD/G Granados, MSW,** Co-Chairs

(1) Prevention Standards Presentation: ***30-Day Public Comment Period Now Open***

(2) Housing Standards

B Planning, Priorities & Allocations (PP&A) Committee — **A Ballesteros, MBA/J Brown,** Co-Chairs

(1) Comprehensive HIV Plan (CHP) Update

(2) PS12-1201 Comprehensive HIV Prevention Program End of Year Progress Report

(3) DHSP Solicitations Summary

C Operations Committee — **T Bivens-Davis/K Stalter,** Co-Chairs

(1) Policies and Procedures

(2) Membership Management

(a) 2017 Membership Cohort/Drive

(3) Training/Orientation

D Public Policy Committee — **A Fox, MPM/W Watts, Esq.,** Co-Chairs

(1) County Legislative/Policy Issues

(a) COH Legislative Docket Updates

(2) State Legislative/Policy Issues

(a) FY 2018 Governor's State Budget | May Revise

(3) Federal Legislative/Policy Issues

(a) FY 2018 President's Proposed Budget

(b) Social Security Administration Revised Criteria for Evaluating HIV Infection

(c) Healthcare Access

AGENDA ORDER/AGENDA ITEMS	MOTIONS/ACTIONS, DATES and LOGISTICS	PARTY(IES) RESPONSIBLE	SCHEDULED TIMES
13. **Caucus,Task Force and Work Group Reports**		**Caucus, Task Force and Work Group** Co-Chairs	11:35am — 11:40am
14. **City/Health District Reports**		**City/Health District Representatives**	11:40am — 11:43am
15. **SPA/District Reports**		**SPA/District Representatives**	11:43am — 11:46am
16. **AIDS Education/Training Centers (AETCs)**		**J Gates, PhD,** AETC	11:46am — 11:49am
17. **Public Comment (*Non-Agendized or Follow-Up*)**		**Public**	11:49pm — 11:59am
18. **Commission Comment (*Non-Agendized or Follow-Up)***		**Commission Members/Staff**	11:59am — 12:09pm
19. **Announcements**		**Commission/Public**	12:09pm — 12:15pm
20. **Adjournment**			12:15pm

PROPOSED MOTION(S)/ACTION(S)

PROCEDURAL MOTION(S):

MOTION # 1:	Adjust, as necessary, and approve the Agenda Order.
MOTION # 2:	Approve minutes from the Commission on HIV meetings, as presented or revised.

COMMISSION ON HIV MEMBERS

Bradley Land, *Co-Chair*	**Ricky Rosales**, *Co-Chair*	**Majel Arnold, MA-HSA**	**Traci Bivens-Davis**
Al Ballesteros, MBA	**Jason Brown**	**Joseph Cadden, MD**	**Danielle Campbell, MPH**
Raquel Cataldo	**Deborah Owens Collins,** PA, MSPAS, AAHIVS	**Michele Daniels**	**Kevin Donnelly**
Matthew Emons, MD	**Michelle Enfield**	**Aaron Fox, MPP**	**Jerry D. Gates, PhD**
Joseph Green	**Terry Goddard, MA**	**Bridget Gordon**	**Grissel Granados, MSW**
Lee Kochems, MA *Eduardo Martinez (Alternate)*	**Abad Lopez**	**Eric Paul Leue**	**Miguel Martinez, MSW, MPH**
Anthony Mills, MD	**José Munoz**	**Derek Murray**	**John Palomo**
Raphael Péna	**Mario Peréz, MPH**	**Juan Preciado**	**Thomas Puckett, Jr.**
Ace Robinson, MPH	**Maria Roman**	**Rebecca Ronquillo**	**Sabel Samone-Loreca**
Martin Sattah, MD	**Terry Smith, MPA**	**LaShonda Spencer, MD**	**Kevin Stalter**
Yolanda Sumpter	**Susan Forrest (Alternate)**	**Will Watts, Esq**	**Terrell Winder**
Octavio Vallejo, MD, MPH			

MEMBERS: 45
QUORUM: 23

for 51 Seats

LEGEND:: **Commissioner/** *Alternate*

All agenda items are subject to action ▣ Public comment will be invited for each item

The Commission Offices are located in Metroplex Wilshire, one building west of the southwest corner of Wilshire and Normandie. Validated parking is available in the parking lot behind Metroplex, just south of Wilshire, on the west side of Normandie. Interpretation services for the hearing impaired and translation services for languages other than English are available free of charge upon request. To arrange for these services, or for additional information about this committee, please contact Dina Jauregui at (213) 738-2816 or djauregui@lachiv.org.

Servicios de interpretación para personas con impedimento auditivo y traducción para personas que no hablan Inglés están disponibles sin costo. Para pedir estos servicios, póngase en contacto con Dina Jauregui al (213) 738-2816 (teléfono), o por fax al (213) 637-4748, por lo menos cinco días antes de la junta.

NOTES on AGENDA SCHEDULING, TIMING, POSTED and ACTUAL TIMES, TIME ALLOTMENTS, and AGENDA ORDER

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

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

External stakeholders who would like to participate in the deliberation of discussion of an a posted agenda item, but who may only be able to attend for a short time during a limited window of opportunity, may call the Commission's Executive Director in advance of the meeting to see if the scheduled agenda order can be adjusted accordingly. Commission leadership and staff will make every effort to accommodate reasonable scheduling and timing requests—from members or other stakeholders—within the limitations and requirements of other possible constraints.

COMMISSON ON HIV MEMBERSHIP ROSTER

Updated 6/6/17

MEMBERSHIP SEAT #	MEMBERSHIP SEAT	Commissioners Seated	Committee Assignement	COMMISSIONER	AFFILIATION *(if any)*	TERM BEGINS	TERM ENDS	Alternates Seated	Pending Appointment (Alternates)	ALTERNATE
1)	Medi-Cal representative			***Vacant***		July 1, 2015	June 30, 2017			
2)	City of Pasadena representative	1	OPS	John Palomo	Pasadena Public Health, City of Pasadena	July 1, 2016	June 30, 2018			
3)	City of Long Beach representative	1	PP&A	Deborah Owens Collins, PA, MSPAS, AAHIVS	Dept. of Health and Human Services, City of Long Beach	July 1, 2015	June 30, 2017			
4)	City of Los Angeles representative	1	EXC	Ricky Rosales	AIDS Coordinator's Office, City of Los Angeles	July 1, 2016	June 30, 2018			
5)	City of West Hollywood representative	1	PP&A	Derek Murray	City of West Hollywood	July 1, 2015	June 30, 2017			
6)	Director, DHSP	1	PP&A	Mario Pérez, MPH	DHSP, LA County Department of Public Health	July 1, 2016	June 30, 2018			
7)	Part B representative	1	PP&A	Majel Arnold,MHA	CA Office of AIDS	July 1, 2016	June 30, 2018			
8)	Part C representative	1	PP	Aaron Fox, MPM	Los Angeles Gay and Lesbian Center (LAGLC)	July 1, 2016	June 30, 2018			
9)	Part D representative	1	PP&A	LaShonda Spencer, MD	LAC + USC MCA Clinic, LA County Department of Health Services	July 1, 2015	June 30, 2017			
10)	Part F representative	1	PP	Jerry D. Gates, PhD	Keck School of Medicine of USC	July 1, 2016	June 30, 2018			
11)	Provider representative #1	1	SBP	Joe Cadden, MD	Rand Shrader Clinic (SPA1), LA County Department of Health Services	July 1, 2015	June 30, 2017			
12)	Provider representative #2	1	PP	Maria Roman	APAIT Health Center	July 1, 2016	June 30, 2018			
13)	Provider representative #3	1	PP&A	Miguel Martinez, MSW, MPH	Children's Hospital Los Angeles	July 1, 2015	June 30, 2017			
14)	Provider representative #4	1	EXC|OPS	Raquel Cataldo	Tarzana Treatment Center	July 1, 2016	June 30, 2018			
15)	Provider representative #5	1	PP	Terry Goddard, MA	Alliance for Housing and Healing	July 1, 2015	June 30, 2017			
16)	Provider representative #6	1	PP&A	Anthony Mills, MD	Southern CA Men's Medical Group	July 1, 2016	June 30, 2018			
17)	Provider representative #7	1	SBP	Terry Smith, MPA	AIDS Project Los Angeles (APLA), Health and Wellness	July 1, 2015	June 30, 2017			
18)	Provider representative #8	1	PP	Martin Sattah, MD	Rand Shrader Clinic (SPA1), LA County Department of Health Services	July 1, 2016	June 30, 2018			
19)	Unaffiliated consumer, SPA 1	1	OPS	Michele Daniels	*unaffiliated consumer*	July 1, 2015	June 30, 2017			
20)	Unaffiliated consumer, SPA 2	1	PPA	Abad Lopez	*unaffiliated consumer*	July 1, 2016	June 30, 2018			
21)	Unaffiliated consumer, SPA 3	1	PPA	Jason Brown	*unaffiliated consumer*	July 1, 2015	June 30, 2017			
22)	Unaffiliated consumer, SPA 4			***Vacant***	*unaffiliated consumer*	July 1, 2016	June 30, 2018	1		Susan Forrest
23)	Unaffiliated consumer, SPA 5	1	PPA	Yolanda Sumpter	*unaffiliated consumer*	July 1, 2015	June 30, 2017			
24)	Unaffiliated consumer, SPA 6			***Vacant***	*unaffiliated consumer*	July 1, 2016	June 30, 2018			
25)	Unaffiliated consumer, SPA 7	1	PPA	Raphael Péna	*unaffiliated consumer*	July 1, 2015	June 30, 2017			
26)	Unaffiliated consumer, SPA 8	1	PP	Lee Kochems, MA	*unaffiliated consumer*	July 1, 2016	June 30, 2018	1		Eduardo Martinez
27)	Unaffiliated consumer, Supervisorial District 1	1	PP	Jose Muñoz	*unaffiliated consumer*	July 1, 2015	June 30, 2017			
28)	Unaffiliated consumer, Supervisorial District 2			***Vacant***	*unaffiliated consumer*	July 1, 2016	June 30, 2018			
29)	Unaffiliated consumer, Supervisorial District 3			***Vacant***	unaffiliated consumer	July 1, 2015	June 30, 2017			
30)	Unaffiliated consumer, Supervisorial District 4	1	EXC|OPS	Kevin Donnelly	*unaffiliated consumer*	July 1, 2016	June 30, 2018			
31)	Unaffiliated consumer, Supervisorial District 5	1	SBP	Thomas Puckett, Jr.	*unaffiliated consumer*	July 1, 2015	June 30, 2017			
32)	Unaffiliated consumer, at-large #1			***Vacant***	*unaffiliated consumer*	July 1, 2016	June 30, 2018			
33)	Unaffiliated consumer, at-large #2	1	EXC|OPS	Joe Green	*unaffiliated consumer*	July 1, 2015	June 30, 2017			
34)	Unaffiliated consumer, at-large #3	1	OPS	Kevin Stalter	The Brotherhood IMPACT Fund	July 1, 2016	June 30, 2018			
35)	Unaffiliated consumer, at-large #4	1	OPS	Bridget Gordon	*unaffiliated consumer*	July 1, 2015	June 30, 2017			
36)	Representative, Board Office 1	1	PPA	Al Ballesteros, MBA	JWCH Institute, Inc.	July 1, 2016	June 30, 2018			
37)	Representative, Board Office 2	1	PP	Will Watts, Esq.	Public Counsel	July 1, 2015	June 30, 2017			
38)	Representative, Board Office 3			***Vacant***		July 1, 2016	June 30, 2018			
39)	Representative, Board Office 4	1	SBP	Ace Robinson, MPH	Long Beach C.A.R.E Program	July 1, 2015	June 30, 2017			
40)	Representative, Board Office 5	1	EXC	Brad Land	*unaffiliated consumer*	July 1, 2016	June 30, 2018			
41)	Representative, HOPWA	1	PP	Rebecca Ronquillo	City of Los Angeles, HOPWA	July 1, 2015	June 30, 2017			
42)	Behavioral/social scientist	1	OPS	Terrell Winder	REACH LA	July 1, 2016	June 30, 2018			
43)	Local health/hospital planning agency representative	1	SBP	Matthew Emons, MD, MBA	LA Care	July 1, 2015	June 30, 2017			
44)	HIV stakeholder representative #1	1	SBP	Grissell Granados, MSW	Children's Hospital Los Angeles	July 1, 2016	June 30, 2018			
45)	HIV stakeholder representative #2			***Vacant***		July 1, 2015	June 30, 2017			
46)	HIV stakeholder representative #3	1	OPS	Juan Preciado	Northeast Valley Health Corporation	July 1, 2016	June 30, 2018			
47)	HIV stakeholder representative #4	1	PP	Eric Paul Leue	Free Speech Coaltion	July 1, 2015	June 30, 2017			
48)	HIV stakeholder representative #5	1	OPS	Danielle Campbell	UCLA/MLKCH	July 1, 2016	June 30, 2018			
49)	HIV stakeholder representative #6	1	OPS	Traci Bivens-Davis	N/A	July 1, 2015	June 30, 2017			
50)	HIV stakeholder representative #7	1	OPS	Sabel Samone-Loreca	*unaffiliated consumer*	July 1, 2016	June 30, 2018			
51)	HIV stakeholder representative #8	1	PPA	Michelle Enfield	AIDS Project Los Angeles (APLA), Health and Wellness	July 1, 2015	June 30, 2017			
	TOTAL	**43**	**0**	**43**				**2**	**0**	

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

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COMMITTEE ASSIGNMENTS
(Updated 6-06-17)

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

EXECUTIVE COMMITTEE

Regular meeting day: Fourth Monday of the month ***Regular meeting time***: 1:00pm–3:00pm

Number of Voting Members: 14 ***Number of Quorum***: 8

Bradley Land	**Co-Chair, Comm./Exec.***	Commissioner
Ricky Rosales	**Co-Chair, Comm./Exec.***	Commissioner
Traci Bivens-Davis	Co-Chair, Operations	Commissioner
Kevin Stalter	Co-Chair, Operations	Commissioner
Al Ballesteros, MBA	Co-Chair, PP&A	Commissioner
Jason Brown	Co-Chair, PP&A	Commissioner
Aaron Fox, MPM	Co-Chair, Public Policy	Commissioner
Will Watts, Esq.	Co-Chair, Public Policy	Commissioner
Joseph Cadden, MD	Co-Chair, SBP	Commissioner
Grissel Granados, MSW	Co-Chair, SBP	Commissioner
Raquel Cataldo	At-Large Member*	Commissioner
Kevin Donnelly	At-Large Member*	Commissioner
Joseph Green	At-Large Member*	Commissioner
Mario Pérez, MPH	DHSP Director	Commissioner

OPERATIONS COMMITTEE

Regular meeting day: Fourth Monday of the month ***Regular meeting time***: 10:00am-12:00pm

Number of Voting Members: 11 ***Number of Quorum***: 6

Traci Bivens-Davis	**Committee Co-Chair***	Commissioner
Kevin Stalter	**Committee Co-Chair***	Commissioner
Danielle Campbell, MPH	*	Commissioner
Raquel Cataldo	*	Commissioner
Michele Daniels	*	Commissioner
Kevin Donnelly	*	Commisisoner
Bridget Gordon	*	Commissioner
Joseph Green	*	Commissioner
Sabel Samone-Loreca	*	Commissioner
John Palomo	*	Commissioner
Juan Preciado	*	Commissioner

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

PLANNING, PRIORITIES and ALLOCATIONS (PP&A) COMMITTEE		
Regular meeting day: 3rd Tuesday of the month	***Regular meeting time***:	1:00pm-4:00pm
Number of Voting Members: 12	***Number of Quorum***: 7	
Al Ballesteros, MBA	**Committee Co-Chair***	Commissioner
Jason Brown	**Committee Co-Chair***	Commissioner
Majel Arnold, MHA	*	Commisioner
Abad Lopez	*	Commissioner
Miguel Martinez, MPH, MSW	*	Commissioner
Anthony Mills, MD	*	Commissioner
Derek Murray	*	Commissioner
Debi Collins Owens, MPA, MSPAS, AAHIVS	*	Commissioner
Raphael Péna	*	Commissioner
LaShonda Spencer, MD	*	Commissioner
Yolanda Sumpter	*	Commissioner
TBD	DHSP staff	DHSP Staff

PUBLIC POLICY COMMITTEE		
Regular meeting day: 1st Monday of the month	***Regular meeting time***:	1:00 pm-3:00pm
Number of Voting Members: 11	***Number of Quorum***: 6	
Aaron Fox, MPM	**Committee Co-Chair***	Commissioner
Will Watts, Esq.	**Committee Co-Chair***	Commissioner
Jerry Gates, PhD	*	Commissioner
Terry Goddard, MA	*	Commissioner
Lee Kochems, MA	*	Commissioner
Eric Paul Leue	*	Commissioner
José Munoz	*	Commissioner
Maria Roman	*	Commissioner
Rebecca Ronquillo	*	Commissioner
Martin Sattah, MD	*	Commissioner
Kyle Baker	DHSP staff	DHSP representative

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

STANDARDS AND BEST PRACTICES (SBP) COMMITTEE

Regular meeting day: 1st Thursday of the month ***Regular meeting time***: 10:00am-12:00pm

Number of Voting Members: 7 ***Number of Quorum***: 4

Grissel Granados, MSW	**Committee Co-Chair***	Commissioner
Joseph Cadden, MD	**Committee Co-Chair***	Commissioner
Matthew Emons, MD, MPH	*	Commissioner
Angelica Palmeros, MSW	*	Committee member
Thomas Puckett, Jr.	*	Commissioner
Terry Smith, MPA	*	Commissioner
Wendy Garland, MPH	DHSP staff	DHSP representative
Ace Robinson, MPH	*	Commissioner

CONSUMER CAUCUS

Regular meeting day: Following Comm. mtg. ***Regular meeting time***: 1:30pm–3:00pm

Open Membership

Kevin Donnelly	**Co-Chair**	Commissioner
Joseph Green	**Co-Chair**	Commissioner
Sabel Samone-Loreca	**Co-Chair**	Commissioner
Al Ballesteros, MBA	Member	Commissioner
Jason Brown	Member	Commissioner
Michele Daniels	Member	Commissioner
Grissel Granados, MSW	Member	Commissioner
Bridget Gordon	Member	Commissioner
Lee Kochems, MA	Member	Commissioner
Brad Land	Member	Commissioner
Abad Lopez	Member	Commissioner
Eduardo Martinez	Member	Alternate
Anthony Mills, MD	Member	Commissioner
José Munoz	Member	Commissioner
Raphael Péna	Member	Commissioner
Thomas Puckett	Member	Commissioner
Maria Roman	Member	Commissioner
Terry Smith, MPA	Member	Commissioner
Kevin Stalter	Member	Commissioner
Yolanda Sumpter	Member	Commissioner

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

WOMEN'S CAUCUS

3rd Wednesday of the month	Regular meeting time:	10:00am-12:00pm
Open Membership		
Bridget Gordon	**Co-Chair**	Commissioner
Yolanda Salinas	**Co-Chair**	Commissioner

YOUTH CAUCUS

Regular meeting time: On haitus until further notice		
Open Membership		
Grissel Granados, MSW	**Chair**	Commissioner
Edd Cockrell	Member	Commissioner
Dahlia Ferlito	Member	Community
Eric Paul Leue	Member	Commissioner

TRANSGENDER TASK FORCE

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

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COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

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

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
CAMPBELL	Danielle	UCLA/MLKCH	TBD
CATALDO	Raquel	Tarzana Treatment Center	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Health Education/Risk Reduction (HERR)
			HIV Counseling and Testing (HCT)
			Medical Care Coordination (MCC)
			Case Management, Home-Based
			Case Management, Transitional - Jails
			Medical Transportation
			Mental Health, Psychotherapy
			Oral Health
			Substance Abuse, Residential
			Substance Abuse, Transitional
			Substance Abuse, Detox
			Biomedical Prevention
			Medical Nutrition Therapy
DANIELS	Michele	Unaffiliated consumer	No Ryan White or prevention contracts
DONNELLY	Kevin	Unaffiliated consumer	No Ryan White or prevention contracts
EMONS	Matthew	LA CARE	No Ryan White or prevention contracts
ENFIELD	Michelle	APLA Health & Wellness	Benefits Specialty
			Case Management, Non-Medical (LCM)
			Case Management, Home-Based
			Health Education/Risk Reduction (HERR)
			HIV Counseling and Testing (HCT)
			Mental Health, Psychotherapy
			Nutrition Support
			Oral Health
			Biomedical Prevention
			Medical Care Coordination (MCC)

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
FORREST	Susan	Behavioral Health Services, Inc.	Substance Abuse, Residential Substance Abuse, Detox
FOX	Aaron	Los Angeles Gay & Lesbian Center	Ambulatory Outpatient Medical (AOM)
			Health Education/Risk Reduction (HERR)
			HIV Counseling and Testing (HCT)
			Medical Care Coordination (MCC)
			Mental Health, Psychiatry
			Mental Health, Psychotherapy
			Non-Occupational HIV PEP
			Biomedical Prevention
			STD Screening and Treatment
GATES	Jerry	Keck School of Medicine of USC	No Ryan White or prevention contracts
GODDARD II	Terry	Alliance for Housing and Healing	Residential Care Facilities for the Chronically Ill (RCFCI)
GORDON	Bridget	Unaffiliated consumer	No Ryan White or prevention contracts
GRANADOS	Grissel	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			Case Management, Transitional - Youth
			Health Education/Risk Reduction (HERR)
			HIV Counseling and Testing (HCT)
			Medical Care Coordination (MCC)
			Biomedical Prevention
			Mental Health, Psychotherapy
GREEN	Joseph	Unaffiliated consumer	No Ryan White or prevention contracts
KOCHEMS	Lee	Unaffiliated consumer	No Ryan White or prevention contracts
LAND	Bradley	Unaffiliated consumer	No Ryan White or prevention contracts
LEUE PAUL	Eric	Free Speech Coalition	No Ryan White or prevention contracts
LOPEZ	Abad	Unaffiliated consumer	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MARTINEZ	Eduardo	AIDS Healthcare Foundation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			MH, Psychiatry
			MH, Psychotherapy
			Medical Specialty
			Oral Health
			HIV Counseling and Testing (HCT)
			STD Screening and Treatment
MARTINEZ	Miguel	Children's Hospital, Los Angeles	Ambulatory Outpatient Medical (AOM)
			Case Management, Transitional - Youth
			Health Education/Risk Reduction (HERR)
			HIV Counseling and Testing (HCT)
			Medical Care Coordination (MCC)
			Mental Health, Psychotherapy
			Biomedical Prevention
MILLS	Anthony	Southern CA Men's Medical Group	Biomedical Prevention
			Medical Care Coordination (MCC)
MUNOZ	Jose	Unaffiliated consumer	No Ryan White or prevention contracts
MURRAY	Derek	City of West Hollywood	No Ryan White or prevention contracts
OWENS COLLINS	Deborah	Long Beach Department of Health & Human Services	Benefits Specialty
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
PALOMO	John	City of Pasadena	HIV Counseling and Testing (HCT)
PENA	Raphael	Unaffiliated consumer	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
PERÉZ	Mario	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
PRECIADO	Juan	Northeast Valley Health Corporation	Mental Health, Psychotherapy
			Benefits Specialty
			Mental Health, Psychiatry
			Oral Health
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
PUCKETT, JR.	Thomas	Unaffiliated Consumer	No Ryan White or prevention contracts
ROBINSON	Ace	Long Beach C.A.R.E Program	Ambulatory Outpatient Medical (AOM)
			Medical Case Management (MCC)
			Additional Contracts TBD
ROMAN	Maria	APAIT Health Center	Case Management, Non-Medical (LCM) Language Services Mental Health, Psychotherapy Health Education/Risk Reduction (HERR) HIV Counseling and Testing (HCT)
RONQUILLO	Rebecca	City of Los Angeles, HOPWA	No Ryan White or prevention contracts
ROSALES	Ricky	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
SÃMONÉ-LORECA	Sabél	Unaffiliated consumer	No Ryan White or prevention contracts
SATTAH	Martin	Rand Schrader Clinic LA County Dept of Health Services	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Mental Health, Psychiatry

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SMITH	Terry	APLA Health & Wellness	Benefits Specialty
			Case Management, Non-Medical (LCM)
			Case Management, Home-Based
			Health Education/Risk Reduction (HERR)
			HIV Counseling and Testing (HCT)
			Mental Health, Psychotherapy
			Nutrition Support
			Oral Health
			Biomedical Prevention
			Medical Care Coordination (MCC)
SPENCER	LaShonda	LAC & USC MCA Clinic	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
STALTER	Kevin	The Brotherhood IMPACT Fund	No Ryan White or prevention contracts
SUMPTER	Yolanda	Unaffiliated consumer	No Ryan White or prevention contracts
WATTS	Will	Public Counsel	Legal Services
WINDER	Terrell	REACH LA	Health Education/Risk Reduction (HERR) HIV Counseling and Testing

HIV Calendar

June 2017

Sun	Mon	Tue	Wed	Thu	Fri	Sat
28 Week 22	29	30 9:30 AM - 1:00 PM Board of Supervisors (BOS)	31 9:30 AM - 11:30 AM BOS Agenda Review	1 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	2	3
4 Week 23	5 HIV Long-Term Survivors' Day 1:00 PM - 3:00 PM Public Policy Committee	6 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 4:00 PM Comprehensive HIV Plan Task Force/Goals and Objectives Workgroup	7 9:30 AM - 11:30 AM BOS Agenda Review	8 9:00 AM - 1:00 PM Commission Meeting	9	10
11 Week 24	12	13 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 3:00 PM Training for Commissioners: Running and Facilitating Meetings	14 9:30 AM - 11:30 AM BOS Agenda Review	15 1:00 PM - 3:00 PM Training for Commissioners: Effective Communication and Active Listening	16	17
18 Week 25	19 10:00 AM - 12:00 PM Transgender Caucus	20 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 4:00 PM Planning, Priorities & Allocations (PP&A)	21 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Women's Caucus	22	23	24
25 Week 26	26 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	27 National HIV Testing Day 9:30 AM - 1:00 PM Board of Supervisors (BOS)	28 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Housing Taskforce	29	30	1

HIV Calendar

July 2017

Sun	Mon	Tue	Wed	Thu	Fri	Sat
25 Week 26	26 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	27 National HIV Testing Day 9:30 AM - 1:00 PM Board of Supervisors (BOS)	28 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Housing Taskforce	29	30	1
2 Week 27	3 1:00 PM - 3:00 PM Public Policy Committee	4 9:30 AM - 1:00 PM Board of Supervisors (BOS)	5 9:30 AM - 11:30 AM BOS Agenda Review 1:00 PM - 4:00 PM Comprehensive HIV Plan Task Force/Goals and Objectives Workgroup	6 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	7	8
9 Week 28	10	11 9:30 AM - 1:00 PM Board of Supervisors (BOS)	12 9:30 AM - 11:30 AM BOS Agenda Review	13 9:00 AM - 1:00 PM Commission Meeting	14	15
16 Week 29	17 10:00 AM - 12:00 PM Transgender Caucus	18 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 4:00 PM Planning, Priorities & Allocations (PP&A)	19 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Women's Caucus	20 1:00 PM - 3:00 PM Training for Commissioners: Data and Epidemiology Overview	21	22
23 Week 30	24 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	25 9:30 AM - 1:00 PM Board of Supervisors (BOS)	26 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Housing Taskforce	27	28	29
30 Week 31	31	1 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 4:00 PM Comprehensive HIV Plan Task Force/Goals and Objectives Workgroup	2 9:30 AM - 11:30 AM BOS Agenda Review	3 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	4	5

HIV Calendar

August 2017

Sun	Mon	Tue	Wed	Thu	Fri	Sat
30 Week 31	31	**1** 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 4:00 PM Comprehensive HIV Plan Task Force/Goals and Objectives Workgroup	**2** 9:30 AM - 11:30 AM BOS Agenda Review	**3** 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	**4**	**5**
6 Week 32	**7** 1:00 PM - 3:00 PM Public Policy Committee	**8** 9:30 AM - 1:00 PM Board of Supervisors (BOS)	**9** 9:30 AM - 11:30 AM BOS Agenda Review	**10** 9:00 AM - 1:00 PM Commission Meeting	**11**	**12**
13 Week 33	**14**	**15** 9:30 AM - 1:00 PM Board of Supervisors (BOS)	**16** 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Women's Caucus	**17**	**18**	**19**
20 Week 34	**21** 10:00 AM - 12:00 PM Transgender Caucus	**22** 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 3:00 PM Training for Commissioners: Planning Council Refresher	**23** 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Housing Taskforce	**24**	**25**	**26**
27 Week 35	**28** 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	**29** 9:30 AM - 1:00 PM Board of Supervisors (BOS)	**30** 9:30 AM - 11:30 AM BOS Agenda Review	**31**	1	2

HIV Calendar

September 2017

Sun	Mon	Tue	Wed	Thu	Fri	Sat
27 Week 35	28 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	29 9:30 AM - 1:00 PM Board of Supervisors (BOS)	30 9:30 AM - 11:30 AM BOS Agenda Review	31	1	2
3 Week 36	4 1:00 PM - 3:00 PM Public Policy Committee	5 9:30 AM - 1:00 PM Board of Supervisors (BOS)	6 9:30 AM - 11:30 AM BOS Agenda Review	7 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	8	9
10 Week 37	11	12 9:30 AM - 1:00 PM Board of Supervisors (BOS)	13 9:30 AM - 11:30 AM BOS Agenda Review	14 9:00 AM - 1:00 PM Commission Meeting	15	16
17 Week 38	18 National HIV/AIDS and Aging Awareness Day 10:00 AM - 12:00 PM Transgender Caucus	19 9:30 AM - 1:00 PM Board of Supervisors (BOS)	20 9:30 AM - 11:30 AM BOS Agenda Review	21	22	23
24 Week 39	25 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	26 9:30 AM - 1:00 PM Board of Supervisors (BOS)	27 National Gay Men's HIV/AIDS Awareness Day 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Housing Taskforce	28	29	30

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http://hiv.lacounty.gov

3. MEETING MINUTES

A. May 11, 2017 Commission Meeting

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6. CO-CHAIRS' REPORT

C. 2017 Membership Cohort/Drive Recruitment Flyer

Los Angeles County Commission on HIV

Join the Los Angeles County Commission on HIV and help plan for the effective delivery of services for impacted populations. Be a part of the legacy to end HIV/AIDS in Los Angeles County.

To apply, complete a Membership Application Form online (http://hiv.lacounty.gov/About-Us).

For assistance, please call (213) 738-2816 or email hivcomm@lachiv.org

Mailing Address: 3530 Wilshire Blvd, Suite 1140, Los Angeles, CA 90010

Treat HIV

Beat HIV

Planning for

Healthier

Communities

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http://hiv.lacounty.gov

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

Los Angeles HOUSING+COMMUNITY Investment Department

Eric Garcetti, Mayor
Rushmore D. Cervantes, General Manager

The Housing + Community Investment Department

Housing Opportunities for Persons with HIV/AIDS (HOPWA)

June 8, 2017

The Community Services and Development Bureau

Operations Division	Consolidated Planning Division
HOPWA—18.6 Million	Consolidated Plan--$120 Million
FamilySource Centers—14.2 Million	Commissions & Community Engagement Includes (6) Commissions:
Homeless Services--$61 Million	Human Relations, Status of Women,
Domestic Violence--$2.3 Million	Transgender Advisory Council,
Loans & Leases—$23 Million	Affordable Housing, Community Action Board, and Community & Family Engagement

3

OVERVIEW

- The Housing Opportunities for Persons with HIV/AIDS (HOPWA) program is a federal program designed to provide housing assistance and related supportive services to low-income persons living with HIV/AIDS (PLWHA) and their families.
- The HOPWA program is administered by the U.S. Department of Housing and Urban Development's (HUD's) Office of HIV/AIDS Housing.

4

OVERVIEW (cont'd)

- HOPWA's strategic objectives are to increase housing stability, expand access to care and reduce the risk of homelessness.
- HOPWA regulations require the most populous unit of local government in an eligible metropolitan statistical area (EMSA) to receive the formula allocation. Therefore, the HOPWA funds received by the Los Angeles Housing and Community Investment Department (HCIDLA) are to be used for programs countywide.
- For the past 3 years a typical annual allocation has been approximately $13,000,000.

**While level funding has been secured through September, a reduction of over 7% in formula funds has been proposed by the Trump Administration.

5

ELIGIBILITY

- Eligible participants are low-income persons defined by HUD as those with incomes at or below 80% of area median income (AMI).
- Eligible participants are those diagnosed with HIV/AIDS, and their families.

6

HOPWA PROGRAM COMPONENTS

- For the program year with the term of April 1, 2017 through March 31, 2018, HCIDLA has 24 agencies offering services in all eight (8) SPAs:
  - Central Coordinating Agency responsible for processing all tenant-based rental assistance for the housing authorities and applications for the move-in grant and STRMU.
  - Four (4) regional offices in SPA 1, 2, 3, 4West, 5, 6, 7 and 8 who may have subcontractors to assess HOPWA clients for needed housing assistance and offer or refer out for supportive services as needed.

7

HOPWA PROGRAM REDESIGN

- Although HCIDLA has always served HOPWA program participants throughout the County, for the past program year, and into this one, we deliberately take a more regional approach to administering the program.
- Our current model consists of a 6 regional lead HOPWA agencies for the eight (8) Service Planning Areas (SPAs), legal services, housing information and referral and animal advocacy to offer rental assistance and any other barriers that may prevent someone living with HIV/AIDS from finding, and maintaining, affordable housing.

HOPWA Program Redesign (cont'd)

- Contracts for Program Year 2016-17 (4/1/16-3/31/17)

AIDS Project Los Angeles -Regional Lead SPA 6 (South Los Angeles) -Training Module (Housing Specialist Certification)	**Alliance for Housing and Healing** -Regional Lead SPA 4/5 (Metro West/West Los Angeles) -Regional Lead SPA 8 (South Bay) -Central Coordinating Agency (STRMU / PHP Move-In Grants) -Residential Service Coordination -Scattered Site Master Leasing
Tarzana Treatment Centers -Regional Lead SPA 1/2 (Antelope Valley / San Fernando Valley)	**Foothill AIDS Project** -Offering crisis housing, housing specialists and supportive services for SPA 3/7 (San Gabriel Valley / East Los Angeles)

LAMP Community -Offering crisis housing, housing specialists and supportive service for SPA 4 (Metro Downtown / East Los Angeles)	**Single Room Occupancy** -Offering crisis housing, housing specialists and supportive services for SPA 4 (Metro Downtown / East Los Angeles) -Residential Services Coordination
Hollywood Community Housing Corp. -Residential Services Coordination	**West Hollywood Community Housing Corp.** -Residential Services Coordination
Project New Hope -Residential Services Coordination -Scattered Site Master Leasing	**Inner City Law Center** -Legal Services
Pets Are Wonderful Support/Los Angeles -Housing Information and Referral -Animal Support and Advocacy	**City of Pasadena** -Tenant Based Rental Assistance
Housing Authority of the City of Los Angeles -Tenant Based Rental Assistance -Project Based Rental Assistance	**Housing Authority of the City of Long Beach** -Tenant Based Rental Assistance -Housing Specialists

Housing Authority of the County of Los Angeles -Tenant Based Rental Assistance	

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HCIDLA HOPWA Contact Information

- HOPWA Hotline (213) 808-8805
- HOPWA E-mail hcidla.hopwa@lacity.org
- Program Analysts
  - Rebecca Ronquillo – Rebecca.Ronquillo@lacity.org
  - Brad Dumm – Brad.Dumm@lacity.org
  - Maisha Hunter – Maisha.Hunter@lacity.org

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Los Angeles City's Measure HHH

- Proposition HHH authorizes the City of Los Angeles to issue $1.2 billion in General Obligation Bonds to address homelessness crisis
- Eligible Uses:
  - Acquisition or improvement of real property to build permanent, supportive housing (PSH) and facilities for the homeless
  - Up to 20% can be use for affordable housing for AT-RISK homeless

**Funds CANNOT be used for operations or services

13

Los Angeles City's Measure HHH

- The goal is to create up to 10,000 permanent, supportive housing units over the course of the next 10 years
- Funds garnered from these bond issuances will accelerate the pace of annual production of permanent, supportive housing units
- The development of housing will be administered by the Housing and Community Investment Department
- The development of facilities will be administered by the City Administrative Office.
- In March, funding for 18 developments was approved:
  - $77 million for PSH: 615 total units, 440 PSH (one development approved will be partially funded with HOPWA funds)
  - $12 million for 6 facilities

14

HCIDLA's Efforts to Combat Homelessness in L.A.

- Oversight of homeless programs administered by LAHSA
- Close to $50M allocated by the City GF in 2016-2017
- $18M allocated for 2017-2018
- Implementation of Comprehensive Homeless Strategy
- HCIDLA's GM on Measure H Steering Committee
- Involved in many homeless taskforce/regional advisory committees

15

Los Angeles County's Measure H

- Estimated to generate $355 Million annually to fund services and other support for the homeless.
- Steering Committee included representatives from County Departments, LAHSA, Home for Good, City of LA CAO and HCIDLA, and other subject-matter experts
- Funding recommendations will be considered by the County Board of Supervisors on June 13, 2017
- A total of (21) County Homeless Strategies eligible for funding

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QUESTIONS & ANSWERS

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8. IMMUNIZATION PROGRAM, DEPARTMENT OF PUBLIC HEALTH REPORT

Patient Centered Vaccine Portfolios

Franklin D Pratt, MD, MPHTM, FACEP
Medical Director
Los Angeles County Immunization Program

How will a person's life be improved by vaccines?

What vaccine induced immunity is recommended?

Defined by a Person's
Age
Medical History
Current Medical Status
Occupation
Prior vaccine history

Defined by a Person's Age, Medical History, Current Medical Status Occupation

- People who are diabetics
- People who have congestive heart failure
- People with other chronic health problems
- Employed as a laboratory technician
- Men who have sex with men (MSM)
- HIV+

Defined by a Person's Age, Medical History, Current Medical Status Occupation,

- Men who have sex with men (MSM)
- HIV+

Childhood vaccinations

- Measles, Mumps, Rubella (MMR)
- Hepatitis (HepB)
- Hepatitis A (HepA)
- Inactivated Polio (IPV)
- Haemophilus influenza (HiB)
- Varicella (VAR)
- Pneumococcal conjugate (PCV13)
- Meningococcal (MCV4)
- Influenza – Flu (IIV) – yearly
- Tetanus, Diphtheria, Pertussis (Tdap)

Adolescent Vaccinations

- Human papillomavirus (HPV)
- Meningococcal (MCV4)
- Tetanus, Diphtheria, Pertussis (Tdap)
- Influenza – Flu (yearly)

Adult Vaccinations

- Zoster (shingles) – subunit vaccine
- Tetanus, Diphtheria, Pertussis (Tdap)
- Influenza – Flu (yearly)
- Pneumococcal Conjugate or Polysaccharide

Implementation

- Working group of clinicians to refine vaccine details
- Consistent dialogue with COH re: patient preferences
- Communications, info sharing with
  - Health care plans
  - Medical organizations
  - Advocacy groups

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12. STANDING COMMITTEE REPORTS:

A. Standards and Best Practices (SBP) Committee

(1) Prevention Standards

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

(2) PS12-1201 Comprehensive HIV Prevention Program End of Year Progress Report

(3) DHSP Solicitations Summary

D. Public Policy Committee

(3) Federal Legislative/Policy Issues

(a) FY 18 President's Proposed Budget

(b) Social Security Administration Revised Criteria for Evaluating HIV Infection

(c) Healthcare Access

Los Angeles County HIV Prevention Standards

Los Angeles County Commission on HIV
June 8, 2017

County of Los Angeles Public Health

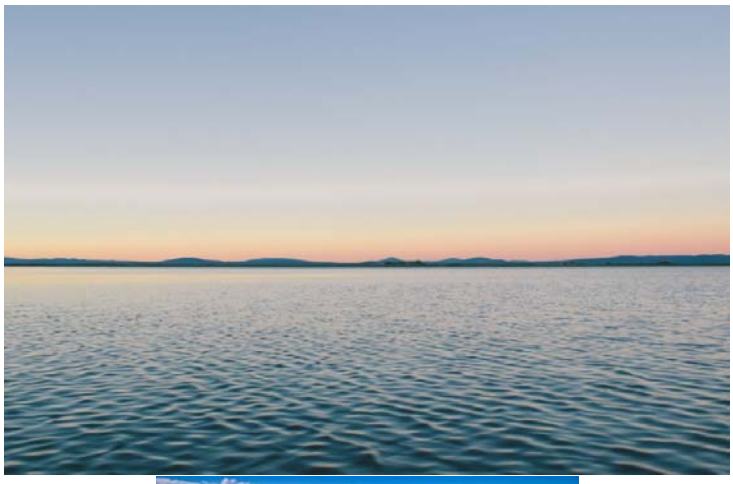
Division of HIV and STD Programs

LOS ANGELES COUNTY COMMISSION ON HIV

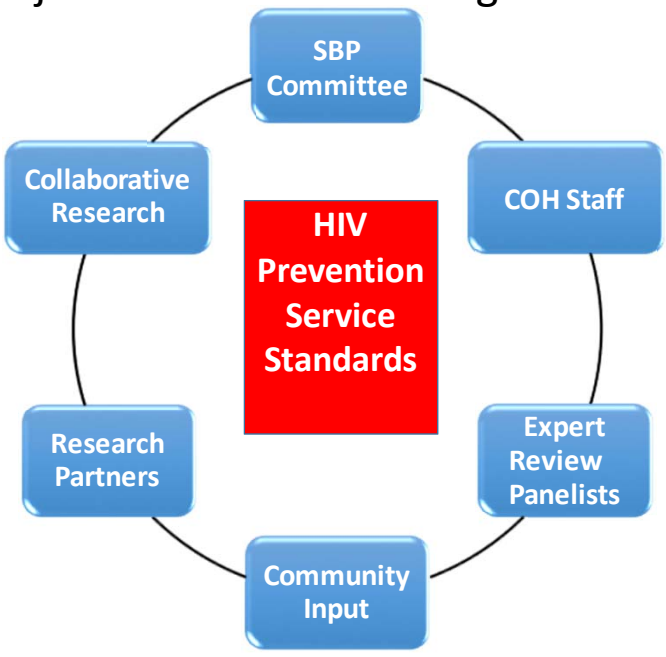
Purpose of HIV Prevention Service Standards

- SBP Committee is charged with developing standards for the organization and delivery of HIV care, treatment and prevention services.
- Used in monitoring contractors and in determining service quality.
- Minimum standards intended to help agencies meet the needs of clients. Providers may exceed standards.

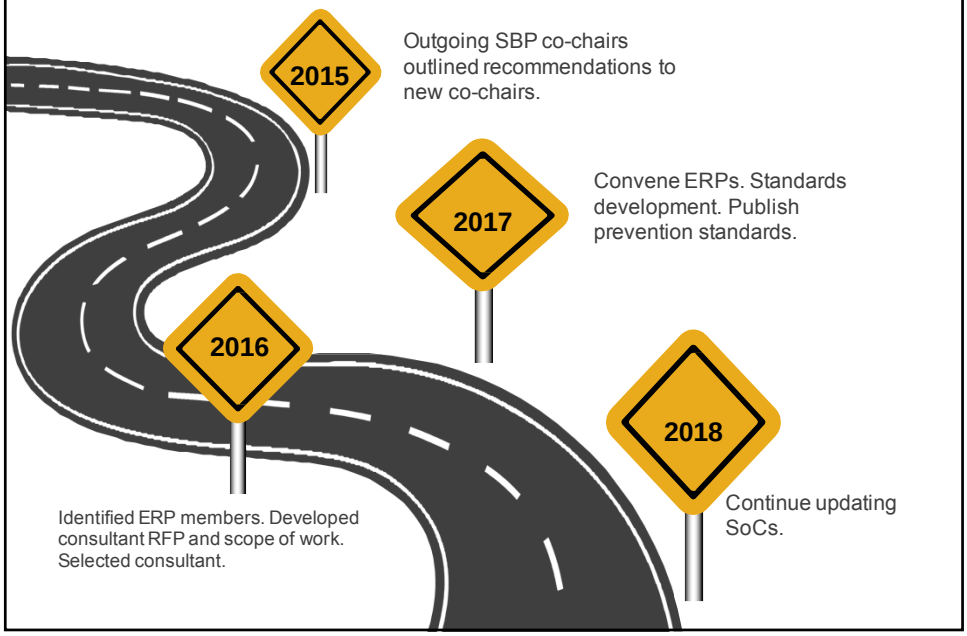
LOS ANGELES COUNTY COMMISSION ON HIV



Project Team and Knowledge Partners



Roadmap for Development of New Prevention Standards



Roles and Responsibilities

SBP Committee

Leads process

Project Team

Writes document, convenes ERPs, and analyzes comments

Commission on HIV

Approves final standards

HIV Prevention Standards Development Process

1. Reviewed key documents
2. Drafted Prevention Service Standards
3. Draft Standards reviewed by 4 Expert Review Panels
4. Drafted next version based on feedback
5. Held Community Review Meetings
6. Updated document for public comment period

LOS ANGELES COUNTY
COMMISSION ON HIV

Expert Review Panelists

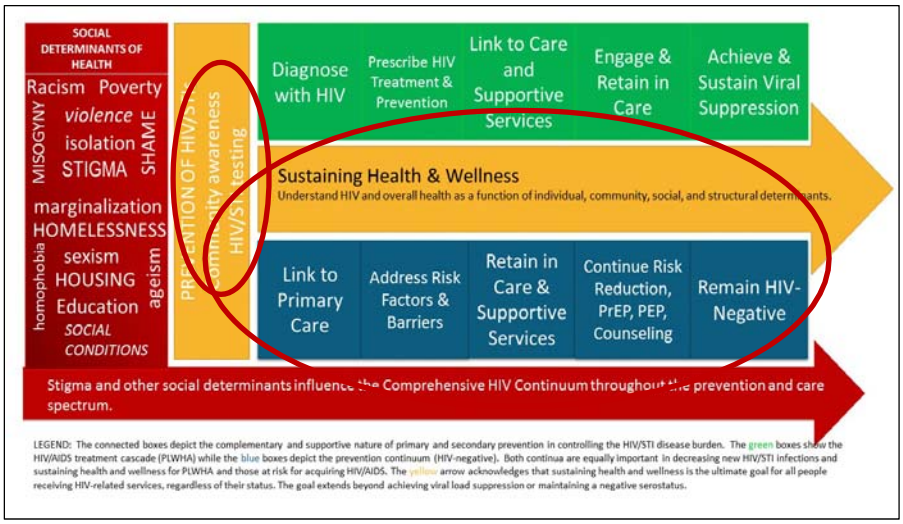
- Panelists review draft documents and other materials before the meeting
- Grantee representative/subject matter experts
- Current providers
  - Public/private
  - Ryan White, CDC-funded, and outside the system
  - Diversity with respect to race/ethnicity, gender, population served, etc.
- Professionals/experts
  - Researchers
  - Academics
  - Consumers

Guiding Questions

1. Are the standards up-to-date and consistent with national standards of high quality HIV and STD prevention services?
2. Are the standards reasonable and achievable for providers?
3. Will the services described meet consumer needs? In this context, "consumers" are defined as those at risk for contracting HIV and STDs.
4. Are proposed standards client-centered?
5. What are the important outcomes we expect for people receiving these services? How can we measure whether or not the service is working for them?

LOS ANGELES COUNTY COMMISSION ON HIV

The Los Angeles County Commission on HIV
Comprehensive HIV Continuum Framework



HIV Prevention Universal Service Standards

HIV prevention services in Los Angeles County must be:

1. Holistic
2. Responsive to the needs and strengths of the populations served
3. Designed to address or mitigate social determinants of health
4. Strength-based
5. Sex-positive
6. Culturally responsive

HIV Prevention Service Standards

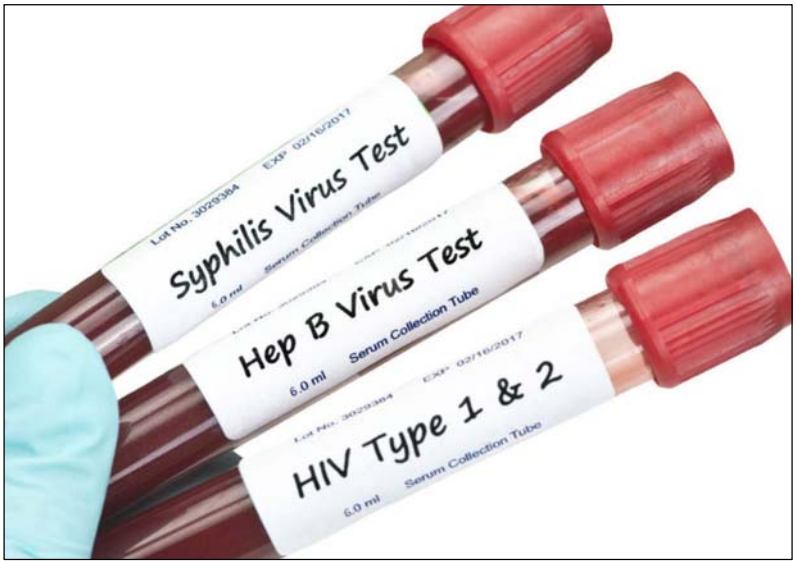
1. Assessment
2. HIV and STD Testing
3. Linkage to Biomedical Prevention Services
4. Referral and Linkage to Non-Biomedical Prevention Services
5. Retention and Adherence to Prevention Services

Assessment

Assessment: Key Components

- Assessments should align with the client's reason(s) for accessing services and point of entry.
- Whenever possible, collect demographic information in a manner that is affirming of various identities.
- Specific topics or areas should be assessed only if the provider is prepared to manage the possible responses, and only if the provider can offer resources, referrals, and /or services in response.
- The assessment process should utilize a health promotion approach.
- The assessment process should include assessing for medical and social factors.

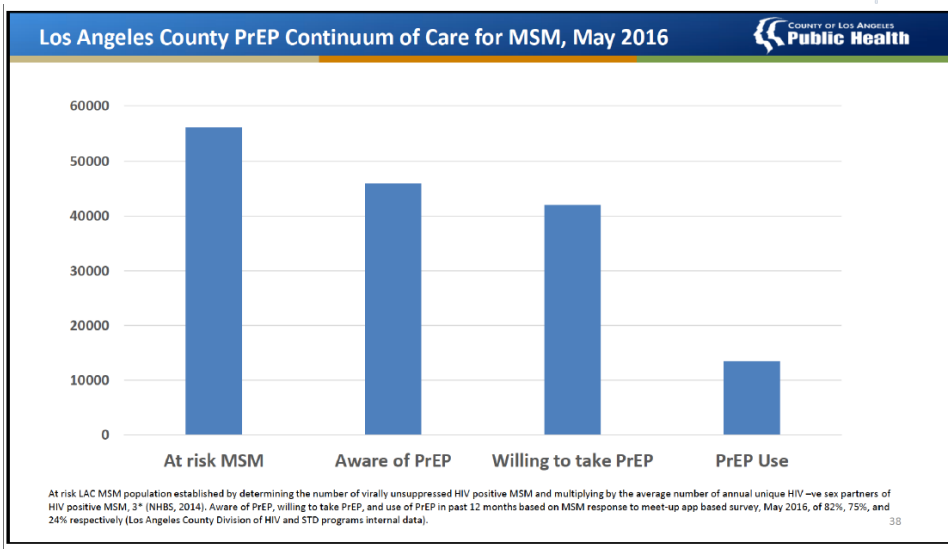
HIV & STD Testing



HIV and STD esting: Key Components

- Individuals at high risk for HIV should get tested every 1-3 months.
- HIV testing must be voluntary and free from coercion.
- Diagnostic HIV testing and opt-out HIV screening should be a part of routine care in all health-care settings.
- HIV testing should be simple, accessible, and straightforward.
- Testing sites should employ strategic targeting and recruitment efforts.
- HIV and STD Testing services must follow the most current guidelines from the CDC.

Linkage to Biomedical HIV Prevention Services



Linkage to Biomedical Prevention Services: Key Components

- The goal of linkage and referral activities is to connect clients to those services that address their needs in the most expeditious manner possible.
- Linkage to biomedical interventions (i.e. PrEP and PEP) is often a priority.
- Linkage standards are based on the Los Angeles County PrEP Continuum: increase awareness, willingness, and uptake.
- If your agency doesn't provide PrEP, develop written protocols/MOUs with agencies/clinics that do provide PrEP, outlining the referral and linkage process
- Connect all high-risk HIV-negative clients to a PrEP Navigator (in-house or external) within 24 hours.

LOS ANGELES COUNTY COMMISSION ON HIV

Referral and Linkage to Non-Biomedical Prevention Services

Referral & Linkage to Non-Biomedical Prevention Services: Key Components

- Not all non-biomedical services that a client may need are easily accessible, therefore hard to ensure *linkage*.
- Emphasis on *active referrals*: address barriers to accessing services by helping the client make contact with a service provider or agency.
- Developing written protocols/MOUs with other HIV/STD prevention and primary care providers and social service agencies to ensure linkage to appropriate prevention services.
- Assisting clients with enrolling in health insurance.
- Actively referring clients who are not accessing regular care to a medical home or primary care provider.
- Assessing possible facilitators and barriers to accessing services.

LOS ANGELES COUNTY COMMISSION ON HIV

Retention and Adherence to Prevention Services

Retention and Adherence to Prevention Services: Key Components

Retention:

- Assist clients with scheduling follow-up visits
- Provide reminders for all visits
- Offer or refer to navigation assistance, when possible
- Reinforce the benefits of prevention services
- Regularly assess facilitators and barriers to retention, and support clients to overcome identified barriers
- Regularly assess clients' need for prevention services: *Have their needs changed? Do they no longer need services? Do they need different services?*

Retention and Adherence to Prevention Services: Key Components

Adherence:

- Inform clients about the benefits of sustained adherence to PrEP and PEP
- Provide adherence support tailored to each client's needs and characteristics, and/or connect clients to medication adherence interventions
- Work with client to develop a plan for stopping PrEP, when appropriate, and transitioning to other prevention options
- Provide or make referrals for services to address factors that may impair adherence (e.g., comorbidity, financial, psychosocial, and structural issues)

Next Steps

- 30-day public comment period (6/8-7/7)
- Email comments to hivcomm@lachiv.org
- Access document via COH website
- http://hiv.lacounty.gov/
- Update/edit as necessary
- Present final document for approval at the Los Angeles County Commission on HIV meeting

Thank you!

Any questions?

2017

Los Angeles County
Commission on HIV

PUBLIC COMMENT PERIOD:
JUNE 8-JULY 7, 2017
PLEASE EMAIL COMMENTS TO:
hivcomm@lachiv.org

PROPOSED HIV PREVENTION SERVICE STANDARDS-FOR PUBLIC COMMENT

The development of service standards is one of the core functions of the Commission on HIV. The public is invited to review the proposed Prevention Service Standards.

HIV PREVENTION SERVICE STANDARDS: Background

PURPOSE of SERVICE STANDARDS: Service standards outline the essential elements of service delivery a provider agency must adhere to when implementing HIV prevention services. The purpose of the service standards is to ensure consistent high-quality service delivery throughout Los Angeles County. Service standards establish the minimal level of service delivery. Providers are encouraged to exceed this minimal level if able to, given their capacity and scope.

A multitude of factors at the structural-, environmental-, interpersonal-, and individual-level impact the risk of HIV infection. Therefore, a multitude of services (e.g. housing, employment, social marketing, counseling, condom distribution, etc.) may also serve to prevent the acquisition of HIV. Because it is not feasible to create standards for every potential prevention service, the HIV Prevention Service Standards described in this document focus on ensuring that every HIV-negative individual at risk of HIV infection is successfully connected to and retained in the prevention service(s) that are appropriate for them at any given point in time.

Also, because there are so many different types of organizations that may provide prevention services, and so many different types of services that may be considered "prevention services," it should be understood that not every category of prevention standards described herein will be applicable to all agencies. For example, an agency that provides HIV testing only, will not be expected to provide adherence services for clients who are accessing PrEP.

DEFINITION OF HIV PREVENTION SERVICES: HIV Prevention Services are those services and/or treatments used alone or in combination to prevent the transmission of HIV. *Biomedical* HIV prevention refers to HIV prevention methods that use antiretroviral treatment (ART) to decrease the risk of HIV transmission by reducing the viral load of people living with HIV (PLWH) and/or by reducing the susceptibility of HIV infection among high-risk HIV-negative individuals.

GOALS OF HIV PREVENTION EFFORTS IN LOS ANGELES COUNTY: Aligned with the Los Angeles County Comprehensive HIV Plan (2017-2021)[1] and the National HIV/AIDS Strategy (NHAS)[2], the overarching goals of HIV prevention efforts in Los Angeles County are to:

1. Reduce new HIV infections, and
2. Reduce HIV-related disparities and health inequities.

METHOD/HIGH IMPACT PREVENTION: In order to achieve our goals, we must implement a *High-Impact Prevention*[3] approach that utilizes combinations of scientifically proven, cost-effective, and scalable interventions targeted to the populations most disproportionately impacted by HIV in Los Angeles County, as indicated by those populations with the highest HIV incidence rates. The Los Angeles County Comprehensive HIV Plan (2017-2021), based on the most recent surveillance data, identifies the following populations that experience the highest HIV incidence rates in Los Angeles County:

- Men who have Sex with Men (MSM)
- Black/African American MSM, Transwomen, and Cisgender Women
- Transwomen
- Young Men (18-29) who have Sex with Men (YMSM)
- Persons living in the Metro, South, and South Bay Service Planning Areas (SPAs)

[1] Los Angeles County Commission on HIV and the Los Angeles County Department of Public Health Division of HIV and STD Programs. Los Angeles County Comprehensive HIV Plan (2017-2021), September 2016.
[2] The National HIV/AIDS Strategy for the United States: Updated to 2020. https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf
[3] High-Impact HIV Prevention: CDC's Approach to Reducing HIV Infections in the United States. https://www.cdc.gov/hiv/policies/hip/hip.html

In addition, there are many other populations and sub-populations highly impacted by HIV, including, but not limited to:

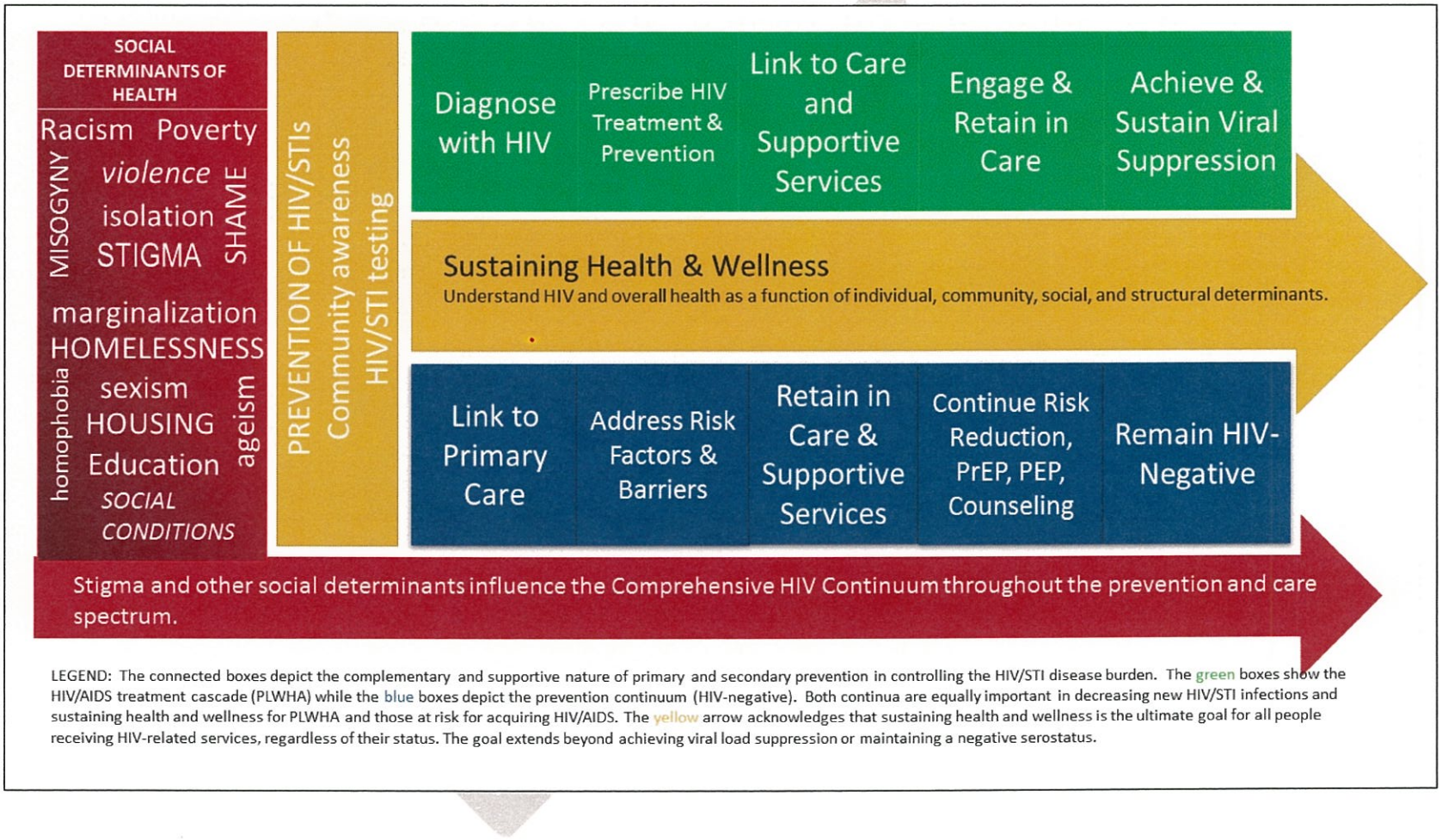
- American Indians/Native Americans
- Latino MSM
- Asian/Pacific Islander MSM
- Latina Cisgender women
- People between the ages of 13-17
- People over the age of 50
- People who inject drugs
- Incarcerated populations
- Stimulant users
- Commercial Sex Workers
- Sex and needle-sharing partners of all above populations

FOUNDATION FOR DEVELOPMENT OF STANDARDS: Comprehensive HIV Continuum Framework

The Los Angeles County Commission on HIV's *Comprehensive HIV Continuum Framework,* depicted in Figure 1, below, was used to guide the development of the HIV Prevention Service Standards. The *Comprehensive HIV Continuum* is an aspirational framework that builds upon the social ecological model to underscore the importance of addressing HIV care and prevention across several dimensions. In the social ecological model, health is viewed as a function of individuals and of the environments in which individuals live, including family, social networks, organizations, communities and societies.[4] The connected boxes depict the complementary and supportive nature of primary and secondary prevention in controlling the HIV/STD disease burden. The green boxes depict the HIV/AIDS treatment cascade (focused on people living with HIV), while the blue boxes depict the prevention continuum (focused on HIV-negative individuals). Both continua are equally important in decreasing new HIV/STD infections. The Los Angeles County Commission on HIV *Standards of Care* address the services that target HIV-positive individuals (i.e. the services relevant to the green boxes). **The HIV Prevention Service Standards, described herein, address the services that target HIV-negative individuals** (i.e. the services relevant to the blue boxes).

[4] Eldredge, L. K. B., Markham, C. M., Kok, G., Ruiter, R. A., & Parcel, G. S. (2016). *Planning health promotion programs: an intervention mapping approach.* John Wiley & Sons.

Figure 1: The Los Angeles County Commission on HIV *Comprehensive HIV Continuum Framework*



LEGEND: The connected boxes depict the complementary and supportive nature of primary and secondary prevention in controlling the HIV/STI disease burden. The green boxes show the HIV/AIDS treatment cascade (PLWHA) while the blue boxes depict the prevention continuum (HIV-negative). Both continua are equally important in decreasing new HIV/STI infections and sustaining health and wellness for PLWHA and those at risk for acquiring HIV/AIDS. The yellow arrow acknowledges that sustaining health and wellness is the ultimate goal for all people receiving HIV-related services, regardless of their status. The goal extends beyond achieving viral load suppression or maintaining a negative serostatus.

Standards Development Process

The development of the HIV Prevention Service Standards included the input and feedback of service providers, consumers, members of the Standards and Best Practices Committee (SBP), and the Los Angeles County Department of Public Health, Division of HIV and STD Programs. In addition, four Expert Review Panels (ERPs) composed of subject matter experts were convened to provide extensive critique on proposed standards. Moreover, two community meetings were convened on May 19, 2017, to further vet the proposed standards. All comments were thoroughly reviewed by the SBP Committee resulting in some recommended revisions.

In order to guide the development of the HIV Prevention Service Standards, SBP Committee members, ERPs, and community stakeholders considered the following questions:

1. Are the standards up-to-date and consistent with national standards of high quality HIV and STD[5] prevention services?
2. Are the standards reasonable and achievable for providers?
3. Will the services meet consumer needs? (In this context, "consumers" are defined as those at risk for contracting HIV and STDs.)
4. Are proposed standards client-centered?
5. What are the important outcomes we expect for people receiving these services? How can we measure whether or not the service is working for them?

[5] Although debatable, for the purposes of this document, we chose to use the term STD (Sexually Transmitted Disease), rather than STI (Sexually Transmitted Infection). Factors that we weighted in making this decision included: perceived stigma; literal meaning of *disease* versus *infection*; and alignment with county, state, and national departmental names. For a great article on the subject, see Dr. H. Hunter Handsfield's article, "Sexually Transmitted Diseases, Infections, and Disorders: What's in a Name?" (http://www.ncsddc.org/blog/sexually-transmitted-diseases-infections-and-disorders-what's-name).

HIV PREVENTION SERVICE STANDARDS

UNIVERSAL HIV PREVENTION SERVICE STANDARDS: In order to achieve our goals, HIV prevention services in Los Angeles County must be:

Holistic: Preventing HIV is typically one priority among many in the lives of people accessing our services. Therefore, HIV prevention services are most effective when they are delivered with the *whole person* in mind. Whenever possible, programs and services should attend to clients' overall physical health, mental health, and spiritual health, as guided by each individual client.

Responsive to the needs and strengths of the populations served: Responsive services are services that are designed and/or delivered with continuous feedback from the populations served. Feedback should help to ensure that the services are culturally appropriate, effective in preventing HIV, respectful of clients, strength-based, sex-positive and destigmatizing, and easily accessed. Feedback methods should include client satisfaction surveys, and other means to continuously assess quality of services (e.g. secret shoppers).

Designed to address or mitigate social determinants of health: Social determinants of health are the economic and social conditions that influence the health of individuals and communities.[6] Social determinants shape the contexts that either increases or decreases an individual's risk of exposure to HIV. Because HIV disparities are inextricably linked to social determinants, interventions or services that focus on social determinants (e.g. housing, education, employment, healthcare, etc.) are necessary to reduce these disparities. The implementation of such social and structural interventions typically requires a great deal of time and effort on behalf of multiple stakeholders, given that social determinants are typically deeply entrenched and institutionalized in our society. For this reason, many HIV prevention agencies may not have the capacity to implement structural or social interventions. However, HIV prevention services should minimally reflect an understanding of the role of social determinants in their design (e.g. consider a client's competing priorities related to housing and employment). HIV prevention agencies, no matter how small, should strive to

[6] World Health Organization, Commission on Social Determinants of Health. Geneva: WHO; 2008. Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health

complement traditional HIV prevention services (e.g. HIV testing), with services that help to mitigate social determinants (e.g. free resume writing workshops).

Strength-Based: A strength-based approach to service design and provision seeks to understand and develop clients' strengths and capabilities that can lead to improved health and quality of life. Services that focus solely on individuals' deficits, needs, problems, or pathologies tend to focus only on what a client needs to "fix" about themselves, thus emphasizing negative behaviors rather than on the potential resiliency and protective factors. Furthermore, when we emphasize what a client is lacking, a dependency is created on the provider and a process of disempowerment occurs. A strength-based approach assumes that individuals have strengths, resources and the ability to recover from adversity; thus allowing a client to see opportunities and solutions rather than just problems and hopelessness. A strength-based approach results in different questions being asked (see Assessment section below) and facilitates an openness and exploration.

Sex-Positive: When services are delivered from a "sex-positive" framework or attitude, they are free from judgment about clients' sexual behaviors, including the behavior itself (as long as it is consensual); the number and type of sexual partners they may have; and the frequency of sexual behaviors they may engage in. A sex-positive attitude also serves to destigmatize sex, and may also serve to destigmatize being gay, being transgender, living with, or being at risk for HIV, etc. Being sex-positive does not mean that you ignore behaviors or circumstances that may increase someone's risk of acquiring HIV or STDs. On the contrary, when clients know that they will not be shamed or judged for the behaviors they engage in, they then will be more likely to disclose important facts and likely will be receptive to information from providers that helps them reduce their risk and/or build upon protective factors.

Culturally Responsive: All HIV prevention organizations should strive to deliver culturally responsive services. Culturally responsive services are those that are respectful of, and relevant to, the beliefs, practices, culture and linguistic needs of diverse consumer/client populations and communities.[7] Cultural responsiveness describes the capacity to respond to the issues of diverse communities. It thus requires knowledge and capacity at different levels of intervention: systemic, organizational, professional and individual. Culturally-responsive services acknowledge that power imbalances exist between groups of people and cultures based on historical and institutional oppression and privilege; that we are not simply "different" from one another. Culturally responsive agencies also create a physical environment that is welcoming, warm, and that communicates a sense of safety for clients.

[7] Adapted from: Curry-Stevens, A., Reyes, M.-E. & Coalition of Communities of Color (2014). *Protocol for culturally responsive organizations*. Portland, OR: Center to Advance Racial Equity, Portland State University.

To practice cultural humility is to maintain a willingness to suspend what you know, or what you think you know, about a person based on generalizations about their culture. Cultural competency implies that one can function with a thorough knowledge of the mores and beliefs of another culture; cultural humility acknowledges that it is impossible to be adequately knowledgeable about cultures other than one's own. What you learn about your clients' culture stems from being open to what they themselves have determined is their personal expression of their culture.[8] Tenets of cultural humility include:

1) Lifelong learning & critical self-reflection
2) Recognizing and challenging power imbalances for respectful partnerships, and
3) Institutional accountability

Summary of Core Prevention Service Categories, Data Indicators, Documentation Needs, and Population-based Outcomes

The HIV Prevention Service Standards detailed in this document seek to ensure the provision of a core set of integrated HIV prevention services aimed at preventing the acquisition of HIV and STDs. The Core Prevention Service Categories are: Assessment, HIV/STD Testing and Retesting, Linkage to Biomedical Prevention Services, Referral and Linkage to Non-Biomedical Prevention Services, and Retention and Adherence to Prevention Services. These categories, in addition to their corresponding data indicators, documentation needs, and population-based outcomes, are outlined in Table 1.

[8] Adapted from: "Cultural Humility: People, Principles and Practices," https://www.youtube.com/watch?v=_Mbu8bvKb_U

Table 1: Summary of Core Prevention Service Categories

Core Prevention Service Categories	***Data Indicators***	***Documentation Needs***	***Population-Based Outcomes (from CHP)***
Assessment	• Number of program participants who complete assessments • Percentage of participants screened for: connection to a medical home; primary care engagement; insurance coverage; STDs; immunizations; pregnancy and family planning; mental health; substance abuse; experiences of trauma and violence; housing and employment status; and sexual health; and sexual and needle-sharing behaviors that may increase their risk of HIV acquisition.	• Completed assessments indicating specific areas or topics assessed and type of assessments used	• Decrease the number of new HIV infections, especially among the following groups: YMSM, Blacks/African Americans, Latino MSM, and Transwomen. • Increase the number of high-risk HIV negative individuals accessing pre-exposure prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP), as needed
HIV/STD Testing and Retesting	• Number of persons tested/screened for HIV and STDs • Number of persons tested/screened for HIV and STDs who have never tested/screened before • Number of testing sites providing integrated testing • Percentage of high-risk negative clients having documentation of HIV/STD testing every 3 months • Type and number of outreach and recruitment methods	• Documentation of HIV/STD testing in client files and data management system • Documentation of type and frequency of outreach and recruitment methods	

Core Prevention Service Categories	***Data Indicators***	***Documentation Needs***	***Population-Based Outcomes (from CHP)***
Linkage to Biomedical Prevention Services	• Percentage of high-risk HIV-negative clients receiving education on PrEP • Percentage of high-risk HIV-negative clients who are interested in PrEP • Percentage of high-risk HIV-negative clients interested in PrEP that are linked to a PrEP Navigator. • Percentage of high-risk HIV-negative clients who received a PrEP prescription • Percentage of high-risk HIV-negative clients receiving education on PEP • Percentage of high-risk HIV-negative clients who received PEP within 72 hours of exposure • Percentage of high-risk HIV-negative clients who accessed PEP and transitioned to PrEP • Percentage of PrEP and PEP clients referred to medication adherence interventions or support services. • Percentage of PrEP and PEP clients who access medication adherence interventions or support services.	• Documentation of PrEP and PEP education • Documentation of client interest in learning more about PrEP (i.e. responded affirmatively to the question, "Would you like to learn more about PrEP or PEP?") • Documentation of linkage to a PrEP Navigator (may be internal or external linkage) • If available, documentation of PrEP or PEP prescription (may be client self-report) • Documentation of former PEP clients who currently access PrEP • Documentation of PrEP and PEP clients who are referred to medication adherence services • Documentation of PrEP and PEP clients who access medication adherence services	• Increase the percent of persons with known HIV status • Decrease the number of sexually transmitted infections (STDs)

Core Prevention Service Categories	***Data Indicators***	***Documentation Needs***	***Population-Based Outcomes (from CHP)***

Referral and Linkage to Non-Biomedical Prevention Services	• Percent of high-risk HIV-negative clients that are referred to needed non-biomedical prevention services, as indicated via the assessment process. This may include referrals to:
	  • behavioral interventions
	  • risk-reduction education
	  • syringe exchange
	  • housing services
	  • mental health services
	  • substance abuse services
	  • food pantries
	  • employment services
	  • health insurance navigation
	  • etc.
	• Percentage of high-risk HIV-negative clients who have not accessed primary care in over one year linked to primary care medical visit within 90 days of assessment.[9]
	• Percentage of HIV prevention agencies that make external and internal[10] condoms available free of charge
		• Documentation of referrals in client files and data management system
		• Documentation of linkage to primary care (may be client self-report)
		• Documentation of condom availability
			Same as above

[9] Assuming that primary care is available to the client, which may not always be the case (i.e. for undocumented individuals, individuals who speak a language other than English, transgender individuals, etc., affordable and accessible primary care may not always be available).

[10] "External" and "internal" condoms are also known as "male" and "female" condoms, respectively, but are not referred to as such in this document since their use is not necessarily aligned with one's gender identity.

Core Prevention Service Categories	***Data Indicators***	***Documentation Needs***	***Population-Based Outcomes (from CHP)***
Retention and Adherence to Prevention Services	• Number of clients who remained engaged in prevention service as needed • Number of clients who adhered to PrEP medication per adherence plan determined with PrEP provider • Number of clients who adhered to PEP for 28-day course	• Documentation of provision of service(s) • Documentation of client engagement in service(s) • Documentation of adherence to PrEP or PEP medication	Same as above

*Note: The viral suppression of HIV-positive individuals is a core prevention strategy in Los Angeles County, however it is not described in these HIV Prevention Service Standards because it is highlighted in the Los Angeles County Commission on HIV *Standards of Care*.

ASSESSMENT

Client assessments are often the first in-depth interaction a client has with a provider agency, and thus can foster a lasting positive relationship built on trust and respect, if conducted correctly. Conversely, an assessment that a client perceives to be judgmental or disrespectful in any way can impede the client's willingness or ability to secure necessary prevention services. For this reason, the assessment process should be conducted by trained personnel. The training should include basic client-centered counseling techniques (e.g. how to communicate in a non-judgmental manner, the use of appropriate body language, etc.), and should also include elements that are specific/relevant to the type of assessment(s) conducted. For example, providers should be trained in how to utilize specific mental health and/or substance abuse screening tools (e.g. Patient Health Questionnaire (PHQ-2)), if the assessment utilizes such tools.

The assessment process should include the following activities and or elements (not necessarily in this order):

1. Explain the purpose of the assessment and obtain verbal consent to continue
2. Conduct the assessment in private, with no other clients, and preferably no other staff members able to hear the conversation
3. Gather relevant information to determine the client's needs, risks, and strengths, when appropriate
4. Inform the client of the services available (internally and externally) and what the client can expect if they were to enroll
5. Establish the client's eligibility for services, including HIV status, if relevant, and other criteria
6. Inform the client of any documentation requirements for the assessment (e.g. income verification for insurance purposes)
7. Collect required county, state, federal client data for reporting purposes
8. Collect basic client information to facilitate client identification and client follow-up
9. Begin to establish a trusting client relationship.

The assessment process is a cooperative and interactive endeavor between the staff and the client, and should be conducted in a strength-based manner, meaning the assessment should highlight clients' skills, competencies and resilience in addition to their challenges and needs. Included below are some examples of strength-based questions[11] that may be asked during an assessment, or over the course of multiple assessments, as appropriate:

[11] Adapted from "50 First Strength-Based Questions" (http://www.changedlivesnewjourneys.com/50-first-strength-based-questions).

1. What is working well (either in general, or with respect to a certain subject – adherence, overall health, etc.)?
2. Can you think of things you have done in the past that have helped with ___?
3. What small thing could you do that would make ____ better?
4. Tell me about what a good day looks like for you? What makes it a good day?
5. On a scale of 1 to 10 how would you say ___ is? What might make that score a little better?
6. What are you most proud of in your life?
7. What achievements have you have made? How did you make them happen?
8. What inspires you?
9. What do you like doing? What makes this enjoyable?
10. What do you find comes easily to you?
11. What do you want to achieve in your life?
12. When things are going well in your life – tell me what is happening?
13. What are the things in your life that help you keep strong?
14. What do you value about yourself?
15. What would other people who know you say you were good at doing?
16. You are resilient, what do you think helps you bounce back?
17. What is one thing you could do to have better health, and feeling of wellbeing?
18. How have you faced / overcome the challenges you have had?
19. How have people around you helped you overcome challenges?
20. What are three things that have helped you overcome obstacles?
21. If you had the opportunity what would you like to teach others?
22. Without being modest, what do you value about yourself, what are your greatest strengths?
23. How could/do your strengths help you to be a part of your community?
24. Who is in your life?
25. Who is important in your life?
26. How would you describe the strengths, skills, and resources you have in your life?
27. What could you ask others to do, that would help create a better picture for you?
28. What are the positive factors in your life at present?
29. What are three (or five or ten) things that are going well in your life right now?
30. What gives you energy?

31. What is the most rewarding part of your life?
32. Tell me about a time when you responded to a challenge in a way that made you feel really on top of things?
33. How have you been able to develop your skills?
34. How have you been able to meet your needs?
35. What kind of supports have you used that have been helpful to you? How did the supports improve things for you?
36. Tell me about any creative, different solutions you have tried. How did this work out?

The client should be the primary source of information during an assessment. However, if appropriate and with client consent, assessments may include additional information from case manager(s), medical or psychosocial providers, caregivers, family members, and other sources of information.

The assessment should be conducted in a client-centered manner that accommodates clients who are unable or otherwise hesitant to attend the appointment at the provider agency. Diverse methods of interaction (e.g., text-based, via social apps, in-person) should be supported, given that confidentiality policies are adhered to.

The assessments or screenings that are conducted should align with the client's reason(s) for accessing services and point of entry. For example, a client who is interested in accessing HIV/STD testing, PEP, or PrEP should not have to endure a lengthy assessment before accessing these services. Clients should be able to access services as expeditiously as possible. However, in some situations, or at a different point in time, a longer assessment may be appropriate.

Whenever possible, collect demographic information in a manner that is affirming of various identities and of intersecting identities. For example, allow for clients to identify their race or ethnicity using whatever categories best fit for them. When asking questions related to gender identify, consider using the two-step question that captures a transgender person's current gender identity as well as their assigned sex at birth: 1. What is your current gender identity? 2. What sex were you assigned at birth, meaning on your original birth certificate? Also, obtain the client's preferred pronoun (he, she, they, etc.).

If appropriate, assess for barriers to accessing services and remaining engaged in services. If barriers are identified, assist the client in identifying potential solutions.

Specific topics or areas should be assessed only if the provider is prepared to manage the possible responses. For example, if questions are asked pertaining to a client's history of trauma, the provider should be prepared to handle a client's potential

range of emotions.

Specific topics or areas should be assessed only if the provider can offer resources, referrals, and /or services in response. Given that providers/agencies have resources, referrals, and/or services at hand, consider including the following topics in client assessments:

- ✓ Connection to spirituality
- ✓ Intimate Partner Violence
- ✓ Trauma
- ✓ Sex-trafficking

The assessment process should utilize a health promotion approach. This includes using information collected during the assessment/ screening to identify appropriate messages that promote health-seeking behavior and minimize risk-behaviors or circumstances. The intention is to offer information, and suggest services and interventions that are tailored to the specific person (and their partners, if relevant) and to highlight current health promoting behaviors and overall strengths of the client.

Health promotion includes:

- ✓ Provision of information or resources related to health in general (may include overall physical health, nutrition, oral health, spiritual health, etc.), behavioral interventions (e.g., brief or intensive risk reduction strategies that encourage safer sex and use of sterile drug-injection equipment, substance use treatment) and/or biomedical interventions (e.g., PrEP, STD services, special reproductive and pregnancy services)
- ✓ Clarifying concepts and misinformation about HIV transmission, acquisition, or prevention methods
- ✓ Provision of information or resources related to specialized counseling and support to members of HIV-serodiscordant relationships
- ✓ Offering a variety of condoms (e.g. external, internal[12], non-latex, etc.) and lubrication options
- ✓ Provision of information or resources related to new, sterile syringes through syringe services programs, pharmacists, physicians, or other legal methods to persons who lack consistent access to sterile drug-injection equipment

[12] "External" and "internal" condoms are also known as "male" and "female" condoms, respectively, but are not referred to as such in this document since their use is not necessarily aligned with one's gender identity.

The assessment process should include assessing for medical and social factors that impact HIV acquisition. Individuals at high risk for HIV acquisition can experience significant personal, social, and structural challenges, such as poverty, mental illness, substance use, unstable housing, and lack of regular medical care. Assessments should include questions pertaining to these medical and social factors that influence HIV acquisition.

HIV/STD TESTING AND RETESTING

HIV and STD testing often serve as the first point of entry in the HIV prevention continuum and for many, the key opportunity to facilitate linkage to a comprehensive array of services. Individuals at high risk for HIV should get tested every 1-3 months, regularly assessed for risks and needs, and linked or re-linked to other HIV prevention services, depending on their needs.

The following are standards that apply to HIV testing[13]:

1. HIV testing must be voluntary and free from coercion. Patients/clients must not be tested without their knowledge.
2. Opt-out HIV screening (notifying the patient/client that an HIV test will be performed, unless the patient/client declines) is recommended in all settings.
3. Specific signed consent for HIV testing should not be required.
4. Use of Ag/Ab combination tests is encouraged unless persons are unlikely to receive their HIV test results.
5. Preliminary positive screening tests for HIV infection must be followed by additional testing to definitively establish the diagnosis.
6. Providers should be alert to the possibility of acute HIV infection and perform an antigen/antibody immunoassay or HIV RNA in conjunction with an antibody test. Persons suspected of recently acquired HIV infection should be referred immediately to an HIV clinical-care provider.
7. Agencies should adhere to local and state public health policies and laws to ensure they deliver high-quality HIV testing services that are culturally competent and linguistically appropriate.
8. HIV testing should be simple, accessible, and straightforward. Minimize client barriers and focus on delivering HIV test results and on supporting clients to access follow-up HIV care, treatment, and prevention services as indicated.

[13] Adapted from *Implementing HIV TeSTDng in Nonclinical Settings: A Guide for HIV TeSTDng Providers.* https://www.cdc.gov/hiv/pdf/teSTDng/cdc_hiv_implementing_hiv_teSTDng_in_nonclinical_settings.pdf

9. To reach populations at high risk for HIV infection, sites should employ strategic targeting and recruitment efforts, establish program goals and monitor service delivery to ensure targeted testing is achieving program goals.
10. To provide the most accurate results to clients, sites should use HIV testing technologies that are the most sensitive, cost-effective, and feasible for use at their agency. Establishing relationships with facilities offering laboratory-based HIV testing is important for referring clients who may have acute HIV infection.
11. Agencies should implement a streamlined model of HIV testing that includes delivering key information, conducting the HIV test, completing brief risk screening, providing test results, providing referrals and/or ensuring linkages to services tailored to the client's specific risk.
12. Sites should consider offering HIV testing services for couples or partnered relationships to (a) attract high-risk clients who are not otherwise testing and (b) identify HIV-discordant couples and previously undiagnosed HIV-positive clients.
13. Diagnostic HIV testing and opt-out HIV screening should be a part of routine care in all health-care settings while also preserving the client's option to decline HIV testing and ensuring a provider-client relationship conducive to optimal clinical and preventive care.
14. Inform clients at high-risk for HIV/STDs about 1) methods to reduce the risk of HIV/STD acquisition; 2) STDs that can facilitate HIV acquisition; 3) the benefits of screening for STDs (that are often asymptomatic) and STD treatment
15. Assess these risk factors for HIV/STD transmission:
    - ✓ Sexual, alcohol, and drug-use triggers (boredom, depression, incarceration, sexual violence, sex work, abuse) and behaviors that may lead to HIV/STD transmission
    - ✓ Recent sex and/or needle-sharing partners who were treated for HIV/STDs, and/or other behaviors they may have that contribute to possible HIV acquisition
    - ✓ Past and recent HIV/STD diagnosis, screening, and symptoms
    - ✓ Survival sex work
    - ✓ Sense of self-worth
    - ✓ Lack of basic health information and/or information pertaining to HIV/STD risk
16. Report cases of HIV/STDs according to jurisdiction requirements and inform clients diagnosed with HIV and/or STDs that case reporting may prompt health departments to offer voluntary, confidential partner services
17. Offer external and internal condoms, and lubrication options

HIV and STD Testing services must follow these guidelines, adapted from the CDC:

- All adults and adolescents ages 13 and older should be tested at least once for HIV.

- Annual chlamydia screening of all sexually active cisgender women younger than 25 years, as well as older cisgender women with risk factors such as a sex partner who has a sexually transmitted infection
- Annual gonorrhea screening for all sexually active cisgender women younger than 25 years, as well as older cisgender women with risk factors such as a sex partner who has a sexually transmitted infection.
- Syphilis, HIV, and hepatitis B screening for all pregnant women, and chlamydia and gonorrhea screening for at-risk pregnant women starting early in pregnancy, with repeat testing as needed, to protect the health of mothers and their infants.
- Screening at least once a year for syphilis, chlamydia, and gonorrhea for all sexually active gay, bisexual, and other men who have sex with men (MSM), as well as sexual active transgender women who have sex with men. MSM or transgender women who have sex with men, who have unprotected sex should be screened more frequently for STDs (e.g., at 3-to-6 month intervals).
- Sexually active gay and bisexual men and sexually active transgender women who have sex with men may benefit from more frequent HIV testing (e.g., every 3 to 6 months).
- Anyone who has unprotected sex or shares injection drug equipment should get tested for HIV at least once a year.

In addition, current recommendations for meningococcal vaccines in Los Angeles County include:

- Vaccinate all MSM patients with Quadrivalent meningococcal conjugate (MCV4) vaccine during current outbreak.
- Routinely vaccinate HIV-infected patients with MCV4 vaccine as per the U.S. Advisory Committee on Immunization Practices (ACIP) recommendations.
- Offer HIV testing along with vaccination to all MSM patients who are not known to be HIV-infected and have not been tested for HIV within the last year.
- Refer MSM patients for free MCV4 vaccine if vaccination is not feasible at their primary care provider.
- Report all suspect cases of IMD immediately to LAC DPH.
- MSM who are not HIV-infected should receive 1 dose of MCV4 vaccine (Menveo® or Menactra®). Because meningococcal vaccine induced immunity wanes, a booster dose can be considered for those whose last dose of MCV4 vaccine was >5 years ago.
- HIV-infected persons should receive 2 doses of MCV4 vaccine (Menveo® or Menactra®), 8-12 weeks apart, as their primary series. Previously vaccinated HIV- infected persons who received only 1 dose of vaccine should receive a second dose at the earliest opportunity, as long as it has been at least 8 weeks from first dose. A booster dose should be given every 5 years if the primary series was administered at >7 years of age.
- Although Menactra® and Menveo® are licensed for persons through 55 years of age, they may be administered to persons 56 years of age and older.

{INSERT LINK TO RECOMMENDED VACCINES FOR PEOPLE AT RISK OF HIV HERE}

LINKAGE TO BIOMEDICAL PREVENTION SERVICES

Once the needs of HIV-negative clients are identified via the assessment and/or screening process, they should be connected to appropriate services to address those needs in the most expeditious manner possible. For this reason, agencies should allow clients to self-refer and or to walk-in and access services on their own.

Linkage to prevention services is a critical component of the Comprehensive HIV Continuum. For high-risk HIV-negative individuals who have recently been tested for HIV and STDs, linkage to biomedical interventions (i.e. PrEP and PEP) is often a priority.

The standards for linkage to biomedical prevention services include:

1. If agencies do not provide PrEP services, they must develop written protocols/MOUs with agencies/clinics that do provide PrEP, outlining the referral and linkage process
2. Inform clients about the benefits of biomedical interventions to prevent the acquisition of HIV
3. Ask all high-risk HIV-negative clients if they are interested in learning more about PrEP or PEP
4. Connect all high-risk HIV-negative clients to a PrEP Navigator (in-house or external) within 24 hours (or 2 business days)
5. Provide immediate, active, and, if necessary, repeated, linkage services to clients with an expressed interest in PrEP, and the immediate need for PEP
6. Provide follow-up assistance to clients who are not able to link to a PrEP Navigator
7. If your agency provides PrEP, assess the client's readiness to engage in PrEP services and barriers and facilitators to starting services
8. Help schedule appointments to see a PrEP Navigator or PrEP provider (in-house or external)
9. Offer convenient scheduling whenever possible (e.g., same-day or priority appointments, extended hours)
10. Maintain a client-friendly environment that welcomes and respects new clients
11. Provide reminder (and accompaniment, if possible) for first appointment, using the client's preferred contact method(s)
12. Offer client navigation assistance and support to encourage attendance (e.g., directions, transportation resources, such as Metro tokens or ride shares)
13. Identify and utilize specific strategies designed to overcome barriers to successful linkage. Such strategies may include:

- ✓ Co-locating HIV testing and biomedical interventions
- ✓ Client accompaniment to access services
- ✓ Multiple case management sessions
- ✓ Motivational counseling
- ✓ Providing trauma-informed care
- ✓ Providing crisis intervention counseling
- ✓ PrEP navigation

14. Offer guidance and assistance on how to obtain financial assistance for PrEP through private- or public-sector sources
15. Assist with health insurance and other benefits, including linkage to health insurance navigators, case management and client navigation, and intervention-specific programs (e.g. PrEP medication and co-pay assistance programs)

REFERRALS AND LINKAGES TO NON-BIOMEDICAL PREVENTION SERVICES:

Although numerous HIV prevention related services exist throughout Los Angeles County, clients in need of services may not be willing or able to access them. For example, an undocumented transgender woman may want to access regular primary care, but may not feel comfortable doing so if she fears transphobia or legal implications. For this reason, while the ultimate goal is *linkage* to a needed service, oftentimes *referrals* are all an agency can be held accountable for.

Standards related to referring clients to non-biomedical services focus on *active referrals* rather than *passive referrals*. The latter defined as telling a client about a service and or giving them a phone number and leaving it up to them to initiate contact. Conversely, active referrals address barriers to accessing services by helping the client make contact with a service provider or agency. This may include scheduling the appointment with the client and/or accompanying them to their first appointment.

Based on information obtained via the assessment process, clients may be in need of any number of prevention services; specialty services that address medical needs (e.g. primary care); and/or social needs (e.g. needs related to housing, employment etc.). Whenever possible, agencies should strive to provide specialty services onsite. If this is not feasible, providers need to ensure that clients are referred to external specialty services. How these services are prioritized depends upon the need of each particular client.

The standards for actively referring clients to non-biomedical prevention services include:

1. Developing written protocols/MOUs with other HIV/STD prevention and primary care providers and social service agencies to ensure linkage to appropriate prevention services
2. Assisting clients with enrolling in health insurance by referring them to a benefits counselor
3. Actively referring clients who are not accessing regular care to a medical home or primary care provider
4. Assessing possible facilitators and barriers to accessing services
5. Tracking outcomes of referral services (i.e. track linkages) and providing follow-up assistance to clients who have not been linked to prevention services
6. Helping schedule the first prevention-related service appointment
7. Actively referring to mental health services, substance use services, behavioral interventions and other psychosocial and ancillary services (e.g. housing, employment, nutritional and social support)
8. Providing transportation assistance to the first visit, when possible
9. Offering convenient scheduling whenever possible (e.g., same-day or priority appointments, extended hours)
10. Maintaining a client-friendly environment that welcomes and respects new clients
11. Providing reminders for first appointment, using the client's preferred contact method
12. Offering client navigation assistance and support to encourage attendance (e.g., directions, transportation resources, such as Metro tokens or ride shares)
13. Identifying and utilizing specific strategies designed to overcome barriers to successful linkage. Such strategies may include:
    - ✓ Co-locating HIV testing and prevention services
    - ✓ Multiple case management sessions
    - ✓ Motivational counseling
    - ✓ Trauma-informed care
    - ✓ Crisis intervention counseling
    - ✓ Navigation assistance, specifically assigning one navigator for each client (i.e. vertical navigation)
14. Maintaining a relationship with a consistent prevention team
15. Offering assistance with health insurance and other benefits, including active referrals to health insurance navigators
16. Make available online directories of providers, agencies, telemedicine agencies, and professional advice hotlines that

offer specialty services. Ensure that these resources are gay- and trans-affirming and otherwise culturally appropriate.

17. Develop and participate in provider networks that offer specialty services for persons with HIV, especially persons who are uninsured or underinsured or who live in underserved areas
18. Develop written protocols, memoranda of understanding, contracts, or other agreements that define financial arrangements, staff and agency responsibilities for providing linkages, making referrals, and the tracking of referral completion and satisfaction
19. Establish policies and procedures to safeguard the confidentiality of personal and health information exchanged during the linkage/referral process
20. Train staff and any specialty service providers in the following topics:
    - Staff roles and responsibilities within the agency
    - Issues such as sex trafficking, substance use, etc. that can provide a better understanding of their clients' needs
    - Identifying specialty service providers who serve the community
    - Tailoring of services to personal characteristics (e.g., language, location, and insurance status)
    - Inter- and intra-agency referral procedures
    - Maintaining confidentiality of collected personal information
    - Advocating for persons who need specialty services
    - Minor consent for HIV/STD testing (consent from youth aged 13 and older)
21. Engage case managers, navigation assistants, or other staff to provide service coordination for persons living with or at risk for HIV who have complex needs
22. Routinely provide print or audiovisual materials that describe specialty services provided onsite or through referrals
23. Monitor the quality of referrals for specialty services to inform quality improvement strategies (e.g., proportion of referred persons who obtained specialty services), client satisfaction, and barriers and facilitators
24. Routinely assess agency staff regarding knowledge and comfort to offer the prevention services the agency is providing, with language that is appropriate for the staff level (plain language for non-medical staff, etc.)
25. Include services related to economic empowerment and job-readiness

RETENTION AND ADHERENCE TO PREVENTION SERVICES

A key component of the Comprehensive HIV Continuum is retention and adherence to prevention services to facilitate ongoing access to the full array of services, including biomedical interventions, behavioral interventions, psycho-social services, etc.

Standards for Retention to all Prevention Services must include:

1. Assisting clients with scheduling follow-up visits
2. De-stigmatizing HIV - people living with HIV, stigma of getting HIV if prevention fails, etc.
3. Providing reminders for all visits, using the client's preferred method of contact
4. Offering or referring to navigation assistance, when possible
5. Reinforcing the benefits of prevention services
6. Regularly assess facilitators and barriers to retention, and supporting clients to overcome identified barriers
7. Regularly assessing clients' need for prevention services: *Have their needs changed? Do they no longer need services? Do they need different services?*

Standards for Adherence to Biomedical Prevention Services must include:

1. Inform clients about the benefits of sustained adherence to PrEP and PEP
2. Provide adherence support tailored to each client's needs and characteristics, and/or connect clients to medication adherence interventions
3. Work with client to develop a plan for stopping PrEP, when appropriate (e.g. temporarily, long-term, or quitting use) and transitioning to other prevention options, including addressing relationship issues and health issues that increase HIV/STD risk
4. Provide or make referrals for services to address factors that may impair adherence (e.g., comorbidity, financial, psychosocial, and structural issues)
5. Offer advice on how to maintain financial assistance for PrEP through private- or public-sector sources
6. Advise clients to take PrEP medications as prescribed; provide information about the regimen, and check for understanding in the following areas:

- ✓ Details of the regimen, including dosing method and schedule, dietary restrictions, and what to do when drinking alcohol or when missing doses
- ✓ Consequences of missing doses
- ✓ Potential side effects
- ✓ Potential interactions with other prescription, nonprescription, and recreational drugs, alcohol, and dietary supplements that may impair PrEP medication effectiveness or cause toxicity that could impair adherence
- ✓ Advising the client that PrEP does not protect them from other STDs and pregnancy

7. Routinely assess the client's questions, concerns, or challenges regarding PrEP use to identify potential problems
8. Assess self-reported adherence at each visit using a nonjudgmental manner
9. Assess and manage side effects at each visit
10. Consider assessing PrEP prescription refills or pill counts, if feasible, when needed to supplement routine assessment of self-reported adherence
11. Address misinformation, misconceptions, negative beliefs, or other concerns about PrEP regimen or adherence
12. Acknowledge the challenges of maintaining high adherence over a time and offer long-term adherence support, especially when health coverage, insurance, or other life circumstances change
13. Promote disclosure of challenges to adherence, and when disclosures occur, address them in a nonjudgmental manner
14. Apply motivational interviewing techniques during routine adherence assessments. These include:
    a. asking about the methods clients have successfully used or could use to increase adherence
    b. asking about recent challenges to adherence and how they could be overcome
15. Offer advice, tools, and training tailored to individual strengths, challenges, and circumstances to support adherence. Examples of advice include:
    a. linking taking PrEP to daily events, such as meals or brushing teeth
    b. using pill boxes, dose-reminder alarms, or diaries as reminders
    c. carrying extra pills when away from home
    d. actions to take if pill supply is depleted or nearly depleted
    e. avoiding treatment interruptions when changing routines (e.g., travel, erratic housing, or legal detention)
    f. consulting HIV care providers before surgery or when experiencing a new health condition or a change in life circumstance that might impair PrEP use (e.g., change in prescription, nonprescription, and other drug use)
16. Encourage persons to seek adherence support from family members, partners, or friends, if appropriate

Key Documents Used:

Ryan Service Standards Guide http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf. Accessed March 31, 2017.

Journal of the International AIDS Society: "Towards an integrated primary and secondary HIV Prevention continuum for the United States: a cyclical process model; Published November 17th, 2016

Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings Recommendations for Adults and Adolescents

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PS12-1201: Comprehensive HIV Prevention Programs for Health Departments

LOS ANGELES COUNTY
END OF YEAR PROGRESS REPORT

Reporting period covers
January 1, 2016 – December 31, 2016

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PROGRESS REPORT (Project Narrative)

Directions: Please answer the following questions for your End of Year Progress Report.

The End of Year Progress Report requires the grantee to report on progress made during the Year 05 reporting period, January 1, 2016 – December 31, 2016. Unless otherwise noted, responses to the questions in this guidance should accurately reflect program activities conducted during the reporting period of January 1, 2016 – December 31, 2016. Your report is due to CDC no later than March 31, 2017. Please email your report to the ps12-1201@cdc.gov mailbox and your assigned PPB Project Officer with a courtesy copy to your assigned Grants Management Specialist (GMS).

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Community Co-Chair	Brad Land	(213) 738-2816	BGLinc@aol.com	3 Years
HIV Planning Group Executive Director	Cheryl Barrit	(213) 738-2816	cbarrit@lachiv.org	

***If your jurisdiction has more than two co-chairs, please add their information in the table (i.e., rural and urban, prevention and care, etc.).**

The following questions are core questions to be used for programmatic and data reporting, for the reporting period of January 1, 2016 – December 31, 2016.

SECTION I: CATEGORY A: Required Core HIV Prevention Program
All four required core components should be implemented during this reporting period.

- ☒ HIV Testing
- ☒ Comprehensive Prevention with Positives
- ☒ Condom Distribution
- ☒ Policy Initiatives

Please provide responses to the following questions for the required core components for Category A. Responses to questions should include all four required components.

1. Describe any **substantial changes** made to your HIV prevention program for any of the four required core components funded under Category A during the reporting period. Please describe the changes made for the specific the program component.

HIV Testing (Non-Healthcare Settings):

Under Category A, HIV testing is primarily taking place in non-healthcare settings. For testing in healthcare settings, see Section II: Category B: Expanded HIV Testing Program.

For HIV testing in non-healthcare settings, **there have been no substantial changes** to any of the testing program modalities (multiple morbidity, Commercial Sex Venues, other targeted testing sites) during the reporting period (January-December 2016).

Through December 2016, Los Angeles County (LAC) is at 98% (65,636/67,000) of our projected HIV testing goal for non-healthcare settings. This number and percent include data from the City of Long Beach (LB) reported by the Division of HIV and STD Programs (DHSP), but provided by the State of California. Additionally, some programs provide targeted testing through Category A in both non-healthcare and healthcare settings. See Section VII of the report for additional information.

As previously reported, for 2014 through 2016 we reduced our annual targets under Category A to 67,000 HIV testing events (per year), while maintaining our goal for positivity rate.

Mobile HIV/STD Testing Unit

During this reporting period, the DHSP Mobile Testing Unit (MTU) was only operational for a four week period and key staff were on leave. Staff were reassigned to provide testing within partnering agencies. This included testing at youth homeless shelters and developing agreements to test residents in City of Los Angeles low-income housing areas.

Comprehensive Prevention with Positives:

Risk Reduction Activities (RRA)

There have been no substantial changes to any of the prevention with positive programs.

Partner Services

This year proved to be a pivotal planning year for re-structuring and reprioritizing HIV/STD Partner Services within LAC. In response to the steady increase of syphilis (including congenital syphilis), gonorrhea (GC), and chlamydia (CT) cases in LAC over the last several years and in light of the increasingly scarce human and financial resources available to aggressively investigate all cases and interrupt the transmission of new infections, DHSP employed a priority-setting process for local disease investigation efforts in 2016.

The revised Partner Services protocol de-prioritized CT and GC partner services activities and focused on prioritized HIV and syphilis partner services. Public Health Nurses as well as Public Health Investigators (i.e, Disease Investigation Specialists) from the Public Health Department external to DHSP were included in this prioritization process. In addition, the changes included but are not limited to: assigning all pregnant females with HIV to Public Health Nurses, reducing CT and GC follow-up activities for treated cases, assigning priority syphilis cases of females of reproductive age to Public Health Nurses, assigning high priority syphilis cases to Public Health Investigators, PHIs co-located STD clinics (non-DHSP staff), and improving the use of HIV Surveillance for HIV cases.

In 2016, DHSP in coordination with Community Health Services (CHS), PHI Administration, and the Bureau of the Medical Director/Disease Control, reached consensus regarding the new prioritization protocol and developed an implementation and training plan. The protocol changes

are slated to launch in April 2017. The changes were rooted in a data driven process based on the Centers for Disease Control and Prevention's (CDC) ***Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection*** (2008) and was further refined in consultation with the California STD Control Branch, the CDC, the University of Washington Public Health Capacity Building Center (who serves as the CDC's Partner Services Capacity Building Agency) as well as public health leaders from other highly impacted state and municipal jurisdictions.

Partner Services and STD Surveillance Data Efforts

In addition to restructuring DHSP's Partner Services unit to better respond to the workload and changing priorities, DHSP's STD Surveillance unit made significant changes to re-program LAC's STD Surveillance database which is also utilized as the Partner Services case management system.

Training and Technical Assistance

To implement the changes, training, presentations, and technical assistance were provided to DPH staff, in particular Public Health Investigators and Public Health Nurses. DHSP worked closely with the CDC capacity building assistance providers to identify training needs and develop trainings for Public Health Nurses. Specifically, training surrounding HIV disclosure and stigma issues were requested training topics that will be provided in early 2017. In addition, Public Health Investigation staff participated in presentations, meetings, and conferences that highlighted the rationale for prioritizing HIV and syphilis cases for Partner Services activities.

Use of HIV Surveillance for Partner Services and Linkage and Re-engagement to HIV Care

DHSP has begun utilizing HIV Surveillance for linkage and re-engagement activities for individuals who are lost or not linked to HIV care via the HIV Linkage and Re-engagement Program (LRP) activities. LRP launched in late February 2016. Preliminary data show that referrals from providers yield better outcomes than utilizing HIV Surveillance as a referral source. However, the HIV Surveillance system has proven to be critical in determining a client's true HIV care disposition, current addresses, and other useful information. The approval for the

broad use of HIV Surveillance for Partner Services activities was provided by DHSP's HIV Surveillance unit in late 2016. Protocols for these activities will be finalized in 2017.

Perinatal

In February 2016, Ms. Amy Danzig was identified and hired for the Medical Records Abstractor (MRA) position. The continued operation and progress of the Enhanced Perinatal Surveillance (EPS) are dependent on only one staff member, the Medical Records Abstractor. Working under the direct supervision of the EPS project manager and epidemiologist, Ms. Azita Naghdi, the MRA has been responsible for assisting the Los Angeles County Department of Public Health Pediatric HIV/AIDS surveillance staff to report prevalent and incident cases of pediatric HIV exposure and infection. In addition, Ms. Danzig has been assisting in the review of mother and infant medical records and abstraction of pertinent information to complete supplemental EPS abstraction forms at participating hospitals and clinics; maintaining multiple databases for EPS; data entry; conducting follow-up with health care providers and laboratories to obtain missing surveillance information; participating in CDC-sponsored conference calls; helping secure IRB approval at the different LAC EPS sites; attending relevant trainings for HIPAA regulations; and ensuring that surveillance practices are consistent with security and confidentiality policies and procedures. Unfortunately, due to limited manpower in past years, timeliness of identifying and following-up on HIV-exposed infants and subsequent abstraction of electronic medical records at our largest perinatal HIV-specialty center, LAC+USC, remains incomplete. For the reporting period January 1, 2016 to December 31, 2016, we were able to complete only 35% of the medical record abstractions at this facility.

In June 2016, an updated Pediatric HIV Confidential Case Report form (PCRF) and Pediatric HIV Exposure Reporting form (PHER), with changes made to sections pertaining to laboratory data, birth history, treatment and service referrals were approved by the CDC and distributed to jurisdictions for data collection purposes.

During this reporting period, Ms. Naghdi was also notified of Dr. Hindo's (PI of the EPS project at Cedars-Sinai Medical Center) departure. This has caused a delay in the submission of the annual IRB continuing review at this facility until a new PI has been identified. In November of 2016, Dr. Vikram Anand was hired as Dr. Hindo's replacement. A meeting was scheduled

between him and Ms. Naghdi, where his role as the new PI for the EPS project at Cedars-Sinai Medical Center was discussed and his duties agreed upon. Necessary modifications and amendments are being made to the IRB before facility approval can be granted.

Condom Distribution:

No changes to report.

Policy Initiatives:

In 2016, we focused on the implementation of our Los Angeles County PrEP implementation strategy which revolves around three goals: 1) increasing consumer awareness of PrEP, 2) increasing provider awareness and use of PrEP, and 3) creating a safety net access system for PrEP. We were pleased to see the passage of a California state bill that now requires HIV post-test counseling which requires a conversation regarding PrEP; the bill provides us more traction in requiring our funded HIV test counselors to attend a PrEP 101 training and to begin integrating PrEP education and referrals into their testing programs. We have also been tracking a state bill that would decriminalize the transmission of HIV that would have dramatic implications for our work in destigmatizing HIV.

2. Describe the **successes** experienced with implementing your HIV prevention program for each of the four required core components funded under Category A during the reporting period. Please specify the program component associated with the successes.

HIV Testing (Non-healthcare settings):

Although we were not able to maintain the 1.0% FOA requirement (see Challenges section), the testing program continued to operate successfully during the reporting period, with testing programs experiencing high testing volume. Testing events took place during Pride events, national testing days, and as a part of the First Ladies Healthcare Initiative which encouraged HIV testing on church property throughout the county; mobile testing sites were constantly assessed using mapping; HIV testing in Storefront Sites and Social Network Sites continue to increase in volume. The number of tests conducted by the Mobile Unit program remained constant.

Multiple Morbidity

Since 2000, DHSP has partnered with three contracted agencies – California State University Long Beach (CSULB), Valley Community Healthcare (previously Valley Community Clinic), and JWCH Institute – to provide multiple morbidity testing services in all eight Service Planning Areas (SPAs) in LAC. In late 2013, APLA Health and Wellness was added, and DHSP initiated mobile HIV/STD testing services targeting the Second Supervisorial District (central and south LAC). In 2015, CSULB's Center for Behavioral Research terminated their MSM MTU program. However, DHSP has continued to expand STD testing with HIV service providers targeting MSM populations throughout the County.

The multiple morbidity testing services provide screening for acute and chronic hepatitis B and C, syphilis, chlamydia, gonorrhea, and HIV all within one visit. Table A shows the number of tests performed during this reporting period.

Table A. DHSP Multiple Morbidity Screening Program, Screening Data, January 1 – December 30, 2016

Agency Name	CT	GC	Syphilis	HBV	HCV
	Tests	Tests	Tests	Tests	Tests
JWCH Institute MTU	656	656	383	0	356
Valley Community Healthcare	596	596	605	0	576
AIDS Project Los Angeles	1,111	1,119	1,056	0	103
DHSP-operated MTU	63	66	58	x	x
Total	2,426	2,437	2,102	0	1,035

DHSP continued to convene HTS Program Coordinator meetings. Topics covered at the three meetings held during the reporting period (March 18th, June 14th and October 27th) included a presentation on DHSP's Linkage and Re-engagement Program, testing events, PrEP training, viewing/presentation of AltaMed Health Services telenovela "Sin Verguenza", STD update, and provided programmatic and administrative updates and information such as 2015 HIV Data Quality Assurance, Competency Assessments, Counselor Database, and Distribution of Incentives. DHSP staff also presented HIV testing data and reviewed data submission deadlines.

DHSP Mobile HIV/STD Testing Unit

Despite not having a mobile testing unit to conduct testing activities, DHSP's MTU team explored other community partnerships to increase visibility and testing opportunities via established sites and continued to target high-risk populations. DHSP counselors began providing comprehensive STD screening and testing including HIV, syphilis, gonorrhea and chlamydia at Transitional Age Youth (TAY) centers and shelters. As there were no existing HIV/STD services for these high-risk homeless youth, DHSP staff were filling a critical need. DHSP is currently providing HIV/STD testing services in six locations serving the homeless, veteran and TAY populations in South LA, populations that experience a disproportionately high burden of disease. Additionally, DHSP works closely with our partners to respond to requests to be a visible presence in the community. This included holding a World AIDS Day Testing Event at a Community Education Center. DHSP is also working with the City of Los Angeles to establish a memorandum of understanding (MOU) to provide testing services in low-income housing projects.

Finally, a comprehensive set of staff development trainings was implemented with all MTU staff, thereby increasing staff competency around the needs of high-risk youth and transgender populations. Trainings included various topics, such as bio-medical prevention options (PrEP and PEP) and identification and awareness of commercially sexually exploited children (CSEC).

Comprehensive Prevention with Positives:

RRA

These programs continued to see participants in the various interventions included in the prevention with positives programs. Individual-level interventions were the most common form of contact with the target population. However, groups continue to be well attended and were a source of support for participants in relation to medication adherence, enrollment and/or retention in care and disclosure of HIV status to partners. Staff of these programs have also participated in trainings on PrEP and PEP and have begun to include these discussions in the group curricula and during individual counseling sessions. During the second half of the reporting period, programs dedicated significant discussion time related to the continuation of health care coverage and the options clients have in LAC.

Partner Services

Support from DPH leadership to refine and enhance Partner Services priorities was crucial. In addition, DHSP began a recruitment fair to hire 10 Public Health Investigation Trainees.

Perinatal

During this report period, LAC applied for IRB continuations and received approval letters from several pediatric HIV-specialty hospitals, including UCLA, Kaiser-Bellflower, LAC+USC, Miller Children's Hospital Long Beach (LBMMC), Harbor-UCLA, and Children's Hospital Los Angeles (CHLA) to identify and report infants born to HIV-positive women at these LAC facilities. From January to December 2016, 95 HIV-exposed infants were reported to DHSP and identified as having received care and treatment in LAC. Of this group, 76 were born in 2016.

Establishing good working relationships and conducting data abstractions at multiple medical facilities in one of the geographically largest counties in the United States require an extensive amount of time, coordination, and manpower. To evaluate the progress toward maximal reduction of perinatal HIV transmission in LAC, pediatric surveillance staff continue to routinely visit all IRB-approved, pediatric HIV-care facilities to identify and report all infants born to HIV-infected mothers in 2016. With the hiring of a new MRA and after some training and practice, Ms. Danzig has successfully conducted all 70 medical record reviews and abstractions for the backlog of cases from all EPS sites for the 2015 birth cohort year. In addition, 68% (52/76) of all medical record abstractions for the 2016 birth cohort year have also been completed. With major remodeling taking place at the LAC+USC Medical Records Department in 2016, Ms. Danzig has recently been granted access to the LAC+USC Maternal, Child & Adolescent Clinic to conduct electronic medical records reviews, therefore, abstractions at LAC+USC will soon be back up to speed and caught up. The efficiency and timeliness of reporting new perinatally-exposed cases, born during the second half of 2016, have also increased.

Most recently in December 2016, our Data and Surveillance Workgroup for the CDC-sponsored Elimination of Mother to Child HIV transmission (EMCT) Stakeholders' group, received notification from Public Health Reports that their manuscript entitled, *Perinatal HIV Exposure*

Surveillance and Reporting in the United States in 2014, was finally published. This long and challenging manuscript was developed in response to the findings from a survey targeting all states and jurisdictions in the U.S. to determine how many sites collect data on perinatal HIV exposures, describe perinatal HIV exposure surveillance activities, assess facilitating factors, technical assistance needs and resources, and how barriers (if any) were overcome to start or enhance state perinatal HIV exposure surveillance. As Co-Chair of the Data and Surveillance Workgroup, Ms. Naghdi helped present the final data results from the survey via a CSTE-sponsored webinar in February 2016. In July 2016, Ms. Naghdi also attended the annual EMCT Stakeholders group meeting in Washington D.C. During the annual meeting, ongoing work on the future of perinatal HIV prevention activities was discussed, including HIV diagnostics, engaging partner and determining HIV status in the perinatal setting, and perinatal HIV surveillance coordination and collaboration across programs to support the framework for elimination. Additionally, another important action item the group has been pursuing deals with the development of a technical guidance protocol for birth registry matches with vital statistics. The goal is for jurisdictions to be able to identify *all* babies born to HIV-positive mothers and, therefore, be able to obtain a true perinatal transmission rate. A more complete ascertainment of all HIV-exposed infants would allow for a more accurate "picture" of perinatal HIV exposure and transmission in each jurisdiction.

Condom Distribution:

We were able to successfully coordinate condom and PrEP outreach at many LGBT pride events, as well as other outreach events in order to enhance the message that there are many ways individuals can protect themselves from HIV. For Calendar Year (CY) 2016, a total of 4,163,950 condoms were distributed.

Policy Initiatives:

We have been able to implement a standardized process by which community medical providers and public health staff can access needed information from HIV surveillance for purposes of continuity of care, as allowed under CA state law (as of 2011). We also implemented our PrEP implementation plan as described above.

3. Describe the **challenges** experienced with implementing your HIV prevention program for each of the four required core components funded under Category A during the reporting period. Please specify the program component associated with the challenges. What plans or actions have been taken to address the challenges?

HIV Testing (Non-Healthcare Settings):

For the reporting year 2016, LAC conducted a total of 65,636 HIV test events primarily within non-healthcare settings, with a positivity rate of 0.77% (508/65,636) for newly diagnosed HIV-positive individuals. This positivity rate is below the FOA requirement of 1.0%.

In response to the above, our initial findings show that the decrease appears to be due to fewer new positives being identified through the Mobile Testing Unit program. One agency/program that historically identified a large number of new HIV cases had their MTU out of commission for six months. Another agency/program which contributed about 60% of the testing volume among MTU and increased its testing volume by 33% in 2016 compared to 2015, saw a decrease in the positivity rates among MTU sites which previously had higher positivity rates. In 2016 this program only had 2 sites that had a new positivity rate >= 1.0%. However in 2015, this same agency/program had 15 sites with a new positivity rate of >=1.0%. The same pattern can be seen in several of the high volume mobile testing programs.

In addition, for agencies that conducted testing programs in both non-healthcare and healthcare settings, very few of the sites where testing was provided in a healthcare setting had a newly diagnosed positivity rate >= 1%. In 2016, there were only a few exceptions where targeted testing in healthcare sites was successful. Three of the nineteen programs had a newly diagnosed positivity rate averaging >=1.0%

DHSP will continue to investigate why the new positivity rate did not reach the FOA requirement. For the agency/program whose MTU was out of commission, the MTU is back in full operation.

Linkage to Care

There was a slight decrease in the successful linkage to medical care from storefront (77%) and social network (72%) sites within 90 days of the positive HIV test. During the first part of the year, a couple of the MTU programs experienced increased linkage to care rates, but this success did not translate to all of the MTU programs; MTUs in total achieved a 64% linkage to care of new HIV-positive testers identified. The challenge to achieving a linkage to care of 85% for all programs, and particularly for MTU programs, is the inability to transport clients who test HIV-positive to clinics outside of the clinic business hours. This increases the probability of losing newly diagnosed clients who test at night or during the weekend. This is the same barrier that the commercial sex venue (CSV) program faces, given that the testing hours for that program are late night and weekends.

DHSP Mobile HIV/STD Testing Unit

DHSP experienced significant set-backs with the operation of our mobile testing unit. The van required substantial repairs, which proved to be cost prohibitive. Ultimately, the decision was made to retire the vehicle rather than supporting ongoing maintenance to keep it functioning and on the road. In the interim, DHSP plans to collaborate with another internal DHSP team that has recently purchased a new MTU. This will allow DHSP to respond as appropriate to community requests, assess overall need and burden of disease among populations being tested, and provide the needed HIV/STD services.

Since the DHSP MTU was not operational, the team began providing storefront testing services in South Los Angeles. DHSP explored a new collaboration with the City of Los Angeles' gang reduction program that was setting up offices inside low income housing areas. This was challenging, as the gang reduction staff were new to their work, had trouble integrating our services, and provided no referrals or promotion of our services to the program participants. Safety concerns also hindered the program. Other options on how to improve this relationship are being considered.

Comprehensive Prevention with Positives:

RRA

Through their efforts later in the year, the Prevention with Positives programs reported a slight increase in the ability to recruit clients to their program who have been recently diagnosed and/or are out of care. The work that these programs conducted in partnering with HIV testing programs and conducting outreach seems to have had some benefit. Peer support continues to be a key component of these programs, as this has proven to be helpful in assisting newly diagnosed clients enter a new system of care that can be confusing and rigid. Data entry into the Evaluation-Web system by providers continues to be a challenge, because they do not have dedicated data-entry staff, thus delaying the entry of these service data into the system.

Partner Services

Partner Services activities are challenged by the volume of HIV and STD priority cases and separate HIV and STD Surveillance systems.

Perinatal

Unfortunately at this time, because there is still no mandated perinatal HIV-exposure reporting in the State of California, the capacity to monitor the epidemic locally remains challenging. Perinatal HIV-exposure reporting is essential to accurately calculate perinatal transmission rates, in order to monitor progress toward elimination of perinatal HIV transmission and to allocate appropriate resources. Mandated perinatal-exposure reporting in California is critical to support the National HIV/AIDS Strategy (NHAS) goal to reduce incidence of new HIV infections among infants by 25%. Unfortunately, without a reliable denominator or plans to suggest that the California Department of Public Health will conduct another Survey of Childbearing Women (SCBW) in the near future, it is difficult to assess our surveillance system for completeness of case ascertainment for the 2016 diagnosis year. Overall, since the EPS project first began in 1999, the total number and percentage of HIV-exposed and infected children reported to EPS have declined around 25% from 100 HIV-exposed cases reported at the initiation of the project to only 76 cases in 2016. We need to further investigate whether this decline is a result of medical advances in HIV testing and treatment and/or due to limited access to conduct perinatal HIV-exposure reporting in LAC.

Due to obstacles facing staff when conducting perinatal HIV surveillance, a position statement on perinatal exposure reporting in California has been written advocating for changes to the state HIV reporting regulations. These efforts will include contacting state legislators to sponsor a bill or an amendment to the existing HIV reporting regulation, in collaboration with DHSP's Chief of Staff and Director of Government Relations. However, due to continued staffing shortages and other priorities facing DHSP, our efforts have been stalled. The current Medical Director for DHSP, Dr. Sonali Kulkarni, will be advocating for changes to the California HIV reporting regulation. Additionally, Ms. Naghdi has also been trying to contact the California State Office of AIDS Surveillance Chief to discuss Section IX of the new Adult HIV Case Report form (ACRF) and its relevance to perinatal exposure reporting. Since the ACRF already asks for the name of the HIV-positive mother's child, their date of birth and hospital of birth, it appears as if perinatal HIV exposure reporting may be permitted. We would like to seek clarification with regards to laws permitting perinatal HIV exposure reporting in California. Unfortunately, due to high staff turnover, it has been difficult to find the right person to discuss these questions with at the California Office of AIDS. The current IRBs are in place at only seven facilities and, therefore, allow DHSP to capture only a subset of the perinatally-exposed pediatric population in LAC. In order to provide timely identification and follow-up of HIV-positive mothers and their exposed infants, and ensure linkage to pediatric HIV specialists for diagnostic testing and monitoring of the infant's health status, it is critical to identify *all* HIV-infected mothers who give birth each year in LAC. The CDC, the CSTE, and the American Academy of Pediatrics (AAP) have all recommended universal HIV perinatal exposure reporting to monitor the number of women living with HIV giving birth each year, the number of HIV-exposed children, as well as the programs to prevent perinatal transmission. In addition, in order to calculate a true perinatal transmission rate for HIV, it is necessary for exposure reporting to be population based and not just facility based. Finally, CDC allocation for future funding of perinatal HIV exposure surveillance activity will rely on jurisdictions having the necessary statutes and regulations in place to perform perinatal exposure reporting activities.

Lastly, because of its size and large concentration of high-risk women, LAC has a sizeable number of HIV-infected women of childbearing age. With more than 150,000 births annually, 30% of all births in California, LAC expects more than 100 HIV-infected women to give birth each year. Our goal is that none of these infants become infected. During this report period, 76

HIV-exposed infants born in LAC were identified and zero perinatal HIV transmissions reported. However in 2015, LAC reported 70 HIV-exposed infants and 2 perinatal transmissions, representing a 3% transmission rate. These moms, with perinatal HIV transmission, struggled with mental health and/or substance issues and engaged in unsafe sexual practices. More prevention activities need to target how mental health and substance abuse issues affect women living with HIV and the impact on perinatal HIV transmissions. As of December 30, 2016, among 5,863 women living with HIV/AIDS in LAC, 2,312 (39%) were of childbearing age (15-44 years). This underscores the need for strategies to ensure that all HIV-infected females have access to adequate prenatal care, timely HIV counseling and voluntary testing, and access to HIV-related care and services.

Condom Distribution:

No significant challenges.

Policy Initiatives:

No significant challenges.

HIV Testing and Comprehensive Prevention with Positives

Note: Quantitative information for HIV testing for Category A in healthcare and non-healthcare settings, as well as aggregate testing data, will be reviewed via the PS12-1201 Data Tables that will be auto-populated with NHM&E data submitted via EvaluationWeb®. Quantitative aggregate data on Interventions and Services for HIV-Positive Individuals, submitted via EvaluationWeb®, will also be included in the PS12-1201 Data Tables. Please review these tables (template) for reference.

Partner Services

1. Provide information on Partner Services (PS) for this reporting period. **See Table 1 below.**

Table 1. Newly Diagnosed, Confirmed HIV-positive Index Patients[1]					
New HIV Cases Reported to HIV Surveillance Program[2]	Newly Diagnosed Index Patients Reported to Partner Services Program[3,4,5]	Newly Diagnosed Index Patients Eligible for Partner Services Interview[6]	Newly Diagnosed Index Patients Interviewed[7] n (%)	Partners Named[8]	Partners Named per Newly Diagnosed Index Patient Interviewed[9]
2,291	1,971	1,965	1,397 71.09%	431	0.31

[1] This table includes data for all partner services, regardless of funding source, not just those funded under PS12-1201.
[2] This is the number of new HIV case reports received by the health department surveillance program during the reporting period, based on date of report, rather than date of diagnosis.
[3] This is the number of newly diagnosed confirmed HIV-positive index patients reported to the health department partner services program during the reporting period, from any source.
[4] New diagnosis status verified, at minimum, by cross-check with the health department surveillance system. Supplementary methods of identifying previous diagnosis, such as review of laboratory reports, medical records, or other data sources (e.g., partner services database, evidence of previous treatment for HIV), or patient interview, may also have been used. If any data source, including patient self-report, indicates previous diagnosis, diagnosis is not new.
[5] Does not include index patients classified as newly diagnosed based only on 1) self-report of having had no previous test or having had a previous negative test or 2) review of other data sources (e.g., medical records, partner services database, treatment database).
[6] This is the number of newly diagnosed confirmed HIV-positive index patients reported to the health department partner services program during the reporting period (Column B), excluding those who are out of jurisdiction or deceased.
[7] This is the number of newly diagnosed confirmed HIV-positive index patients reported to the health department partner services program during the reporting period and eligible for partner services interview (Column C), who were interviewed for partner services by the health department or a person trained and authorized by the health department to conduct partner services interviews.
[8] This is the total number of partners named for whom the information provided by the index patient or otherwise available should be sufficient to allow the partner to be identified and notified by health department partner services workers.
[9] This is the average number of partners named by the newly diagnosed index patients who were interviewed.

Calculations:

E = (D/C) x 100

G = F/D

Condom Distribution

1. Provide the total number of condoms distributed overall (to HIV-positive individuals and high-risk HIV-negative individuals) during the reporting period.

Total number of condoms distributed overall: 4,163,950

Policy Initiatives

1. What policy initiatives did you focus on during the reporting period? Please indicate the type/level of intended impact for each policy initiative (e.g., change on a local level, health department level, or statewide/legislative level) as well as the stage of the policy process (e.g., identification, development, implementation, evaluation). Please also indicate if any are new policy initiatives. If no policy initiative was focused on during the reporting period, please explain.

The focus of our policy efforts in 2016 revolved around biomedical prevention, specifically the implementation of our local LAC PrEP strategy, which revolves around three goals: increasing consumer awareness of PrEP, 2) increasing provider awareness and use of PrEP, and 3) creating a safety net access system for PrEP. We successfully developed and rolled out a PrEP social marketing campaign, trained numerous medical providers through CMEs and technical assistance, and contracted with 9 agencies with 13 clinics to provide PrEP to low income individuals at elevated risk of HIV. This will greatly expand the number of individuals who receive comprehensive prevention education and HIV testing on a regular basis, in addition to PrEP or PEP.

2. Please indicate if the following occurred during this reporting period:
   Did you make any updates to the current HIV Outbreak Response Plan? ☐ Yes ☒ No
   Did you identify any emerging HIV infections in populations/areas within the jurisdiction, as a result of having an HIV outbreak response plan in place? ☐ Yes ☒ No
   If yes, please provide a brief update.
   Did you identify any emerging HIV infections in populations/areas within the jurisdiction, as a result of participating in molecular HIV surveillance? ☐ Yes ☒ No
   If yes, please provide a brief update on any follow-up prevention activities (e.g., Partner Services) to support this activity.

We have utilized our linkage and reengagement staff (similar to Partner Services staff) to link newly diagnosed cases and virally unsuppressed cases to care for two separate transmission networks identified by CDC's molecular surveillance team. However, we have not identified any emerging HIV infections as a result of this activity, and we did not do aggressive partner elicitation and notification because of the time delay. Our hope is that as this process becomes routinized at CDC and we can find out the information closer to real-time, we'll be better positioned to do linkage plus partner services for these cases.

CATEGORY A: Recommended Components
Please indicate which recommended components were implemented during this reporting period.
If none, please select "None" and continue to the Required Activities section.

☒ Evidence-based HIV Prevention Interventions for High-Risk HIV-negative Individuals
☒ Social Marketing, Media and Mobilization
☒ PrEP and nPEP **(Through a combination of funds)**
☐ Syringe Services Program
☐ None

Please provide responses to the following questions for the recommended components for Category A, if implemented. Responses to questions should cover all three recommended components.

1. Describe any **substantial changes** made to your HIV prevention program for the recommended components funded under Category A during the reporting period. Please describe the changes made for the specific program component.

Evidence-based HIV Prevention Interventions for High-Risk HIV-negative Individuals:

No substantial changes were made during the reporting period. DHSP anticipates that new prevention programs targeting young African-American and Latino men who have sex with men and Transgender Individuals will begin in 2017. At the time of this report, the solicitation process was concluding negotiations with nine successful proposers.

Community Level Interventions

As reported in the APR, a new contractor to provide Faith-based HIV/AIDS Prevention Services within the African-American community was awarded a contract. Due to circumstances beyond our control, the identified contractor choose not to accept the contract after it was fully executed. Hence, these services were not implemented during the second half of the reporting period as previously planned. The current faith based provider targeting Latino communities of faith continues to conduct community level interventions and are currently creating relationships with African-American faith leaders to assist with the implementation of these interventions.

Social Marketing, Media, and Mobilization:

We successfully launched a social marketing campaign for PrEP and PEP that integrates well into our existing condom campaign. We plan to integrate treatment as prevention into the campaign in 2017.

PrEP and nPEP:

2. Describe the **successes** experienced with implementing your HIV prevention program for the recommended components funded under Category A during the reporting period. Please specify the program component associated with the successes.

Evidence-based HIV Prevention Interventions for High-Risk HIV-negative Individuals:

Through CDC PS15-1506, we successfully launched our PrEP strategy to increase PrEP awareness, use and access.

Programs targeting high-risk HIV-negative individuals continue to see steady participation in the various program interventions. The programs are implemented in both an individual-level and group-level format. Staff of these programs have attended several PrEP- information workshops that result in the exchange of correct information to their clients, thus increasing the interest in high-risk clients to consider the use of PrEP. Additionally, these programs continue to successfully link clients to HIV and STD testing and treatment.

Social Marketing, Media, and Mobilization:

In 2016, we launched "The Protectors" campaign, which is playful and appealing to young adults, and has the potential to easily integrate multiple prevention messages. See our website getprepla.com. We had a very successful debut of our campaign at multiple LGBT pride events in the community and have become a known presence at many community health forums.

PrEP and nPEP:

We conducted numerous medical provider trainings, implemented PrEP in our STD clinics, and launched our safety net system of PrEP Centers of Excellence, which offer PrEP and PEP to low income individuals in LAC.

3. Describe the **challenges** experienced with implementing your HIV prevention program for the recommended components funded under Category A during the reporting period. Please specify the program component associated with the challenges. What plans or actions have been taken to address the challenges?

Evidence-based HIV Prevention Interventions for High-Risk HIV-negative Individuals:

Interventions that require attendance at several sessions continue to be challenging for these programs. The retention of participants in multi-session group series is challenging, especially when competing with other priorities that include employment, school and social engagements. These programs have adapted to these challenges by offering group sessions late in the afternoon, and/or on evenings and on weekends. They also continue to incorporate a holistic approach to addressing client's needs by referring clients to mental health, substance abuse treatment, vocational training, etc.

Social Marketing, Media, and Mobilization:

No significant challenges.

PrEP and nPEP:

No significant challenges.

<u>Evidence-based HIV Prevention Interventions for High-Risk HIV-negative Individuals</u>
☐Not applicable

1. Did you support evidence-based HIV prevention interventions for high-risk HIV-negative individuals during the reporting period?
   ☒ Yes ☐ No
   If yes, briefly describe which populations and what activities were supported.

HIV prevention interventions for high-risk HIV-negative individuals were delivered to men who have sex with men, transgender individuals and the Latino faith community. Interventions included individual-level, group-level and community level activities. Services were provided in

various venues that included community centers, clubs, parks and places of worship. Issues addressed in these interventions ranged from information related to PrEP and PEP access and acceptability, insurance coverage, HIV and STD screening and treatment, condom negotiation, and communication with partners about sexual risk taking. Documented referrals to HIV testing, STD screening, and substance use treatment.

Note: Quantitative aggregate data on Interventions and Services for High-Risk HIV-negative Individuals, submitted via EvaluationWeb®, will be included in the PS12-1201 Data Tables. Please review these tables (template) for reference.

Social Marketing, Media and Mobilization

☐ **Not applicable**

1. Did you promote and/or support a CDC social marketing campaign during the reporting period?
   ☒ Yes ☐ No
   If yes, please indicate the specific CDC social marketing campaign.

DHSP continues to utilize materials developed through the "Let's Stop HIV Together", the Latino MSM campaign "Reasons/Razones", and "Testing Makes Us Stronger". Materials are shared internally and with providers to distribute during testing events, outreach activities, health fairs, and in mobile testing units.

Pre-exposure Prophylaxis (PrEP)

☐ **Not applicable**

1. Did you provide services to support PrEP for high-risk populations during the reporting period?
   ☒ Yes ☐ No **(through CDC PS15-1506)**
   If yes, briefly describe which populations and what activities were supported.

Using our PS15-1506 CDC PrIDE funding, we implemented our local LAC PrEP strategy, which revolves around three goals: 1) increasing consumer awareness of PrEP, 2) increasing provider awareness and use of PrEP, and 3) creating a safety net access system for PrEP. We successfully developed and rolled out a PrEP social marketing campaign, trained numerous medical providers through CMEs and technical assistance, and contracted with 9 agencies with 13 clinics to provide PrEP to low income individuals at elevated risk of HIV. The target populations for these

activities in 2016 were African American and Latino MSM and transgender men and women. For 2017, we will be trying to reach more high-risk heterosexual women.

Non-occupational Post-exposure Prophylaxis (nPEP) Services
☐ **Not applicable**

1. Did you provide services to support nPEP for high-risk populations during the reporting period?
   ☒ Yes ☐ No
   If yes, briefly describe which populations and what activities were supported.

Our nPEP activities have been integrated completely into our PrEP related activities. Our providers do both PrEP and PEP. In addition, we have been working with our local PrEP workgroup to do more targeted outreach and education about PEP to emergency room and urgent care providers.

Syringe Services Program (SSP)
☒ **Not applicable**

1. Did you submit a determination of need (DON) for SSP? ☐ Yes ☐ No
   If yes, did you redirect funds for 2016? ☐ Yes ☐ No

2. Did you provide services to support SSP for high risk populations during the reporting period?
   ☐ Yes ☐ No
   If yes, briefly describe which populations and what activities were supported.

CATEGORY A: Required Activities
All three required activities should be conducted during this reporting period.

☒ Jurisdictional HIV Prevention Planning
☒ Capacity Building and Technical Assistance
☒ Program Planning, Monitoring and Evaluation, and Quality Assurance

Jurisdictional HIV Prevention Planning

1. Did you make any changes to your HIV planning group (HPG) to realign with the new Integrated HIV Prevention and Care Plan Guidance during the reporting period (e.g., changes in composition or structure, bylaws, frequency of meeting, etc.). If yes, please describe the changes made. **Please provide the membership profile information for your HPG. See Appendix B.**

Strengthened COH Membership and Skills

The Commission on HIV (COH), the local HIV community planning body, under the leadership of the Operations Committee, scaled up its efforts to strengthen the skills of members in order to better align with the new Integrated Plan guidance.

- Filled 92% of the COH seats, with continuing recruitment efforts to fill remaining vacancies.
- Conducted a comprehensive 3-hour New Member Orientation training for new members.
- Completed an electronic COH Member Manual and a 2017 training series for Commissioners to increase community planning knowledge and skills.
- Conducted community outreach events, reaching over 100 community members, to promote the work of the COH and educate the community about HIV/STD services in LAC.
- While no changes to bylaws were made, the Operations Committee reviewed and updated 10 policies and procedures related to membership and meeting management.

2. Describe the **successes** experienced with implementing your HIV prevention planning activities during the reporting period.

Improved Planning for Community Health

The COH used the Comprehensive HIV Plan as the driving document to guide its priorities and planning activities.

- Completed the Los Angeles County Comprehensive HIV Plan (CHP) 2017-2021, the County's second integrated HIV services plan road map for achieving the goals of the National HIV/AIDS Strategy 2020 (NHAS). This plan was developed in partnership with DHSP and innumerable community and organizational partners. It presents a blueprint for HIV services along the entire spectrum of HIV prevention and care.
- Upon approval of the CHP, COH committees reviewed the CHP and integrated specific activities most relevant to their functions. For example, the Priorities, Planning and Allocation Committee used the CHP to help inform the update of the Minority AIDS Initiative Plan, Program Directives, and prevention planning efforts; the Standards and

Best Practices Committee used the CHP to revise and update the Comprehensive HIV Continuum and started preparing for the development prevention service standards; the Operations Committee created a training plan to ensure planning council members have the skills necessary to successfully fulfill their duties as community planners.

- The updated Comprehensive HIV Continuum better integrates prevention and recognizes the role that social determinants of health play in driving the acquisition and transmission of HIV. The Comprehensive HIV Continuum serves as a key planning tool in developing service standards for HIV/STD services in LAC.
- Completed seven community listening sessions as part of the COH's ongoing community needs assessment to better understand the barriers to services faced by populations most impacted by HIV/AIDS and STDs
- Hosted second annual Trans Health Summit, providing a safe space and educational forum for providers and the trans community to discuss and address HIV, STD and health issues unique to this underserved population

3. Describe the **challenges** experienced with implementing your HIV prevention planning activities during the reporting period. What plans or actions have been taken to address the challenges?

The recruitment of a State Medicaid (Medi-Cal) and a recently incarcerated individual continues to be a challenge. The Executive Director will continue to work with the Operations Committee and other partners to secure representatives for these seats. The recruitment of younger consumers (18-29 years) has been a challenge. To mitigate this challenge, the Youth Caucus disseminated social media invitations to their peers to attend the COH meetings to encourage participation and provide public comments on youth-related HIV issues.

Capacity Building and Technical Assistance (CBA/TA)

1. Did you access CBA/TA services during the reporting period? ☒ Yes ☐ No

2. **Note:** CBA provided via CDC-funded providers will be pulled via CRIS. However, please explain (be specific) if any of the CBA/TA provided did not meet your needs/expectations. **N/A**

3. Please provide the type of CBA/TA received and the name(s) of CBA/TA provider(s) for any **non-CDC provided CBA to include training provided by your internal training unit (if applicable).**

As part of our training portfolio, DHSP's Quality Management team provides training and capacity building to DHSP contractors. See Attachment 1 for a listing of trainings offered in CY 2016.

Program Planning, Monitoring and Evaluation, and Quality Assurance

1. Did you make any **substantial changes** to your program planning, monitoring and evaluation, and quality assurance activities during the reporting period?
   ☐ Yes ☐ No
   If yes, please describe the changes made.

Program Planning

Linkage and Re-engagement Program

During 2016, DHSP made significant strides in developing and implementing data to care programming. The Linkage and Re-engagement Program (LRP) which is funded by HRSA, was officially launched in the spring of 2016 and affected changes within the County by offering a new service for clinics and other community partners to refer for clients lost to care and for newly diagnosed clients who have never been linked to a medical provider.

LRP trained staff to use surveillance and other data systems to identify clients and to develop important partnerships with high risk social networks, medical clinics, Medical Care Coordination teams, and the jails. Critical collaborative working relationships were established during this phase of the program.

Quality Assurance (QA)

During this reporting period, there were no substantial changes to the Quality Assurance activities. DHSP's Clinical and Quality Management (CQM) team continues to focus efforts on maintaining high levels of service quality offered directly and through our supported partners. Clinical and Quality Management is charged with training, ongoing competencies and proficiencies, monitoring testing site quality assurance activities, responding to grievances and incidences, and compiling and analyzing data.

DHSP partnered with the Gang Reduction & Youth Development (GRYD) Foundation to provide HIV/STD testing and prevention services. Initially the focus of these services was on winter shelters and recreational centers for homeless youth located within communities of government assisted residences. Testing and prevention services continued beyond the winter months and continue to expand to additional sites. As these sites are identified, DHSP's CQM team works closely with DHSP's Contracted Community Services team to develop HIV/STD testing services tailored to meet the needs of each site.

Testing Technologies

DHSP continues to evaluate several new testing technologies in order to expand services offered to LAC residents. The Determine HIV-1/2 Ag/Ab Combo, a 4th generation rapid point of care CLIA waived test, is being added to DHSP's options of testing devices. During this reporting period a training curriculum was developed and piloted with DHSP's surveillance team. DHSP continues the process of developing additional protocols and quality assurance guidelines to better equip community partners in the development of quality testing services.

As previously reported, barriers which have delayed the rollout of this 4th generation rapid test to DHSP-supported agencies have largely been resolved. The curriculum was completed along with piloting it to select DHSP staff. Also, during the latter part of 2016, a contract with the vendor had been secured.

In addition to rapid HIV tests, DHSP continues to explore ways to provide rapid point of care syphilis testing and rapid point of care hepatitis C testing. As preparations are underway in developing the policies, procedures and quality assurance guidelines, the capacity to support and implement these technologies will continue to be explored in 2017.

DHSP had collaborated with LA County Department of Health Services (DHS) for more than 2 years to assist their Family Planning Clinical Program to implement opt-out testing in their Title X clinics to test patients at risk for STDs and pregnancy for HIV using rapid testing. Title X is the only federal grant program dedicated solely to providing individuals with comprehensive

family planning and related preventive health services. The program (DHS' Women's Health and Innovation program) had expanded to three women's clinics located at Hubert H. Humphrey Comprehensive Health Center, H. Claude Hudson Comprehensive Health Center and Harbor-UCLA Medical Center. However, as of August 30, 2016, their focus and funds were re-directed to other services and resulted in discontinuation of their HIV testing initiative. During a 26-month period the program tested over 5,500 patients.

A deficiency assessment was conducted on CQM's internal procedures and revealed a lack of standard procedures among the team members providing quality assurance oversight to supported testing programs. During this reporting period collaborative efforts between Clinical and Quality Management's Quality Assurance (QA) team and the Provider Support Services team began developing a comprehensive protocol for conducting Competency Assessment Testing (CAT) and testing site quality assurance assessments. This protocol will document in detail all the processes and steps involved when the QA team conducts site visits to the affected agencies. It is anticipated the protocol will be completed early in calendar year 2017.

DHSP's CQM team also continues to assist community partners who are not directly supported by DHSP but get their support from other sources. DHSP supports all efforts in Los Angeles County for HIV/STD prevention, screening and linkage to care and treatment, and therefore, offer its expertise to organizations seeking to provide these services. Three such agencies with whom DHSP's CQM section has met to discuss planning, implementing and evaluating phases of developing an HIV testing program are Black AIDS Institute, Claris Health and Via Care L.A. (formerly Bienvenidos). As agencies progress in their testing program development, CQM's team of PHNs/RNs continue to provide direction and technical assistance along with agency staff trainings to facilitate the agency's Quality Assurance Plan development.

2. How are you using the most current epidemiologic and surveillance data for program planning, implementation, and evaluation purposes during the reporting period (i.e., data to care)? Include the types of data used. How are you disseminating your program monitoring and evaluation data and providing feedback to your healthcare and non-healthcare providers and other community partners? If the surveillance team is receiving updated information (e.g., updated risk, residence, contact, or linkage status information) from program staff, please explain what data and how it helps surveillance (e.g., surveillance data are more up to date and accurate).

Use of HIV Surveillance Data for Program Planning

DHSP uses surveillance data to plot the entire continuum of HIV for LAC. Surveillance data are used to identify geographic areas of LAC with increased or increasing HIV and STD burden, identify specific target populations with increased proportion of seropositivity, and identify previously diagnosed persons who are not currently linked to medical care, in order to develop and place programs where the need is greatest. These data inform program planning. For example, LRP is a DPH-based program that focuses on locating people living with HIV in LAC who are HIV-positive and 1) never linked into HIV care, or 2) who 'fell' out of care, in order to link or re-engage them into consistent and appropriate HIV medical care. LRP was developed using the best practices and lessons learned from previous demonstration projects conducted by DHSP that tested new and innovative strategies to identify out-of-care PLWH in order to link and re-engage them in primary HIV medical care, including the use of surveillance data to initially identify HIV-positive clients who were not in HIV medical care.

Dissemination of Program Monitoring and Evaluation Data

As a large urban health department, DHSP manages both the HIV/AIDS surveillance system (HARS) and the STD surveillance system (STD NETTS). In addition, DHSP obtains data directly from DHSP-funded HIV and STD programs via electronic transfer, scanning, or manual data entry. Data are collected from non-contracted HIV testing sites such as independent health departments within LAC, directly funded CDC testing programs, and large agencies or healthcare settings in the Los Angeles area. These data populate DHSP's HIV Testing database and care services Casewatch system. To complement these data systems, DHSP also securely stores a number of datasets such as: needs assessments (e.g., Los Angeles Coordinated HIV Care Assessment (LACHNA) and LACHNA-Care), original epidemiologic studies, demonstration projects, and research projects. These data in totality assist DHSP in planning, evaluating, and conducting quality assurance to maximize prevention, care and treatment efforts in LAC.

DHSP has improved data dissemination by increasing the use of its website and the automation of reports. DHSP staff have automated a number of reports (e.g., monthly HTS reports, quarterly HTS reports, exit interview contractor monitoring reports, quality management reports, partner services activities reports, etc.) that expedite monitoring, evaluation, and planning activities.

These reports are available to and utilized by DHSP grants management team, research and evaluation staff, contract program auditors (program managers), quality management staff, and contractors. Reports are posted on the DHSP website (e.g., Care Utilization Report, HTS Annual Report, HIV Epidemiologic Profile, HIV/AIDS Annual Surveillance Report, STD Annual Report, Book of Maps, etc.), while other data or results are shared in meetings, local conferences or workgroups, national conferences, and in published manuscripts. For example, HTS data are presented to all DHSP contracted HTS providers at regular meetings; data and findings are shared with community planning groups, Medical Advisory Committee, DPH Annual Science Summit participants, ESRI (GIS software related), and at numerous local and national conferences. In addition, DHSP disseminates data results and key findings with CDC project officers and other representatives during site visits. In order to increase data dissemination, DHSP plans to create more automated reports, continue to update and populate the new integrated HIV and STD website, create and post project abstracts/profiles, and increase the number of published manuscripts.

SECTION II: CATEGORY B: Expanded HIV Testing Program

Please indicate which Category B components were implemented during this reporting period. *If none, please select "None" and continue to the Staffing and Management section.*

☒ HIV Testing in Healthcare Settings (required)
☐ HIV Testing in Non-healthcare Settings (optional)
☐ Service Integration (optional)
☐ None

Currently, 24 healthcare settings are funded or supported by DHSP to provide routine, opt-out HIV testing.

- Twelve Department of Public Health STD Clinics
- One Community STD Clinic (Los Angeles LGBT Center)
- Three Comprehensive Health Centers (Hubert H. Humphrey Comprehensive Health Center, H. Claude Hudson Comprehensive Health Center, and Harbor-UCLA Medical Center)
- Four Community Health Centers (THE Clinic, Clinica Oscar Romero, Central City Community Health Center, and St. John's Well Child Family Center)
- One Dental Clinic (USC School of Dentistry)
- One Emergency Department (LAC+USC Medical Center), and
- Two Jails/Correctional Facilities (K6G and CRDF)

Please provide responses to the following questions for your funded Category B HIV testing program. Responses to questions should cover all funded components.

1. Did you make any **substantial changes** to your expanded HIV testing program in healthcare settings and non-healthcare settings, including service integration? If yes, please describe the changes made.

HIV Testing in Healthcare settings:

Under Category B, 100% of testing is taking place within healthcare settings. For testing in non-healthcare settings, see Section I: Category A: Required Core HIV Prevention Program- HIV Testing.

Contracted Non-County clinics

There were no substantial changes for the reporting period.

Comprehensive Health Centers

As reported earlier, DHS' program had expanded HIV testing to three women's clinics located at Hubert H. Humphrey Comprehensive Health Center, H. Claude Hudson Comprehensive Health Center and Harbor-UCLA Medical Center. However, as of August 30, 2016, their focus and funds were re-directed to other services and resulted in discontinuation of their HIV testing initiative.

DPH STD Clinics

We did not make any significant changes to our routine testing program.

Jails/Correctional Facilities

Men's Central Jail (MCJ-K6G)

DHSP counselors continue to offer comprehensive HIV/STD testing to all inmates housed in the K6G unit at Men's Central Jail including HIV, syphilis, chlamydia and gonorrhea. Despite working with a challenging population, DHSP staff conduct active outreach to educate and encourage inmates to test and also provide them with condom distribution. Staff also continue to maintain a close collaboration and working relationship with the Los Angeles Sheriff's Department (LASD) to ensure deputies are aware of the importance of the public health services being provided.

Century Regional Detention Facility (CRDF)

DHSP staff continue to offer HIV testing in the housing pods at CRDF to all inmates. Due to the high rates of STDs in this population, we have recently begun to examine the feasibility of adding testing for gonorrhea and chlamydia to this program. While DHSP currently offers gonorrhea and chlamydia screening and testing to all females at intake in the Inmate Reception Center, the environment poses additional challenges to universal implementation. Offering these tests in the housing pods as well would provide an opportunity to target any individuals that were missed during the booking process.

HIV Testing in Non-healthcare settings: N/A
Service integration: N/A

2. Describe the **successes** experienced with implementing your HIV testing program in healthcare settings and non-healthcare settings, including service integration, during the reporting period.

HIV Testing in Healthcare settings:

DHSP's goal for routine testing in healthcare settings was to conduct 60,000 HIV test events for 2016 and to identify 588 newly identified HIV-positive individuals. At the end of the year, LAC is reporting 87% (52,384/60,000) of our projected HIV testing goal for healthcare settings.

At the end of the year, 52,384 test events had been conducted with an HIV positivity rate of 1.11% (582/52,384) for newly diagnosed HIV-positive individuals. This positivity rate exceeds the FOA requirement of 0.10%.

Our routine testing providers continue to integrate testing into their clinical practice and serve as local champions. Our LASD jail medical leadership agreed to work to integrate laboratory based HIV testing into their existing clinic procedures by adding in a "flag" into their electronic medical record (EMR) so that providers ordering labs for any patient who hasn't had an HIV testing in the past 6 or 12 month would be reminded to order an HIV test.

Men's Central Jail (MCJ-K6G)

Given the demanding work environment of providing services in a correctional facility to incarcerated populations, staff are required to be resourceful and find creative solutions in order to work successfully with our LASD partners. It can be a challenge to combine the provision of essential public health services while ensuring public safety is not compromised. There is a high turnover of staff within LASD, therefore DHSP staff have to routinely educate new deputies to the importance of the services we provide. This includes meeting with LASD senior staff (Lieutenants, Captains and Commanders) and involving DHSP senior leadership to actively maintain open communication and understanding of processes and procedures used during testing.

LASD often requires that DHSP staff issue medical passes and wait while custody assistants transport inmates to the testing location. This can be very time-consuming and limits the number of inmates that DHSP can test daily. DHSP staff have established close relationships with the

deputies on the floor to be able to escort the inmates to the test location with the oversight of the deputies thereby making the procedure much more efficient for all parties involved.

Century Regional Detention Facility (CRDF)

DHSP closely examined and further streamlined the process for female inmates who have tested positive for STIs and are released without treatment. This included ensuring positive inmates were immediately identified and referred if still in custody, refining the procedure for follow-up in the community including establishing a clear contact log procedure and resolving all open cases in Casewatch for data quality management and reporting purposes.

DHSP has also improved communication and collaboration with nursing staff at CRDF by maintaining an active presence inside the correctional facility by all levels of managers. Supervisorial staff have taken the time, on numerous occasions, to meet in person with nursing staff to address issues such as storage constraints, laboratory reporting, faxing of lab results and other daily duties that have strengthened the relationship between DHSP and LASD to further enhance services being provided for the inmates.

HIV Testing in Non-healthcare settings: N/A
Service integration: N/A

3. Describe the **challenges** experienced with implementing your HIV testing program in healthcare settings and non-healthcare settings, including service integration, during the reporting period. What plans or actions have been taken to address the challenges?

HIV Testing in Healthcare settings:

Contracted Non-County Clinics

At the end of the reporting period, the majority of the programs experienced a reduction in the number of people being tested. Although, the higher performing program, such as the LGBT Center, continued to see an increase in the number of clients being tested. Most of the routine testing sites are general practice clinics, where there continues to be a reluctance by patients to accept an HIV test, even when it's made as part of a routine medical assessment.

County Facilities

We have struggled with bringing on routine HIV testing in two particular settings: 1) a large county ambulatory care center in a highly impacted part of LAC, and 2) our LASD Jails. For the ambulatory care center, we had multiple conversations with physician and administrative leaders but in the end, there was no single champion who was willing to see the process through to fruition. The issue of how HIV-positive results would be followed up was one that plagued the group as there was no existing system to build off of. For the LAC jails, we have not been able to work with them on fulfilling their agreement to implement the EMR flag to ensure more testing but hope to do so in 2017.

Men's Central Jail (MCJ-K6G)/Century Regional Detention Facility (CRDF)
DPH's Public Health Lab's (PHL) reporting system, which is used by DHSP testing counselors to collect and request specimen samples, underwent an upgrade this past year and all operating systems needed to be updated. This posed a significant challenge when interfacing with the security firewall at LASD. Staff faced numerous and time-consuming setbacks with implementation that resulted in using paper acquisitions to request lab results at times. Coordination of these technical services were required between PHL, DHSP IT and LASD IT, all agencies with offices in different physical locations lending an additional layer of complexity to the situation. However, all DHSP staff have now been trained, are familiar with the new system, and all operating systems have been cleared to be used inside the LASD firewall.

HIV Testing in Non-healthcare settings: N/A
Service integration: N/A

Billing Redirection

4. Please provide a brief update on progress made with the Category B billing redirection during this reporting period. Please include progress made on billing for HIV services, training, staffing, contracts, and needs assessment/business case analysis.

In late 2016, we utilized funds (including carryover) to continue the progress/work being made toward third party billing. Funds supported electronic medical record (EMR) implementation activities which are critical for third party billing. Phases covered this period were *Project Initiation and Planning*, development of the *Implementation Approach*, and completion of a Public Health Lab (PHL) study (*APHL LIMS Study*) to assess and determine costs, benefits, capability, gaps, risks, and mitigation plan if the LIMS is implemented at the County PHL.

Our public health STD clinic partners have been able to make tremendous progress planning for their EMR implementation in 2017. Once the EMR goes live, they will work with their consultant on implementing the billing infrastructure for certain clinic patients.

5. Please describe the **successes** experienced with implementing this sustainable HIV testing effort during this reporting period.

Our public health department leadership has been very supportive of EMR implementation and the thoughtful use of billing so as to increase overall revenue but not drive patients away.

6. Please describe the **challenges** experienced with implementing this sustainable HIV testing effort during this reporting period. What plans or actions have been taken to address the challenges?

We still have not been able to outline how billing will be implemented and how we will avoid driving away patients who are used to seeking HIV/STD services in our STD clinics specifically for the confidentiality (that may be limited in a billing environment where patients receive a statement of evidence of benefits for anything their insurance pays for).

HIV Testing in Healthcare Settings *(required)* and Non-Healthcare Settings *(optional)*
Note: Quantitative information for HIV testing for Category B in both healthcare and non-healthcare settings, as well as aggregate testing data, will be reviewed via the PS12-1201 Data Tables that will be auto-populated with NHM&E data submitted via EvaluationWeb®. Please review these tables (template) for reference.

1. Please indicate if any of the funded healthcare settings/providers within the jurisdiction were able to utilize 3rd party reimbursement and/or bill for HIV testing. **See Table 2 below.** Estimate the percentages of total test events in healthcare and non-healthcare (*if applicable*) settings that were paid for by PS12-1201 Category B funds, by 3rd party reimbursement, and by other funds. If other funds were used, please specify the source of those funds (e.g., state funds).

Table 2. Estimated Percentages of Test Events Paid for by PS12-1201 Category B Funds, by 3rd Party Reimbursement, and by Other Funds.

Funding Source	Estimated Percent of Test Events	
	Healthcare Settings	Non-Healthcare Settings
PS12-1201 Category B	100%	N/A%
Medicaid	0%	N/A%
Private Insurance	0%	N/A%
Other (please specify)		
▪	%	%

SECTION III: STAFFING AND MANAGEMENT

1. Please indicate any organizational and/or key staffing changes (i.e., health department staff responsible for implementing interventions and services for PS12-1201) that occurred during the reporting period. Please indicate any vacant staff positions and provide a detailed plan with timeline for hiring/filling vacancies. Were there any delays in executing contracts during the reporting period? If so, please explain and include any program implications.

For 2016, there were no key organizational or staffing changes. Although DHSP continues to experience delays in filling a majority of its vacant positions, we have made progress in filling most of our long term vacancies by emphasizing recruitment, exam postings and interviews for these positions. However, there are still a number of other factors that are causing delays in DHSP filling all of its vacant positions. Also, due to grant funding limitation for this federal program, DHSP identified most of its vacant positions on the budget as In-Kind and not grant funded.

In early 2017, CDC requested information on vacant positions for Category A & B. DHSP provided the status of vacant positions and estimated hire dates.

SECTION IV: RESOURCES ALLOCATION

Category A:

1. Include the percentage of Category A funding resources allocated to the required and recommended program components for Year 5 (2016). ***Note:*** *Percentage should be inclusive of both internal health department expenses (e.g., personnel and administrative cost) as well as funding resources being allocated external to the health department for the required and recommended components.* ***Percentages for required and recommended components including SSP should total 100%.***

   Year 5 (2016):

Required components:	80%
Recommended components:	20%
Total:	100%
SSP (if applicable):	0%

2. Please identify each city/MSA with at least 30% of the HIV epidemic within the jurisdiction. For directly-funded cities, please report areas (or zip codes) within the MSA with at least 30% of the HIV epidemic within the jurisdiction. If no area represents at

least 30% of the HIV epidemic, then identify the top three MSA/MDs, cities, or areas within the jurisdiction that have the greatest burden of disease. **See Appendix A: Resource Allocation.**

Category B:

1. Include the percentage of Category B funding resources allocated to HIV testing in healthcare settings and non-healthcare settings for Year 5 (2016). ***Note:*** *Percentage should be inclusive of both internal health department expenses (e.g., personnel and administrative cost) as well as funding resources being allocated external to the health department for the required and optional components.* ***Percentage for healthcare settings and non-healthcare settings should total 100%.***

Year 5 (2016):

HIV testing in healthcare settings:	100%
HIV testing in non-healthcare settings:	0%
Total:	100%

Billing Redirection: 19%

All Categories:

1. Please provide information for the funding allocation tables for 2016.

Note: The PS12-1201 funding table template for 2016 is included in EvaluationWeb. The 2016 information is due by March 15, 2017.

SECTION V: CERTIFICATION OF NHM&E DATA SUBMISSION

1. As a part of the PS12-1201 Cooperative Agreement, in addition to the submission of the progress reports to CDC, grantees must also submit the required National HIV Monitoring and Evaluation (NHM&E) data variables, through the CDC-approved system (i.e., EvaluationWeb®) and commit by the designated due date.

   Please certify below:

   ☒ We certify that the department of health has submitted/will submit all of the required NHM&E data (HIV Testing data, Partner Services data, Risk Reduction Activities (RRA) data, 2016 Funding Tables, as well as any other required aggregate data variables) to CDC via EvaluationWeb® and have committed/will commit them by the designated due date. And, that we have reviewed the EvaluationWeb® auto-populated PS12-1201 Data Tables.

2. Please include any additional comments and/or clarifications for your submitted NHM&E data and/or the PS12-1201 Data Tables. Please also include any justification(s) for partial/late data submission. Information provided will be used for consideration during the review process.

   ☐ No additional comments and/or clarifications needed.

   ☒ Additional comments and/or clarifications provided here:

Healthcare Settings in Category A

LAC primarily provides HIV testing in healthcare settings through Category B funding. However, there are some programs that provide targeted testing through Category A in both non-healthcare and healthcare settings. For this reason, 17,473 test events (including LB) are reported under Category A.

Note: *To better align the progress reporting and NHM&E data submission processes, as well as to reduce data burden, the quantitative NHM&E data entered into EvaluationWeb® will automatically populate the PS12-1201 Data Tables, with the exception of the tables included in this guidance. This report will draw directly from required NHM&E data that you have submitted to CDC via EvaluationWeb®. As a follow-up to your data submission, please review the PS12-1201 auto-populated quantitative data tables (for Category A and Category B) within EvaluationWeb®. These quantitative reports will be used by project officers in addition to the qualitative progress report for the review and feedback process.*

SECTION VII: ADDITIONAL INFORMATION

1. Additional Information

Please provide any other explanatory information or data you think would be important for CDC to receive (e.g., additional coordination and collaborations to support PS12-1201, local processes or procedures impacting program implementation).

None to report.

APPENDICES

Appendix A: Resource Allocation

Areas within the Jurisdiction with the Greatest Burden of HIV Disease

Identify each city/MSA with at least 30% of the HIV epidemic within the jurisdiction. For directly-funded cities, please report areas (or zip codes) within the MSA with at least 30% of the HIV epidemic within the jurisdiction. If no area represents at least 30% of the HIV epidemic, then identify the top three MSA/MDs, cities, or areas within the jurisdiction that have the greatest burden of disease.

Reporting of MSAs/Cities/Areas with ≥ 30% of the HIV Epidemic within the Jurisdiction			
MSA/CITY/AREA	**Percentage of HIV Epidemic within the Jurisdiction**	**Percentage of PS12-1201 Funds Allocated**	**Components and Activities Funded**
Service Planning Area (SPA) 4	**39%**	**33%**	**HIV Testing Services, Risk Reduction Activities, and Social Marketing Activities (Erase Doubt and Condom Campaign)**
***In determining funds allocated by SPA, DHSP utilized the GEN (for SPA 4 is 26.5%). The GEN considered homelessness/poverty, HIV & STDs.**			

Appendix B: HIV Prevention and Care Planning Group (HPG)

HPG Membership and Stakeholder Profile
(January 1, 2016 – December 31, 2016)
This profile is to be completed annually by the HPG co-chairs (or appropriate designees).

Membership Profile	
Name of HPG/Jurisdiction:	Los Angeles County Commission on HIV
Type of HPG:	***Please select one:***
	☐ **Statewide** ☒ **Directly funded city/local jurisdiction**
Structure of HPG:	***Please select one:***
	☐ **Prevention Only**
	☒ **Integrated Prevention and Care** **Please provide the month/year the group integrated:** June 2013
	☐ **Other - Integrated with other planning bodies** **If your Planning Group is integrated with other planning bodies, please describe:**
Type of Plan:	***Please select one:***
	☐ **Integrated state/city prevention and care plan**
	☐ **Integrated state-only prevention and care plan**
	☐ **Integrated city-only prevention and care plan**
	☒ **Other:** Integrated County-only prevention and care plan
Types of Key Stakeholders represented as voting members (e.g., health department staff, PLWHA, CBOs, HOPWA, faith community):	Pursuant to County Ordinance Code 32.9, the following stakeholders represent our voting membership: (4) City/Health District members: represents health and social service institutions, who have epidemiology skills or experience and knowledge of Hepatitis B, C and STDs; (1) Director, Division of HIV and STD Programs (DHSP): represents RWP Part A grantee; (4) Ryan White Program Part B-F members: represents Ryan White grant recipients in the County

	(8) Provider members: represents organizations in the County selected to ensure geographic diversity and who reflect the epicenters of the epidemic, including: ▪ An HIV specialty physician from an HIV medical provider, ▪ A Community Health Center/Federally Qualified Health Center ("CHC"/ "FQHC") representative, ▪ A mental health provider, ▪ A substance abuse treatment provider, ▪ A housing provider, ▪ A provider of homeless services, ▪ A representative of an AIDS Services Organization ("ASO") offering federally funded HIV prevention services, and ▪ A representative of an ASO offering HIV care and treatment services; (17) Unaffiliated Consumer members: ▪ represents Service Planning Areas (SPA) 1-8 and who are recommended by consumers and/or organizations in the SPA, ▪ represents supervisorial district, who are recommended by consumers and/or organizations in the district, and ▪ consumers serving in an at-large capacity, who are recommended by consumers and/or organizations in the County (2) Board of Supervisors members: represents supervisorial offices (1) HOPWA member: (1) Local health/hospital planning agency member: represents a health plan in Covered California (1) Behavioral/Social Scientist member: represents the respective professional communities (6) HIV Stakeholder members: represents one or more of the following: ▪ Faith-based entities engaged in HIV prevention and care, ▪ Local education agencies at the elementary or secondary level, ▪ The business community, ▪ Union and/or labor, ▪ Youth or youth-serving agencies, ▪ Other federally funded HIV programs,

	▪ Organizations or individuals engaged in HIV-related research, ▪ Organizations providing harm reduction services, (3) Alternate member: represents a substitute for HIV-positive Commissioners when they cannot fulfill their respective Commission duties and responsibilities
Jurisdiction's website for HIV Planning, if available:	http://hiv.lacounty.gov
Web link for Integrated HIV Prevention and Care Plan, if available:	http://hiv/lacounty.gov

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HIV AND STD PROGRAMS
Solicitations Summary

Stage	Service Category	Actual/Est. Release Date	Est. Contract Start Date	Status/Notes
Contract Negotiations	Promoting Health Care Engagement	10/15/2015	7/1/2017	Conducting lengthy contract negotiations
	Temporary Medical Care Coordination (MCC) Services	9/19/2016	5/1/2017	Ongoing open solicitation for expanded MCC services; negotiating temporary agreements with 2 agencies to start May 2017; one contract is executed
Funding Recommendations	Mental Health Services	6/28/2016	8/1/2017	Health Deputy memo sent; following up on questions
	Mental Health Services in SPA 6	9/27/2016	8/1/2017	Health Deputy memo sent; following up on questions
	Prevention Services in Long Beach	8/17/2016	1/1/2018	Finalizing funding recommendations; sending health deputy memo beginning of May 2017
Released	Language Services	4/17/2017	3/1/2018	Proposals due May 22, 17; services to start by 3/1/18 or sooner
In Development	Legal Services	6/5/2017	3/1/2018	Final rough draft under review by DHSP; services to start 3/1/18 or sooner
	Medical Subspecialty Services	7/1/2017	3/1/2018	Final rough draft under review by DHSP
	Ambulatory Outpatient Medical (AOM)/MCC Services	8/1/2017	3/1/2018	AOM/MCC - C&G working on final rough draft; New MCC contracts will replace temporary agreements
	Oral Health Services (General/Specialty Dentistry)	9/6/2017	3/1/2018	DHSP developing FFS rates

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HIV AND STD PROGRAMS
Solicitations Summary

Stage	Service Category	Actual/Est. Release Date	Est. Contract Start Date	Status/Notes
Planning	Health Education/Risk Reduction Services	1/1/2018	1/1/2019	Planning underway; waiting for results of negotiations with Promoting Health and for new CDC FOA before developing RFP
	STD Screening Services	TBD	TBD	Planning meeting scheduled for May 1, 2017
	HIV Testing Services	1/1/2018	1/1/2019	
	Residential Care (RCFC & TRCF) Services	3/1/2018	3/1/2019	DHSP in discussions with DHS to use Master Agreement for Housing Health Program
	Substance Use Services	TBD	TBD	Working with SAPC to include a RWP client service category to the RFSQ they are developing for new substance use services
Completed	Biomedical Prevention Services WOS	3/7/2016	8/2/2016	Contracts in place; open continuous RFSQ
	Biomedical Prevention Services RFSQ	7/23/2015	N/A	Master Agreements completed
	STD Prevention Services in South LA	12/1/2014	3/10/2015	Contract in place
	Social Marketing/Media Services	10/24/2014	5/19/2015	Contract in place
Parking Lot	STD Social Marketing/Media Services	TBD	TBD	
	Nutrition Support Services	TBD	3/1/2019	
	Non-Medical Case Management	TBD	3/1/2019	Includes Benefits Specialty, TCM, and Jails
	Home-based Case Management	TBD	7/1/2019	

County of Los Angeles
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SACHI A. HAMAI
Chief Executive Officer

May 26, 2017

To: Supervisor Mark Ridley-Thomas, Chairman
Supervisor Hilda L. Solis
Supervisor Sheila Kuehl
Supervisor Janice Hahn
Supervisor Kathryn Barger

From: Sachi A. Hamai for
Chief Executive Officer

WASHINGTON, D.C. UPDATE ON THE PRESIDENT'S PROPOSED FEDERAL FISCAL YEAR 2018 BUDGET

Executive Summary

On May 23, 2017, the President proposed a $4.1 trillion budget for Federal Fiscal Year (FFY) 2018, which projects collecting $3.65 trillion in revenue, with $440 billion in deficit spending. The FFY 2018 budget, "A New Foundation for American Greatness," proposes, over the next ten years, to cut $1.6 trillion in nondefense discretionary spending and $1.4 trillion from Medicaid. Major domestic spending reductions are proposed, which are described below, while defense spending is proposed to increase by $54 billion in FFY 2018 and $489 billion over the next decade.

The President's FFY 2018 budget proposes large cuts to mandatory (entitlement) spending programs from which the County receives the majority of its Federal funding. The proposed budget assumes the enactment of H.R. 1628, the American Health Care Act (AHCA), which the House passed on May 4, 2017. H.R. 1628 would cut $839 billion from Medicaid over ten years, primarily through the repeal of the Medicaid expansion contained in the Affordable Care Act (ACA). The budget also calls for an additional $610 billion in Medicaid cuts through FFY 2027 by capping Federal Medicaid funding to States, through either a per-capita spending cap or a block grant, and by allowing states to impose work requirements for beneficiaries.

The President's budget requests $191 billion in cuts to the Supplemental Nutrition Assistance Program (SNAP) over 10 years; proposes a 9.7 percent cut to the Temporary Assistance for Needy Families (TANF) program; and proposes to eliminate or significantly reduce discretionary spending for programs the County receives funding

for community development, housing, public health, public safety and workforce development. The President's budget for FFY 2018 largely reflects proposals and priorities that were outlined in the President's "budget blueprint," which was released in March 2017. There is no significant impact to either Social Security or Medicare in the proposed budget.

The reaction to many of the President's budget proposals was widespread opposition among Democrats, and Republicans have also expressed notable concerns with the major reductions on spending. Legislation to implement the Administration's budget must be passed before September 30, 2017, the end of the Federal Fiscal Year. In particular, major reductions in entitlement programs will be difficult to enact in such a short time frame, and it is unclear if the votes exist in both the House and Senate to implement them.

Major Mandatory Spending Programs

The President's budget requests that Congress make substantial changes to mandatory spending programs in FFY 2018, including:

Supplemental Nutrition Assistance Program (SNAP): The President's budget requests $73.8 billion for SNAP for FFY 2018, which is a reduction of $4.7 billion from $78.5 billion in FFY 2017. The Administration proposes to establish a State match for SNAP benefits, beginning with a national average of 10 percent in FFY 2020 to 25 percent by FFY 2023. Combined, these reforms are estimated to save nearly $191 billion over ten years. In addition, the budget would allow states to condition program eligibility by imposing work requirements on recipients.

Temporary Assistance for Needy Families (TANF): The President's budget proposes to reduce TANF spending by $2.2 billion. This includes a $1.62 billion cut to the TANF block grant and the elimination of the TANF Contingency Fund ($608 million). The reduction proposes to eliminate the portion of the TANF block grant that states may transfer from TANF to the Social Services Block Grant (SSBG). In addition, the budget proposes to eliminate the SSBG, which is funded at $1.583 billion in FFY 2017.

Children's Health Insurance Program (CHIP): The President's budget proposes to reauthorize CHIP for two years, but calls for an immediate cap to the availability of Federal matching funds. The FFY 2018 budget proposes to reduce CHIP funding by $2.756 billion, from $15.952 billion in FFY 2017 to $13.196 billion in FFY 2018. The budget also proposes to serve children only up to 250 percent of the Federal poverty level. Currently, California serves children up to 266 percent.

Foster Care and Permanency: The President's budget provides $8.7 billion for the Foster Care, Adoption Assistance, Guardianship Assistance, and Independent Living

programs, including Title IV-E. These programs are proposed to receive a slight increase in funding consistent with program growth.

Programs through which the County receives funding that are proposed to be eliminated in FFY 2018 include the following:

- Community Development Block Grants ($3 billion)
- Home Investment Partnerships Program ($950 million)
- HUD-VASH Vouchers ($40 million)
- Community Services Block Grant ($715 million)
- State Criminal Alien Assistance Program ($210 million)
- Low Income Home Energy Assistance Program ($3.39 billion)
- Community Service Employment for Older Americans ($400 million)

Programs through which the County receives funding that are proposed to be reduced in FFY 2018 include the following:

Program (Dollars in Millions)	FFY 2017	FFY 2018	Change
Section 8 Tenant-Based Rental Assistance	$20,292	$19,318	-$974
Section 8 Project-Based Rental Assistance	$10,816	$10,751	-$65
Homeless Assistance Grants	$2,383	$2,250	-$133
Public Housing Capital Fund	$1,942	$628	-$1,314
Public Housing Operating Fund	$4,400	$3,900	-$500
Ryan White AIDS Grants	$2,319	$2,260	-$59
Child Care and Development Block Grant	$2,856	$2,761	-$95
Mental Health Block Grant	$563	$416	-$147
Hospital Preparedness Program	$255	$227	-$28
Public Health Emergency Preparedness	$660	$551	-$109
State Homeland Security Grant	$412	$349	-$63
Urban Area Security Initiative	$580	$449	-$131
Byrne Justice Assistance Grant	$335	$250	-$85
Emergency Management Performance Grant	$350	$279	-$71
WIOA Adult Training	$816	$490	-$325
WIOA Youth Training	$873	$608	-$265
WIOA Dislocated Workers	$1,021	$699	-$322

Other Programs of County Interest

Base Realignment and Closure (BRAC): The President's budget proposes to pursue a Base Realignment and Closure round beginning in 2021 in order to potentially save $2 billion by 2027.

Public Works: The President's budget requests $17.982 million in operations and maintenance funding for the Los Angeles County Drainage Area (LACDA) and $2 million for the Whittier Narrows Dam.

Infrastructure Initiative: The President's budget includes $200 billion in additional outlays for infrastructure priorities beyond the regular departmental requests. However, it does not break out how that funding would be distributed among categories such as highways; bridges; water quality and supply; ports; broadband; and veterans' facilities. Furthermore, the Administration's proposal would rely on the principles of making targeted federal investments on transformative regional projects, encouraging states and localities to raise their own dedicated revenues for infrastructure, divesting certain functions better performed by the private sector, and leveraging more public-private partnerships.

Transportation: The President's budget proposes a $928 million reduction in the Transit New Starts program and to limit funding to projects with existing full funding grant agreements only. The budget notes that local transit projects should be funded by states and localities that benefit from their use. This proposal may penalize communities which have voter-approved local tax measures and may negatively impact the investments in new transit lines in Los Angeles County via the Measure R and Measure M transportation sales tax measures.

Federal Aviation Administration (FAA): The President's budget reflects a multi-year process to remove the responsibility of providing air traffic control services from the FAA and placing it under the control of a private non-profit corporation.

Immigration: The President's budget proposes increased funding for border security and immigration enforcement, including: 1) $2.6 billion for border infrastructure, including funding to design and construct a physical wall along the southern border; 2) more than $300 million to hire 500 new Border Patrol Agents and 1,000 new Immigration and Customs Enforcement law enforcement personnel in 2018; 3) an additional $1.5 billion for expanded detention, transportation, and removal of illegal immigrants; and 4) an additional $214 million to hire 75 additional immigration judge teams.

This office is working with affected departments to determine the potential County impact of these proposals.

Budget Outlook

As this office previously reported in the March 17, 2017 memorandum on the President's "America First" budget blueprint, the County is likely to see some reductions in domestic discretionary programs in such areas as public health, community development, and workforce training. However, the budget blueprint was largely silent on potential cuts in mandatory (entitlement) programs such as Medicaid, SNAP, and TANF, which are not funded through the annual appropriations process. If enacted, the proposed cuts in entitlement programs in the President's FFY 2018 full budget proposal would have a severe impact on the County through the potential elimination of the Affordable Care Act's Medicaid expansion, a potential 25 percent state match for food stamp benefits by FFY 2023, and a proposed 10 percent cut in TANF funding.

The reaction to many of the President's budget proposals was widespread opposition among Democrats, and Republicans have also expressed notable concerns with the major reductions on spending. Legislation to implement the Administration's budget must be passed before September 30, 2017, the end of the Federal Fiscal Year. In particular, major reductions in entitlement programs will be difficult to enact in such a short time frame, and it is unclear if the votes exist in both the House and Senate to implement them. In addition, the House and Senate are just beginning the appropriations process for FFY 2018, and the Senate has still not committed to advancing a companion bill to the American Health Care Act. The Administration and leaders in Congress also want to pursue a comprehensive tax reform package in the next few months despite the fact that nothing specific has been introduced. Finally, Congress will also need to take action on the debt ceiling in the fall.

With the heavy legislative agenda facing Congress, it is uncertain if leaders will be able to pass legislation to adopt the President's proposed budget, particularly with the significant cuts proposed to entitlement programs. Major changes are particularly problematic in the Senate, which has a 52 - 48 partisan divide. The fact that there are only ten legislative weeks left in FFY 2017 presents significant timing challenges to the Republican leadership in both chambers.

We will continue to keep you advised.

SH:JJ:MR
OR:SS:ma

c: All Department Heads

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NEWS

Change in Social Security Disability: HIV-Positive Recipients May Now Have to Go Through Reviews

By Enid Vázquez

May 31, 2017

People living with HIV (PLWH) who receive government disability checks have previously received that income without going through reviews.

As of March 1, the Social Security Administration (SSA) began requiring that PLWH prove they are still disabled. Like others receiving disability payments, they will have to go through a Continuing Disability Review (CDR). These are conducted every one to seven years.

There are exceptions. Not subjected to a CDR are those with HIV who have

- Multicentric Castleman disease,
- primary central nervous system lymphoma,
- primary effusion lymphoma,
- progressive multifocal leukoencephalopathy, or
- pulmonary Kaposi sarcoma.

"The big take-away here: if you are receiving disability benefits, it is very important to stay in medical care. Document every symptom and have your doctor note them. Document, document, document," said Marina Kurakin of the Legal Council for Health Justice, in Chicago, who wrote "Money Trail" in the November + December 2016 issue of *Positively Aware*.

She said that one of the biggest concerns now is those who received disability based on mental health status but are not currently seeing a therapist and individuals who are working part-time while receiving disability benefits.

Previously, PLWH were screened out of CDRs. That simply means that they did not have to undergo the reviews. Today, some of those people are actually very healthy. A review may put their disability income at risk.

It's not yet known when CDRs are expected to begin for people living with HIV. Legal advocates for PLWH, however, point out that the Social Security Administration moves slowly. If there are staff and budget cuts, SSA can be expected to move even more slowly.

Said Bashirat Osunmakinde, Director of Care for the AIDS Foundation of Chicago, in an e-mail to area providers, "The important take-away for HIV-positive folks on disability is this: do your best to keep up with your medical appointments, get all the care you need, and make sure your doctor/nurse/PA/therapist knows everything that's going on with you. If you do not have ongoing medical records, then when your CDR comes up you won't have much evidence that you are still disabled. Do not tell your doctor, 'I'm fine,' if in fact you are having a lot of trouble with diarrhea and fatigue and neuropathy. Many clients have been so used to their long-standing symptoms that they do not even talk about them with their medical providers anymore, and when they

do not communicate their ongoing, longstanding problems to their providers, those problems disappear from the medical record, and thus no longer exist in the eyes of Social Security."

Osunmakinde also strongly advised Social Security disability recipients to stress to their providers the need to chart everything. "Often, providers will not note in medical records the longstanding, unchanging problems, because they are not actively treating them," he wrote.

The SSA change came about after the agency revised its criteria for evaluating HIV as a disability on January 17.

See "Yes, SSA Disability Just Made a Slight Change for HIV-Positive Recipients; No, You Shouldn't Freak Out" at thebody.com. Information about the SSA change, while a little technical, can be found at secure.ssa.gov/apps10/reference.nsf/links/02282017105458AM.

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May 2017 | Issue Brief

What is at Stake in ACA Repeal and Replace for People with HIV?

Lindsey Dawson, Jennifer Kates

As debate continues surrounding repealing and replacing or transforming aspects of the Affordable Care Act (ACA), and as one such proposal has passed the U.S House of Representatives, questions remain about the potential impact of such changes on high needs populations, including people with HIV. Prior to the ACA, many people with HIV faced significant barriers to accessing health coverage despite national treatment guidelines recommending starting antiretroviral therapy at time of diagnosis.[1] Several of the ACA's key provisions addressed these barriers (see Table 1) and recent analysis demonstrates that the ACA significantly increased insurance coverage for people with HIV.[2]

Table 1. Key ACA Provisions Expanding Access and Eliminating Barriers to Coverage for People with HIV

Expanding Access
Creation of Marketplaces for purchasing private coverage (Including subsidies for those 100-400% FPL)
Medicaid expansion with eligibility based on income and residency alone (Effectively, state option. 32 states including DC expanded as of May 2017)
Eliminating Barriers
Prohibition of pre-existing conditions exclusions
End to rate setting based on health status
Elimination of annual and lifetime benefits limits
Creation of a benefits floor, including prescription drug coverage

This brief explores the potential implications of different ACA repeal scenarios and related administrative actions on people with HIV. In particular, it looks at the main policy areas under consideration that stand to affect people with HIV the most: (1) the future of the ACA's Medicaid expansion; (2) changes to the traditional Medicaid program; and (3) the pathway forward for private market reforms, including the ACA's health insurance marketplaces. (For a detailed overview of the major policy proposals that have been introduced to date, including the amended American Health Care Act (AHCA), see Kaiser Family Foundation's interactive ACA replacement plan comparison tool).[3]

Changes to Medicaid Would Likely Have the Biggest Impact on People with HIV

Medicaid is the single largest source of coverage for people with HIV in the U.S. and its role for those with HIV has significantly expanded under the ACA. Indeed, the Medicaid expansion provision is arguably the aspect of the law that has had the most far reaching effects on people with HIV, driving a nationwide increase in access

to insurance.[4] Proposals that have been put forward, including the amended AHCA which has now passed the House, have sought to change both the Medicaid expansion and the traditional Medicaid program.

The Medicaid Expansion. Prior to the ACA, under federal law, individuals could not qualify for Medicaid based on income alone.[5] Enrollees had to be *both* low income *and* fall into another category, known as "categorical eligibility," such as disability, pregnancy, or being parents. This excluded most low-income childless adults from coverage and created a particular "catch-22" for many low-income people with HIV who could not qualify for Medicaid until they were already quite sick and disabled, often as a result of developing AIDS, despite the availability of recommended medications that could prevent such disease progression.[6] The ACA fundamentally changed this, requiring states to expand their Medicaid programs to cover individuals below 138% FPL based on income and residency status alone; although a June 2012 US Supreme Court decision effectively made the expansion a state option. To date 32 states (including D.C.) have expanded their programs (where an estimated 62% of people with HIV live).[7] As part of the expansion, the federal government offered states a historically generous federal match to cover this new population, with 100% federal funding for the first few years, gradually decreasing to 90% in 2020 and beyond.[8] A recent analysis found that increased Medicaid coverage in expansion states drove a nationwide increase in coverage for people with HIV in 2014, the first year after the Medicaid expansion went into effect.[9]

As part of the repeal and replace debate, the Medicaid expansion has been a major focus because of the impact unraveling this source of coverage would have on the 32 states that have expanded and the millions enrolled through this pathway. The AHCA would retain the expansion but use the (less generous) traditional state match for new enrollees starting in 2020 and for existing enrollees without continuous coverage. A less generous match could mean states would be less willing to cover the new adult population in the years to come and in fact several states already have triggers in place to rescind coverage for the current group if the federal match declines to certain levels. It would also provide a disincentive for other states to expand in the future.

The Traditional Medicaid Program. Proposals to transform the current open-ended nature of federal matching funds to states for the traditional Medicaid program have also been part of the debate. Proposals, including converting the program to a block grant or per capita cap would fundamentally change the financing and structure of the program and shift costs to states.[10] The AHCA proposes a per capita cap approach as a way to limit federal spending and increase state flexibility. However, such an approach could impact access for people with HIV. Under restructured and constrained financing, states would probably respond by reducing services or eligibility to accommodate a loss in federal dollars. Beneficiaries may see increased cost-sharing and providers, reductions in reimbursement rates. As these programs could be structured in a multitude of ways, it will be important to watch how proposals might impact access to coverage for people with HIV in terms of eligibility, benefits, cost-sharing, beneficiary protections, and enrollment requirements. These proposals to change per beneficiary spending would apply to the HIV disability population in traditional Medicaid as well as the newly eligible expansion population.

Administrative Actions. Apart from repealing the expansion or fundamentally changing the financing and structure of the Medicaid program through legislation, the administration can permit broader flexibility for states through the use of 1115 Medicaid waivers which allow states to experiment with new approaches that can result in significant changes. On March 14, 2017, Health and Human Services (HHS) Secretary Price and

Centers for Medicaid and Medicare Services (CMS) Administrator Seema Verma sent a letter to governors outlining the administration's approach to Medicaid policy. It highlighted the flexibility the administration intends to provide to states with respect to state plan amendments and 1115 waivers. It specifically notes the potential for waivers to include higher beneficiary cost-sharing and adopt alternative benefit designs with features such as health savings accounts and work requirements, all provisions that could impact access to care and treatment for people with HIV.[11]

Lessons from History

People with HIV have previously faced capitated health financing with respect to ADAP (the prescription drug component of the federal Ryan White Program). Through the program, states receive capped federal grants distributed by formula. For much of ADAP's history, demand outpaced funding and the states instituted waiting lists. At their height, over 9,000 people with HIV were on waiting lists. Steps were taken to address the emergency (including culling formularies, changing eligibility, infusion of emergency funding, and receiving higher rebates from drug companies), but this experience demonstrated how block grant health financing is not necessarily sustainable or reliable and poses critical public health challenges in the infectious disease context.

Proposed Changes to the Individual Insurance Market Also Stand to Affect People with HIV

The ACA made significant changes to the private insurance market, removing many barriers to access and introducing new benefits and non-discrimination standards. Current legislative proposals and administration actions that seek to modify aspects of the law could scale back some of these changes.

Pre-existing condition protections and rate setting. Prior to the ACA, it was nearly impossible for people with HIV to access private coverage through the individual market. In most states, issuers were permitted to take health status and history into account when deciding whether to issue an individual policy, including under what terms, and in determining premium cost.[12] Most with HIV were considered "uninsurable" and either denied individual market coverage outright or, when offered, rates were typically unaffordable and/or policies included sweeping exclusions.[13] Under the ACA, individuals are guaranteed access to health insurance through the individual market regardless of health, rates cannot be set based on health status, and lifetime and annual limits are prohibited. Retaining this provision had been a central feature of the original AHCA but doing so is difficult without the individual mandate. The AHCA's approach is to require a surcharge for those without continuous coverage. The amended version of AHCA passed by the House would significantly erode this protection, permitting states to use a waiver to charge people with pre-existing conditions higher premiums and to sell policies without the Essential Health Benefits (EHBs – more discussion on EHBs below).[14] Such changes could mean that access to coverage may again be more limited for those with HIV and other pre-existing conditions.

Financial Assistance. One of the key provisions in the ACA is the creation of health insurance marketplaces which offer a centralized way for consumers to purchase insurance coverage and financial assistance for those with incomes between 100-400% of the Federal Poverty Level (FPL). This includes Advanced Premium Tax Credits (APTCs), which make the cost of premiums more affordable and cost-sharing reductions (CSRs) which

limit out-of-pocket expenses for the subset with incomes between 100-250% FPL. People with HIV are significantly more likely to be low-income and thus these subsidies will have been particularly important for this population.[15] Without access to APTCs and CSRs, which nearly 10 million enrollees have, many would not be able to afford insurance coverage, including those with HIV.[16]

The replacement policies that have been put forward would repeal or change the way financial assistance in the private market is provided. The AHCA would do away with cost-sharing reductions and offer a flat tax credit to be used towards premiums that vary by age but not by income; meaning those with the lowest incomes might have faced the greatest difficulty in affording coverage. Also, the credits would not vary by region (based on a benchmark plan) as they do under the ACA so those living in areas with very high premiums might face greater difficulty affording coverage.

Benefits Provisions. Prior to the ACA, there was no standardized federal benefit package in the private market. Under the ACA, individual and small group insurance policies must cover a suite of 10 "essential health benefits," including prescription drugs (see full list in note); [17] while whole health and comprehensive care is critical for people with HIV, access to antiretroviral treatment is the most fundamental benefit. Allowing states to obtain waivers of the EHB requirement, as is currently being discussed, would potentially limit coverage for HIV care and treatment. Even if the EHBs are retained, how those benefits are defined could be changed through rulemaking and redefining of EHBs could reduce access to care and treatment for people with HIV.

Administrative Actions. The administration can also reverse past and create new regulations through the rulemaking process or make and modify policy by issuing sub-regulatory guidance. Changes to rule making can impact how the ACA is implemented including through benefit design, cost-sharing, oversight, beneficiary protections, and market stability. For instance, HHS released a final Market Stabilization rule in April of 2017 that will change continuity of coverage requirements, shorten the open enrollment period, tighten special enrollment periods, loosen Actuarial Value (plan generosity) requirements, and pullback on network adequacy and essential community provider requirements and regulatory oversight.[18] Loosening of the network and essential community provider networks in particular could be limiting for people with HIV as it may mean fewer Ryan White and infectious disease providers in plan networks.

Alongside the Market Stabilization rule discussed above, HHS released guidance on plan certification for 2018 and beyond.[19] Building on an Executive Order, CMS detailed its plans to defer certain plan regulatory and oversight functions to states using the federal marketplace related to licensing, good standing, network adequacy (as also addressed in the final rule), and in some cases formulary review.[20] It is unclear how this shift towards state oversight will affect such access.

Lastly, starting in 2017 states are permitted to submit 1332 waivers requests, which like 1115 waivers allow states to experiment with coverage requirements and delivery but are specific to private health insurance and the marketplaces (rather than Medicaid). On March 13, 2017, Secretary Price sent a letter to the governors encouraging the use of 1332 waivers. Such waivers provide states with greater flexibility to shape their private markets including plan structure and marketplaces as insurance purchasing centers.

The Ryan White HIV/AIDS Program Will Likely Become Even More Important for People with HIV

The Ryan White HIV/AIDS Program is the federal health safety-net program providing primary HIV medical care, treatment, and support services for uninsured and underinsured people with the disease. Prior to the ACA, Ryan White supported about half of all people diagnosed with HIV and most already had some form of coverage (72% in 2013). Since the implementation of the major ACA reforms, the number of Ryan White clients has increased slightly and the share with coverage has also increased, suggesting that the program continues to play an important role in the lives of people with HIV regardless of insurance status.[21]

For those who gained coverage in the private market or through Medicaid under the ACA, Ryan White has been able to fill in the gaps in coverage and provide critical support services not typically covered by traditional payers, such as case management, transportation, and extended provider visits. In addition, in 2015 nearly 30,000 people with HIV receive insurance purchasing assistance through the Ryan White Program, an activity that has increased under the ACA as people with HIV had greater and more affordable access to the private market.[22,23] For those who did not gain new coverage – largely because they live in a state that has not expanded Medicaid - Ryan White continues to provide their primary HIV care and treatment.

Under an ACA repeal, coverage gains that have occurred as a result of the law through the Marketplaces and Medicaid expansion could be lost. It is likely that individuals who lose coverage would return to Ryan White to meet their full HIV care and treatment needs, but it is unclear whether the program would be able to absorb clients into traditional HIV care and treatment with existing resources and without resorting to waitlists (see Text Box: Lessons from History). Additionally, Ryan White is not an insurance program and covers only HIV related care so those who have gained insurance coverage and transition back to Ryan White exclusively would face losing access to coverage for other health conditions and emergency services. While the program would still be permitted to assist clients with the cost of insurance, the ability of Ryan White to do so as commonly as it does today without the ACA's subsidies and rate setting protections is in question since by statute such arrangements must be cost-effective for the program.[24]

In addition to the impact changes to the ACA would have on the program, the federal budget process also plays a critical role in the future of Ryan White. While the Trump Administration's "budget blueprint" or so-called "skinny budget" calls Ryan White out as a priority safety net provider, it also proposes an 18% cut for HHS overall. It is yet to be seen whether the full budget (expected in May) will preserve current levels of funding or propose cuts to the program and ultimately, how Congress will finalize FY18 appropriations. If cuts are realized, the Ryan White Program may not be able to sustain existing levels of service provision, especially if more individuals seek assistance from a program with less funding.

Endnotes

[1] Department of Health and Human Services. *Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents.* 2016. Available at https://aidsinfo.nih.gov/contentfiles/lvguidelines/adultandadolescentgl.pdf

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[3] Kaiser Family Foundation. *Compare Proposals to Replace The Affordable Care Act.* 2017. http://kff.org/interactive/proposals-to-replace-the-affordable-care-act/

[4] Kates, J. and Dawson, L. Kaiser Family Foundation. *Insurance Coverage Changes for People with HIV Under the ACA.* February 2017. http://kff.org/hivaids/issue-brief/insurance-coverage-changes-for-people-with-hiv-under-the-aca/

[5] Some states used a waiver to create an eligibility pathway with their own funds to cover this population.

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[8] In the traditional Medicaid program, the highest match a state receives is Mississippi's at 75.65% and the Median (including DC) match is Oklahoma's at 58.57%.

[9] Kates, J. and Dawson, L. Kaiser Family Foundation. *Insurance Coverage Changes for People with HIV Under the ACA.* February 2017. http://kff.org/hivaids/issue-brief/insurance-coverage-changes-for-people-with-hiv-under-the-aca/

[10] For more information, on block grants and per capita caps see: – Robin Rudowitz. Kaiser Family Foundation. *5 Key Questions: Medicaid Block Grants & Per Capita Caps.* 2017. http://kff.org/medicaid/issue-brief/5-key-questions-medicaid-block-grants-per-capita-caps/

[11] Price, Thomas E. (Sec. HHS) and Verma, Seema (Administrator CMS). Letter to Governors. March 14, 2017. Available at: https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf

[12] For a detailed look at pre-ACA insurance practices related to eligibility and rate setting see: Claxton, G., Levitt, L., and Pollitz, K. *Pre-ACA Market Practices Provide Lessons for ACA Replacement Approaches.* 2017. http://kff.org/health-costs/issue-brief/pre-aca-market-practices-provide-lessons-for-aca-replacement-approaches/

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[16] Marketplace Enrollees Receiving Financial Assistance as a Share of the Subsidy-Eligible Population. http://kff.org/health-reform/state-indicator/marketplace-enrollees-eligible-for-financial-assistance-as-a-share-of-subsidy-eligible-population/?currentTimeframe=0

[17] The Essential Health Benefits package includes: While the benefits are not defined specifically, except with respect to certain preventative services, impacted plans must cover services related to the following categories: ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health and substance use services (on par with other health services), prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness services, and pediatric services.

[18] 82 *Fed. Reg.* 18346-18382 (April 18, 2017), available at https://www.federalregister.gov/documents/2017/04/18/2017-07712/patient-protection-and-affordable-care-act-market-stabilization.

[19] Department of Health and Human Services. Centers for Medicare and Medicaid Services. *Guidance to States on Review of Qualified Health Plan Standards in Federally-facilitated Marketplaces for the Plan Years 2018 and Later.* April 13, 2017. https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/QHP-Certifcation-Reviews-Guidance-41317.pdf

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[24] Compared to the cost of directly purchasing medications.

County of Los Angeles
CHIEF EXECUTIVE OFFICE
Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
http://ceo.lacounty.gov

SACHI A. HAMAI
Chief Executive Officer

March 13, 2017

To: Supervisor Mark Ridley-Thomas, Chairman
Supervisor Hilda L. Solis
Supervisor Sheila Kuehl
Supervisor Janice Hahn
Supervisor Kathryn Barger

From: Sachi A. Hamai
Chief Executive Officer

WASHINGTON, D.C. UPDATE ON HOUSE COMMITTEES' ACTION ON THE AMERICAN HEALTH CARE ACT

On March 9, 2017, the House Ways and Means Committee and the House Energy and Commerce Committee passed legislation along party lines that would repeal and replace significant portions of the Affordable Care Act (ACA). The measure, H.R. 277, the American Health Care Act (AHCA), was released only three days prior to its approval.

The House Ways and Means Committee, which has jurisdiction over the tax provisions of the AHCA, passed its section of the bill by a vote of 23 to 16. The House Energy and Commerce Committee, which has jurisdiction over Medicaid and other provisions, approved its section by a vote of 31 to 23. The AHCA now proceeds to the House Budget Committee which will combine the committee-approved measures for the budget reconciliation process, prior to its consideration on the House floor.

Major Provisions of the American Health Care Act

The American Health Care Act proposes the following major provisions of importance to the County.

Medicaid Expansion: The AHCA would repeal the state option to expand Medicaid coverage to childless adults with incomes up to 133 percent of the Federal Poverty Level (FPL) effective December 31, 2019. States that have not opted into the Medicaid expansion, could do so and enroll individuals through 2019 at the enhanced 90 percent Federal match rate. In 2020, enrollment in the Medicaid expansion would "freeze" and states would no longer be able to sign-up new enrollees at the enhanced rate. After 2020, states would be able to continue to enroll individuals in Medicaid; however, Federal reimbursement would drop to the state's current Federal match rate. In California, the match rate is 50 percent.

As previously reported, California has disproportionately benefited from the ACA's Medicaid expansions relative to other states. In FFY 2015, the State alone received 35 percent ($20.3 billion) of all Federal expenditures on medical assistance provided to newly eligible adult Medicaid enrollees.

Medicaid Per Capita Cap: The AHCA would convert Medicaid from an open-ended entitlement program to a "per capita cap" system in which states would receive a capped amount for each person enrolled in Medicaid. The per capita caps would go into effect in 2020 and would establish different funding levels for specified populations enrolled in Medicaid. The baseline rate would be based on the FFY 2016 Medicaid enrollment and expenditures, and would increase annually using the medical care component of the Consumer Price Index. Capping the Federal share of Medicaid would shift the proportionate costs exceeding the Federal cap to states and counties.

Medicaid Eligibility: The AHCA would enact various changes related to Medicaid eligibility, including eliminating expanded presumptive eligibility determination conducted at hospitals and requiring states to determine eligibility no less than every six months for persons in the expansion population. The AHCA would also enact changes to the Medicaid Program which existed prior to the enactment of the ACA. These changes include eliminating three-month retroactive eligibility for new enrollees, after October 1, 2017, and eliminating the "reasonable opportunity period" for Medicaid applicants to provide proof of citizenship or immigration status.

Medicaid Disproportionate Share Hospital (DSH) Payments: The ACA included significant reductions in DSH payments to hospitals with high volumes of Medicaid and uninsured patients based on the assumption that the Medicaid expansion and increased rates of health insurance coverage would reduce hospitals' burden of uncompensated care. The AHCA would restore the DSH reductions for current expansion states in FFY 2020 and for non-expansion states in FFY 2018.

Public Health and Prevention Fund: The AHCA would eliminate the Public Health and Prevention Fund which provides a permanent funding stream to augment prevention and public health services, including diabetes prevention, preventive health screening, laboratory and disease tracking activities, and comprehensive immunization program services, including vaccinations to control infectious disease outbreaks.

Community First Choice Option: The AHCA would sunset the six percentage point increase in the Federal match for the Community First Choice (CFC) option to states that provide personal care services in a home or community-based setting to individuals needing an institutional level of care. In FFY 2015, California received $320.5 million for the In-Home Supportive Services (IHSS) Program from the CFC option. A significant number of IHSS recipients are being served under this Federal option which helps to keep some of the most vulnerable residents in their homes and out of long-term care.

Employer and Individual Mandates: The AHCA would repeal the mandate that businesses with 50 or more full-time (or part-time equivalent) employees offer health insurance to full-time employees. It would also repeal the requirement for individuals to purchase health care coverage or pay a penalty.

Cadillac Tax: The AHCA would retain the 40 percent excise tax on high-cost employer-sponsored health care coverage. However, the implementation date would be delayed from January 1, 2020, to January 1, 2025.

Legislative Outlook

On March 13, 2017, the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) released their estimates of the budgetary effects for the AHCA. According to the CBO and JCT, the AHCA would reduce Federal deficits by $337 billion from FFY 2017 to FFY 2026. The largest savings would come from reductions in Medicaid spending and from the elimination of health care subsidies. CBO and JCT estimate that the number of uninsured persons would rise to 21 million in 2020 and then to 24 million in 2026, largely due to changes in Medicaid.

House leadership expects to have the legislation on the House floor prior to the Easter recess in early April, and has indicated that they expect to secure the votes for passage. The Senate also is expected to consider the AHCA prior to the recess in early April; however, Senate Republicans have already indicated that they plan to offer amendments to the measure when it is considered on the Senate floor.

Pursuant to the Board-approved motion on February 21, 2017, the County's Washington, DC advocates are advocating in strong opposition to this legislation that would have a significant impact on the County by repealing major provisions of the ACA and the Medicaid program which provide critical services to our residents.

This office is also working with the Department of Health Services and other affected departments to further determine the County impact of specific provisions proposed under the AHCA.

We will continue to keep you advised.

SAH:JJ:MR
OR:VE:lm

c: All Department Heads
Legislative Strategists

LOS ANGELES COUNTY COMMISSION ON HIV
3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
http://hiv.lacounty.gov

16. AIDS EDUCATION TRAINING CENTERS (AETCs)

AETC AIDS Education & Training Center Program Pacific

Los Angeles
Pacific AIDS Education and Training Center

Last Tuesday HIV Training

JUNE 27, 2017
9:00am—12:00PM

Registration begins at 8:30am

8:30am — Registration
9:00am — Part 1
10:30am — Break
10:45am — Part 2
12:15pm — Closing/Box Lunch

LOCATION:

Charles Drew University
Cobb Building Boardroom 281
1731 East 118th
Los Angeles, CA 90059

Blue and Green Metro Lines

Parking
Free Parking at CDU structure on 118th St
Parking Lot Address: 1740 E. 118th St
Los Angeles CA 90059

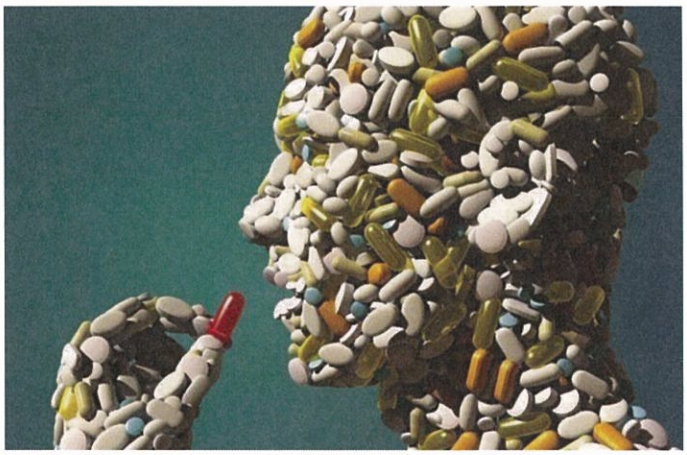
- This is a **FREE** training
- This course is geared towards medical professionals who work with HIV+ patients.
- **3 CEs** available for LCSWs, MFTs and RNs
- Certificates of completion will be available to participants after completion of online evaluation.
- For disability accommodations or to submit grievances please contact Kevin-Paul at

kevinpaul@HIVtrainingCDU.org

Continuing LCSW and MFT Education Credit Courses meet the qualifications for 3 Hours of continuing education credit for MFTs and/or LCSWs as required by the California Association of Marriage and Family Therapists. Provider #PCE 128280 Continuing Nursing Education Credit.
These courses are approved for 3 Contact Hours by the California Board of Registered Nursing. Provider #15484. *Pharmacists registered in CA may use BRN CEs as per their governing board.

NEVER MIX, NEVER WORRY:

What Providers Should Know about HIV and Psychotropics



Presented by
Andrew Kurtz, LMFT
James A. Peck, PsyD
UCLA Integrated Substance Abuse Programs
Pacific Southwest Addiction Technology Transfer Center

REGISTER ONLINE:

https://tinyurl.com/NeverMix-NeverWorry

By the end of this training participants will be able to:

* Describe the epidemiology, neurobiology, and mechanism of action of psychotropic medication use.
* Identify at least two (2) psychotropics and the corresponding mental health diagnosis they are used to treat.
* Discuss at least three treatment interventions to avoid drug-drug interactions and/or enhance medication use as directed.
* Describe two medication side effects that could be misdiagnosed as a symptom of HIV or a mental health disorder.

The CDU PAETC Last Tuesday HIV Training Series is a free event for providers who serve patients living with HIV.

LOS ANGELES COUNTY COMMISSION ON HIV
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19. ANNOUCEMENTS

Do You Identify as Native American?

Are You an HIV+ Transgender Woman, Gay Male, Bisexual Male, or Two Spirit?

We are enrolling HIV+ individuals to share their opinions and experiences about health care

Check your eligibility here:

https://www.surveymonkey.com/r/MaroonHealth

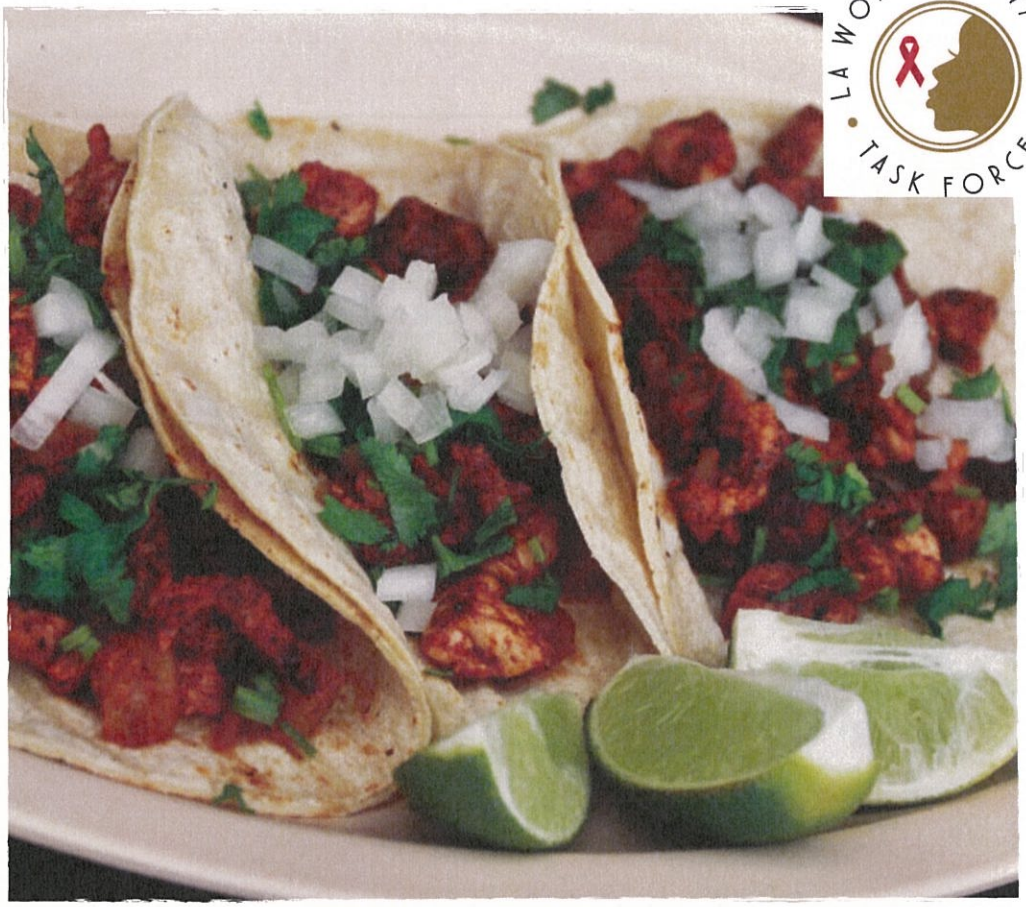
For more information email:
health@maroonsociety.com
Call:
213-222-8504

MAROON SOCIETY

PARTICIANTS WILL RECEIVE $150 CASH!

LA WOMEN'S HIV/AIDS TASK FORCE

JULY
22



HIGH TEA & TACOS

Follow us on social media!
Instagram
@lahivwomenstaskforce
Facebook @lahiv
www.lahivtaskforce.com
RSVP (424) 261-4426

AHF Theater
6500 W. Sunset Blvd., Los Angeles 90028
11am-3pm

Please join us for a morning of support, education, and food. RSVP at https://www.eventbrite.com/e/high-tea-and-tacos-tickets-34430618908

AHF PHARMACY™

CHIPTS
Center for HIV Identification, Prevention and Treatment Services

2017-2018 Mentored Pilot Grant Program

The Center for HIV, Identification, Prevention and Treatment Services (CHIPTS) is proud to announce a new vision and process for its annual pilot grant program, with a focus on mentored research awards for investigators (ranging from Doctoral Students to Assistant Professors). Applicants are encouraged to submit applications of innovative and transformative domestic and international social, behavioral, policy, and combination bio-behavioral pilot studies that will produce data and experiences that will support future funded grants and or career development for early-stage investigators. Proposals should focus on the intersection of HIV/AIDS treatment and prevention and mental health and or substance use co-morbidities. Proposals may budget **up to $50,000** in total costs and must be able to be completed within 12 months from date of award. It is anticipated that at least two awards will be made. Investigators from any Southern California university, college, healthcare organization, or community-based organization (CBO) may apply, and will be matched with a UCLA CHIPTS faculty mentor/sponsor.

The proposal process will occur in three phases, which includes: 1) submission of a one-page letter of intent due on Monday, June 19, 2017 by 2:00 PM Pacific Time; 2) participation in a mandatory proposal mentoring meeting with the CHIPTS Development Core Director and CHIPTS faculty with expertise relevant to the research concept, to occur between June 26 and July 14; and 3) submission of an application due July 31, 2017 by 2:00 PM Pacific Time. Review and notice of funding decisions will be made by August 31. All applications and correspondence should be directed to Dallas Swendeman, PhD, MPH, Director, CHIPTS Development Core at dswendeman@mednet.ucla.edu. Details are outlined below.

1. Applicant Eligibility

- Assistant Professors
- Assistant to Associate Research Scientists (or equivalent level within their organization), with a statement of intent for an independent research career
- Post-Doctoral Fellows
- Doctoral Students (budget limited to $15,000)
- Applicants may be from any Southern California university, college, healthcare organization, or CBO.

2. Faculty Mentors/UCLA Sponsors

- Applicants may propose a senior mentor (i.e., Associate Professor level or higher) with whom they have an established relationship at their institution or at UCLA.
- Doctoral students and post-doctoral fellows may propose a mentor at the Assistant Professor level, but CHIPTS may also match a more senior mentor for the team.
- If the proposed mentor is not from UCLA, then CHIPTS will match the applicant with a UCLA CHIPTS faculty mentor for additional mentoring and for IRB requirements (see below).
- If a mentor is not proposed, then CHIPTS will identify and match a mentor for the applicant.

3. UCLA Institutional Review Board (IRB) Requirement

- A single IRB of record at UCLA is required, which is consistent with new NIH guidelines. Applicants from an institution or organization other than UCLA will be matched with a UCLA CHIPTS faculty sponsor to meet this IRB requirement.

4. Research Priority – Intersection of HIV/AIDS with Mental Health and or Substance Use

- The proposed research must focus on CHIPTS' core theme of addressing the intersection of HIV/AIDS treatment and prevention and mental health and/or substance use co-morbidities. This vision recognizes that getting to 90-90-90 and ending the HIV/AIDS pandemic will require supporting the most vulnerable and marginalized populations living with and at-risk for HIV infection to progress through the HIV Care or Prevention Continuums. This call is intentionally broad to encourage a wide range of innovative proposals with high potential to impact either HIV incidence or rates of HIV virologic suppression.

5. One-Page Letter of Intent (LOI) – Due Monday, June 19, 2017 by 2:00 PM Pacific Time

- LOIs may be up to one page with 0.5 inch margins and 11-point font.
- LOIs must include the following:
    - Your name, degrees, and full contact information (position, institution affiliation, email, phone, mailing address)
    - Brief summary of the proposed project, including the research question, target population(s), location(s) of research, and methods
    - Mentor's name (as available)
    - Total amount of funding requested
- LOIs will be evaluated for responsiveness to the call based on eligibility and merit by CHIPTS faculty.
- Notification of approved LOIs will be sent by June 16, 2017.
- Applicants of approved LOIs will be invited to participate in a proposal mentoring meeting to discuss and refine the research concept further before developing the full application.

6. Proposal Mentoring Meeting – June 26 to July 14, 2017

- The proposal mentoring meeting will occur either in-person at UCLA or by video conference (Skype) between June 26 and July 14. The meeting will include the applicant, proposed mentor(s), and CHIPTS team members. The goal of the mentoring meeting is to discuss the research concept in more detail than the LOI provides and to provide feedback on design, aims, budget, and timelines.

7. Application – Due Monday, July 31, 2017 by 2:00 PM Pacific Time

The application includes a **three-page proposal narrative** (single spaced, 0.5 inch margins, 11-point font), which includes:

- Specific aims (< 0.5 page)
- Research plan, which includes Significance (< 0.5 page), Innovation (< 0.5 page), Approach (~1 page).
- Training and mentoring statement (< 0.5 page) highlighting the training opportunities provided to the applicant by the proposed research, including the mentor(s) and their role(s).
- Proposed publications and grant applications expected to result from the research (< 0.5 page)
- References may be included on additional page(s) and do not count towards the 3-page limit.

In addition to the proposal narrative, applicants must submit **a budget and budget justification** with their application.

- Applicants must use the PHS 398 Form Page 4 only (Detailed Budget for Initial Budget Period) to submit their budget. Please see attached form.
- In addition to completing the PHS 398 Form Page 4, applicants must submit a brief budget justification (<1 page) describing their expenses and include a timeline of activities.
- Research personnel costs, supplies and small equipment costs are allowable in pilot grants to the extent that they can be justified as being directly related to the proposed research project.
- Travel may be included only if deemed necessary to conduct the study.
- **Indirect costs are not permitted on pilot grants.** Any possible overlap with other sources of support must be made clear and be justified in the application.
- Please note that CHIPTS may not award the full budget requested based on expert review and balancing funds for meritorious proposals.
- **All funds awarded for 2017-2018 projects must be spent within 12 months of date of award.**
- **Funding is subject to final award approval from the National Institute of Mental Health. No funds will be transferred until all NIH regulatory documents and approval have been received (including IRB approval).** Any

overdrafts are the sole responsibility of the individual pilot grant awardee. Consistent with NIH policy, any change in budget category (such as personnel, supplies, equipment) exceeding 25% requires prior written approval by the Development Core Director.

Additionally, applicants must submit a **biosketch** of the lead investigator with their application.

- Only the biosketch of the lead investigator is required and must be in the new NIH format (https://grants.nih.gov/grants/forms/biosketch.htm).
- Biosketches of mentors or other faculty participants are not required.
- No additional appendices or materials will be reviewed as part of the application.

Applications that do not follow the above guidelines, including those that exceed the page limit, may be returned without review.

8. Review and Notice of Funding Decisions by August 31, 2017

Proposals will be reviewed by a committee of CHIPTS faculty and members of the CHIPTS Community Advisory Board. Review criteria are based on:

- Responsiveness to CHIPTS' broad theme of addressing the intersection of HIV/AIDS treatment and prevention with mental health and or substance use;
- NIH review guidelines for Significance, Innovation, Approach, and Environment (but note that environment for this call refers to the research setting/partner, not the applicant's institutional home);
- Potential for the applicant's career development for publications and subsequent research grant applications for HIV research.

9. Requirements of Funded Applicants

1. Certification of IRB review and approval must be provided and accepted by CHIPTS before the research may occur.
2. Funded investigators must present their proposed work, progress, and final outcomes at annual CHIPTS Next Generation Conferences and at one CHIPTS Community Advisory Board meeting annually.
3. An annual progress report will be due September 28, 2018.
4. A final report will be due on May 31, 2019, which includes **a brief scientific summary, a final financial report, abstract of work completed, publications submitted and planned, and grant applications submitted and planned relevant to the seed grant.**
5. All publications or presentations resulting in whole or in part from support by CHIPTS should acknowledge CHIPTS as the funding source - **NIMH Grant # P30MH58107.**
6. **Funded investigators must respond to annual requests for updates on publications and grant applications, for the duration of funding of CHIPTS.** This is critical to CHIPTS accountabilities to NIH. CHIPTS recognizes that pilot grants often continue to produce publications, grant proposals, and other activities with project partners for many years after data collection is completed.
7. Funded investigators will be requested to serve as reviewers for future pilot program applications.

ADDRESS FOR QUESTIONS AND FINAL SUBMISSIONS:

Dallas Swendeman, PhD, MPH
Director, CHIPTS Development Core
E-mail: dswendeman@mednet.ucla.edu

All materials (LOI, Full Proposal) should be submitted by email to Dr. Swendeman