LOS ANGELES COUNTY
COMMISSION ON HIV

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

# COMMISSION ON HIV
## Meeting

**Thursday, May 11, 2023**
**9:00am-1:00pm (PST)**

**St. Anne's Conference & Events Center**
**155 N. Occidental Blvd., LA 90026**

***Complementary Valet Parking Available: Please indicate to the valet you are attending the Commission meeting***

Agenda and meeting materials will be posted on our website at http://hiv.lacounty.gov/Meetings

**Notice of Teleconferencing Sites:**

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

Bartz-Altadonna Community Health Center
43322 Gingham Ave, Lancaster, CA 93535

**Members of the Public May Join in Person or Virtually.**
**For Members of the Public Who Wish to Join Virtually, Register Here:**
https://lacountyboardofsupervisors.webex.com/weblink/register/r104425cd7df7b7febb9879dba1686fed
To Join by Telephone: 1-213-306-3065
Password: COMMISSION Access Code: 2595 761 6930

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

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Apply to become a Commission Member at:
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For application assistance call (213) 738-2816 or email hivcomm@lachiv.org

LOS ANGELES COUNTY COMMISSION ON HIV

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

# AGENDA FOR THE REGULAR MEETING OF THE LOS ANGELES COUNTY COMMISSION ON HIV (COH)

**Thursday, May 11, 2023 | 9:00 AM – 1:00 PM**

## St. Anne's Conference & Events Center
## 155 N Occidental Blvd, Los Angeles, CA 90026

***Complimentary On-Site Valet Parking Provided:***
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**MEMBERS OF THE PUBLIC: TO JOIN VIRTUALLY, REGISTER HERE:**
https://lacountyboardofsupervisors.webex.com/weblink/register/r104425cd7df7b7febb9879dba1686fed
To Join by Telephone: 1-213-306-3065 Password: COMMISSION Access Code: 2595 761 6930

**AGENDA POSTED**: May 8, 2023

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

**PUBLIC COMMENT**: Public Comment is an opportunity for members of the public to comment on an agenda item, or any item of interest to the public, before or during the Commission's consideration of the item, that is within the subject matter jurisdiction of the Commission. To submit Public Comment, you may join the virtual meeting via your smart device and post your Public Comment in the Chat box -or- email your Public Comment to hivcomm@lachiv.org -or- submit your Public Comment electronically here. All Public Comments will be made part of the official record.

**ACCOMMODATIONS:** Interpretation services for the hearing impaired and translation services for languages other than English are available free of charge with at least 72 hours' notice before the meeting date. To arrange for these services, please contact the Commission Office at (213) 738-2816 or via email at HIVComm@lachiv.org.

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

**ATTENTION:** Any person who seeks support or endorsement from the Commission on any official action may be subject to the provisions of Los Angeles County Code, Chapter 2.160 relating to lobbyists. Violation of the lobbyist ordinance may result in a fine and other penalties. For information, call (213) 974-1093.

LOS ANGELES COUNTY COMMISSION ON HIV

## 1. ADMINISTRATIVE MATTERS

| | | | |
|---|---|---|---|
| **A.** | Call to Order & Meeting Guidelines/Reminders | | 9:00 AM – 9:05 AM |
| **B.** | County Land Acknowledgment | | 9:05 AM – 9:07 AM |
| **C.** | Introductions, Roll Call, & Conflict of Interest Statements | | 9:07 AM – 9:10 AM |
| **D.** | Assembly Bill 2449 Attendance Notification for "Emergency Circumstances" | **MOTION #1** | 9:10 AM – 9:13 AM |
| **E.** | Approval of Agenda | **MOTION #2** | 9:13 AM – 9:15 AM |
| **F.** | Approval of Meeting Minutes | **MOTION #3** | 9:15 AM – 9:17 AM |
| **G.** | Consent Calendar | **MOTION #4** | 9:17 AM – 9:20 AM |

## 2. REPORTS - I

**A.** Executive Director/Staff Report — 9:20 AM – 9:25 AM

**(1)** County/Commission Operations | UPDATES

a. Member Ryan White Program (RWP) Conflict of Interest Forms

**(2)** Dear Colleague Letter Re: Joint HIV Outbreak & Housing Response Efforts

**(3)** Dear Colleague Letter Re: Disproportionate Impact STIs, Incl Mpox, Have on People with HIV

**(4)** RWP Part C, Bureau of Primary Health Care (BPHC) Ending the HIV Epidemic Primary Care HIV Prevention Award Recipients

**(5)** Equity Lens for Decision-Making Tool

**B.** Co-Chairs' Report — 9:30 AM – 9:45 AM

**(1)** Acknowledgement of National HIV Awareness Days for May 2023

a. 5/18 HIV Vaccine Awareness Day #HVAD

b. 5/19 National Asian & Pacific Islander HIV/AIDS Awareness Day #API

**(2)** May-July 2023 Commission Meeting Schedule

**(3)** April 13, 2023 COH Meeting | FOLLOW-UP & FEEDBACK

a. Address HIV in the Native American communities

**(4)** Conferences, Meetings & Trainings | OPEN FEEDBACK (Opportunity for members to share **Commission-related** information from events attended)

**(4)** Member Vacancies & Recruitment

**C.** California Office of AIDS (OA) Report (Part B Representative) — 9:45 AM – 9:55 AM

**(1)** OAVoice Newsletter Highlights

**(2)** California Planning Group (CPG): COH Representation **MOTION #5**

**D.** LA County Department of Public Health Report (Part A Representative) — 9:55 AM – 10:55 AM

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

a. Programmatic and Fiscal Updates

- Part II Unmet Needs Presentation: Out of Care
- HIV Surveillance Update & Data Challenges for Native American Communities (July presentation)

b. Mpox Briefing Update

LOS ANGELES COUNTY COMMISSION ON HIV

**3. REPORTS – I (cont'd)**

**E.** Housing Opportunities for People Living with AIDS (HOPWA) Report 10:55 AM – 11:10 AM

**F.** Ryan White Program Parts C, D, and F Report 11:10 AM – 11:15 AM

**G.** Cities, Health Districts, Service Planning Area (SPA) Reports 11:15 AM – 11:20 AM

**BREAK** 11:20 AM – 11:30 AM

**3. REPORTS - II** 11:30 AM – 12:25 PM

**A.** Operations Committee

**(1)** Membership Management

**a.** New Member Applications

**b.** 2023 Renewal Membership Drive

**c.** Seat Vacate | Eduardo Martinez, Alternate **MOTION #6**

**(2)** Policies & Procedures

**(3)** Assessment of the Administrative Mechanism (AAM)

**(4)** 2023 Training Series

**(5)** Recruitment, Outreach & Engagement

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

**(1)** Status Neutral Planning

**(2)** Stakeholder Townhall Meeting Planning

**C.** Standards and Best Practices (SBP) Committee

**(1)** Universal Service Standards and Patient Bill of Rights Review

**(2)** Medical Care Coordination (MCC) Review

**(3)** Nutrition Support Services Standard Review

**D.** Public Policy Committee (PPC)

**(1)** County, State and Federal Policy, Legislation, and Budget

**a.** 2023-2024 Legislative Docket (State Bills) | **MOTION #7**

**b.** 2023-2024 Policy Priorities

**c.** County Coordinated STD Response

**d.** Act Now Against Meth (ANAM) Platform Update

**E.** Caucus, Task Force and Work Group Report 12:25 PM – 12:40 PM

**(1)** Aging Caucus | June 13, 2023 @ 1-3PM **Virtual*

**(2)** Black/African American Caucus | May 18, 2023 @ 4-5PM **Virtual*

**(3)** Consumer Caucus | May 11, 2023 @ 2-4PM **Hybrid: Virtual & In-Person @ St. Anne's*

**(4)** Transgender Caucus | May 23, 2023 @ 10AM-11:30AM **Virtual*

**(5)** Women's Caucus | July 17, 2023 @ 2-4PM **Virtual*

**(6)** Vision & Mission Statement Review Workgroup | **Virtual; TBD*

**(7)** Prevention Planning Workgroup | May 24,2023 @ 4-5:30PM **Virtual*

**(8)** Bylaws Review Taskforce | TBD **Virtual*

## 5. MISCELLANEOUS

**A.** Public Comment 12:40 PM – 12:50 PM

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

**B.** Commission New Business Items 12:50 PM – 12:55 PM

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

**C.** Announcements 12:55 PM – 1:00 PM

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

**D.** Adjournment and Roll Call 1:00 PM

*Adjournment in the memory of Dr. Wilbert C. Jordan and Banko Brown for the meeting of May 11, 2023.*

| PROPOSED MOTION(S)/ACTION(S) | |
|---|---|
| **MOTION #1** | Approve Remote Attendance by Member(s) Pursuant to Assembly Bill 2449 Attendance Notification for "Emergency Circumstances", as presented. |
| **MOTION #2** | Approve meeting agenda, as presented or revised. |
| **MOTION #3** | Approve meeting minutes, as presented or revised. |
| **MOTION #4** | Approve Consent Calendar, as presented or revised. |
| **MOTION #5** | Approve the extension of Danielle Campbell, MPH's term as the COH representative on the CPG through 2025. Alternatively, appoint another member to serve as the CPG representative on behalf of the COH, as presented or revised. |

| CONSENT CALENDAR | |
|---|---|
| **MOTION #6** | Approve recommendation to vacate Eduardo Martinez, Alternate, as presented or revised, and forward to Board of Supervisors (BOS) for approval. |
| **MOTION #7** | Approve 2023-2024 Legislative Docket (State Bills), as presented or revised. |

LOS ANGELES COUNTY
COMMISSION ON HIV

| COMMISSION ON HIV MEMBERS | | | |
|---|---|---|---|
| *Luckie Fuller, Co-Chair* | *Bridget Gordon, Co-Chair* | Miguel Alvarez | Everardo Alvizo, LCSW |
| Jayda Arrington | Al Ballesteros, MBA | Alasdair Burton | Danielle Campbell, MPH |
| Mikhaela Cielo, MD | Mary Cummings | Erika Davies | Pearl Doan |
| Kevin Donnelly | Felipe Findley, PA-C, MPAS, AAHIVS | Arlene Frames | Joseph Green |
| Felipe Gonzalez | Karl Halfman, MA | William King, MD, JD, AAHIVS | Lee Kochems, MA |
| Jose Magaña | Eduardo Martinez (*Alternate) | Leon Maultsby, MHA | Anthony Mills, MD |
| Andre Moléttе | Derek Murray | Dr. Paul Nash, CPsychol, AFBPsS FHEA | Katja Nelson, MPP |
| Jesus “Chuy” Orozco | Mario J. Pérez, MPH | Mallery Robinson (*Alternate) | Reverend Redeem Robinson |
| Ricky Rosales | Harold Glenn San Agustin, MD | Martin Sattah, MD | LaShonda Spencer, MD |
| Kevin Stalter | Justin Valero, MPA | Jonathan Weedman | |
| **MEMBERS:** | **39** | | |
| **QUORUM:** | **20** | | |

**LEGEND:**

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

LOS ANGELES COUNTY
COMMISSION ON HIV

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HIVCOMM@LACHIV.ORG • https://hiv.lacounty.gov

# VISION

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

# MISSION

The Los Angeles County Commission on HIV focuses on the local HIV/AIDS epidemic and responds to the changing needs of People Living With HIV/AIDS (PLWHA) within the communities of Los Angeles County. The Commission on HIV provides an effective continuum of care that addresses consumer needs in a sensitive prevention and care/treatment model that is culturally and linguistically competent and is inclusive of all Service Planning Areas (SPAs) and Health Districts (HDs).

# County of Los Angeles
# Land Acknowledgment
**(Adopted December 1, 2022)**

The County of Los Angeles recognizes that we occupy land originally and still inhabited and cared for by the Tongva, Tataviam, Serrano, Kizh, and Chumash Peoples. We honor and pay respect to their elders and descendants -- past, present, and emerging -- as they continue their stewardship of these lands and waters. We acknowledge that settler colonization resulted in land seizure, disease, subjugation, slavery, relocation, broken promises, genocide, and multigenerational trauma. This acknowledgment demonstrates our responsibility and commitment to truth, healing, and reconciliation and to elevating the stories, culture, and community of the original inhabitants of Los Angeles County. We are grateful to have the opportunity to live and work on these ancestral lands.

We are dedicated to growing and sustaining relationships with Native peoples and local tribal governments, including (in no particular order) the: Fernandeño Tataviam Band of Mission Indians, Gabrielino Tongva Indians of California Tribal Council, Gabrieleno/Tongva San Gabriel Band of Mission Indians, Gabrieleño Band of Mission Indians - Kizh Nation, Board of Supervisors Statement Of Proceedings November 1, 2022 San Manuel Band of Mission Indians, San Fernando Band of Mission Indians.

To learn more about the First Peoples of Los Angeles County, please visit the Los Angeles City/County Native American Indian Commission website at www.lanaic.lacounty.gov .

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# CODE OF CONDUCT

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

**All participants and stakeholders should adhere to the following:**

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

Approved (11/12/1998); Revised (2/10/2005; 9/6/2005); **Revised (4/11/19; 3/3/22)**

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DRAFT

*While not required of meeting participants, signing-in constitutes public notice of attendance. Presence at meetings is recorded solely based on sign-in sheets, and not signing-in constitutes absence for Commission members. Only members of the Commission on HIV are accorded voting privileges, thus Commissioners who have not signed in cannot vote. Sign-in sheets are available upon request.*

# APRIL 13, 2023
# COMMISSION ON HIV (COH) MEETING MINUTES
# 9:00AM-1:00PM

**510 S. Vermont Ave**
**Terrace Level Conference Room A (TK11)**
**Los Angeles, CA 90020**

**Teleconference Sites:**
California Department of Public Health, Office of AIDS
1616 Capitol Ave, Suite 75-61, Sacramento, CA 95814

Bartz-Altadonna Community Health Center
43322 Gingham Ave, Lancaster, CA 93535

| COMMISSION MEMBERS<br>P=Present \| A=Absent \| EA=Excused Absence | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Miguel Alvarez | P | Everardo Alvizo, MSW | P | Jayda Arrington | P | Al Ballesteros, MBA | A | Alasdair Burton (*Alt*) | P |
| Danielle Campbell, MPH | A | Mikhaela Cielo, MD | P | Mary Cummings | P | Erika Davies | P | Pearl Doan | A |
| Kevin Donnelly | P | Felipe Findley, PA-C, MPAS, AAHIVS | P | Arlene Frames | A | Luckie Fuller | A | Bridget Gordon | P |
| Joseph Green | A | Felipe Gonzalez | P | Karl Halfman, MA | A | William King, MD, JD, AAHIVS | A | Lee Kochems, MA | P |
| Jose Magaña *(Alt)* | P | Eduardo Martinez *(Alt)* | A | Leon Maultsby, MHA | P | Anthony Mills, MD | A | Andre Molette | P |
| Derek Murray | A | Paul Nash, CPsychol, AFBPsS, FHEA | A | Katja Nelson, MPP | A | Jesus "Chuy" Orozco | A | Mario J. Pérez, MPH | P |
| Mallery Robinson *(Alt)* | A | Reverend Redeem Robinson | A | Ricky Rosales | P | Harold Glenn San Agustin, MD | A | Martin Sattah, MD | P |
| LaShonda Spencer, MD | A | Kevin Stalter | P | Justin Valero | A | Jonathan Weedman | P | | |
| **COMMISSION STAFF & CONSULTANTS** | | | | | | | | | |
| Cheryl Barrit, MPIA; Catherine Lapointe, MPH; Lizette Martinez, MPH; Dawn McClendon; Jose Rangel-Garibay, MPH; and Sonja Wright, BA, MSOM, LAc, Dipl. OM, PES | | | | | | | | | |
| **DIVISION OF HIV AND STD PROGRAMS (DHSP) STAFF** | | | | | | | | | |
| Wendy Garland, PhD; Lene Reynolds, MPH; and Julie Tolentino, MPH | | | | | | | | | |

**Meeting agenda and materials can be found on the Commission's website at:**
https://assets-us-01.kc-usercontent.com/0234f496-d2b7-00b6-17a4-b43e949b70a2/a675c7d1-e5c9-4275-ad32-fc63fac7cb48/Pkt_COHMtg_041323_Final.pdf

1. **ADMINISTRATIVE MATTERS**
   - **A. CALL TO ORDER & MEETING GUIDELINES/REMINDERS**
     Bridget Gordon, Commission on HIV (COH) Co-Chair, called the meeting to order at 9:19 AM and went over meeting guidelines and reminders; see meeting packet.
   - **B. COUNTY LAND ACKNOWLEDGEMENT**
     B. Gordon provided a County Land Acknowledgement to recognize the land originally and still inhabited and cared for by the Tongva, Tataviam, Kizh, and Chumas Peoples; see meeting packet for full statement.
   - **C. INTRODUCTIONS, ROLL CALL, & CONFLICT OF INTEREST STATEMENTS**
     James Stewart, Parliamentarian, conducted roll call.
     **ROLL CALL (PRESENT):** M. Alvarez, J. Arrington, A. Ballesteros, A. Burton, M. Cielo, M. Cummings, K. Donnelly, F. Findley, L. Kochems, A. Molette, R. Rosales, M. Sattah, J. Weedman, and B. Gordon
   - **D. ASSEMBLY BILL 2449 ATTENDANCE NOTIFICATION FOR "EMERGENCY CIRCUMSTANCES"**
     **MOTION #1:** Approve Remote Attendance by Member(s) Pursuant to Assembly Bill 2449 Attendance Notification for "Emergency Circumstances", as presented. ***No commissioners invoked remote attendance under AB 2449; no vote held.***
   - **E. APPROVAL OF AGENDA**
     **MOTION #2:** Approve meeting agenda, as presented or revised. ✓***Passed by Consensus***
   - **F. APPROVAL OF MEETING MINUTES**
     **MOTION #3:** Approve meeting minutes, as presented or revised. ✓***Passed by Consensus***
   - **G. CONSENT CALENDAR**
     **MOTION #4:** Approve Consent Calendar, as presented or revised. ✓***Passed by Consensus***

2. **REPORTS – I**
   - **A. EXECUTIVE DIRECTOR/STAFF REPORT**
     - **(1) County/Commission Operations | UPDATES**
       Cheryl Barrit, Executive Director, COH, provided the following County/COH operational updates:
       - C. Barrit thanked staff from the Department of Public Health (DPH) in recognition of National Public Health Week.
       - C. Barrit informed the COH that Catherine Lapointe, COH staff, has accepted a job offer from the Department of Public Health and will be leaving her position at the COH in the next few weeks. C. Barrit commended C. Lapointe on her great work with the COH, especially around social media promotion.

**a. Conflict of Interest Form**

Commissioners are now required to complete an additional Conflict of Interest and Affiliation Disclosure form, as instructed by HRSA during their February site visit. COH staff e-mailed the form to all commissioners on March 23, 2023.

**(2) Reimagining COH Meetings/Schedule**

The Executive Committee will finalize the COH meeting schedule and determine if the May COH meeting will be cancelled at their April 27th meeting.

**B. CO-CHAIRS' REPORT**

**(1) Welcome New Members**

B. Gordon welcomed new commissioners Leon Maultsby and Jonathan Weedman.

**(2) Bylaws Review Taskforce | RECRUITMENT**

Dawn McClendon, COH staff, informed the COH that recruitment for the Bylaws Review Task Force will end on April 27, 2023. The purpose of the task force is to review the current COH bylaws for updates.

**(3) Recognition of National Youth HIV/AIDS Awareness Day**

B. Gordon provided an acknowledgement of National Youth HIV/AIDS Awareness Day (NYHAAD); see meeting packet for more information on NYHAAD.

**(4) Recognition of National Transgender HIV Testing Day**

B. Gordon provided an acknowledgement of National Transgender HIV Testing Day; see meeting packet for more information.

**(5) March 8, 2023 COH Meeting | FOLLOW-UP & FEEDBACK**

**a. Address HIV in the Native American Communities**

At the March 8, 2023 COH Meeting, Dr. William King requested the COH to provide a statement to acknowledge the effect of HIV on Native American communities. Speaker suggestions can be sent to COH staff. Mario Pérez, Director, DHSP noted that DHSP can provide an HIV surveillance update among Native Americans at the July COH meeting.

**(6) Conferences, Meetings & Trainings | OPEN FEEDBACK (Opportunity for members to share Commission-related information from events attended)**

Jayda Arrington reported that she attended the COH Mandatory trainings and found them to be helpful in understanding how the COH operates.

**a. NMAC Biomedical HIV Prevention Summit | April 11-12, 2023**

Miguel Alvarez attended the National Minority AIDS Council (NMAC) Summit in Las Vegas, Nevada from April 11-12, 2023. He shared that the summit was overall sex positive and featured speakers from underrepresented communities affected by HIV, such as Black women and Native American people. He shared that he was grateful to live in California after hearing about the political situation affecting the

LGBTQ+ community in other states. The summit also covered the topics of doxycycline for HIV prevention and the development of the HIV vaccine. Felipe Findley asked how the COH can support other states. M. Alvarez suggested sending a letter of support.

**(7) Member Vacancies & Recruitment**

B. Gordon reported that there are 10 vacant unaffiliated consumer seats on the COH. Criteria for unaffiliated consumers includes the following: 1) be a person living with HIV; 2) a Ryan White Program client; and 3) not employed by an agency receiving funding for Ryan White Program Part A.

**a. Third Executive At-Large Seat Open Nomination & Elections**

**MOTION #5:** Approve third candidate(s) for Executive At-Large seat(s), as elected.
***✓Passed by Consent Calendar***

M. Alvarez was nominated for the third Executive At-Large seat, accepted the nomination, and was elected.

**C. CALIFORNIA OFFICE OF AIDS (OA) REPORT (PART B REPRESENTATIVE)** – *No report provided.*

**(1) OAVoice Newsletter Highlights**

**D. LA COUNTY DEPARTMENT OF PUBLIC HEALTH REPORT (PART A REPRESENTATIVE)**

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

**a. Programmatic and Fiscal Updates**

- **Unmet Need Presentation**

  Dr. Wendy Garland, DHSP staff, provided an unmet need presentation; see meeting packet for presentation slides. The presentation was followed by a robust question and answer session. Questions and feedback from the group included the following:

  - Daryl Russel asked if DPH has considered expanding the unmet need definition for the County by including care beyond medical services. Dr. Garland responded that this is addressed in the Ryan White Program utilization report.
  - Kevin Stalter asked how DHSP knows that 43% of infections are from not in care versus undiagnosed. Dr. Garland responded that DHSP used an analysis conducted by the Centers for Disease Control and Prevention (CDC). K. Stalter also inquired if the cause of the drop in new HIV infections can be attributed to COVID-19 and less testing.
  - Alasdair Burton asked if DHSP tracks demographics for where local residents are getting tested. Dr. Garland noted that this is a good question and will look into it.

- M. Pérez emphasized the need for other health systems, such as Medi-Cal, to provide HIV testing and care.
- Al Ballesteros asked how DHSP knows how many people are living with undiagnosed HIV. Dr. Garland responded that the DHSP surveillance team uses a standardized algorithm developed by the CDC to estimate the total number of new cases each year. Historical data and CD4 information are used to estimate how many people living with HIV (PLWH) are aware of their status.
- Jayda Arrington commented that more HIV awareness is needed across Los Angeles County (LAC).
- L. Maultsby commented that it is important to educate everyone who comes in for an HIV test on risky sexual behaviors.
- F. Findley requested if it is possible to send out mass HIV home test kits to increase testing rates.
- Dr. David Hardy commented that it was good to see that high priority populations [Latinx men who have sex with men (MSM) between the ages 18-40] are not getting late HIV diagnoses; however, it was concerning to see that cisgender Latinx women older than 45 are getting late diagnoses. The data show an unmet need for this population.
- D. Russell commented that data on why people are not getting tested are needed.
- J. Weedman and K. Stalter commented that HIV testers should refrain from asking excessive personal questions. M. Perez commented that it is important to ask questions to gain a better understanding of individual HIV risk factors. Robert Contreras agreed and noted that although certain questions are intrusive, they are necessary to collect sufficient data.

- **HRSA Ryan White Part A & EHE Site Visit** – *No report provided.*
- **DHSP Workforce Summit**
  Dawn McClendon, COH staff, reported on behalf of Julie Tolentino, DHSP staff, that the DHSP Workforce Summit held on March 16-17, 2023 had an excellent turnout. The summit was held based on feedback from frontline HIV service providers at the 2019 COH Annual Meeting as part of the workforce development efforts under the Ending the HIV Epidemic (EHE) Initiative. DHSP is hoping to hold another conference next year and is also

discussing a conference specifically for consumers, possibly in partnership with the COH.

Additional updates were reported as follows :

- ✓ Dr. Neva Chapeutte will be providing technical assistance and capacity building to the HIV workforce
- ✓ DHSP is launching a PrEP public health detailing program for providers that will reach over 1,000 providers.
- ✓ Being Alive is launching a buddy program that will provide peer support to people living with HIV which has been a program that K. Salter has been advocating for.
- ✓ The contract with Equity Impact Consulting has been executed to begin the needs assessment for Black-led agencies which was a recommendation from the Black Caucus.

- ✓ Ending the HIV Epidemic mini-grants, which were designed to support agencies and smaller CBOs to apply for County funds (another recommendation from the Black Caucus) to implement innovative interventions, are launching this month.

**b. Mpox Briefing Update**

M. Perez noted that there were no mpox cases in LAC in the past week.

**E. HOUSING OPPORTUNITIES FOR PEOPLE LIVING WITH AIDS (HOPWA) REPORT** – *No report provided.*

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

Part D: Dr. Mikhaela Cielo reported that the Los Angeles HIV Women's Task Force will be hosting a Women's Wellness Summit on Wednesday, May 17th from 8:00AM-3:00PM at the California Endowment. The event will feature yoga, Zumba, medication, nutrition information, and sound bath sessions for women living with or affected by HIV.

Part F: Sandra Cuevas reported that the AIDS Education and Training Center (AETC) just finished their nine-week HIV professional education program. She also reported that the AETC will be hosting Coping with Hope on Friday, May 26th at the California Endowment.

**G. CITIES, HEALTH DISTRICTS, SERVICE PLANNIN AREA (SPA) REPORTS**

City of Long Beach: Everardo Alvizo reported that the Long Beach HIV Planning Group met on April 12th and had a robust meeting. He also reported that the Long Beach Unified School District partnered with Planned Parenthood to provide sexual health education to high school students. E. Alvizo thanked those who attended the Transgender Day of Visibility event at Bixby Park and reported that the event was successful.

City of Los Angeles (CLA): Ricky Rosales reported that the Mayor's budget will be released on April 20th. CLA will have 24 hours to respond to the budget.

## 3. REPORTS – II

### A. OPERATIONS COMMITTEE

E. Alvizo provided the report. The Operations Committee last met on March 23rd from 10AM-12PM. The Committee welcomed new members L. Maultsby and J. Weedman to the COH. At the last meeting, the Committee heard from Miguel Alvarez for the March "Getting to Know You" exercise. At the April meeting, Jose Magaña will share a few things about himself. The next meeting will be held in-person on April 27th from 10AM-12PM.

**(1) Membership Management**

**a. New Member Applications**

The Committee conducted seven interviews in March. Two applicants met the criteria for unaffiliated consumers and the remaining applicants met the criteria for HIV stakeholder seats. There are approximately six applicants waiting to be interviewed.

**b. José Magaña | Seat Change from Alternate to Provider Representative #1**

**MOTION #6:** Approve Seat Change for José Magaña from Alternate to Provider Representative #1, as presented or revised. ✓***Passed by Consent Calendar***

**(2) Policies & Procedures**

**a. Policy #08.1104: Co-Chair Terms & Elections**

**MOTION #7:** Approve updates to Policy #08.1104: Co-Chairs Terms & Elections, as presented or revised ✓***Passed by Consent Calendar***

**b. Proposed Revisions to Code of Conduct | Public Comment Period: March 23-April 21, 2023**

At the last meeting, Jose Rangel-Garibay, COH staff, presented the proposed updates to the Code of Conduct. After review and discussion, the Committee decided to hold a 30-day public comment period and will continue the discussion at their April meeting.

**(3) Assessment of the Administrative Mechanism (AAM) | UPDATES**

At the last meeting, C. Barrit presented the final AAM document. The presentation slides can be found in the March Operations Committee meeting packet.

**(4) 2023 Training Series**

E. Alvizo reminded commissioners that all members are required to attend the live training sessions or view the recordings on the COH website.

**(5) Recruitment, Outreach & Engagement**

The Committee continues to identify opportunities and support members to participate in outreach, recruitment, and engagement activities to promote the COH and its work.

**B. PLANNING, PRIORITIES AND ALLOCATIONS (PP&A) COMMITTEE**

K. Donnelly provided the report. The PP&A Committee last met on March 21st and shared their short-term and long-term goals for the Committee. Dr. Michael Green, DHSP staff, shared his goal of using this restructuring period to rethink how the HIV service menu aligns with the migration of clients away from Ryan White Program-supported medical care for low-income individuals. Dr. Anthony Mills requested that the COH be involved in discussions with the County before decisions are made rather than being informed after the fact. The next meeting will take place on Tuesday, April 18th from 1-3PM at the Vermont Corridor.

**(1) Status Neutral Training & Technical Assistance Planning**

At the last meeting, the Committee shared long-term goals including moving toward status-neutral planning, the integration of the Prevention Planning Workgroup (PPW) with PP&A and working towards producing tangible results in ending the HIV epidemic. The Committee began a discussion around status neutral planning and developing a common understanding of a prevention and care planning approach to the priority planning and resource allocation process.

**C. STANDARDS AND BEST PRACTICES (SBP) COMMITTEE**

**(1) Oral Healthcare Service Standards**

**MOTION #8:** Approve Oral Healthcare Service Standards, as presented or revised.
***✓Passed by Consent Calendar***

**(2) Universal Service Standards and Patient Bill of Right | UPDATES**

K. Stalter reported that at the last meeting, the SBP Committee completed their review of the Universal Service Standards and the Patient Bill of Rights. The Committee will present their edits to the different COH subgroups before posting the item for a public comment period.

**(3) Medical Care Coordination (MCC) | REVIEW**

At the last meeting, the Committee heard from Dr. Garland who provided an update on a MCC workforce survey. COH staff are working with Dr. Garland to coordinate a presentation of the key highlights from the survey at a future SBP meeting.

The Committee also completed their initial read-through of the Nutrition Support Service Standards review and made a few edits and recommendations. The Committee will continue the review at their next meeting on Tuesday, May 2nd from 10AM-12PM.

**D. PUBLIC POLICY COMMITTEE (PPC)**

**(1) County, State and Federal Policy, Legislation, and Budget**

**a. 2023-2024 Legislative Docket Development**

L. Kochems reported that the PPC last met on April 3rd and dedicated the majority of their meeting to reviewing the 2023-2024 Legislative Docket. The PPC decided to split the docket by State and Federal bills. The PPC completed their positions on all State bills and will forward the first half of the docket to the Executive Committee for approval. At their next meeting, the Committee will finalize their stances on all Federal bills included in the docket.

**b. 2023-2024 Policy Priorities**

The Committee decided to table their discussion on the County Coordinated STD response memo to the Board of Supervisors (BOS).

**c. Presidential Advisory Council on HIV/AIDS (PACHA) Resolution on MSM Donation Deferral Policy**

The Committee reviewed the PACHA Resolution on MSM Blood Donation Deferral Policy and heard a report from COH staff regarding the recent Food and Drug Administration (FDA) proposed guidelines that would eliminate the current restrictions based on sexual orientation and replace them with a risk-based questionnaire for all blood donors. The BOS had a motion on their February 7, 2023 meeting agenda requesting a give-signature letter to FDA Commissioner Robert M. Califf in support of the newly proposed FDA guidelines. The motion was approved and the letter was sent on February 9, 2023.

**d. Braidwood v. Becerra Ruling**

On March 30, 2023, District Court Judge O'Connor issued a ruling that blocks the federal government from requiring health plans from requiring health plans to cover PrEP medications.

**e. County Coordinated STD Response**

The Committee tabled discussion on the STD response memo to the BOS.

**E. CAUCUS, TASK FORCE AND WORK GROUP REPORT**

**(1) Aging Caucus | June 13, 2023 @ 1-3PM **Virtual meeting***

K. Donnelly reported that the Aging Caucus began preliminary planning for an educational panel to commemorate National HIV/AIDS and Aging Awareness Day in September. The Caucus agreed to form a small group to do additional planning work. Dr. Paul Nash reported that he attended the American Society on Aging Conference where he was a keynote speaker and presented on the intersectionality of HIV and aging.

At the last meeting, Pamela Ogata, DHSP staff, reported that the workgroup on gerontology assessment and training for providers met on April 3, 2023. DHSP will begin reimagining Ambulatory Outpatient Medical (AOM) and Medical Care Coordination (MCC) services to include older adults.

The Caucus also discussed the best and strategic role for the Caucus to support HIV and aging related goals in the Comprehensive HIV Plan (CHP) 2022-2026.

**(2) Black/African American Caucus | April 20, 2023 @4-5 PM **Virtual meeting***

D. McClendon reported that the Caucus met on Thursday, March 23rd and discussed the needs assessment for Black-led and servicing organizations. Sean J. Lawrence, Laura Bogart, and Matt Mutchler presented findings from their research study Project Rise. The Caucus reviewed its workplan activities and proposed that the Caucus participate in the Taste of Soul on October 21, 2023 to fulfill its Community Engagement efforts. D. McClendon thanked all who attended the meeting for their participation and engagement.

**(3) Consumer Caucus | April 13, 2023 @ 2-4PM **Hybrid meeting (in-person & virtual)***

A. Burton reported that the Consumer Caucus last met on March 9th and debriefed on the March COH meeting. The Caucus agreed to change their meeting time to 1:30-3:00PM immediately following the full-body COH meeting. At their April meeting, the Caucus will hear from Chuy Orozco, who will provide a HOPWA report. Lunch will be provided.

**(4) Transgender Caucus | April 25, 2023 @ 10AM-12PM **In-person meeting @ Vermont Corridor***

J. Rangel-Garibay reported that the Transgender Caucus last met on March 28th and elected Xelestiál Moreno-Luz as their 2023 co-chair. The Caucus will host their next meeting in-person on April 25th from 10-11:30AM at the Vermont Corridor. The meeting will feature a presentation on the COH and the role of the Transgender Caucus, a review of the COH legislative docket, and a presentation from Camila Camaleón who will discuss her advocacy work on transgender health at a statewide level.

**(5) Women's Caucus | April 17, 2023 @ 2-4PM **Virtual meeting***

Shary Alonzo reported that there are no new updates since the last Women's Caucus meeting on January 23rd. The Caucus decided to meet quarterly, and their next meeting will take place on April 17th, where they will begin planning for a two-part Virtual Lunch and Learn series to address coping with grief and loss.

**(6) Vision & Mission Statement Review Workgroup | **No meetings scheduled***

K. Donnelly reported that the Mission & Vision Workgroup engaged in a robust brainstorming session to review and propose updates to the COH Mission & Vision statements. The workgroup discussed the importance of focusing on inclusivity and equity; infusing status neutral language; addressing whole person care; social determinants of health; and incorporating elements of the EHE pillars. The Workgroup presented the updates to the Executive Committee on March 23rd and requested that a 30-day public comment period be initiated to garner feedback from commissioners. The public comment period ends on April 21st. See meeting packet for revised Vision & Mission statements.

**(7) Prevention Planning Workgroup | May 24, 2023 @ 4-5:30PM **Virtual meeting***

K. Donnelly reported that the PPW last met on March 22nd and continued their discussion on status neutral planning. The PPW also discussed how to incorporate the consumer voice into the conversation, hosting regional townhall discussions, and collaborating with other commissions that work with priority populations. Lizette Martinez, COH staff, provided a brief review of the revised 2023 workplan. The PPW also identified potential speakers to provide recommended capacity building trainings identified in the Knowledge, Attitudes, and Beliefs (KAB) survey results.

**(8) Bylaws Review Taskforce | TBD **Virtual meeting***

E. Alvizo reported that the Bylaws Review Taskforce met on April 10th and agreed to extend the deadline for member participation until April 27th. E. Alvizo and A. Burton were chosen to serve as Taskforce co-chairs. Felipe Gonzalez requested if HIV-negative individuals who use Ryan White Program prevention services could be considered unaffiliated consumers. C. Barrit responded that by HRSA's definition, unaffiliated consumers must be PLWH.

## 4. MISCELLANEOUS

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

*No public comments.*

**B. COMMISSION NEW BUSINESS ITEMS: Opportunity for Commission members to recommend new business items for the full body or a committee level discussion on non-agendized matters not posted on the agenda, to be discussed and (if requested) placed on the agenda for action at a future meeting, or matters requiring immediate action because of an emergency, or where the need to act arose after the posting of the agenda.**
Damone Thomas recommended including HIV counselors in the decision-making process. He also shared that there is a rise in the use of unregulated Viagra use.

**C. ANNOUNCEMENTS: Opportunity for members of the public to announce community events, workshops, trainings, and other related activities. Announcements will follow the same protocols as Public Comment.**
F. Findley announced that that the National Latinx Conference on HIV, HCV, and SUD will take place from May 11-13, 2023 in New Orleans. The conference will discuss several topics, including the intersection of HIV and incarceration.

**D. ADJOURNMENT AND ROLL CALL: Adjournment for the meeting of April 13, 2023**
The meeting was adjourned by B. Gordon at 12:43 PM. J. Stewart conducted roll call.

**ROLL CALL (PRESENT):** M. Alvarez, E. Alvizo, J. Arrington, A. Ballesteros, A. Burton, M. Cielo, K. Donnelly, F. Findley, F. Gonzalez, L. Kochems, J. Magaña, L. Maultsby, A. Mills, R. Rosales, K. Stalter, J. Weedman, and B. Gordon

| **MOTION AND VOTING SUMMARY** | | |
|---|---|---|
| **MOTION 1**: Approve remote attendance by Member(s) Pursuant to Assembly Bill 2449 Attendance Notification for "Emergency Circumstances", as presented. | No vote held. | **NO VOTE HELD** |
| **MOTION 2**: Approve meeting agenda, as presented or revised. | Passed by Consensus. | **MOTION PASSED** |
| **MOTION 3:** Approve meeting minutes, as presented or revised. | Passed by Consensus. | **MOTION PASSED** |
| **MOTION 4:** Approve Consent Calendar, as presented or revised | Passed by Consensus | **MOTION PASSED** |

| MOTION AND VOTING SUMMARY | | |
|---|---|---|
| **MOTION 5:** Approve third candidate(s) for Executive At-Large seat(s), as elected. | Passed by Consent Calendar | **MOTION PASSED** |
| **MOTION 6:** Approve Seat Change for José Magaña from Alternate to Provider Representative #1, as presented or revised. | Passed by Consent Calendar | **MOTION PASSED** |
| **MOTION 7:** Approve updates to Policy #08.1104: Co-Chairs Terms & Elections, as presented or revised. | Passed by Consent Calendar | **MOTION PASSED** |
| **MOTION 8:** Approve Oral Healthcare Service Standards, as presented or revised. | Passed by Consent Calendar | **MOTION PASSED** |

LOS ANGELES COUNTY COMMISSION ON HIV

# 2023 MEMBERSHIP ROSTER| UPDATED 4.17.23

| SEAT NO. | MEMBERSHIP SEAT | Commissioners Seated | Committee Assignment | COMMISSIONER | AFFILIATION (IF ANY) | TERM BEGIN | TERM ENDS | ALTERNATE |
|---|---|---|---|---|---|---|---|---|
| 1 | Medi-Cal representative | | | ***Vacant*** | | July 1, 2021 | June 30, 2023 | |
| 2 | City of Pasadena representative | 1 | EXC\|SBP | Erika Davies | City of Pasadena Department of Public Health | July 1, 2022 | June 30, 2024 | |
| 3 | City of Long Beach representative | 1 | EXC\|OPS | Everardo Alvizo, LCSW | Long Beach Health & Human Services | July 1, 2021 | June 30, 2023 | |
| 4 | City of Los Angeles representative | 1 | PP | Ricky Rosales | AIDS Coordinator's Office, City of Los Angeles | July 1, 2022 | June 30, 2024 | |
| 5 | City of West Hollywood representative | 1 | PP&A | Derek Murray | City of West Hollywood | July 1, 2021 | June 30, 2023 | |
| 6 | Director, DHSP | 1 | EXC | Mario Pérez, MPH | DHSP, LA County Department of Public Health | July 1, 2022 | June 30, 2024 | |
| 7 | Part B representative | 1 | PP&A | Karl Halfman, MA | California Department of Public Health, Office of AIDS | July 1, 2022 | June 30, 2024 | |
| 8 | Part C representative | 1 | PP | Leon Maultsby | Charles R. Drew University | July 1, 2022 | June 30, 2024 | |
| 9 | Part D representative | 1 | SBP | Mikhaela Cielo, MD | LAC + USC MCA Clinic, LA County Department of Health Services | July 1, 2021 | June 30, 2023 | |
| 10 | Part F representative | | | ***Vacant*** | | July 1, 2022 | June 30, 2024 | |
| 11 | Provider representative #1 | 1 | OPS | Jose Magana | The Wall Las Memorias | July 1, 2021 | June 30, 2023 | |
| 12 | Provider representative #2 | 1 | SBP | Andre Molette | Men's Health Foundation | July 1, 2022 | June 30, 2024 | |
| 13 | Provider representative #3 | 1 | SBP | Harold Glenn San Agustin, MD | JWCH Institute, Inc. | July 1, 2021 | June 30, 2023 | |
| 14 | Provider representative #4 | 1 | PP&A | LaShonda Spencer, MD | Charles Drew University | July 1, 2022 | June 30, 2024 | |
| 15 | Provider representative #5 | | | ***Vacant*** | | July 1, 2021 | June 30, 2023 | |
| 16 | Provider representative #6 | 1 | PP&A | Anthony Mills, MD | Men's Health Foundation | July 1, 2022 | June 30, 2024 | |
| 17 | Provider representative #7 | 1 | EXC | Alexander Luckie Fuller | APLA | July 1, 2021 | June 30, 2023 | |
| 18 | Provider representative #8 | 1 | SBP | Martin Sattah, MD | Rand Shrader Clinic, LA County Department of Health Services | July 1, 2022 | June 30, 2024 | |
| 19 | Unaffiliated consumer, SPA 1 | | | ***Vacant*** | | July 1, 2021 | June 30, 2023 | |
| 20 | Unaffiliated consumer, SPA 2 | | | ***Vacant*** | | July 1, 2022 | June 30, 2024 | |
| 21 | Unaffiliated consumer, SPA 3 | 1 | EXC\|OPS \|PP&A | Joseph Green | *Unaffiliated Consumer* | July 1, 2021 | June 30, 2023 | |
| 22 | Unaffiliated consumer, SPA 4 | | | ***Vacant*** | | July 1, 2022 | June 30, 2024 | |
| 23 | Unaffiliated consumer, SPA 5 | 1 | EXC\|SBP | Kevin Stalter | *Unaffiliated Consumer* | July 1, 2021 | June 30, 2023 | |
| 24 | Unaffiliated consumer, SPA 6 | 1 | OPS | Jayda Arrington | *Unaffiliated Consumer* | July 1, 2022 | June 30, 2024 | |
| 25 | Unaffiliated consumer, SPA 7 | | | ***Vacant*** | | July 1, 2021 | June 30, 2023 | Mallery Robinson (SBP) |
| 26 | Unaffiliated consumer, SPA 8 | 1 | EXC\|PP&A | Kevin Donnelly | *Unaffiliated Consumer* | July 1, 2022 | June 30, 2024 | |
| 27 | Unaffiliated consumer, Supervisorial District 1 | | | ***Vacant*** | | July 1, 2021 | June 30, 2023 | |
| 28 | Unaffiliated consumer, Supervisorial District 2 | 1 | EXC | Bridget Gordon | *Unaffiliated Consumer* | July 1, 2022 | June 30, 2024 | |
| 29 | Unaffiliated consumer, Supervisorial District 3 | 1 | SBP | Arlene Frames | *Unaffiliated Consumer* | July 1, 2021 | June 30, 2023 | Eduardo Martinez (SBP/PP) |
| 30 | Unaffiliated consumer, Supervisorial District 4 | | | ***Vacant*** | | July 1, 2022 | June 30, 2024 | |
| 31 | Unaffiliated consumer, Supervisorial District 5 | 1 | PP&A | Felipe Gonzalez | Unaffiliated Consumer | July 1, 2021 | June 30, 2023 | |
| 32 | Unaffiliated consumer, at-large #1 | | | ***Vacant*** | | July 1, 2022 | June 30, 2024 | |
| 33 | Unaffiliated consumer, at-large #2 | | | ***Vacant*** | | July 1, 2021 | June 30, 2023 | |
| 34 | Unaffiliated consumer, at-large #3 | | | ***Vacant*** | | July 1, 2022 | June 30, 2024 | |
| 35 | Unaffiliated consumer, at-large #4 | | | ***Vacant*** | | July 1, 2021 | June 30, 2023 | |
| 36 | Representative, Board Office 1 | 1 | EXC\|PP&A | Al Ballesteros, MBA | JWCH Institute, Inc. | July 1, 2022 | June 30, 2024 | |
| 37 | Representative, Board Office 2 | 1 | EXC\|OPS | Danielle Campbell, MPH | UCLA/MLKCH | July 1, 2021 | June 30, 2023 | |
| 38 | Representative, Board Office 3 | 1 | EXC\|PP | Katja Nelson, MPP | APLA | July 1, 2022 | June 30, 2024 | |
| 39 | Representative, Board Office 4 | 1 | EXC\|OPS | Justin Valero, MA | No affiliation | July 1, 2021 | June 30, 2023 | |
| 40 | Representative, Board Office 5 | 1 | PP&A | Jonathan Weedman | ViaCare Community Health | July 1, 2022 | June 30, 2024 | |
| 41 | Representative, HOPWA | 1 | PP&A | Jesus Orozco | City of Los Angeles, HOPWA | July 1, 2021 | June 30, 2023 | |
| 42 | Behavioral/social scientist | 1 | EXC\|PP | Lee Kochems | *Unaffiliated Consumer* | July 1, 2022 | June 30, 2024 | |
| 43 | Local health/hospital planning agency representative | | | ***Vacant*** | | July 1, 2021 | June 30, 2023 | |
| 44 | HIV stakeholder representative #1 | 1 | PP | Alasdair Burton | No affiliation | July 1, 2022 | June 30, 2024 | |
| 45 | HIV stakeholder representative #2 | 1 | PP | Paul Nash, CPsychol AFBPsS FHEA | University of Southern California | July 1, 2021 | June 30, 2023 | |
| 46 | HIV stakeholder representative #3 | 1 | PP | Pearl Doan | No affiliation | July 1, 2022 | June 30, 2024 | |
| 47 | HIV stakeholder representative #4 | 1 | PP&A | Redeem Robinson | No affiliation | July 1, 2021 | June 30, 2023 | |
| 48 | HIV stakeholder representative #5 | 1 | PP | Mary Cummings | Bartz-Altadonna Community Health Center | July 1, 2022 | June 30, 2024 | |
| 49 | HIV stakeholder representative #6 | 1 | PP | Felipe Findley, PA-C, MPAS, AAHIVS | Watts Healthcare Corp | July 1, 2021 | June 30, 2023 | |
| 50 | HIV stakeholder representative #7 | 1 | PP&A | William D. King, MD, JD, AAHIVS | W. King Health Care Group | July 1, 2022 | June 30, 2024 | |
| 51 | HIV stakeholder representative #8 | 1 | EXC\|OPS | Miguel Alvarez | No affiliation | July 1, 2022 | June 30, 2024 | |
| | **TOTAL:** | 37 | | | | | | |

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

**LOA: Leave of Absence**

Overall total: 39

LOS ANGELES COUNTY
COMMISSION ON HIV

# COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 3/21/23

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

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

| COMMISSION MEMBERS | | ORGANIZATION | SERVICE CATEGORIES |
|---|---|---|---|
| **CAMPBELL** | **Danielle** | UCLA/MLKCH | Oral Health Care Services |
| | | | Medical Care Coordination (MCC) |
| | | | Ambulatory Outpatient Medical (AOM) |
| | | | Transportation Services |
| **CIELO** | **Mikhaela** | LAC & USC MCA Clinic | Biomedical HIV Prevention |
| | | | HIV Testing Storefront |
| | | | HIV Testing Social & Sexual Networks |
| **CUMMINGS** | **Mary** | Bartz-Altadonna Community Health Center | No Ryan White or prevention contracts |
| **DAVIES** | **Erika** | City of Pasadena | HIV Testing Storefront |
| | | | HIV Testing & Sexual Networks |
| **DOAN** | **Pearl** | No Affiliation | No Ryan White or prevention contracts |
| **DONNELLY** | **Kevin** | Unaffiliated consumer | No Ryan White or prevention contracts |
| **FINDLEY** | **Felipe** | Watts Healthcare Corporation | Transportation Services |
| | | | Ambulatory Outpatient Medical (AOM) |
| | | | Medical Care Coordination (MCC) |
| | | | Oral Health Care Services |
| | | | Biomedical HIV Prevention |
| | | | STD Screening, Diagnosis and Treatment |
| **FRAMES** | **Arlene** | Unaffiliated consumer | No Ryan White or prevention contracts |
| **FULLER** | **LUCKIE** | APLA Health & Wellness | Case Management, Home-Based |
| | | | Benefits Specialty |
| | | | Nutrition Support |
| | | | HIV Testing Social & Sexual Networks |
| | | | STD Screening, Diagnosis and Treatment |
| | | | Sexual Health Express Clinics (SHEx-C) |
| | | | Health Education/Risk Reduction |
| | | | Biomedical HIV Prevention |
| | | | Oral Healthcare Services |
| | | | Ambulatory Outpatient Medical (AOM) |
| | | | Medical Care Coordination (MCC) |
| | | | HIV and STD Prevention Services in Long Beach |
| | | | Transportation Services |
| **GONZALEZ** | **Felipe** | Unaffiliated consumer | No Ryan White or Prevention Contracts |
| **GORDON** | **Bridget** | Unaffiliated consumer | No Ryan White or prevention contracts |

| COMMISSION MEMBERS | | ORGANIZATION | SERVICE CATEGORIES |
|---|---|---|---|
| **GREEN** | **Joseph** | Unaffiliated consumer | No Ryan White or prevention contracts |
| **HALFMAN** | **Karl** | California Department of Public Health, Office of AIDS | Part B Grantee |
| **KOCHEMS** | **Lee** | Unaffiliated consumer | No Ryan White or prevention contracts |
| **KING** | **William** | W. King Health Care Group | No Ryan White or prevention contracts |
| **MAGANA** | **Jose** | The Wall Las Memorias, Inc. | HIV Testing Storefront |
| | | | HIV Testing Social & Sexual Networks |
| **MARTINEZ** | **Eduardo** | AIDS Healthcare Foundation | Ambulatory Outpatient Medical (AOM) |
| | | | Benefits Specialty |
| | | | Medical Care Coordination (MCC) |
| | | | Mental Health |
| | | | Oral Healthcare Services |
| | | | STD Screening, Diagnosis and Treatment |
| | | | HIV Testing Storefront |
| | | | HIV Testing Social & Sexual Networks |
| | | | Sexual Health Express Clinics (SHEx-C) |
| | | | Transportation Services |
| | | | Medical Subspecialty |
| | | | HIV and STD Prevention Services in Long Beach |
| **MARTINEZ (PP&A Member)** | **Miguel** | Children's Hospital Los Angeles | Ambulatory Outpatient Medical (AOM) |
| | | | HIV Testing Storefront |
| | | | STD Screening, Diagnosis and Treatment |
| | | | Biomedical HIV Prevention |
| | | | Medical Care Coordination (MCC) |
| | | | Transportation Services |
| | | | Promoting Healthcare Engagement Among Vulnerable Populations |
| **MAULTSBY** | **Leon** | Charles R. Drew University | HIV Testing Storefront |
| | | | HIV Testing Social & Sexual Networks |

| COMMISSION MEMBERS | | ORGANIZATION | SERVICE CATEGORIES |
|---|---|---|---|
| **MILLS** | **Anthony** | Southern CA Men's Medical Group | Biomedical HIV Prevention |
| | | | Ambulatory Outpatient Medical (AOM) |
| | | | Medical Care Coordination (MCC) |
| | | | Promoting Healthcare Engagement Among Vulnerable Populations |
| | | | Sexual Health Express Clinics (SHEx-C) |
| | | | Transportation Services |
| **MINTLINE (SBP Member)** | **Mark** | Western University of Health Sciences (No Affiliation) | No Ryan White or prevention contracts |
| **MOLLETTE** | **Andre** | Southern CA Men's Medical Group | Biomedical HIV Prevention |
| | | | Ambulatory Outpatient Medical (AOM) |
| | | | Medical Care Coordination (MCC) |
| | | | Promoting Healthcare Engagement Among Vulnerable Populations |
| | | | Sexual Health Express Clinics (SHEx-C) |
| | | | Transportation Services |
| **MURRAY** | **Derek** | City of West Hollywood | No Ryan White or prevention contracts |
| **NASH** | **Paul** | University of Southern California | Biomedical HIV Prevention |

| COMMISSION MEMBERS | | ORGANIZATION | SERVICE CATEGORIES |
|---|---|---|---|
| **NELSON** | **Katja** | APLA Health & Wellness | Case Management, Home-Based |
| | | | Benefits Specialty |
| | | | Nutrition Support |
| | | | HIV Testing Social & Sexual Networks |
| | | | STD Screening, Diagnosis and Treatment |
| | | | Sexual Health Express Clinics (SHEx-C) |
| | | | Health Education/Risk Reduction |
| | | | Biomedical HIV Prevention |
| | | | Oral Healthcare Services |
| | | | Ambulatory Outpatient Medical (AOM) |
| | | | Medical Care Coordination (MCC) |
| | | | HIV and STD Prevention Services in Long Beach |
| | | | Transportation Services |
| | | | Nutrition Support |
| **OROZCO** | **Jesus ("Chuy")** | HOPWA-City of Los Angeles | No Ryan White or prevention contracts |
| **PERÉZ** | **Mario** | Los Angeles County, Department of Public Health, Division of HIV and STD Programs | Ryan White/CDC Grantee |
| **ROBINSON** | **Mallery** | We Can Stop STDs LA (No Affiliation) | No Ryan White or prevention contracts |
| **ROBINSON** | **Redeem** | All Souls Movement (No Affiliation) | No Ryan White or prevention contracts |
| **ROSALES** | **Ricky** | City of Los Angeles AIDS Coordinator | No Ryan White or prevention contracts |
| **SATTAH** | **Martin** | Rand Schrader Clinic<br>LA County Department of Health Services | Biomedical HIV Prevention |
| | | | HIV Testing Storefront |
| | | | HIV Testing Social & Sexual Networks |

| COMMISSION MEMBERS | | ORGANIZATION | SERVICE CATEGORIES |
|---|---|---|---|
| **SAN AGUSTIN** | **Harold** | JWCH, INC. | HIV Testing Storefront |
| | | | HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV) |
| | | | STD Screening, Diagnosis and Treatment |
| | | | Health Education/Risk Reduction |
| | | | Mental Health |
| | | | Oral Healthcare Services |
| | | | Transitional Case Management |
| | | | Ambulatory Outpatient Medical (AOM) |
| | | | Benefits Specialty |
| | | | Biomedical HIV Prevention |
| | | | Medical Care Coordination (MCC) |
| | | | Transportation Services |
| **SPENCER** | **LaShonda** | Oasis Clinic (Charles R. Drew University/Drew CARES) | Biomedical HIV Prevention |
| | | | HIV Testing Storefront |
| | | | HIV Testing Social & Sexual Networks |
| **STALTER** | **Kevin** | Unaffiliated consumer | No Ryan White or prevention contracts |
| **VALERO** | **Justin** | No Affiliation | No Ryan White or prevention contracts |
| **WEEDMAN** | **Jonathan** | ViaCare Community Health | Biomedical HIV Prevention |

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave, 14th Floor, Los Angeles, CA 90020
TEL. (213) 738-2816
WEBSITE: hiv.lacounty.gov | EMAIL: hivcomm@lachiv.org

***ALL COMMITTEE MEETINGS ARE HELD VIRTUALLY UNTIL FURTHER NOTICE***

# COMMITTEE ASSIGNMENTS

Updated: April 17, 2023
**Assignment(s) Subject to Change**

| EXECUTIVE COMMITTEE | | |
|---|---|---|
| Regular meeting day: 4th Thursday of the Month<br>Regular meeting time: 1:00-3:00 PM<br>Number of Voting Members= 14 \| Number of Quorum= 8 | | |
| **COMMITTEE MEMBER** | **MEMBER CATEGORY** | **AFFILIATION** |
| **Bridget Gordon** | **Co-Chair, Comm./Exec.*** | **Commissioner** |
| **Alexander Fuller** | **Co-Chair, Comm./Exec.*** | **Commissioner** |
| **Miguel Alvarez** | At-Large | Commissioner |
| **Everardo Alvizo, LCSW** | Co-Chair, Operations | Commissioner |
| **Al Ballesteros** | Co-Chair, PP&A | Commissioner |
| **Danielle Campbell, MPH** | At-Large | Commissioner |
| **Erika Davies** | Co-Chair, SBP | Commissioner |
| **Kevin Donnelly** | Co-Chair, PP&A | Commissioner |
| **Joe Green** | At-Large | Commissioner |
| **Lee Kochems** | Co-Chair, Public Policy | Commissioner |
| **Katja Nelson, MPP** | Co-Chair, Public Policy | Commissioner |
| **Mario Pérez, MPH** | DHSP Director | Commissioner |
| **Kevin Stalter** | Co-Chair, SBP | Commissioner |
| **Justin Valero, MA** | Co-Chair, Operations | Commissioner |

| OPERATIONS COMMITTEE | | |
|---|---|---|
| Regular meeting day: 4th Thursday of the Month<br>Regular meeting time: 10:00 AM-12:00 PM<br>Number of Voting Members= 7 \| Number of Quorum= 4 | | |
| **COMMITTEE MEMBER** | **MEMBER CATEGORY** | **AFFILIATION** |
| **Everardo Alvizo** | **Committee Co-Chair*** | **Commissioner** |
| **Justin Valero** | **Committee Co-Chair*** | **Commissioner** |
| **Miguel Alvarez** | * | Commissioner |
| **Jayda Arrington** | * | Commissioner |
| **Danielle Campbell** | * | Commissioner |
| **Joseph Green** | * | Commissioner |
| **Jose Magaña** | * | Alternate |

| PLANNING, PRIORITIES & ALLOCATIONS (PP&A) COMMITTEE | | |
|---|---|---|
| Regular meeting day: 3rd Tuesday of the Month<br>Regular meeting time: 1:00-4:00 PM<br>Number of Voting Members= 1 4\| Number of Quorum= 8 | | |
| **COMMITTEE MEMBER** | **MEMBER CATEGORY** | **AFFILIATION** |
| **Kevin Donnelly** | **Committee Co-Chair*** | Commissioner |
| **Al Ballesteros** | **Committee Co-Chair*** | Commissioner |
| **Felipe Gonzalez** | * | Commissioner |
| **Joseph Green** | * | Commissioner |
| **Karl Halfman, MA** | * | Commissioner |
| **William D. King, MD, JD, AAHIVS** | * | Commissioner |
| **Miguel Martinez, MPH** | ** | Committee Member |
| **Anthony Mills, MD** | * | Commissioner |
| **Derek Murray** | * | Commissioner |
| **Jesus "Chuy" Orozco** | * | Commissioner |
| **Redeem Robinson** | * | Commissioner |
| **LaShonda Spencer, MD** | * | Commissioner |
| **Jonathan Weedman** | * | Commissioner |
| **Michael Green, PhD** | DHSP staff | DHSP |

| PUBLIC POLICY (PP) COMMITTEE | | |
|---|---|---|
| Regular meeting day: 1st Monday of the Month<br>Regular meeting time: 1:00-3:00 PM<br>Number of Voting Members= 11 \| Number of Quorum= 6 | | |
| **COMMITTEE MEMBER** | **MEMBER CATEGORY** | **AFFILIATION** |
| **Lee Kochems, MA** | **Committee Co-Chair*** | Commissioner |
| **Katja Nelson, MPP** | **Committee Co-Chair*** | Commissioner |
| **Alasdair Burton** | * | Commissioner |
| **Mary Cummings** | * | Commissioner |
| **Pearl Doan** | * | Commissioner |
| **Felipe Findley, MPAS, PA-C, AAHIVS** | * | Commissioner |
| **Jerry Gates, PhD** | * | Commissioner |
| **Eduardo Martinez** | ** | Alternate |
| **Leon Maultsby** | * | Commissioner |
| **Paul Nash** | * | Commissioner |
| **Ricky Rosales** | * | Commissioner |

## STANDARDS AND BEST PRACTICES (SBP) COMMITTEE

**Regular meeting day: 1st Tuesday of the Month**
**Regular meeting time: 10:00AM-12:00 PM**
**Number of Voting Members = 11 | Number of Quorum = 6**

| COMMITTEE MEMBER | MEMBER CATEGORY | AFFILIATION |
|---|---|---|
| **Kevin Stalter** | **Committee Co-Chair*** | **Commissioner** |
| **Erika Davies** | **Committee Co-Chair*** | **Commissioner** |
| **Danielle Campbell** | * | Commissioner |
| **Mikhaela Cielo, MD** | * | Commissioner |
| **Arlene Frames** | * | Commissioner |
| **Mark Mintline, DDS** | * | Committee Member |
| **Andre Molette** | * | Commissioner |
| **Mallery Robinson** | * | Alternate |
| **Harold Glenn San Agustin, MD** | * | Commissioner |
| **Martin Sattah** | * | Commissioner |
| **Wendy Garland, MPH** | DHSP staff | DHSP |

## CONSUMER CAUCUS

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

## AGING CAUCUS

**Regular meeting day/time: 1st Tuesday of Each Month @ 1pm-3pm**
**Co-Chairs: Kevin Donnelly & Paul Nash**
***Open membership***

## TRANSGENDER CAUCUS

**Regular meeting day/time: 4th Tuesday of Every Other Month @ 10am-12pm**
**Co-Chairs: Yara Tapia & Xelestial Moreno**
***Open membership***

## WOMEN'S CAUCUS

**Regular meeting day/time: Virtual - 3rd Monday of Each Quarter @ 2-4:00pm**
**The Women's Caucus Reserves The Option of Meeting In-Person Annually**
**Next Meeting Scheduled For April 17th, 2023**
**Co-Chairs: Shary Alonzo & Dr. Mikhaela Cielo**
***Open membership***

## PREVENTION PLANNING WORKGROUP

**Regular meeting day/time: 4th Wednesday of Each Month @ 5:30pm-7:00pm**
**Chair: Miguel Martinez, Dr. William King & Greg Wilson**
***Open membership***

# Conflict of Interest and Affiliation Disclosure Form

Consistent with the Los Angeles County Code 3.29.046 (Conflict of Interest), the Los Angeles County Commission on HIV (Commission), members are required to abide by the Conflict of Interest and Disclosure requirements of the Commission, the County of Los Angeles, the State of California (including Government Code Sections 87100, 87103, and 1090, et seq.), the Ryan White Program, as outlined in Human Resources & Services Administration (HRSA) and relevant Center of Disease Control (CDC) prevention grant guidance. ***Please note that this Conflict of Interest and Affiliation Disclosure Form is not affiliated with and is separate from the County's Statements of Economic Interests - Form 700 required by the State of California Fair Political Practices Commission.***

*Conflict of Interest, for purposes of the Ryan White Program, is defined as having a financial interest in, serving as a board member, being employed by, having been employed by, or having a contract or agreement with, an organization, partnership, or any other entity, whether public or private, that receives Ryan White Part A funds*. These provisions extend to direct ascendants and descendants, siblings, spouses and domestic partners of Commission members and non-Commission Committee-only members*.

Additionally, as an integrated HIV prevention and care planning body for Los Angeles County, the Commission extends disclosure to those having a financial interest in, serving as a board member, being employed by, having been employed by, or having a contract or agreement with, an organization, partnership, or any other entity, whether public or private, that receives CDC HIV-prevention funding from Los Angeles County.**

**If you, a family member, or a member of your household also have a role as an employee or a Board member of an organization or agency that has received or is seeking Part A Program funds from Los Angeles County, please disclose that information below.*

***If you have a role as an employee or a Board member of an organization or agency that has received or is seeking CDC HIV-prevention funding through Los Angeles County, please disclose that information.*

**If you are a client and your only relationship with an organization or agency is that you receive, or are eligible for, services or you participate on a client or consumer advisory board, that would not be considered a conflict of interest.**

Commission Member Name: _____

As defined above, do you have a Conflict of Interest(s): ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

# Conflict of Interest and Affiliation Disclosure Form

***Affiliation Disclosure***

Regarding Ryan White Program Part A funding, please check the entities with which you (or your ascendants, descendants, siblings, spouses, or domestic partners) have been professionally affiliated with in the past twelve (12) months. Regarding CDC HIV-prevention funding, please check the entities with which you have been professional affiliated with in the past twelve (12) months. ****DO NOT CHECK AGENCIES WHERE YOU VOLUNTEER OR ARE A CLIENT***

- ☐ AIDS Healthcare Foundation
- ☐ African American AIDS Policy and Training Institute (d.b.a. Black AIDS Institute)
- ☐ Alliance for Housing and Healing
- ☐ AltaMed Health Services Corporation
- ☐ APLA Health & Wellness
- ☐ Asian American Drug Abuse Program
- ☐ Automated Case Management Services, Inc.
- ☐ Being Alive: People with AIDS Coalition
- ☐ Bienestar Human Services, Inc.
- ☐ Center for Health Justice, Inc.
- ☐ Central City Community Health Center
- ☐ Charles R. Drew University of Medicine & Science
- ☐ Children's Hospital of Los Angeles
- ☐ City of Long Beach, Dept of Health & Human Services
- ☐ City of Pasadena Public Health Department
- ☐ Coachman Moore & Associates, Inc.
- ☐ Community Health Alliance of Pasadena
- ☐ Dignity Health (dba St. Mary Medical Center)
- ☐ East Los Angeles Women's Center
- ☐ East Valley Community Health Center, Inc.
- ☐ El Centro del Pueblo
- ☐ El Proyecto del Barrio, Inc.
- ☐ Entercom California, LLC
- ☐ Essential Access Health
- ☐ Focus International, Inc. d.b.a. Focus Interpreting
- ☐ Friends Research Institute, Inc.
- ☐ Greater Los Angeles Agency on Deafness, Inc.
- ☐ Healthcare Staffing Solutions, Inc.
- ☐ Heluna Health
- ☐ In The Meantime Men's Group
- ☐ Inner City Law Center
- ☐ JWCH Institute, Inc.
- ☐ LAC+USC Foundation Medical Center Foundation, Inc.
- ☐ Los Angeles Centers for Alcohol & Drug Abuse
- ☐ Los Angeles LGBT Center
- ☐ Men's Health Foundation
- ☐ Minority AIDS Project
- ☐ Northeast Valley Health Corporation
- ☐ Project Angel Food
- ☐ Project New Hope
- ☐ Public Health Foundation Enterprises, Inc. (dba Heluna Health)
- ☐ Realistic Education in Action Coalition to Foster Health (dba REACH LA)
- ☐ Special Service for Groups
- ☐ St. John's Well Child and Family Center
- ☐ T.H.E. Clinic, Inc.
- ☐ Tarzana Treatment Centers, Inc.
- ☐ The Center Long Beach (One in Long Beach, Inc.)
- ☐ The Regents of California, University of Los Angeles (UCLA)
- ☐ The Salvation Army
- ☐ The Wall Las Memorias, Inc.
- ☐ University of Southern California
- ☐ USC- MCA Center Keck School of Medicine
- ☐ Venice Family Clinic
- ☐ Via Care Community Health Center, Inc.
- ☐ Watts Healthcare Corporation
- ☐ Westside Family Health Center
- ☐ Other Agency/Organization Not listed: _____


# Conflict of Interest and Affiliation Disclosure Form

All members are expected to comply with the foregoing disclosure of conflicts of interest and affiliations, as defined and in accordance with governing authority, to ensure that planning activities and decisions by the Commission are performed in a manner that promotes transparency in meeting the needs of people living with and impacted by HIV in Los Angeles County.

By signing below, you are acknowledging that all the information provided on this form is true and accurate and that you have described any and all relationship with Ryan White Part A and CDC HIV-prevention funded providers.

Print Name: _____

Signature:_____Date: ____/____/_____

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Resources and Services Administration

Rockville, MD 20857
HIV/AIDS Bureau

April 26, 2023

Dear Ryan White HIV/AIDS Program Colleagues:

As sexually transmitted infections (STIs), including the recent mpox outbreak, continue to have a disproportionate impact on people with HIV, the Health Resources and Services Administration's (HRSA) HIV/AIDS Bureau's (HAB) Ryan White HIV/AIDS Program (RWHAP) plays a critical role in addressing STIs for people with HIV. This includes access to treatment for STIs through RWHAP AIDS Drug Assistance Program (ADAP) formularies.

ADAPs ensure that eligible people with HIV can access medications that improve individual health outcomes and reduce HIV transmission. Similarly, affordable access to STI treatment decreases the potential for STI transmission. While many ADAP formularies may already provide access to medications used to treat STIs, ADAPs are encouraged to review their formulary to ensure that all preferred and second line medications recommended in the STI treatment guidelines are included, especially in jurisdictions with higher STI prevalence.

The 2022-2025 National HIV/AIDS Strategy (NHAS)[1] identifies HIV and STIs as syndemic conditions that adversely interact with each other and contribute to a greater impact of disease and ongoing health disparities and inequities. Rates of STIs are higher among people with HIV than people without HIV, and people with HIV who have one or more STI are more likely to transmit HIV to a partner. Furthermore, people without HIV with one or more STIs are more likely to contract HIV.[2] Overall, STI rates have increased across the U.S. since 2017, posing an alarming risk both for people with HIV and for new HIV infections,[3] especially impacting NHAS priority populations including communities of color, men who have sex with men (MSM), heterosexual women, and youth.[4]

Per the RWHAP statute, RWHAP recipients and subrecipients are required to follow the federally approved HIV clinical practice guidelines, including the Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV, which cover the treatment of STIs. In addition, the 2021 STI Treatment Guidelines[5] from the Centers for Disease Control and Prevention (CDC) include updated treatment recommendations and expanded risk factor-based testing for select STIs. When implemented as recommended, the revised guidelines can reduce barriers to STI treatment, decrease transmission rates, and improve cure rates.

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[1] National HIV/AIDS Strategy for the United States 2022-2025

[2] Sexually transmitted infections and HIV in the era of antiretroviral treatment and prevention: the biologic basis for epidemiologic synergy.

[3] https://www.cdc.gov/std/hiv/stdfact-std-hiv-detailed.htm

[4] National HIV/AIDS Strategy for the United States 2022-2025

[5] CDC Releases 2021 STI Treatment Guidelines

During the recent mpox outbreak, the infection was primarily spread through sexual contact. Although an effective response that included vaccination has led to a decrease in new cases and the expiration of the mpox public health emergency,[6] low-level mpox transmission is still occurring and could lead to another outbreak, especially among individuals engaging in sex while attending large community gatherings. Therefore, it is important to remain aware of current mpox vaccination and testing recommendations, particularly for people with HIV who are immunocompromised, as they are more likely to have severe mpox disease. New resources are now available on the CDC's website about how individuals can stay healthy throughout the summer.[7] Please also visit the HRSA HAB mpox webpage[8] for more information, including how RWHAP services can support mpox vaccination.

Please contact your HRSA HAB project officer if you have questions. Thank you for working with us to support the health and safety of people with HIV.

Sincerely,

/Laura W. Cheever/

Laura Cheever, MD, ScM
Associate Administrator
HIV/AIDS Bureau

[6] Statement From HHS Secretary Becerra on mpox
[7] https://www.cdc.gov/lgbthealth/summer/index.html
[8] https://ryanwhite.hrsa.gov/resources/mpox

April 12, 2023

Dear Recipients:

In recent years, numerous HIV outbreaks among people experiencing homelessness and housing instability have been identified[i]. Housing status is a social determinant of health that has a significant impact on HIV prevention and care outcomes. The experiences of homelessness and housing instability are linked to higher viral loads and failure to attain or sustain viral suppression[ii] among people with HIV. The Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program (RWHAP) clients with unstable or temporary housing have lower levels of viral suppression than those with stable housing (77.3% clients versus 90.8%) clients [iii]. Homelessness and housing instability are also associated with increased vulnerability for HIV acquisition. Stable housing provides a foundation from which people can participate in HIV prevention services and is associated with reductions in behaviors associated with getting or transmitting HIV[iv].

The National HIV/AIDS Strategy for the United States (2022-2025) sets a bold target to decrease homelessness and housing instability for people with HIV by 50 percent. The Strategy also calls for improved coordination among federal, state, and local governments and community-based organizations to quickly detect and respond to HIV outbreaks[v]. As such, the Centers for Disease Control and Prevention (CDC) Division of HIV Prevention, the U.S. Department of Housing and Urban Development (HUD) Office of HIV/AIDS Housing (OHH), and HRSA's HIV/AIDS Bureau (HAB) have partnered on recent responses to HIV outbreaks among people experiencing homelessness and housing instability.

Based on the lessons learned through our joint outbreak response efforts, CDC, HUD, and HRSA encourage communities to take the following actions to effectively prepare for and respond to these outbreaks:

- Health departments and housing providers should integrate and assess HIV prevention, care, and housing data on individuals impacted by outbreaks to

determine the extent to which they are experiencing homelessness or housing instability and to identify gaps and coordinate service delivery to improve housing stability and health outcomes.

- Personnel involved with outbreak response should assess HIV prevention, care, and treatment needs and leverage all available resources to establish integrated models of service delivery that meet people where they are.
- Individuals engaged in local outbreak response efforts should identify and leverage housing resources to assist people experiencing homelessness and housing instability in their community in addition to those available through HUD's Housing Opportunities for Persons With AIDS (HOPWA) program. Although HOPWA is a critical housing program for people with HIV, current funding does not meet the need for housing services for this population. In addition, HOPWA is unable to serve people who do not have HIV. Information on non-HOPWA housing resources can be found in the attached APPENDIX Federal Support for Housing Services and HIV Outbreak Response.
- Housing providers should implement Housing First and other low-barrier housing models that offer flexibility, individualized support, and client choice in the provision of housing assistance and supportive services, including integration with substance use disorder services.
- Housing providers should explore shared housing arrangements to foster social connection, decrease housing costs, and expand available units to people with HIV and those without HIV who need prevention services.
- Housing providers should use grant funds for housing navigator positions to partner with HIV prevention and care outreach workers to provide linkage and referrals to housing programs and resources for people experiencing homelessness or housing instability.

These recommendations are based on experiences in communities with HIV outbreaks among people experiencing homelessness and housing instability. In these communities, people with HIV may also experience a variety of additional challenges, including substance use, mental health disorders, other infectious and non-infectious diseases, incarceration, food insecurity, unemployment, trauma and loss, and stigma[vi]. Some communities experienced difficulties in responding to these outbreaks due to a lack of low-barrier or Housing First housing options, including insufficient options for people with a history of incarceration or people who actively use injection drugs. Another barrier to HIV prevention efforts was limited capacity for substance use disorder services. In addition, the jurisdictions reported a need for flexible housing assistance models to serve those at different

stages of homelessness or housing instability, regardless of their HIV status, to transition to safe, stable housing with social support.

The lessons learned from these recent outbreak response efforts underscore the need for ongoing collaboration among state and local public health, healthcare, housing, and social services providers to prepare for and respond to HIV outbreaks, reduce HIV transmission, and improve HIV care and viral suppression outcomes. In at least two of these communities, Homeless Management Information System (HMIS) data provided important insights to HIV surveillance staff in identifying needs and guiding efforts to determine eligibility for and link people to appropriate housing and services as available.

In all the communities that experienced outbreaks, the assessment of service gaps played a critical role in addressing both immediate and long-term service needs. State and local health departments worked with service providers to expand service delivery, including co-location of services, training and capacity development at sites, and the establishment of new partnerships with trusted providers in the community. Many of these activities can be done before an outbreak occurs, as identifying gaps and developing new models of service delivery strengthen the overall system of care for all people regardless of HIV status.

As we work to end the HIV epidemic, collaboration among public health, healthcare, housing, and social services providers is critical for effective detection and response to outbreaks and the prevention of future outbreaks among people experiencing homelessness or housing instability. Community efforts to provide safe and stable housing, reduce new HIV infections, and increase access to care and support for people with HIV, are necessary in order to achieve the goals of the National HIV/AIDS Strategy and the Ending the HIV Epidemic in the U.S. (EHE) Initiative. We look forward to our continued federal collaboration and work with our state and local partners to take actions to end the HIV epidemic in the United States.

Sincerely,

/Jonathan Mermin/
Jonathan H. Mermin, MD, MPH
Rear Admiral and Assistant Surgeon General, USPHS
Director

National Center for HIV, Viral Hepatitis, STD, and TB Prevention
Centers for Disease Control and Prevention

/Jemine A. Bryon/
Jemine A. Bryon
Deputy Assistant Secretary
Office of Special Needs
Housing and Urban Development

/Laura Cheever/
Laura Cheever, MD, ScM
Associate Administrator
HIV/AIDS Bureau
Health Resources and Services Administration

**APPENDIX**
**Federal Support for Housing Services and HIV Outbreak Response**

## HUD

It is especially important that HUD-funded organizations engage in HIV outbreak response efforts to house and stabilize people with HIV and people who do not have HIV but would benefit from prevention services. Grant funding under HUD's Housing Opportunities for Persons With AIDS (HOPWA) program can be used to support a range of housing assistance types and supportive services for low-income people with HIV and their families. Grant funding under HUD's Continuum of Care (CoC) and Emergency Solutions Grants (ESG) programs can be used to provide emergency, transitional, and permanent housing, outreach, and supportive services to individuals and families experiencing homelessness who are either HIV-positive or those who need HIV prevention services. In addition, these programs can fund housing search activities for eligible individuals and families.

The HOPWA, CoC, and ESG programs allow for shared housing arrangements where one or more individuals or households agree to share the space and cost of a permanent rental housing unit. The benefits of shared housing models include increased social connection and decreased isolation, reduced housing costs, and opportunity to access better housing options. These programs also promote the adoption of Housing First principles by funded housing providers, which include having few programmatic prerequisites, low-barrier admission policies, quick and successful connection to permanent housing, proactively offered but voluntary supportive services, and a focus on housing stability.

HUD staff and technical assistance (TA) providers can offer guidance and support to communities encountering an HIV outbreak among people experiencing homelessness or housing instability. Individuals engaged in outbreak detection and response efforts should contact their local HUD Office of Community Planning and Development (CPD), which can provide information and facilitate connections to local housing and service providers and can coordinate with Office of HIV/AIDS Housing and other HUD staff to provide guidance and technical assistance to assist with outbreak response efforts on the HUD Exchange TA portal. HMIS Privacy and Security Standards: Emergency Data Sharing for Public Health or Disaster Purposes includes information for communities covered under HMIS Privacy and Security Standards of the capabilities and limitations of sharing client information during public health or disaster emergencies.

As people of color are overrepresented in both the HIV epidemic and in the numbers of people experiencing homelessness, HUD recognizes the need for communities to better understand and address these issues. The Racial Equity page on the HUD Exchange website includes resources, data toolkits, and research reports related to identifying disparities and implementing responses to address the overrepresentation of people of color in the homeless system.

Congress appropriated significant additional resources to HUD to help communities respond to COVID-19 and the resulting economic crisis, including funding under the Coronavirus Aid, Relief, and Economic Security (CARES) Act and the American Rescue Plan (ARP) that are being utilized to address homelessness and housing instability. The HOPWA and ESG programs were allocated supplemental grant funds under the CARES Act that communities may use for COVID-19 preparedness and response activities, including rental assistance, homelessness prevention, and supportive services for people with HIV and people experiencing homelessness. ARP funding is being administered through HUD's HOME Investment Partnerships (HOME) program and has the purpose of assisting individuals or households who are homeless or at risk of homelessness and other vulnerable populations by providing housing, rental assistance, supportive services, and non-congregate shelter, to reduce homelessness and increase housing stability.

**HRSA**

RWHAP funding can be used for a variety of support services, including housing, that help people with HIV stay in HIV care and treatment. RWHAP recipients determine which services to fund depending on community needs and resources. The allowable support services, such as housing, can help bridge gaps that exist in the current services and help limited resources stretch further.

The RWHAP AIDS Education and Training Center (AETC) Program provides training that is critical to capacity development in areas experiencing an HIV outbreak or at risk for an outbreak. Available training includes HIV testing, preexposure prophylaxis (PrEP), HIV treatment, and integrating mental health and substance use treatment into HIV care, as well as other topics that can help address service needs. Communities have been able to successfully expand HIV care and treatment in non-traditional settings that have resulted in integrated models, such as one-stop shops.

In 2017, HRSA and HUD released a joint statement to funded organizations encouraging the sharing of data across systems to better coordinate and integrate

medical and housing services for people with HIV. In 2019, the agencies released a toolkit for service providers with best practices for sharing data and improving service coordination.

The Bureau of Primary Health Care's (BPHC) National Health Care for the Homeless Program supports community-based organizations to provide high-quality, accessible health care, including HIV prevention services, to people experiencing homelessness.

**CDC**

CDC's Division of HIV Prevention provides technical assistance and support for responding to HIV clusters and outbreaks. CDC support can include assistance with epidemiologic analysis and interpretation, connection with peers across the country doing similar work, identification of promising best practices and innovative delivery of prevention activities, and assistance with planning and implementing response activities for specific clusters or outbreaks. Organizations with needs or interests related to HIV outbreak response in their community should contact their state or local health department, who can facilitate collaboration with CDC as needed.

CDC also funds a Capacity Building Assistance (CBA) Provider Network to provide free CBA services to state and local health departments, community-based organizations, and healthcare organizations to support their implementation of high-impact HIV prevention initiatives. Providers can provide support in several areas, including addressing social determinants of health, HIV services for disproportionately impacted populations, such as those experiencing homelessness or unstable housing, and cluster detection and response. More information on each organization funded can be found in the CBA Provider Service Directory. Additionally, online, virtual, and in-person trainings are available, including a training on homelessness for public health providers.

CDC funds state and local health departments to implement evidence-based, high-impact programs to improve access to HIV and other health and social services; this includes a range of activities related to detecting and responding to HIV clusters and outbreaks. CDC also prioritizes hearing from and collaborating with people with HIV through roundtables, town halls, and ongoing community listening sessions focused on issues that intersect with HIV and affect health outcomes, including housing.

Through the Ending the HIV Epidemic in the U.S. Initiative (EHE), CDC funds 32 state and local health departments to implement locally tailored and integrated solutions to meet the unique needs of their communities, including flexibilities to use funds to support housing. CDC also funds over 100 community-based organizations and their clinical partners to deliver comprehensive HIV services to communities disproportionately affected by HIV. In addition, CDC supports the Housing Learning Collaborative, a virtual learning community to build capacity of EHE jurisdictions to develop and implement innovative programs to respond to housing-related needs. CDC published an issue brief on the role of housing in Ending the HIV Epidemic and federal efforts to address housing and HIV more broadly.

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[i] Lyss S, Buchacz K, McClung RP, Asher A, Oster AM. Responding to Clusters and Outbreaks of Human Immunodeficiency Virus Among People Who Inject Drugs: Recent Experience and Lessons Learned. *J Infect Dis*. 2020 Sep 2;222(Supplement_5): S239-S249.

[ii] Aidala, A. A., Wilson, M. G., Shubert, V., Gogolishvili, D., Globerman, J., Rueda, S., Bozack, A. K., Caban, M., & Rourke, S. B. Housing Status, Medical Care, and Health Outcomes Among People Living With HIV/AIDS: A Systematic Review. *American Journal of Public Health*, 106(1), e1–e23. 2016.

[iii] Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2021. ryanwhite.hrsa.gov/data/reports. Published December 2022.

[iv] Aidala, et al. 2016.

[v] The White House. National HIV/AIDS Strategy for the United States 2022–2025. Washington, DC. 2021.

[vi] Lyss, et. al. 2020

**FOR DISCUSSION PURPOSES ONLY**
**Health Resources and Services Administration (HRSA)**
**Ryan White Program Part C Recipients in Los Angeles County**
**and**
**Bureau of Primary Health Care (BPHC) Ending the HIV Epidemic Primary Care HIV Prevention Recipients in Los Angeles County**
***Orange text – denotes representation on the Commission on HIV as of 4/19/23 (includes alternates)***

## I. Ryan White Program Part C Early Intervention Services (EIS) Recipients – FY 2021 & 2022

- Part C EIS grants fund primary health care and support services in outpatient settings for people with HIV.
- Funding for 3 years, with new and competing continued issued via a Notice of Funding Opportunity.

| ORGANIZATION NAME | AWARD AMOUNT FY 2021 | AWARD AMOUNT FY 2022 |
|---|---|---|
| AIDS Healthcare Foundation | $299,983 | $1,387,211 |
| AltaMed Health Services Corporation | $918,952 | $852,385 |
| Bartz-Altadonna Community Health Center | $280,589 | $252,136 |
| Charles R. Drew University of Medicine and Science | $403,977 | $346,542 |
| Dignity Health - DBA Saint Mary Medical Center | $881,556 | $822,885 |
| El Proyecto Del Barrio | $192,495 | $198,511 |
| JWCH Institute, Inc. | $262,990 | $296,870 |
| T.H.E. Clinic, Inc. | $307,859 | $271,537 |
| Tarzana Treatment Centers, Inc. | $356,514 | $306,750 |
| Northeast Valley Health Corporation | $447,805 | $450,822 |
| University of Southern California, School of Medicine | $325,259 | $345,859 |
| Venice Family Clinic | $319,569 | $302,322 |
| Watts Healthcare Corporation | $275,727 | $255,214 |
| Los Angeles LGBT Center | $779,075 | $738,484 |
| **TOTAL AMOUNT** | **$6,052,350** | **$6,827,528** |

**Ryan White Program Part C Capacity Development Recipients – FY 2022**

- Part C Capacity Development grants help organizations strengthen their infrastructure. This helps grant recipients improve their ability to develop, enhance, or expand access to high-quality HIV primary health care services for people with HIV in low-income or rural communities.
- Funding for 1 year

| ORGANIZATION NAME | AWARD AMOUNT FY 2022 |
|---|---|
| Bartz-Altadonna Community Health Center | $150,000 |
| Bienestar Human Services, Inc. | $150,000 |
| East Valley Community Health Center, Inc. | $150,000 |
| St. John's Well Child And Family Center, Inc. | $150,000 |
| Via Care Community Health Center, Inc. | $150,000 |
| **TOTAL AMOUNT** | **$750,000** |

## II. HRSA Bureau of Primary Health Care (BPHC) Ending the HIV Epidemic Primary Care HIV Prevention Recipients in Los Angeles County

**Award recipients will use funds to increase the:**

- Number of patients counseled and tested for HIV.
- Number of patients prescribed pre-exposure prophylaxis (PrEP).
- Percentage of patients newly diagnosed with HIV who are linked to care and treatment within 30 days of diagnosis.

**FY 2020 Awards in Los Angeles County**

| ORGANIZATION NAME | CITY | AWARD AMOUNT |
|---|---|---|
| ALTAMED HEALTH SERVICES CORPORATION | LOS ANGELES | $417,912 |
| APLA HEALTH & WELLNESS | LOS ANGELES | $261,233 |
| BARTZ-ALTADONNA COMMUNITY HEALTH CENTER | LANCASTER | $256,071 |
| BEHAVIORAL HEALTH SERVICES INC | GARDENA | $252,468 |
| CENTRAL CITY COMMUNITY HEALTH CENTER, INC. | ROSEMEAD | $268,231 |
| CLINIC INC, THE | LOS ANGELES | $263,355 |
| EAST VALLEY COMMUNITY HEALTH CENTER INC | WEST COVINA | $264,715 |
| EL PROYECTO DEL BARRIO, INC | ARLETA | $268,099 |
| JWCH INSTITUTE, INC. | COMMERCE | $289,548 |
| LOS ANGELES LGBT CENTER | LOS ANGELES | $278,196 |
| NORTHEAST VALLEY HEALTH CORPORATION | SAN FERNANDO | $329,066 |
| ST. JOHN'S WELL CHILD AND FAMILY CENTER, INC. | LOS ANGELES | $305,039 |
| VALLEY COMMUNITY HEALTHCARE | NORTH HOLLYWOOD | $274,893 |
| VENICE FAMILY CLINIC | VENICE | $264,541 |

| ORGANIZATION NAME | CITY | AWARD AMOUNT |
|---|---|---|
| WATTS HEALTHCARE CORPORATION | LOS ANGELES | $270,534 |
| **TOTAL AMOUNT** | | **$4,263,901** |

**FY 2021 Awards in Los Angeles County**

| ORGANIZATION NAME | CITY | AWARD AMOUNT |
|---|---|---|
| ALL-INCLUSIVE COMMUNITY HEALTH CENTER | BURBANK | $342,098 |
| CENTER FOR FAMILY HEALTH & EDUCATION, INC. | PANORAMA CITY | $345,137 |
| CENTRAL NEIGHBORHOOD HEALTH FOUNDATION | LOS ANGELES | $348,808 |
| EISNER PEDIATRIC & FAMILY MEDICAL CENTER | LOS ANGELES | $365,537 |
| HARBOR COMMUNITY CLINIC | SAN PEDRO | $341,063 |
| HEALTH ACCESS FOR ALL, INC. | LOS ANGELES | $344,157 |
| LOS ANGELES CHRISTIAN HEALTH CENTERS | LOS ANGELES | $347,216 |
| MISSION CITY COMMUNITY NETWORK, INC. | NORTH HILLS | $342,198 |
| POMONA COMMUNITY HEALTH CENTER DBA PARKTREE CHC | POMONA | $345,963 |
| SAN FERNANDO COMMUNITY HOSPITAL | SAN FERNANDO | $340,405 |
| SOUTH CENTRAL FAMILY HEALTH CENTER | LOS ANGELES | $353,475 |
| SOUTHERN CALIFORNIA MEDICAL CENTER, INC. | EL MONTE | $346,672 |
| THE LOS ANGELES FREE CLINIC | LOS ANGELES | $348,195 |
| UNIVERSAL COMMUNITY HEALTH CENTER | LOS ANGELES | $342,870 |
| VIA CARE COMMUNITY HEALTH CENTER, INC. | LOS ANGELES | $346,411 |
| WESTSIDE FAMILY HEALTH CENTER | SANTA MONICA | $345,390 |
| YEHOWA MEDICAL SERVICES | CARSON | $338,781 |
| **TOTAL AMOUNT** | | **$3,450,360** |

**FY 2022 Awards in Los Angeles County**

| ORGANIZATION NAME | CITY | AWARD AMOUNT |
|---|---|---|
| CHILDREN'S CLINIC 'SERVING CHILDREN AND THEIR FAMILIES' THE | Long Beach | $325,000 |
| COMMUNITY MEDICAL WELLNESS CENTERS, USA | Long Beach | $325,000 |
| ASIAN PACIFIC HEALTH CARE VENTURE, INC. | Los Angeles | $325,000 |
| BENEVOLENCE INDUSTRIES INCORPORATED | Los Angeles | $325,000 |

| ORGANIZATION NAME | CITY | AWARD AMOUNT |
|---|---|---|
| CHINATOWN SERVICE CENTER | Los Angeles | $325,000 |
| UNIVERSITY MUSLIM MEDICAL ASSOCIATION, INC. | Los Angeles | $325,000 |
| COMMUNITY HEALTH ALLIANCE OF PASADENA | Pasadena | $325,000 |
| **TOTAL AMOUNT** | | **$2,275,000** |

HARVARD T.H. CHAN
SCHOOL OF PUBLIC HEALTH
Office of Diversity and Inclusion

# Equity Lens for Decision Making

Below are the current equity lens questions for use in planning, decision-making and implementation for policies, practices, and programs. These are a guide only, and there may be other factors to consider. The Lens is an ever-evolving tool for decision making, that changes as our constructs and understandings change.

## SECTION 1: Basic Racial Equity Lens

1. What is the policy, program or decision under review?
2. What racial, cultural and/or ethnic group(s) experience disparities related to this policy, program or decision? Are they at the table? (If not, why?)
3. How might the policy, program or decision affect the group(s)? How might it be perceived by the group(s)?
4. Does the policy, program or decision improve, worsen, or make no change to existing disparities? Please elaborate. Does it result in systemic change that addresses institutional racism?
5. Does the policy, program, or decision produce any intentional benefits or unintended consequences for the affected group(s)?
6. Based on the above responses, what are the possible revisions to the policy, program, or decision under review?
7. What next step is recommended and how will it be advanced?

*Adapted from: Portland State University Equity Lens Assessment Tool*

## SECTION 2: Multi-Dimension Equity Lens

(Broad inclusion of multiple as well as intersecting historically marginalized groups and underserved populations) These questions provide more global considerations and speak to macro issues such as policy as well as individual project, program or micro issue decision making, action and implementation.

### People

- How have we adequately ensured that our operational processes are inclusive and that elements of the process have not created barriers to meaningful participation?
- Which stakeholder groups would we like to have included but were unable to facilitate?
- Who is affected—positively, negatively, or not at all—by this decision, process, and actions? List positives and negatives.
- What are the specific ways this decision, process, or action, etc. is expected to reduce disparities and advance social justice?
- How have you intentionally involved stakeholders who are also members of the communities affected by the strategic investment or resource allocation? How do you validate your assessment?

### Place

- On the basis of Harvard Chan School of Public Health's social, physical and cultural location, how does this process compensate for access limitations of various stakeholder groups?
- How have we modified our process to support access by marginalized community stakeholders?

### Process

- How are our processes supporting the empowerment of communities historically most affected by inequities?
- How are processes ensuring that participants' emotional and physical safety needs are addressed?
- How are processes supporting participants' need to be productive and feel valued?
- How are our processes building ongoing community capacity for involvement with Harvard Chan School of Public Health by those communities historically most affected by inequities?
- How are we using this opportunity to contribute to the leadership development of those from marginalized communities?
- What types of biases have influenced the work of your group and how have these been identified and addressed?
- What improvements to team processes can you support for naming and identifying unaddressed bias?
- What have we learned about effective practices that we can recommend being continued by other offices and departments?
- What are the barriers to more equitable outcomes? (e.g. mandated, political, financial, programmatic, or managerial)

# National Asian and Pacific Islander HIV/AIDS Awareness Day – May 19


May 19 is National Asian and Pacific Islander HIV/AIDS Awareness Day (NAPIHAAD). Share the social media posts below to help spark conversations about HIV and reduce HIV stigma in Asian and Pacific Islander communities. You can also find and share *Let's Stop HIV Together* campaign resources for Pacific Islander people.

**Hashtags:** #NAPIHAAD #APIMay19 #StopHIVTogether

## Social Media Posts

### Promoting National Asian and Pacific Islander HIV/AIDS Awareness Day (May 19)


Download or share:

**Post 1:**

May 19 is National Asian & Pacific Islander HIV/AIDS Awareness Day, a day to combat stigma in Asian and Pacific Islander communities. When we reduce HIV stigma and promote prevention, testing, and treatment, we can #StopHIVTogether. http://bit.ly/3ZU99wK #NAPIHAAD #APIMay19

**Post 2:**

Today is National Asian & Pacific Islander HIV/AIDS Awareness Day, a day devoted to eliminating HIV stigma in Asian and Pacific Islander communities. Learn more about the role that everyone plays in stopping HIV stigma: http://bit.ly/3JqBLqq. #NAPIHAAD #APIMay19 #StopHIVTogether

# Together We Can Stop HIV Stigma


Download or share:

We can help #StopHIVStigma in Asian and Pacific Islander communities by being intentional and thoughtful in how we talk about people, health, and experiences. Learn how you can do your part: http://bit.ly/40ajLrg. #NAPIHAAD #APIMay19 #StopHIVTogether

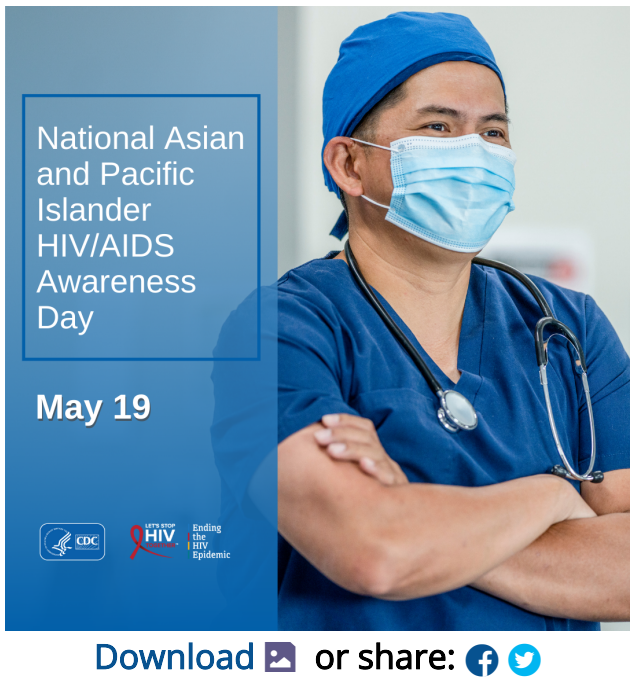

Download or share:

HIV stigma can keep people from getting tested for HIV. This National Asian & Pacific Islander HIV/AIDS Awareness Day, help #StopHIVStigma in Asian and Pacific Islander communities and start talking about HIV testing options: http://bit.ly/3ZTXOwT. #NAPIHAAD #StopHIVTogether


Download or share:

How can we prevent HIV in Asian and Pacific Islander communities? We can start talking about HIV prevention options like condoms and PrEP, about testing, and about medicines that treat HIV: http://bit.ly/3JmkSgG. #NAPIHAAD #APIMay19 #StartTalkingHIV

# Clinicians Help Stop HIV Stigma




Download or share:

Health care providers: You can help Asian & Pacific Islander communities stay healthy by providing robust HIV screening, prevention, and treatment services. Visit #HIVNexus for free CDC resources for your practice and patients: http://bit.ly/3n1iF2Q. #NAPIHAAD #StopHIVTogether

## More Resources

### *Let's Stop HIV Together* Resources

- Social Media Toolkits
- Digital Toolkit for Clinicians
- Campaign Resources for Pacific Islander People (also includes Native Hawaiian People)
- Campaign Resources for All Audiences
- HIV Prevention Services Locator

### Other CDC Resources

- HIV Risk Reduction Tool
- HIV Nexus: Resources for Clinicians

### HIV.gov Resources

- Ready, Set, PrEP

## About *Let's Stop HIV Together*

CDC's *Let's Stop HIV Together (Together)* campaign is the national campaign of the *Ending the HIV Epidemic in the U.S.* (EHE) initiative and the *National HIV/AIDS Strategy*. *Together* is an evidence-based campaign created in English and Spanish. It aims to empower communities, partners, and health care providers to reduce HIV stigma and promote HIV testing, prevention, and treatment.

## Follow

@StopHIVTogether

@StartTalkingHIV

@CDCHIV

@StartTalkingHIV

@CDC HIV

Last Reviewed: March 22, 2023

# Progress Toward an HIV VACCINE

Development of a **safe, effective, preventive HIV vaccine** remains key to realizing a durable **end to the HIV/AIDS pandemic**. NIAID and its global partners are pursuing numerous research strategies to develop next-generation vaccine candidates.

## Developing an HIV vaccine is challenging

HIV **mutates rapidly** and has unique ways of evading the immune system.

**MOST VACCINES**

...mimic the immune responses of recovered patients. There are no documented cases of a person living with HIV developing an immune response that cleared the infection. Researchers are working to define and understand the responses that may protect against HIV.

...are inactivated or weakened viruses. Inactivated HIV was not effective at eliciting immune responses in clinical trials. A live form of HIV is too dangerous to use.

...are effective against pathogens that are rarely encountered. People in high-risk groups might be exposed to HIV daily.

## But we've made progress

Results from the landmark **RV144** clinical trial in Thailand, reported in 2009, provided the first signal of HIV vaccine efficacy: a 31 percent reduction in HIV infection among vaccinees. RV144 evaluated the safety and efficacy of a **prime-boost** combination of two vaccine components given in sequence: one using a harmless virus as a **vector**—or carrier—to deliver HIV genes and a second containing a protein found on the HIV surface.

Broadly neutralizing antibodies, or **bNAbs**, can stop many HIV strains from infecting human cells in the laboratory. A minority of people living with HIV naturally produce bNAbs, but usually too late after infection to overcome the virus. Researchers have isolated bNAbs from the blood of people living with HIV and are studying them in detail in an effort to design novel vaccine candidates.

## And we're working to do more

To build on this progress, NIAID is pursuing two general approaches, each of which has many components. Numerous investigational vaccines are at different stages of development.


### Scientists are developing novel prime-boost regimens that elicit strong, long-lasting protective immune responses.

The Pox-Protein Public-Private Partnership, or **P5**, comprises organizations including NIAID working to build on the modest success of RV144 and increase understanding of the immune responses linked to protection against HIV infection. Results from HVTN 702, a vaccine efficacy trial in South Africa aiming to build on the RV144 results, are expected in late 2020.

Scientists are developing improved **vectors** that deliver HIV genes to host cells, resulting in production of HIV proteins, and trigger anti-HIV immune responses. In the Imbokodo vaccine efficacy trial, researchers are evaluating a prime-boost regimen that includes mosaic antigens created from genes from many HIV variants.

Researchers are working to determine how **adjuvants**—vaccine components that enhance antigen-specific immune responses—affect the potency, durability and other aspects of vaccine-induced immunity.

### Scientists are working to harness the potential of bNAbs to protect HIV-negative people from acquiring HIV.

Scientists are studying the **design and delivery of antigens**—vaccine components that stimulate specific immune responses—to develop vaccine candidates that may induce HIV-negative people's immune systems to make bNAbs.

**Passive immunization** involves giving injections or intravenous infusions of bNAbs as an HIV prevention strategy. The ongoing AMP studies aim to determine whether giving HIV-negative people bNAb infusions is safe, tolerable and effective at preventing HIV infection.

Researchers also are investigating **vectored immunoprophylaxis**, which involves injecting a vector containing bNAb genes to produce antibodies that may prevent HIV infection.

## For more on the latest advances in HIV vaccine research, visit:

NIH National Institute of Allergy and Infectious Diseases
www.niaid.nih.gov
facebook.com/niaid.nih
@NIAIDNews

**Los Angeles County Commission on HIV (COH)**
**2023 Meeting Schedule**
**Version 05.2.23 – FOR DISCUSSION /IDEA GENERATION & PLANNING PURPOSES ONLY**

- **Bylaws:** Section 5. Regular meetings. In accordance with Los Angeles County Code 3.29.060 (Meetings and committees), the Commission shall meet at least ten (10) times per year. Commission meetings are monthly, unless cancelled, at a time and place to be designated by the Co-Chairs or the Executive Committee. The Commission's Annual Meeting replaces one of the regularly scheduled monthly meetings during the fall of the calendar year.
- The Executive Committee may choose to form a smaller group of Commissioners to review, refine and adjust meeting schedule, topics, and discussion format (e.g., listening sessions, panels, break out groups)
- Topics listed below are not in any particular order; may be rearranged by the Co-Chairs/Executive Committee.
- Months without meetings may be used to complete desired outcomes and action steps that arise from discussions.

| **Proposed Meeting Schedule and Topics - Commission Meetings** | | |
|---|---|---|
| **Month** | **Community Discussion Topic** | **Suggested Prompts/Facilitation Questions** |
| ~~March~~ | ~~• First in-person meeting since March 2020~~<br>~~• Finish motions from Feb. 9 meeting~~<br>~~• Present new meeting approach and meeting schedule to full council for feedback and public comment~~ | |
| ~~April~~ | ~~Unmet Needs Estimate presentation and discussion from DHSP Part 1 Late Diagnoses~~ | • How do we use unmet needs estimate to address the needs of priority populations and key geographic areas?<br>• Identify key realistic action items for the Commission as result of the discussion.<br>• *Held discussion at PP&A meeting on 4/18/23 to use unmet needs data for service rankings, allocations, and directives*<br>• *PP&A discussed looking at other data sources to understand unmet needs of PLWH who are experiencing homelessness. How do we close the gap in their needs?* |
| May | Unmet Needs Presentation Part 2 Out of Care from DHSP | |

| | | |
|---|---|---|
| June | Unmet Needs Presentation Part 3 In Care, Virally Suppressed from DHSP | |
| July | HIV Surveillance Update and Data Challenges for Native American Population | |
| August | TBD (possibly cancel) | |
| September | TBD | |
| October | TBD | |
| November | **ANNUAL CONFERENCE** | Theme and topics TBD |
| December | **TBD or Cancel** | |

the OA Voice
Issue: May 2023

## INSIDE:


- Updates
- Strategic Plan
- Strategy A
- Strategy B
- Strategy C
- Strategy G
- Strategy J
- Strategy K
- Strategy N

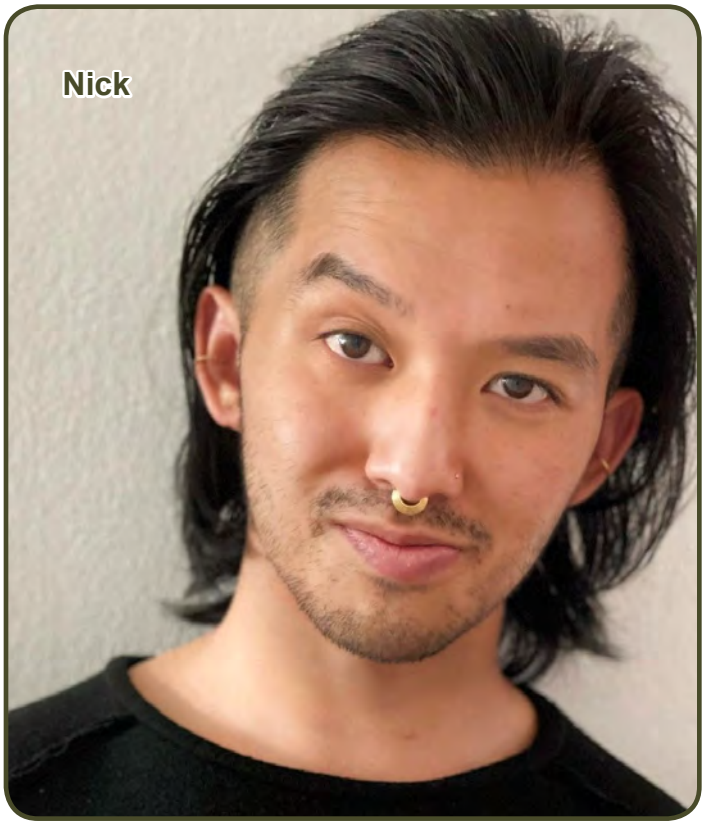

This newsletter is organized to align the updates with Strategies from the ***Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention, and Care Plan*** (Integrated Plan). The Integrated Plan is available on the Office of AIDS' (OA) website.

## STAFF HIGHLIGHT

OA would like to welcome **Nicholas Wong**, the new Clinical Quality Management Specialist in the ACEI Branch. Nick is an experienced program manager with a background in public health and design. Before joining OA, he worked with the California Department of Public Health (CDPH) Testing Task Force as a program manager and the San Francisco Homeless Outreach Team as their operations coordinator.

Nick holds a bachelor's degree in Interior Design from San Francisco State University and a master's degree in Public Health from the University of Southern California. During his time studying Interior Design, Nick focused on creating spaces that enhance the health and well-being of individuals with disabilities. He even designed a commercial space specifically for neurodivergent children as part of his capstone project. In his MPH program, Nick conducted research on shelter utilization in San Francisco during inclement weather, which aimed to inform and improve outreach and emergency response policies.

In addition to his professional pursuits, Nick is an accomplished dancer with over 15 years of experience. He continues to take dance classes in his free time and stays active through weightlifting and rock climbing. Nick is also passionate about exploring his creativity through acting and design. And when he's not working


Nick

or pursuing his hobbies, Nick can be found indulging in his love for video games.

## HIV AWARENESS

**May 18 is National HIV Vaccine Awareness Day** (HVAD). HVAD is observed to recognize and appreciate the scientists, health professionals, community member and volunteers who are tirelessly working to develop a vaccine to prevent HIV. This day also provides an opportunity

to bring education and awareness to the importance of preventive HIV vaccine research. This work is essential to ending the HIV pandemic.

**May 19 is National Asian & Pacific Islander HIV/AIDS Awareness Day** (APIHAAD). This day aims to raise awareness about the unique and important impacts of HIV on Asian and Pacific Islander communities. This day of observance is dedicated to combat stigma and to end the silence and shame that surrounds this issue of HIV in these communities.

**May is Hepatitis Awareness Month** and **May 19th is designated as Hepatitis Testing Day** (HTD). The primary goal of HTD is to bring responsiveness of hepatitis B and hepatitis C and to encourage people to learn their status. According to CDC, an estimated 862,000 people are living with hepatitis B and 2.4 million with hepatitis C oftentimes without symptoms until later stages of the infection. Those unaware of their status can potentially spread the disease to others, are more susceptible to complications and other illnesses, and even death. Do your part today and get tested and know your status!

# GENERAL UPDATES

### COVID-19

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

### Mpox

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

Spanish mpox digital assets are now available for LHJs and CBOs.

### Racial Justice and Health Equity

The Racial & Health Equity (RHE) workgroup aims to gain insight and understanding of racial and health equity efforts throughout the CDPH and take next steps towards advancing RHE in our work. The workgroup has formed subcommittees to address community stakeholder engagement challenges, improve OA policy and practices to support RHE and increasing OA knowledge and attitude on RHE among leadership and staff.

### HIV/STD/HCV Integration

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

# ENDING THE EPIDEMICS STRATEGIC PLAN OA/STD

Thanks to the California Planning Group (CPG) who hosted a ***Strategic Plan and Implementation Blueprint*** discussion during their May in-person meeting in Long Beach. CPG focused their discussion on the Stigma Free section of the Plan and talked about what success looks like in providing stigma free services.

Ending the HIV, HCV, and STI syndemic will require breaking down negative beliefs to make it

safer for people to share their status with others and seek the preventive services and health care they need and deserve, knowing that they can expect to be treated with dignity and respect. Thanks to all who are working to end HIV/STI/HCV stigma in California.

The URL below documents our work, including the phase-1 roadmap, the recording of our Statewide Town Hall, and the list of completed regional listening sessions:

- **https://facenteconsulting.com/work/ending-the-epidemics/**

# STRATEGY A

## Improve Pre-Exposure Prophylaxis (PrEP) Utilization:

### PrEP-Assistance Program (AP)

As of May 1, 2023, there are 203 PrEP-AP enrollment sites covering 189 clinics that currently make up the PrEP-AP Provider network.

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

Data on active PrEP-AP clients can be found in the three tables displayed on page 5 of this newsletter.

# STRATEGY B

## Increase and Improve HIV Testing:

OA has expanded its Building Healthy Online Communities (BHOC) self-testing program to allow for rapid OraQuick test orders in all jurisdictions in California.

# TAKEMEHOME

The program, **TakeMeHome**, (https://takemehome.org/) is advertised on gay dating apps, where users see an ad for home testing and are offered a free HIV-home test kit. In March, 240 individuals in 33 counties ordered self-test kits, with 204 individuals ordering 2 tests. Most individuals ordering tests identify as cisgender men (81.9% of those sharing gender) and Hispanic/Latinx (51.7% of those sharing race or ethnicity). Eleven (4.6 %) orders came in through the Spanish language portal. Most participants reported either never having tested for HIV before (30.4%) or not testing for HIV in at least one year (32.1%). OA is excited to help make HIV testing more accessible through this program.

OA's existing TakeMeHome Program continues in the six California Consortium Phase I Ending the HIV Epidemic in America counties. In the first 31 months, between September 1, 2020, and March 31, 2023, 5310 tests have been distributed. This month, mail-in lab tests (including dried blood spot tests for HIV, syphilis, and Hepatitis C, as well as 3-site tests for gonorrhea and chlamydia) accounted for 254 (71.6%) of the 355 total tests distributed.

Of individuals ordering a test in March, 37.5% reported never before receiving an HIV test, and 51.3% were 17 to 29 years of age. Among individuals reporting race or ethnicity, 36.8% were Hispanic/Latinx, and of those reporting sexual history, 50.6% indicated 3 or more partners in the past 12 months. To date, 577 recipients have completed an anonymous follow up survey, with 94.6% indicating they would recommend TakeMeHome HIV test kits to a friend. The most common behavioral risks of HIV exposure reported in the follow up survey were being a man who has sex with men (71.1%) or having had more than one sex partner in the past 12 months (63.6%).

## STRATEGY C

### Expand Partner Services:

The California Prevention Training Center (CAPTC) in collaboration with CDPH, OA and the Sexually Transmitted Diseases Control Branch (STDCB) is happy to announce the Virtual DIS Summit 2023. The theme for the Summit is DIS, Cornerstones of Public Health: Then, Now and into the Future. Save the Dates – June 5th, 7th, & 9th – Registration opens in May. For questions or more information contact linda.desantis@ucsf.edu.

## STRATEGY G

### Improve Availability of HIV Care:

OA's HIV Care Branch is looking for a new Housing Opportunities for Persons with AIDS (HOPWA) Program provider for Santa Cruz County. We released a Request for Application (RFA) (#23-10079) on April 24, 2023, with a **closing date of May 19, 2023**. The award amount is approximately $215,000.

HOPWA provides housing assistance and supportive services to prevent or reduce homelessness for persons living with HIV (PLWH). Local government entities (e.g., health departments or community development agencies) and non-profit community-based organizations may apply.

View the RFA at https://www.cdph.ca.gov/programs/cid/doa/pages/HOPWA-RFA-23-10079.aspx.

## STRATEGY J

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

As of May 1, 2023, the number of ADAP clients enrolled in each respective ADAP Insurance Assistance Program are shown in the chart at the bottom of this page.

## STRATEGY K

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

**> Funding Opportunity: Opioid Use and Stimulant Use Education, Outreach and Prevention for Increased Risk Communities** *(continued on page 6)*

| ADAP Insurance Assistance Program | Number of Clients Enrolled | Percentage Change from March |
|---|---|---|
| Employer Based Health Insurance Premium Payment (EB-HIPP) Program | 489 | + 3.10% |
| Office of AIDS Health Insurance Premium Payment (OA-HIPP) Program | 5,736 | - 0.86% |
| Medicare Part D Premium Payment (MDPP) Program | 1,039 | - 18.90% |
| **Total** | **7,264** | **- 3.80%** |

*Source: ADAP Enrollment System*

## Active PrEP-AP Clients by Age and Insurance Coverage:

| Current Age | PrEP-AP Only | | PrEP-AP With Medi-Cal | | PrEP-AP With Medicare | | PrEP-AP With Private Insurance | | TOTAL | |
|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | N | % |
| **18 - 24** | 268 | 8% | --- | --- | --- | --- | 27 | 1% | 295 | 8% |
| **25 - 34** | 1,089 | 31% | 3 | 0% | 1 | 0% | 247 | 7% | 1,340 | 39% |
| **35 - 44** | 891 | 26% | --- | --- | 1 | 0% | 174 | 5% | 1,066 | 31% |
| **45 - 64** | 447 | 13% | 1 | 0% | 20 | 1% | 92 | 3% | 560 | 16% |
| **65+** | 21 | 1% | --- | --- | 187 | 5% | 9 | 0% | 217 | 6% |
| **TOTAL** | **2,716** | **78%** | **4** | **0%** | **209** | **6%** | **549** | **16%** | **3,478** | **100%** |

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

| Current Age | Latinx | | American Indian or Alaskan Native | | Asian | | Black or African American | | Native Hawaiian/ Pacific Islander | | White | | More Than One Race Reported | | Decline to Provide | | TOTAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | N | % | N | % | N | % | N | % | N | % |
| **18 - 24** | 162 | 5% | --- | --- | 36 | 1% | 12 | 0% | 1 | 0% | 59 | 2% | 3 | 0% | 22 | 1% | 295 | 8% |
| **25 - 34** | 787 | 23% | 2 | 0% | 116 | 3% | 83 | 2% | 3 | 0% | 268 | 8% | 10 | 0% | 71 | 2% | 1,340 | 39% |
| **35 - 44** | 698 | 20% | 3 | 0% | 85 | 2% | 38 | 1% | 1 | 0% | 196 | 6% | 5 | 0% | 40 | 1% | 1,066 | 31% |
| **45 - 64** | 360 | 10% | 2 | 0% | 33 | 1% | 16 | 0% | 1 | 0% | 133 | 4% | --- | --- | 15 | 0% | 560 | 16% |
| **65+** | 21 | 1% | 1 | 0% | 3 | 0% | 3 | 0% | --- | --- | 185 | 5% | --- | --- | 4 | 0% | 217 | 6% |
| **TOTAL** | **2,028** | **58%** | **8** | **0%** | **273** | **8%** | **152** | **4%** | **6** | **0%** | **841** | **24%** | **18** | **1%** | **152** | **4%** | **3,478** | **100%** |

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

| Gender | Latinx | | American Indian or Alaskan Native | | Asian | | Black or African American | | Native Hawaiian/ Pacific Islander | | White | | More Than One Race Reported | | Decline to Provide | | TOTAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | N | % | N | % | N | % | N | % | N | % |
| **Female** | 170 | 5% | --- | --- | 4 | 0% | 10 | 0% | 1 | 0% | 12 | 0% | --- | --- | 3 | 0% | 200 | 6% |
| **Male** | 1,662 | 48% | 8 | 0% | 251 | 7% | 138 | 4% | 5 | 0% | 803 | 23% | 16 | 0% | 129 | 4% | 3,012 | 87% |
| **Trans** | 177 | 5% | --- | --- | 15 | 0% | 4 | 0% | --- | --- | 15 | 0% | 1 | 0% | 6 | 0% | 218 | 6% |
| **Unknown** | 19 | 1% | --- | --- | 3 | 0% | --- | --- | --- | --- | 11 | 0% | 1 | 0% | 14 | 0% | 48 | 1% |
| **TOTAL** | **2,028** | **58%** | **8** | **0%** | **273** | **8%** | **152** | **4%** | **6** | **0%** | **841** | **24%** | **18** | **1%** | **152** | **4%** | **3,478** | **100%** |

*All PrEP-AP charts prepared by: ADAP Fiscal Forecasting Evaluation and Monitoring (AFFEM) Section, ADAP and Care Evaluation and Informatics Branch, Office of AIDS. Client was eligible for PrEP-AP as of run date: 04/30/2023 at 12:01:16 AM Data source: ADAP Enrollment System. Site assignments are based on the site that submitted the most recent application.*

The California Department of Health Care Services (DHCS), in partnership with The Center at Sierra Health Foundation, released two requests for applications (RFAs). The projects will fund drug education and prevention for two spirit (2s), lesbian, gay, and bisexual 2S/LGBTQ+ and Communities of Color. **Submissions are due May 8th**.

- **2S/LGBTQ+ Communities** - This RFA has a total of $5 million in available funds to be awarded to 25 to 35 organizations, with a maximum of up to $200,000 per organization.
- **Communities of Color** - This RFA has a total of $12 million in available funds to be awarded to 50 to 60 organizations, with a maximum of up to $250,000 per organization. Contracts will cover activities for the period of July 1, 2023, through June 30, 2024.

### Research: Negative Health Effects of Involuntary Displacement of People Experiencing Homelessness Who Inject Drugs

Involuntary displacement, also known as sweeps, forces people experiencing homelessness (PEH) to regularly relocate from one temporary location to another. Involuntary displacement is often done without connecting people to services. A study concluded that involuntary displacement is estimated to worsen overdose, hospitalizations and decrease initiations of medication for opioid use disorder (MOUD) and contribute to deaths among PEH who inject drugs.

The study can be found at https://pubmed.ncbi.nlm.nih.gov/37036716/

### Naloxone Vending Machines on Sovereign Land in San Diego County

The Pala Band of Mission Indians partnered with Harm Reduction Coalition of San Diego to install the first naloxone vending machine on sovereign land. Funded through San Diego County, the machine is located at the Pala Fire Department and will be a vital tool in reducing fentanyl overdoses and preventing opioid-related deaths. Two additional vending machines are scheduled for installation.

Watch the local news clip at https://www.nbcsandiego.com/news/local/pala-band-of-mission-indians-installs-naloxone-vending-machine-calls-it-first-for-u-s-tribal-lands/3213039/

## STRATEGY N

## Enhance Collaborations and Community Involvement:

The CPG and OA hosted the first Spring in-person CPG meeting post the COVID-19 pandemic. The meeting was held on Monday, May 1 – Wednesday, May 3, 2023, at the Hyatt Regency, in Long Beach, CA. On May 1st we hosted our fifth CPG Leadership Academy, which focused on skills and capacity building for current CPG members only. May 2nd and 3rd were open to the public with a public-comment period on both of those days.

The meeting agenda and additional information can be found at https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_CPG.aspx

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

# CPG Membership

## 5.3 AT-LARGE CPG MEMBERS

At-large CPG members are chosen for their ability to advocate for and represent the voices and perspectives of a wide range of key stakeholders, people representative of, or impacted by, the HIV epidemic in California. Members may be people working with at-risk populations, living with HIV, or conducting HIV care and prevention activities. CPG community members must be residents of California. CPG community members are invited to serve because of their life experience and expertise and are not to function as official representatives of any agency or organizational affiliation.

## 5.4 NOMINATED CPG MEMBERS

Nominated CPG members are appointed by the local planning body that they are representing. Their appointment to the CPG is confirmed by the "Letter of Nomination" that the CPG receives from each planning body. Nominated members serve as liaisons and share the work that is being done in their local community with the CPG membership, occasionally this may include additional meetings with other nominated aftertake the information learned from the CPG meetings and go back to their local planning body to provide detailed updates of the information shared during CPG meetings. The CPG will appoint only one nominated member per planning body to serve a full term. If a local planning body has two Co-Chairs, they must choose one to appoint to CPG. A nominated CPG membership is not a rotating position. Should the appointed member fall ill or resign, the second Co-chair can assume the position.

## SECTION I: MEMBERSHIP

### 1.1 SELECTION PROCESS FOR INDIVIDUAL MEMBERS

All appointed members must be selected through an application process, which must be conducted as three and five-year member terms expire or as members resign.

The selection process for At-large members will take place when the CPG Membership subcommittee has determined there is a need to fill vacant membership seats. The new membership review process must identify potential new members in terms of planning skills, knowledge, experience and expertise, areas of interest, and other specific factors as determined by the CPG and the Office of AIDS (OA). The need to sustain parity, inclusion, and representation will be a factor in selecting CPG members.

The new membership application review and approval process for At-large CPG members will be as follows:

I. Legal Consultation
   Office of AIDS (OA) will consult with the California Department of Public Health (CDPH) Office of Legal Services to ensure that requests for applicant

information comply with the Information Practices Act under Civil Code section 1798.17.

II. Membership Recruitment

A. Initial Recruitment – will entail communicating the announcement to various OA stakeholders and networks.
B. Additional targeted recruitment – will be conducted if the applicant pool does not represent the epidemic.

III. Development of Screening Tools and Processes

All steps of the recruitment process, timeline and tools will be developed by OA staff and approved by OA management; and opportunity for stakeholder feedback is also provided (e.g., CPG Membership subcommittee, CPG Community Co-Chairs).

A. Membership criteria will be defined based on HRSA and CDC requirements and recommendations.
B. OA staff will create application review and summary forms based on Membership Criteria.
C. OA will create an internal shared drive folder, with restricted access, for CPG applications and review forms to protect applicants' confidential public health and personal information.
D. External reviewers will be identified and selected to be a part of the application review panel. Only CPG nominated members can be selected.
E. Interview questions will be developed that ensure applicants have an opportunity to address areas of knowledge, experience, and skills that may not have been identified in initial application materials. Points will be assigned to each question.

IV. Review Considerations

OA will ensure parity, inclusion, and representation (PIR), as defined by CDC, among CPG members. All applicants, including those nominated to represent Planning Councils, are assessed based on PIR-based principles.

V. Application Review Process

Stage I. – Application Review

A. A review panel(s) will be established that consists of staff from OA Care branch, staff from OA Prevention branch, staff from STD Control Branch, and nominated CPG members. One representative of all reviewer types (Care, Prevention, STD, and nominated CPG members) will review each application. Each reviewer must sign a Confidentiality Agreement form (CDPH 8689).
B. Reviewers from the review panel will rate each applicant's level of expertise using a Likert Scale with a numerical value assigned to each part, e.g. High (3), Medium (2), Low (1), and None (0).

Stage II. – Selection Process for Interviews

A. The applicants who scored the highest on the application review and/or represent communities underserved and disproportionately affected by HIV, will be selected for an interview.

a. New applicants (those who are not currently CPG members) who score within the top five numerical scores will be selected for an interview
b. Current CPG members who are terming out and have submitted a complete application and score within the top 15 numerical scores will be selected for an interview .
c. Other applicants will be considered for interviews if they fill a demographical gap in the current make-up of CPG membership in order for the CPG to be more reflective of the community living with or at risk of acquiring HIV

Stage II – Phone Interviews

A. The interview panel will consist of OA/STD staff from the application review process.
B. The panel will include one staff person from the HIV Prevention Branch, one from the Care Branch, and one from the STD Control Branch, if possible.
C. Each panel will have a lead person that will coordinate internal staff availability and schedule phone interviews with the group of applicants assigned to them.
D. Applicants must receive the interview questions 2 days prior to the interview.
The interview panel will utilize a set of interview questions and rate each applicant's response using a Likert Scale with a numerical value assigned to each question, e.g. High (3), Medium (2), Low (1), and None (0).

VI. Final Approval of CPG Members

A. OA management will approve a list of applicants recommended from the review panel for approval based on overall interview scores.
B. The OA Division Chief will approve the final list of CPG members.
C. All applicants will be notified on whether or not they were appointed to the CPG.

If an applicant is offered CPG membership and subsequently declines, OA assesses the existing group makeup to determine if any membership gap results. If a membership gap is determined to exist, then the remaining pool of applicants will be considered first. If the membership gap is still unable to be filled by the remaining pool of applicants, then a targeted recruitment effort will be initiated by OA, with CPG assistance, to address PIR among affected communities, or other membership needs.

# 2022 California Planning Group Members

**Roster**

| NAME | OCCUPATION | AFFILIATION |
|---|---|---|
| Evelyn Alvarez | Chronic Disease Prevention Coordinator | Monterey County Public Health Department |
| Amilcar Avendano | Program Manager | Caring Choices |
| Angie Percam | Health Educator | Monterey |
| Carl Baker | Legislative Director | Desert AIDS Project |
| Carolyn Kuali'i | Consultant/Capacity Building Specialist | Self-Employed, Alameda County |
| Cesar Cedabes | Communications/Events Coordinator | UCSF-Gladstone Center for AIDS Research, San Francisco |
| Claire Nartker | Retired | Santa Clara County HIV Planning Council |
| Clarmundo Sullivan | Executive Director | Golden Rule Services |
| Damone Thomas | Member | Center for HIV Identification, Prevention, and Treatment Services (CHIPTS) |
| Danielle Campbell | Staff Research Associate | UCLA/MLKCH |
| David "Jax" Kelly | Director | Let's Kick ASS (AIDS Survivor Syndrome) |
| David Utuone | Manager | Tru Evolution |
| Dean Jackson | HIV Program Manager | The Source LGBT+ Center |
| Gabriela Leon | Ambulatory Outpatient Program Manager | Men's Health Foundation |
| Holvis Delgadillo | Discharge Planning Coordinator | California Forensic Medical Group |
| Isabella Ventura | Nurse Practitioner (NP) | Lyon-Martin Health Center |
| Jena Adams | HIV Prevention Coordinator | Fresno County Department of Public Health |
| Jack Johnson Hooks | Research Assistant | Center of Excellence for Transgender Health (CoE), UCSF |
| Jayda Arrington | Unaffiliated Consumer | UCLA Family AIDS Network Community Advisory Board |
| John Paul Soto | Senior Program Manager | LSS of Northern California |
| Mikie Lochner | Community Leader | San Diego Planning Council |
| Yara Tapia | Project Specialist | Department of Population and Public Health Sciences<br>Keck School of Medicine<br>University of Southern California |
| Keith Sellons | Activist | Inland Empire Planning Council |
| Thomas Knoble | Manager, SFDPH | San Francisco County Planning Council |
| Lorie Violette | Program Coordinator | Face to Face, Sonoma County |
| Michael Weiss | Program Services Coordinator | Humboldt County Department of Health and Human Services |
| Miguel Martinez | Project Manager | Children's Hospital Los Angeles |
| Natalie Sanchez | Director of the Family AIDS Network at UCLA | UCLA Department of Pediatrics |

| | | |
|---|---|---|
| Nicholas Lagunas | Prevention Assistant Manager | San Ysidro Health |
| Rafael Gonzalez | Community Health Educator/Education Manager | Rainbow Alliance |
| Richard Benavidez | Retired | Sacramento Planning Council |
| Robyn Learned | Harm Reduction Consultant | NASTAD |
| Roger Al-Chaikh | Territory Account Manager | ViiV Heathcare, San Francisco |
| Timothy ‘Teejay” Johnson | Unaffiliated Consumer | Disability Community |
| Tony Sillemon | Administrative Manager | Alta Bates Medical Center, East Bay Medical Center |

# Characterizing Unmet Need for Medical Care: Results from Health Resources and Services Administration-HIV/AIDS Bureau's Updated Approach

Wendy Garland, MPH
Chief Epidemiologist
Program Monitoring & Evaluation
Division of HIV and STD Programs

Los Angeles County Commission on HIV
May 11, 2023

# Presentation Overview

- Follow-up to presentation at annual meeting on updated approach to estimate unmet need

- Second of three presentations to discuss estimates
  - Late diagnoses (April 2023)
  - **Unmet need for medical care, or not in care (May 2023)**
  - In care but not virally suppressed (June 2023)

- Define of unmet need measures and populations, present results and discuss how to use in our work

# What is Unmet Need?

- Defined by HRSA HIV/AIDS Bureau as:

  " the need for HIV-related health services by individuals with HIV who are aware of their status, but are not receiving regular primary [HIV] health care."
- Estimated Unmet Need has been a reporting requirement for RWHAP recipients since 2005
- Data and methods to estimate unmet need have evolved with improvements in HIV care and data quality
- New and expanded methodology released 2021 and implemented in 2022

1."HRSA/HAB Definitions Relate to Needs Assessment," prepared for the Division of Service Systems, HIV/AIDS Bureau by Mosaica: The Center for Nonprofit Development and Pluralism, June 10, 2002.

# Evolving Definition of Unmet Need

**2005**

- Focus on people aware of their HIV/AIDS diagnosis but not in regular HIV medical care
- People living with diagnosed HIV and AIDS with no evidence of care (at least one **viral load [VL]** or **CD4 test** or **ART prescription**) in past 12 months

**2017**

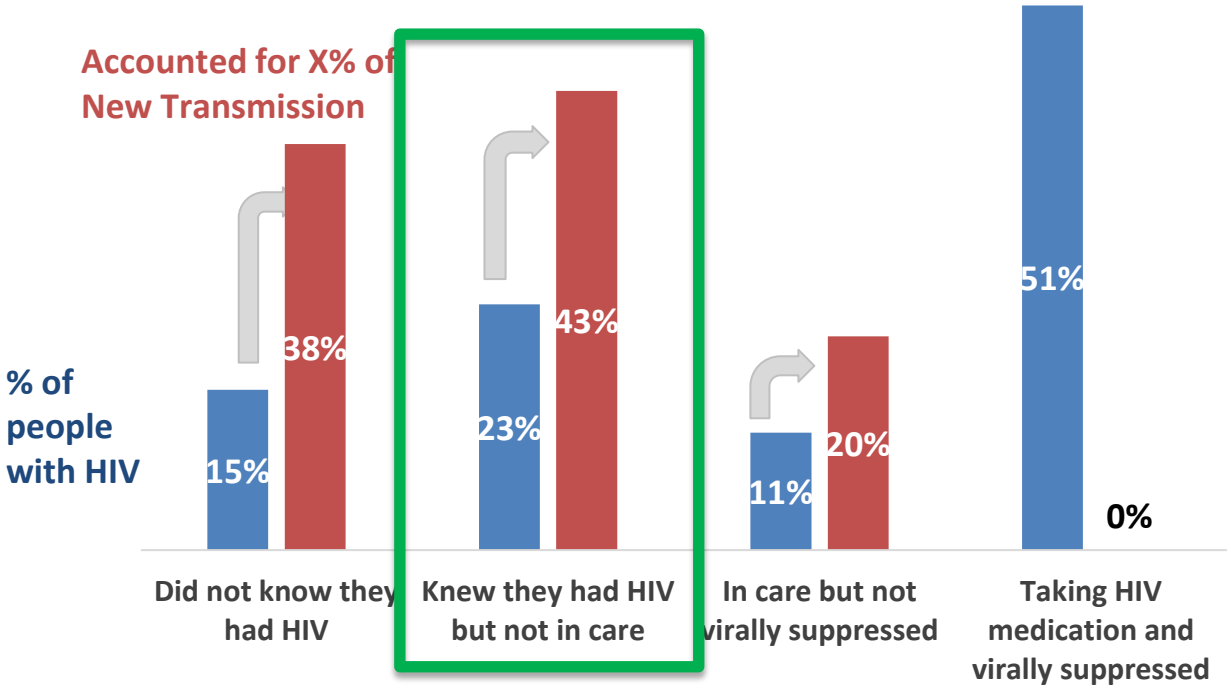
- Care markers updated to align with HIV Care Continuum Definitions
- People living with diagnosed HIV and AIDS with no evidence of care (2 or more **medical visits** or **VL** or **CD4 tests** at least 90 days apart) in past 12 months

**2021**

- Revised care markers and expanded populations
- People living with **diagnosed HIV** with no evidence of care (at least one **VL or CD4 test**) in the past 12 months
- Adds two new indicators:
  - Persons diagnosed with HIV in the past 12 months with **LATE DIAGNOSIS (Stage 3 (AIDS)** diagnosis or an **AIDS-defining condition** ≤ 3 month after HIV diagnosis**)**
  - Persons living with diagnosed HIV **IN MEDICAL CARE** (at least one VL or CD4 test) who were **NOT VIRALLY SUPPRESSED** in the past 12 months

# Unmet need estimates attempt to measure the gaps between the HIV care continuum

- To reduce HIV transmission

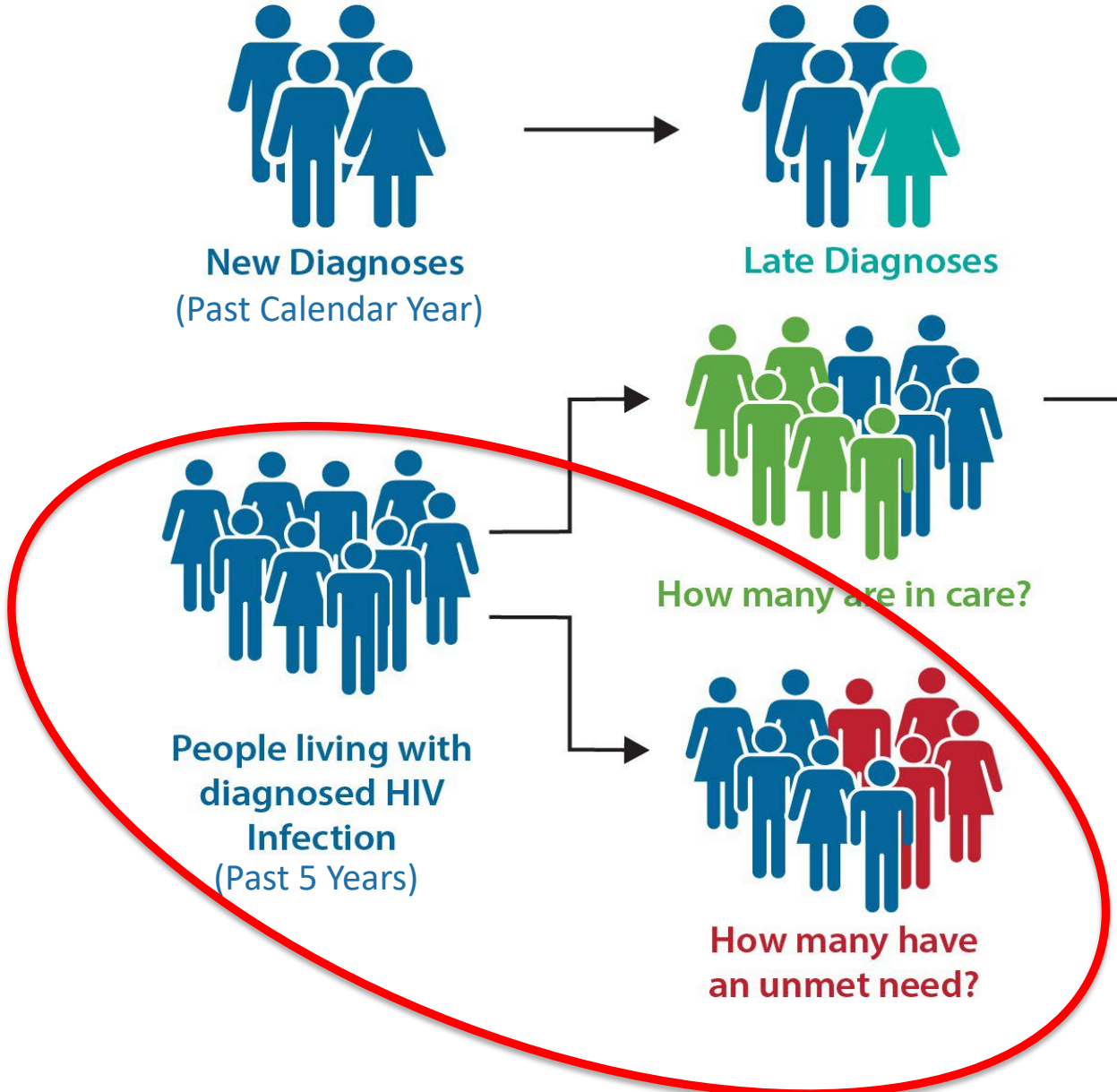



**HIV Transmissions in the United States, 2016**[1]

- To improve health outcomes among PLWDH
  - Start ART early in infection
  - Reduce HIV comorbidities, coinfections and complications
  - Slow disease progression
  - Extend life expectancy
  - Reduce HIV-related mortality


1. Li Z, Purcell DW, Sansom SL, Hayes D, Hall HI. *Vital Signs:* HIV Transmission Along the Continuum of Care — United States, 2016. MMWR Morb Mortal Wkly Rep 2019;68:267–272. DOI: http://dx.doi.org/10.15585/mmwr.mm6811e1 .
2. National HIV/AIDS Strategy for the United States (2022-2025). https://files.hiv.gov/s3fs-public/NHAS-2022-2025.pdf

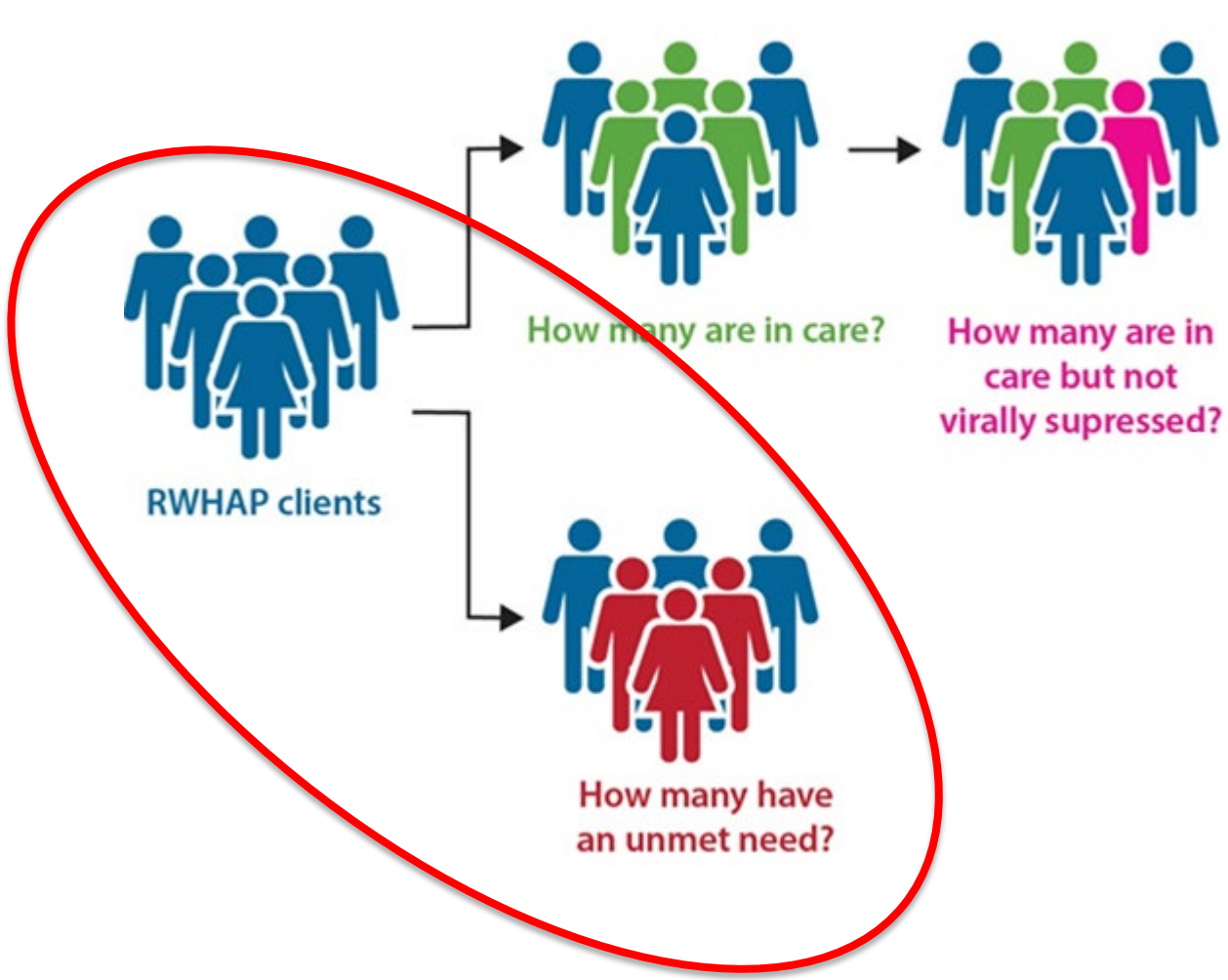
# LAC Populations for Estimates of Unmet Need




What do the data look like for three priority populations (chosen by jurisdiction)?

1. Hollywood-Wilshire HD
2. Central HD
3. Long Beach HD

# RWP Populations for Estimates of Unmet Need




1. Hollywood-Wilshire HD
2. Central HD
3. Long Beach HD

What do the data look like for three priority populations (chosen by jurisdiction)?

# Approaches to Identify Disparities and Gaps - Examples

## Across/Between Group Comparison*

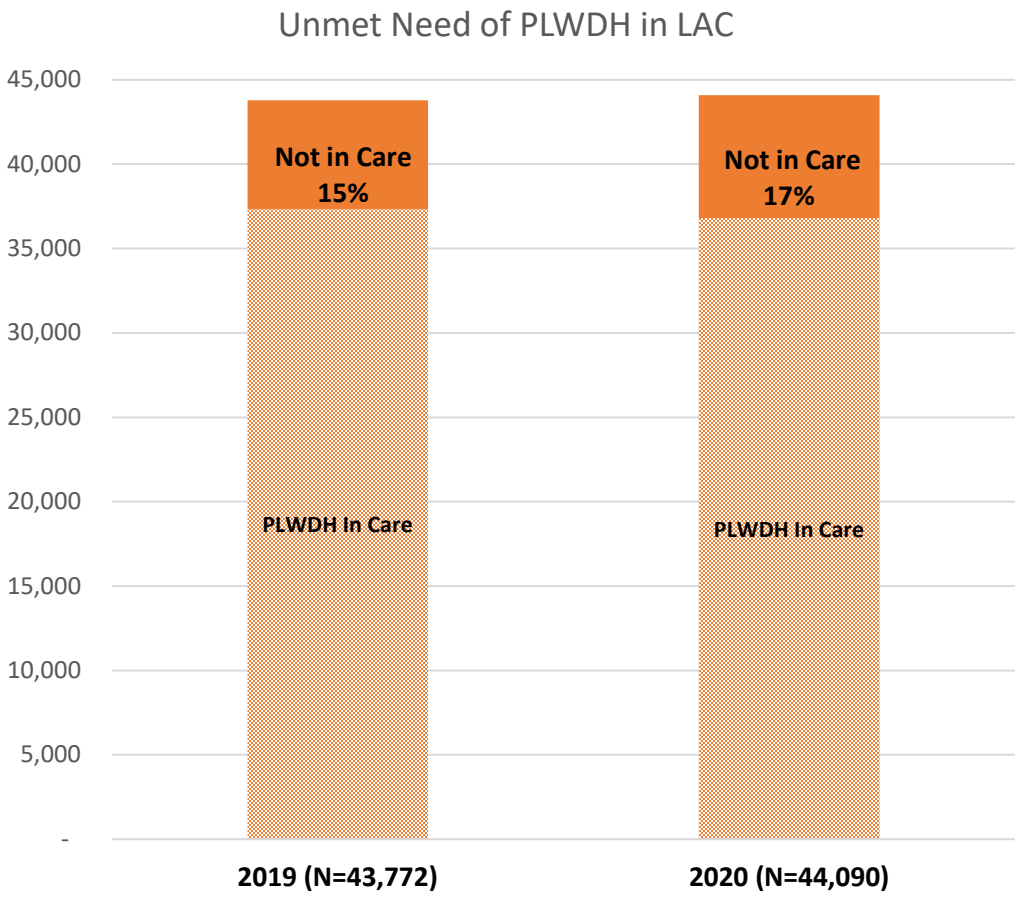
- Helpful for describing a population
  - Latino males made up 24% of LAC residents in 2020
- Identify disparities across populations
  - Latino males made up 53% of LAC residents newly diagnosed HIV in 2020
  - Proportional difference between residents who were Latino males (24%) to compared to new diagnoses who were Latino males (53%)

## Within Group Comparisons*

- Helpful to identify how specific groups are impacted compared to each other
  - Linkage to care among newly diagnosed
    - Hollywood-Wilshire HD residents (85%) vs.
    - Central HD residents (67%) vs.
    - Long Beach HD residents (80%)

*Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2021. http://publichealth.lacounty.gov/dhsp/Reports/HIV/2021AnnualHIVSurveillanceReport.pdf.

# Considerations when thinking about this data




- These data represent the characteristics of:
  - LAC residents with living with confirmed HIV diagnoses in 2020 reported to DHSP
  - RWP clients who accessed services in 2020
- These data do not reflect
  - Why PLWDH may or may not access HIV care services
- Unmet need is estimated using HIV surveillance and program data – both may be incomplete due to reporting delay For example, changes in unmet need from 2019 to 2020 may be due to
  - Decreased laboratory access or availability due to COVID-19
  - Fewer people seeking care services

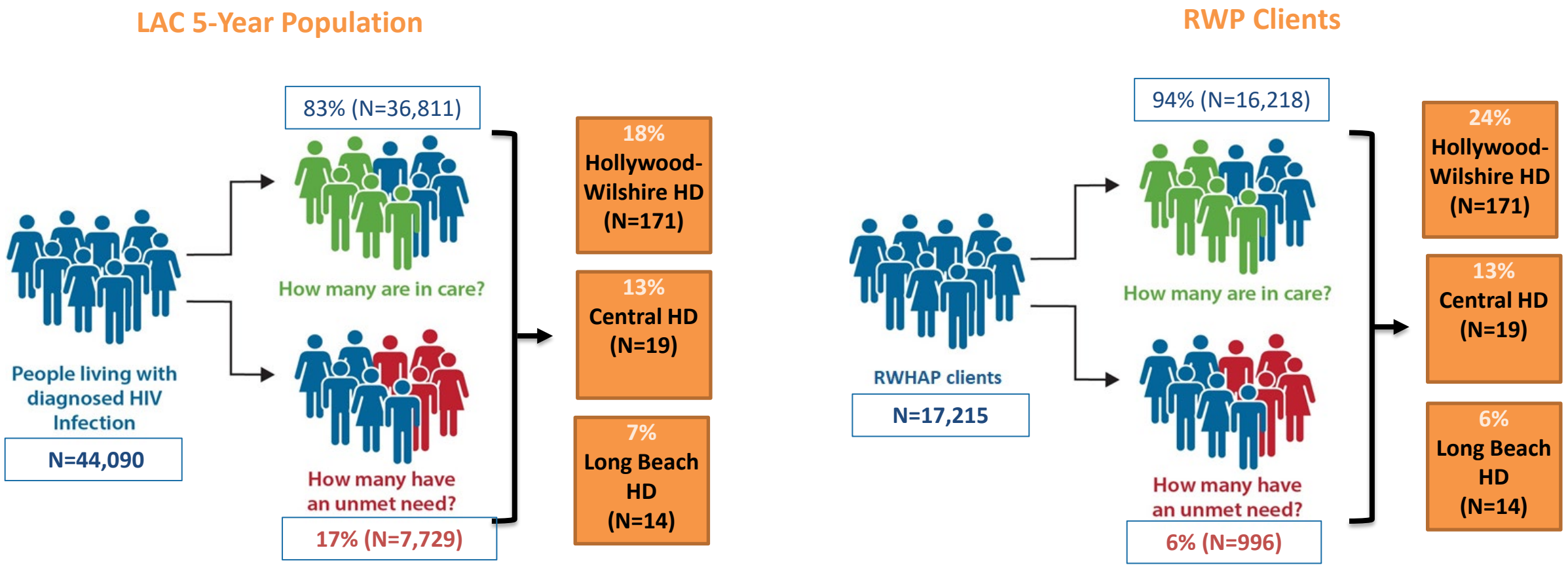
# Unmet Need Estimate:  Not In Care among PLWDH and RWP Clients in LAC, 2020

# Context for Unmet Need for Medical Care

- Local goal: increase engagement/receipt of care to 90% by 2025
  - 68% of PLWDH were engaged in care in 2020[1]
- Unmet need includes PWLH who may have not linked following diagnosis or have fallen out of care
  - Approximately 76% of new diagnoses were linked to care in ≤ 1 month[1]
  - On average, it takes 3.1 months to re-engage LRP clients into care and ranged from <1 month to 18 months[2]
- Challenges to provider knowing care status
  - Helpful to track how well our care system supports early treatment and responsive services


1.Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2021. http://publichealth.lacounty.gov/dhsp/Reports/HIV/2021AnnualHIVSurveillanceReport.pdf.
2.Division of HIV and STD Programs, Linkage and Re-Engagement Program, 2016-2019.

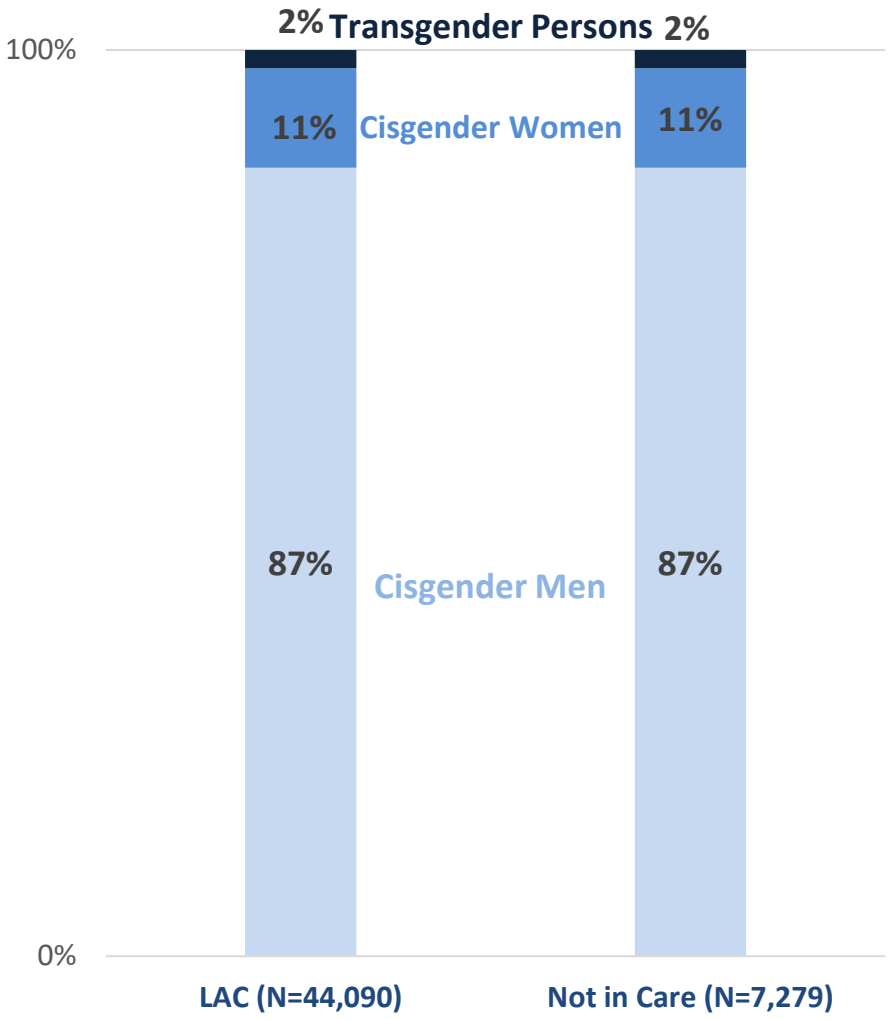
# Estimated Unmet Need among LAC PLWDH and RWP Clients, 2020




- Unmet need was lower among RWP clients compared to LAC
- In LAC and in the RWP, unmet need was highest among residents of Hollywood-Wilshire health district

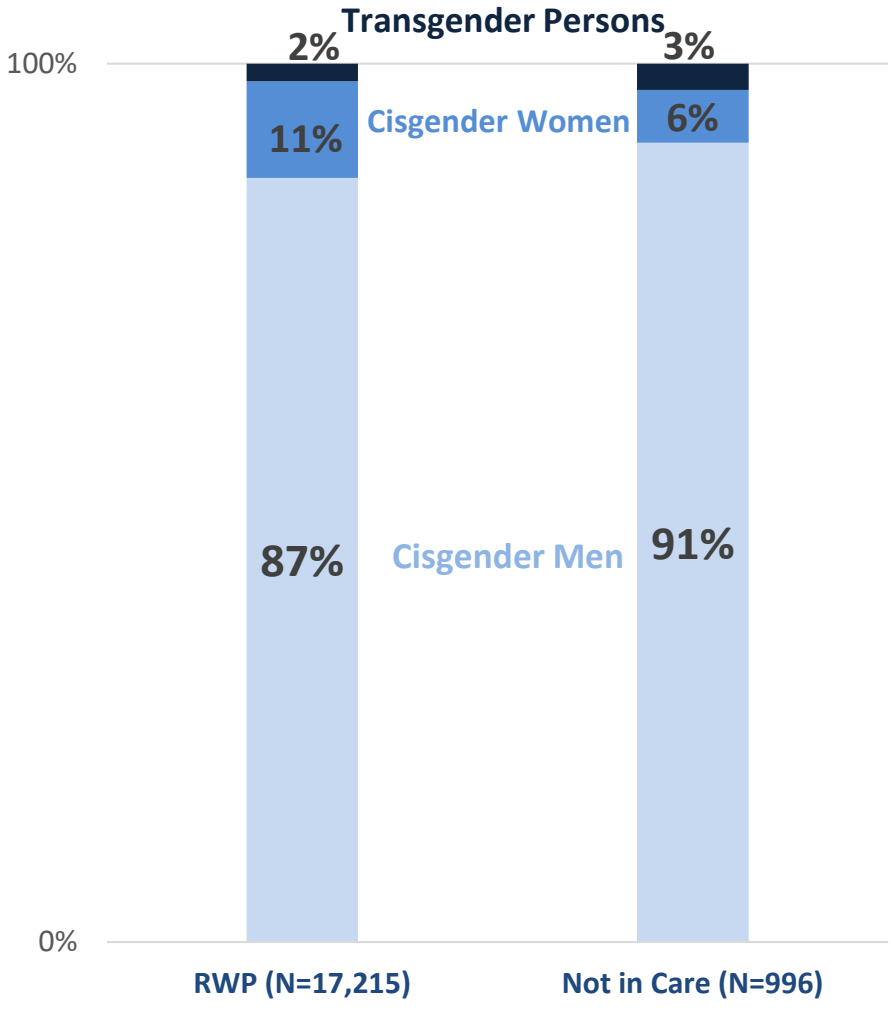
# Unmet Need in LAC and RWP by Gender Identity, 2020

## LAC PLWDH



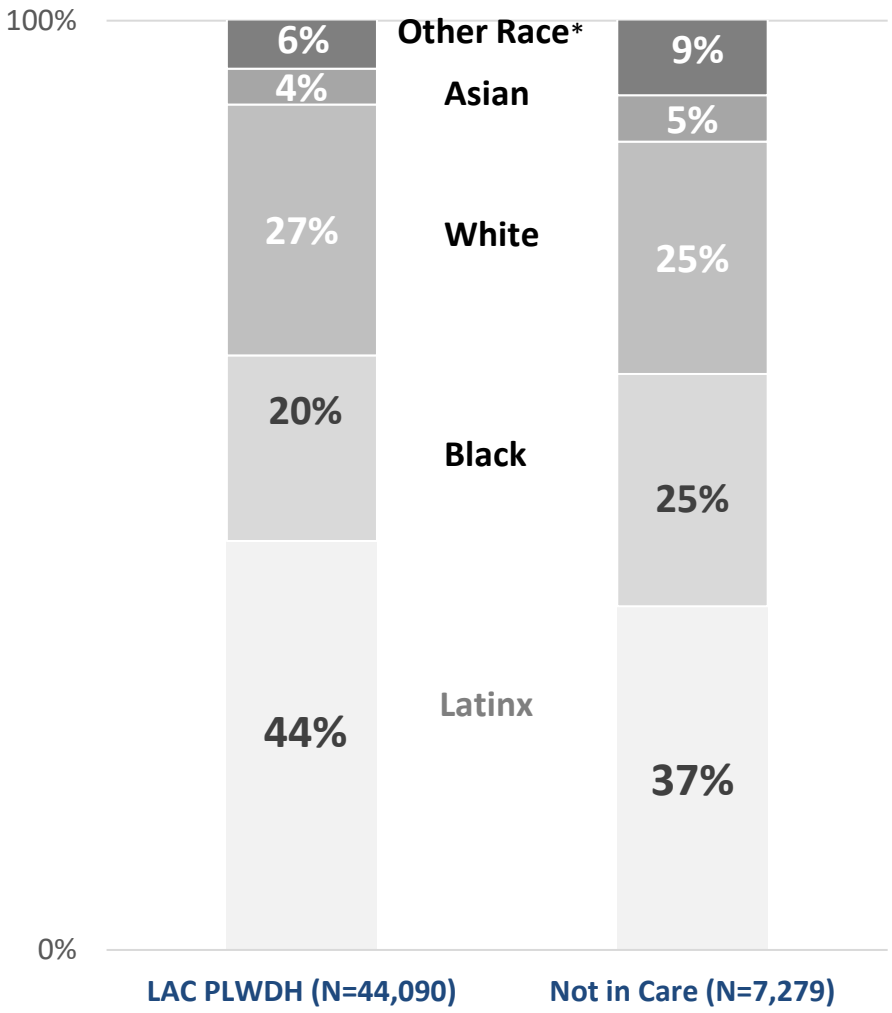

- The largest percent of PLWH and RWP clients were cisgender men
- Cisgender men represented the majority of persons not in care
- In RWP, cisgender men represented 87% of clients but 91% of unmet need

## RWP CLIENTS



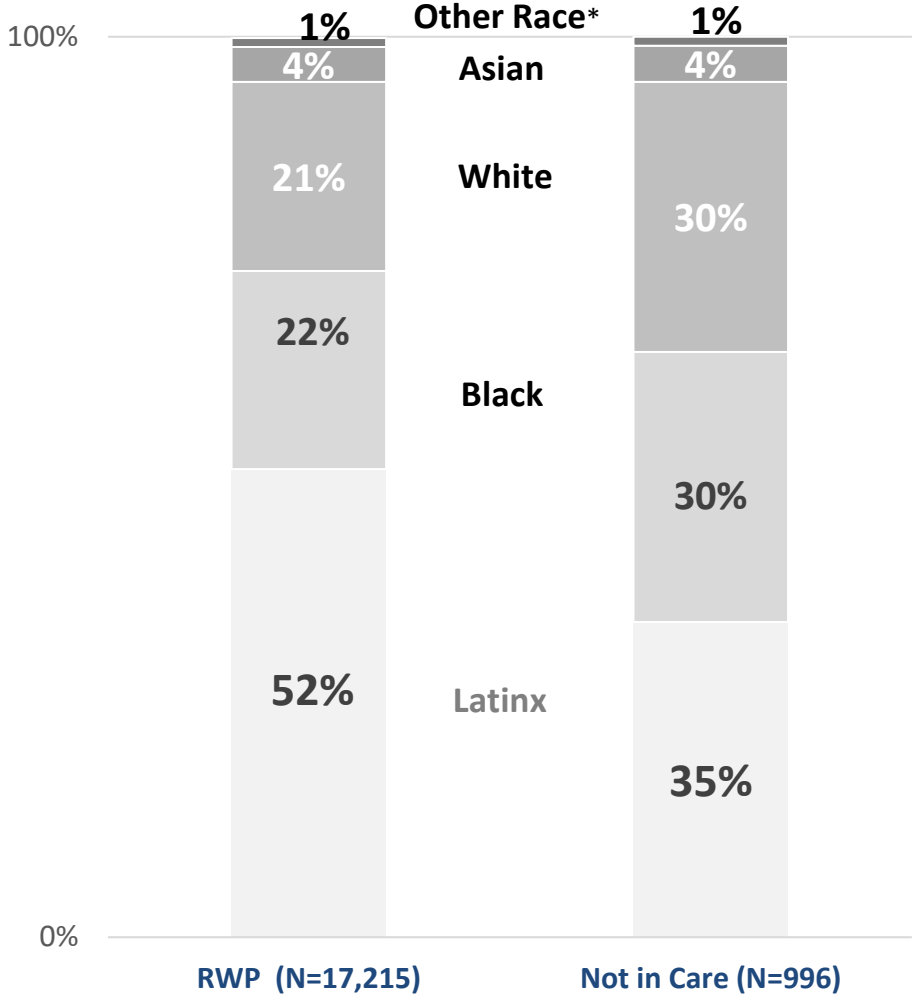
# Unmet Need in LAC and RWP by Racial/Ethnic Group, 2020

## LAC PLWDH




- A higher percent of RWP clients were Latinx vs. LAC
- Fewer RWP clients were of other racial/ethnic groups compared to LAC
- In both populations, unmet need was disproportionately higher among Black PLWDH and RWP clients
- 21% of RWP clients were White but represented 30% of unmet need

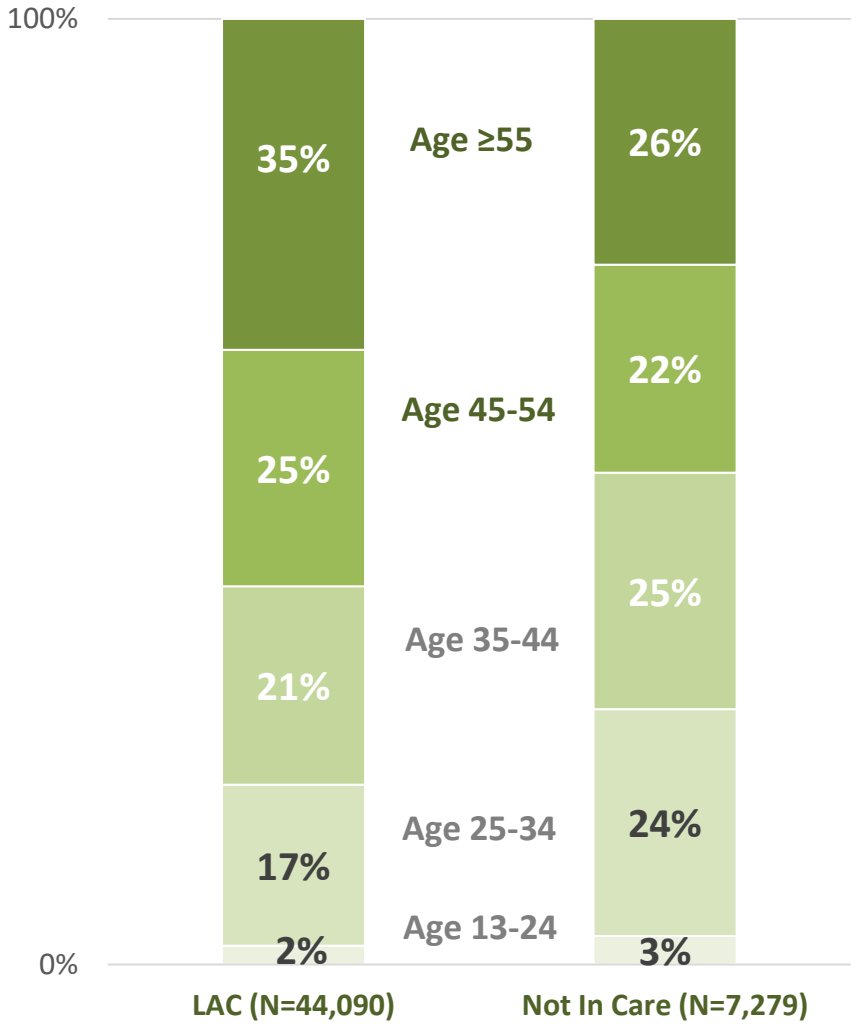
## RWP CLIENTS




*Persons of other racial/ethnic groups include: Multiple race, American Indian/Alaska Native, Native Hawaiian/Pacific Islander, and race/ethnicity not reported.

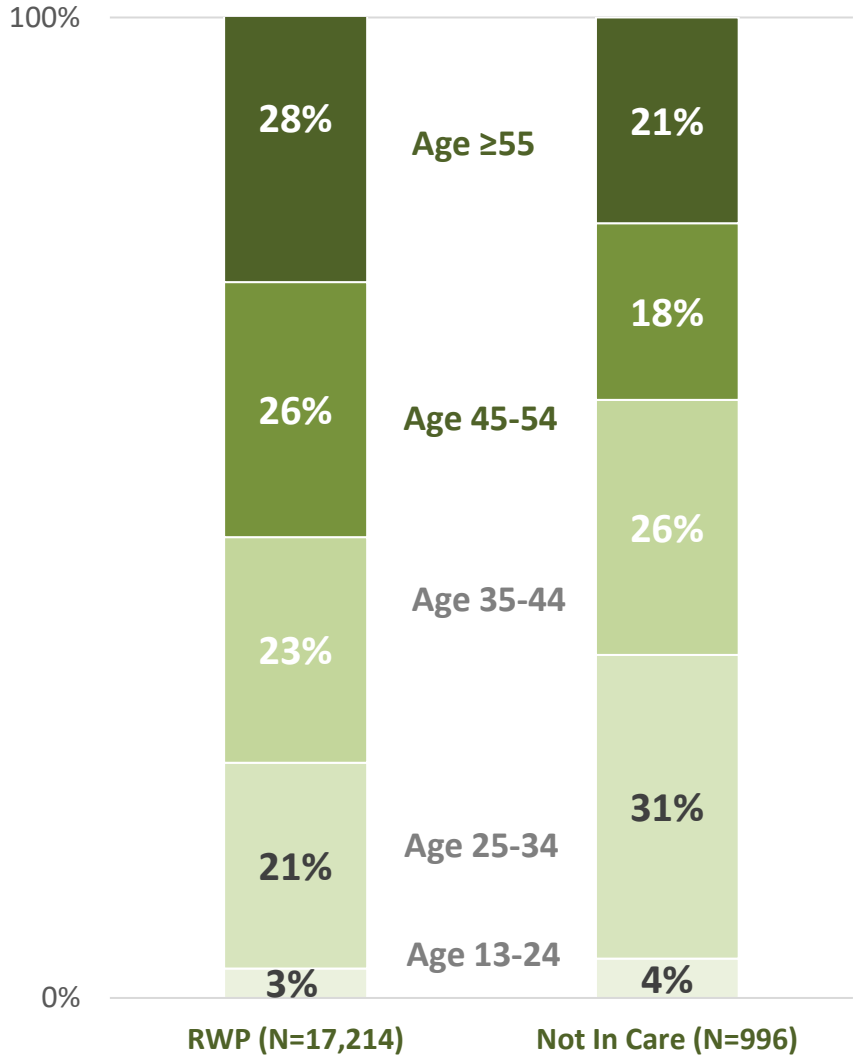
# Unmet Need in LAC and RWP by Age Group, 2020

## LAC PLWDH



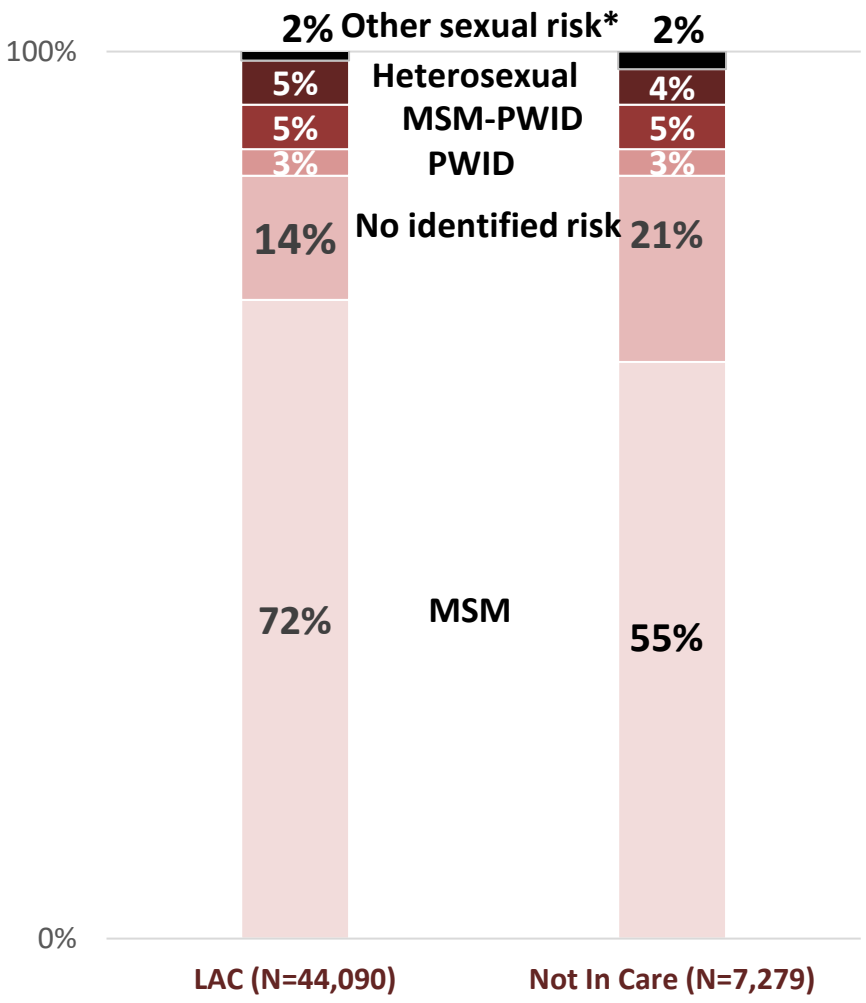

- The majority LAC PLWDH and RWP clients were ≥ age 45
- PLWDH ≥age 55 years represented the 35% PLWDH in LAC, however they represented 26% of unmet need
- While 40% of PLWDH in LAC were <age 45 they represented 52% of people with unmet need
- Similarly, clients <age 45 represented 47% of RWP clients but 62% of unmet need

## RWP CLIENTS



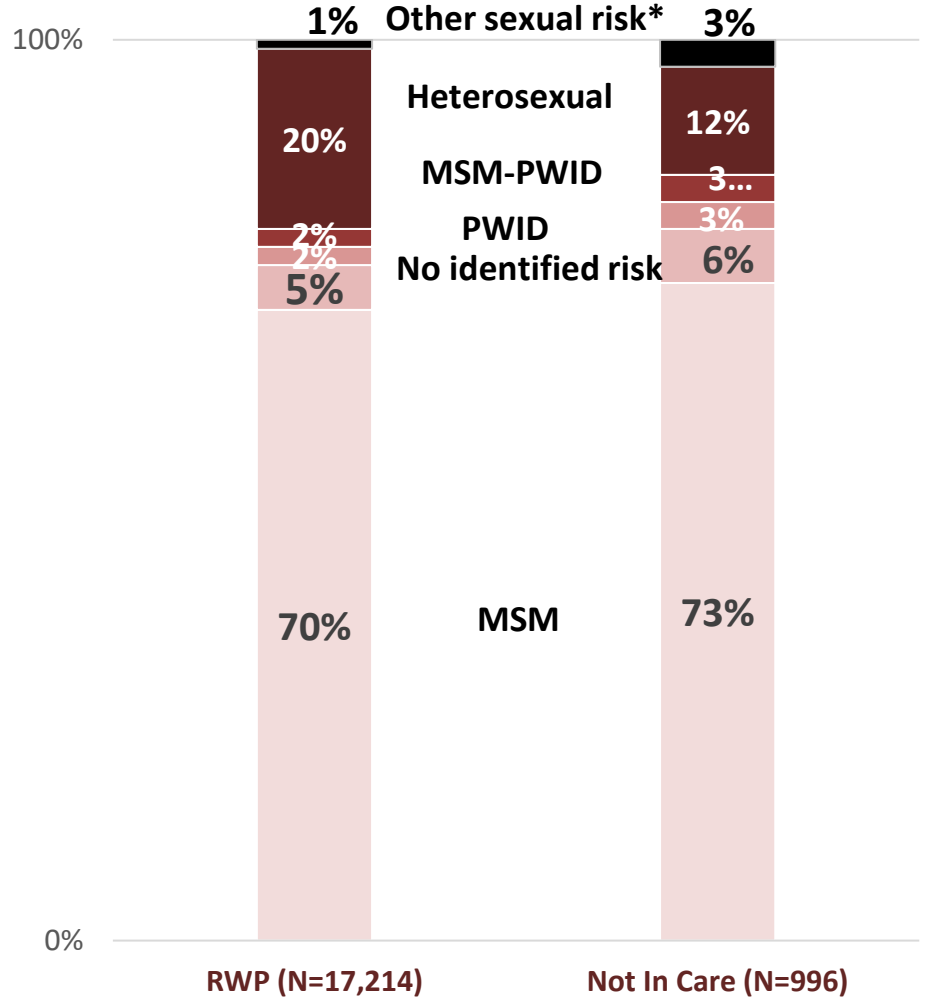
# Unmet Need in LAC and RWP Populations by HIV Risk Category, 2020

## LAC PLWDH




- The majority of LAC PLWDH and RWP clients were MSM
- While 14% of LAC PLWDH had no identified risk, they represented 21% of unmet need
- Relative to population size, MSM represented a lower percent of LAC PLWDH with unmet need

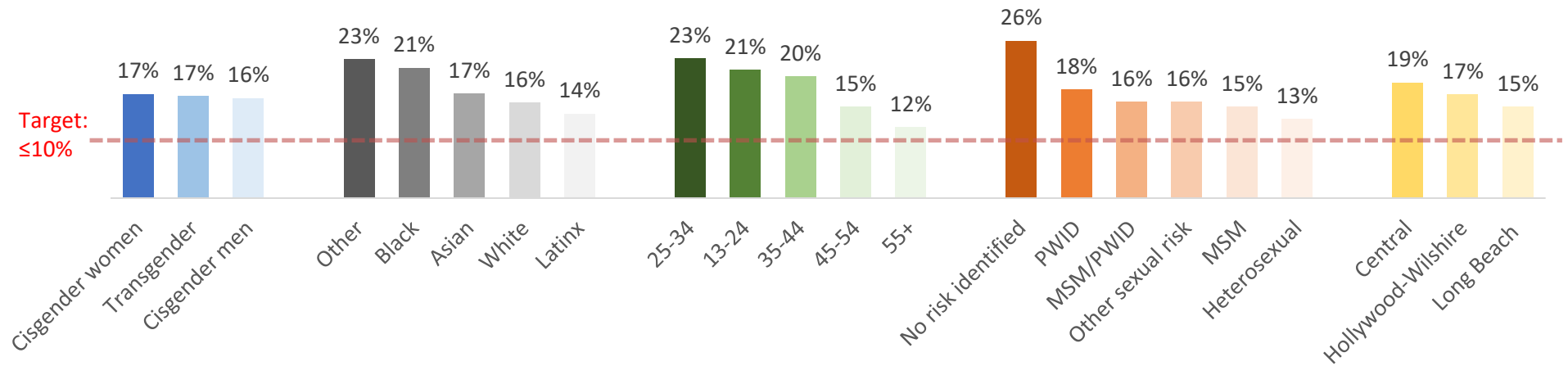
## RWP CLIENTS

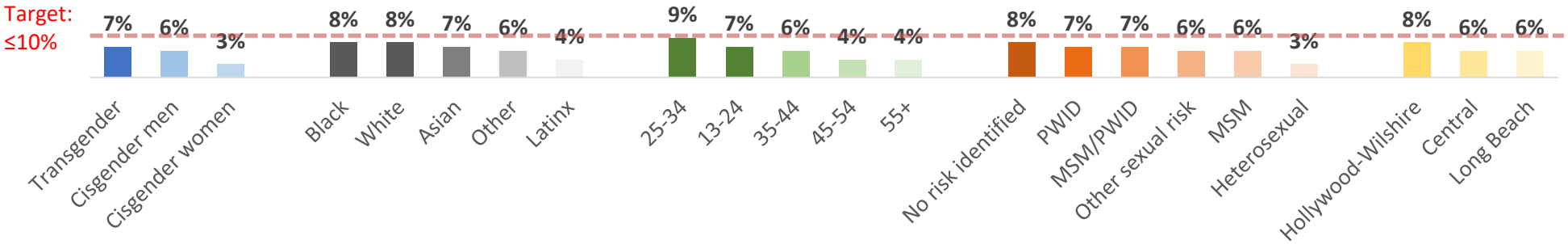



Definitions: MSM: Men who have sex with men; PWID: People who inject drugs

*Other sexual risk includes: sexual contact among transgender individuals, sexual contact and PWID among trans individuals.

## LAC PLWDH




**Unmet need was lower in RWP vs LAC within all categories**

**Unmet need exceeded the target in LAC however met the target in RWP**

## RWP CLIENTS



Los Angeles County PLWDH Population-Level Unmet Need Estimates within Categories of Age, Gender, Race/Ethnicity, Transmission/Risk Categories and Health District, 2020.

# Key Takeaways

## Population-level (LAC)

| | |
|---|---|
| Largest burden of unmet need (not in care) | • Cisgender men<br>• Latinx PLWDH<br>• 55 years and older<br>• MSM<br>• Hollywood-Wilshire HD |
| Unequal % of PLWDH vs unmet need | • Black PLWDH<br>• <45 years of age<br>• No identified HIV risk |
| Highest % of unmet need within population | • Black and other racial/ethnic groups<br>• <35 years of age<br>• With no risk identified<br>• Central HD |

## Program-level (RWP)

| | |
|---|---|
| Largest burden of unmet need (not in care) | • Cisgender men<br>• Latinx clients<br>• Aged 25-34 years<br>• MSM<br>• Hollywood-Wilshire HD |
| Unequal % of RWP clients vs unmet need | • Black and White clients<br>• <45 years of age<br>• Other sexual risk |
| Highest % of unmet need within population | • Transgender clients<br>• Black and White clients<br>• <35 years of age<br>• No identified risk, PWID, MSM/PWID,<br>• Hollywood-Wilshire HD |

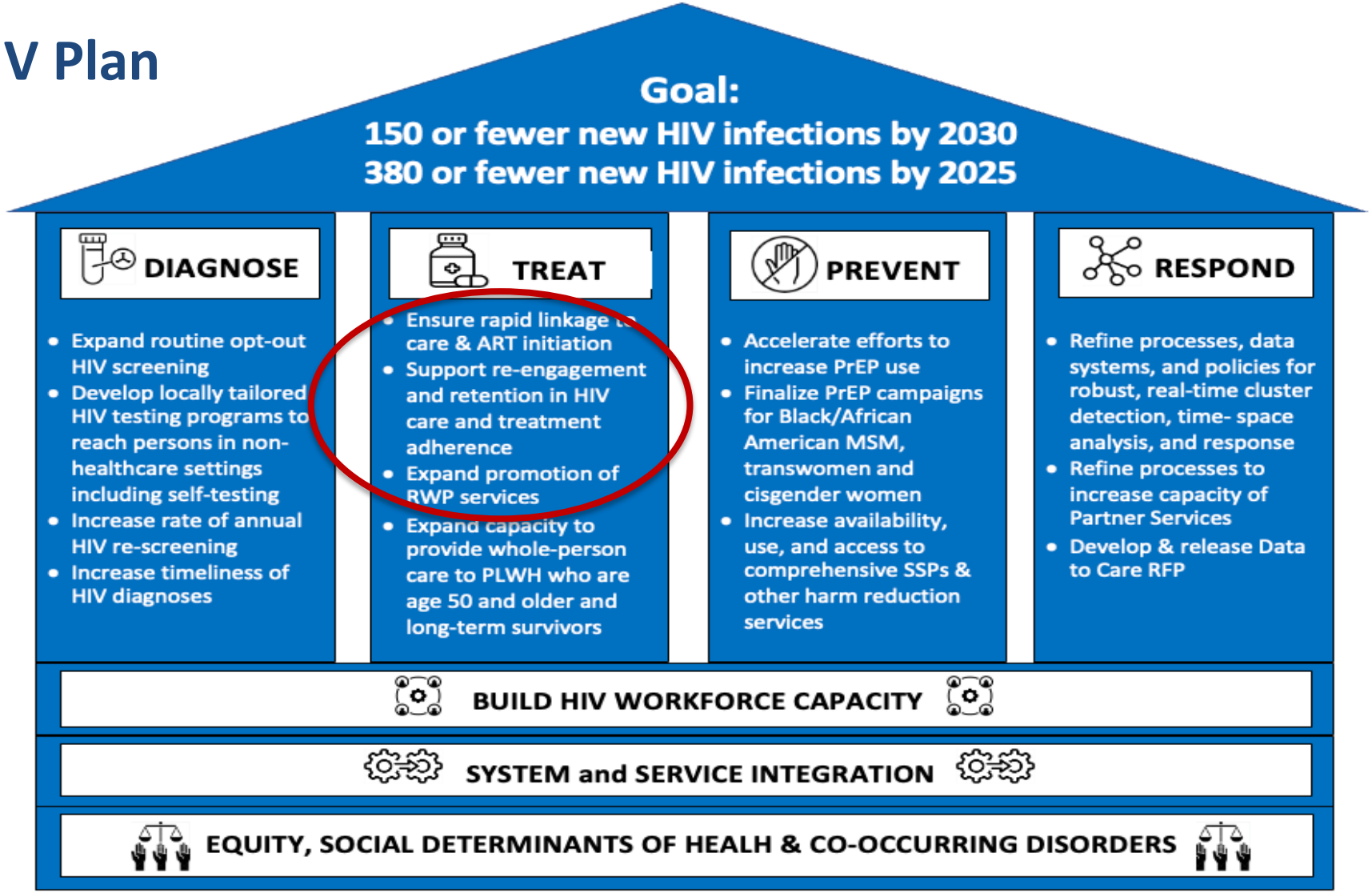
# Questions

# Discussion – using the unmet need estimate for planning

# LAC Comprehensive HIV Plan Snapshot

**Priority Populations**

- Latinx MSM
- Black MSM
- Transgender persons
- Cisgender women of color
- PWID
- Persons < age of 30
- PLWH ≥age 50




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 (2022- 2026), December 2022: 1-136.

# What are strategies to improve engagement in care?

- Identify and address barriers at the provider-level[2]
  - Address identified needs with supportive services (housing, financial, transportation)
  - Minimize clinic barriers (extended clinic hours, flexible scheduling)
  - Improve patient experience and satisfaction and build trust (welcoming and courteous staff, linguistically and culturally appropriate services)
  - Use reminders for appointment reminders and alert providers about missed appointments
  - Provide client-centered supportive/case management services
- Health Department-level
  - Identify, locate, and reengaging patients who have been lost to care through “Data to Care” activities[2]
- Focus on those populations that account for a large portion of PLWDH who have unmet need for medical care
  - LAC: persons with no identified HIV exposure risk reported, PWID, PLWDH aged 13-25

1.Giordano T.P. Strategies for Linkage to and Engagement With Care: Focus on Intervention. *Top AntiVir Med,* 2018, doi: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6017130/

# How can our services improve engagement in care and reduce unmet need?

- Expanding access to RWP wraparound services
  - Clinical vs. community based

- Facilitate entry to care
  - Rapid ART and same-day appointments
  - ER and hospital discharge
  - Intersection with justice system?

- Expand existing access points
  - Mobile or street-based

- New access points
  - Non-traditional partners?

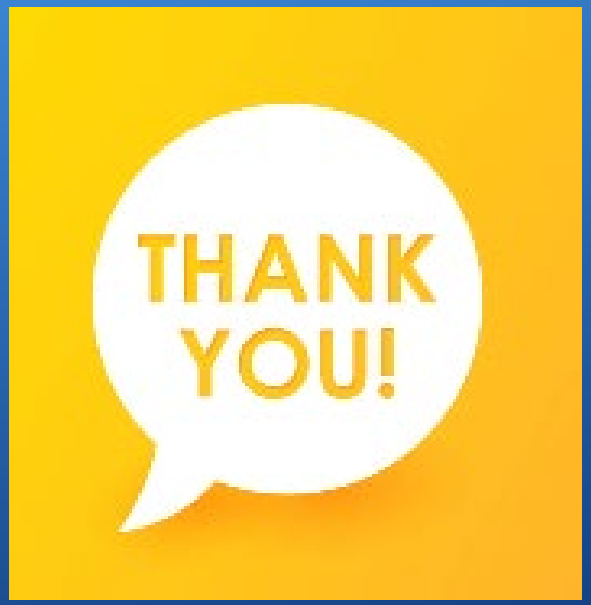
- Linguistically and culturally appropriate services
- Service promotion

# Next Steps for Unmet Need Estimates

- Continue measure-focused presentations to COH
  - In Care but Not Virally Suppressed – June

- Further analyses are needed to
  - Identify predictors of unmet need among LAC residents

- Summary report completed mid-2023




Special thanks to the following people without whom this presentation would not be possible:

Sona Oksuzyan, PhD

Janet Cuanas, MPP

Virginia Hu, MPH

Michael Green, PhD, MHSA

# References and Resources

- Webinar video and slides:  Enhanced Unmet Need Estimates and Analyses: Using Data for Local Planning https://targethiv.org/library/enhanced-unmet-need-estimates-and-analyses-using-data-local-planning

- Webinar video and slides:  https://targethiv.org/library/updated-framework-estimating-unmet-need-hiv-primary-medical-care

- Methodology for Estimating Unmet Need:  Instruction Manual https://targethiv.org/library/methodology-estimating-unmet-need-instruction-manual

LOS ANGELES COUNTY
COMMISSION ON HIV

# 2023 Training Schedule

- All trainings are open to the public.
- Click on the training topic to register.
- Recordings will be available on our website for those unable to join live trainings.
- Certifications of Completion will be provided.
- All trainings are virtual.

| Topic | Date |
|---|---|
| General Orientation and Commission on HIV Overview * | March 29<br>3:00 - 4:30 PM |
| Priority Setting and Resource Allocation Process & Service Standards Development * | April 12<br>3:00 - 4:30 PM |
| Tips for Making Effective Written and Oral Public Comments | May 24<br>3:00 - 4:00 PM |
| Ryan White Care Act Legislative Overview<br>Membership Structure and Responsibilities * | July 19<br>3:00 - 4:30 PM |
| Public Health 101 | August 16<br>3:00 - 4:30 PM |
| Sexual Health and Wellness | September 20<br>3:00 - 5:00 PM |
| Health Literacy and Self-Advocacy | October 18<br>3:00 - 4:30 PM |
| Policy Priorities and Legislative Docket Development Process * | November 15<br>3:00 - 4:30 PM |
| Co-Chair Roles and Responsibilities | December 6<br>4:00 - 5:00 PM |

***Mandatory core trainings for all commissioners.***

# ISSUE BRIEF

# Status Neutral HIV Care and Service Delivery Eliminating Stigma and Reducing Health Disparities

**Today, powerful HIV prevention and treatment tools can keep people healthy and help end the HIV epidemic.** Combining these tools in a status neutral approach can help people maintain their best health possible, while also improving outcomes in HIV prevention, diagnosis, care, and treatment. A status neutral approach to HIV-related service delivery aims to deliver high-quality, culturally affirming health care and services at every engagement, supporting optimal health for people with and without HIV. This approach is especially important now to reduce the unacceptably high number of annual HIV infections and help close the persistent gaps along the HIV prevention and care continuum, which indicate that not enough people are being engaged or retained in HIV prevention and treatment.

## Many Barriers May Keep People from Being Engaged in HIV Care.

- **HIV testing, treatment, and prevention services are often offered separately,** can be challenging to navigate, and further emphasizes a division between people with HIV and people who could benefit from prevention.
- **Separating HIV services from other routine healthcare** misses opportunities to engage people in HIV testing, prevention, and treatment when they seek sexual health or other non-HIV-focused services.
- Providing critical support services—like housing, food, and transportation assistance—is essential to keeping someone in ongoing care, but these **services are not necessarily offered** alongside what are considered "traditional" HIV care and prevention services.
- **Stigma** embedded in the experience of many people seeking HIV treatment and prevention services can stop people from visiting health care providers labeled as "HIV" or "STD" clinics.
- Everyone has **implicit biases** that affect their perceptions of others. The HIV care or prevention services someone receives may be affected by healthcare and other service providers' implicit biases on race/ethnicity, sexual orientation, gender identity, age, and other factors. These biases, in some cases, may be why a person does not return for care and services.

Many HIV prevention experts believe a status neutral approach can help improve care and service provision and eliminate structural stigma by meeting people where they are, offering a "whole person" approach to care, and putting the needs of the person ahead of their HIV status. The status neutral approach aims to advance health equity and drive down disparities by embedding HIV prevention and care into routine care. Integrating HIV prevention and care with strategies that address social determinants of health can help reduce barriers to accessing and remaining engaged in care.

The status neutral approach also aims to increase efficiency, since the clinical and social services that prevent or treat HIV are nearly identical and can be unified in a single service plan rather than different plans based on an individual's HIV status. Adopting a status neutral approach is one way to help deliver better prevention and care and ultimately decrease new HIV infections and support the health and quality of life of people living with HIV in the United States.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

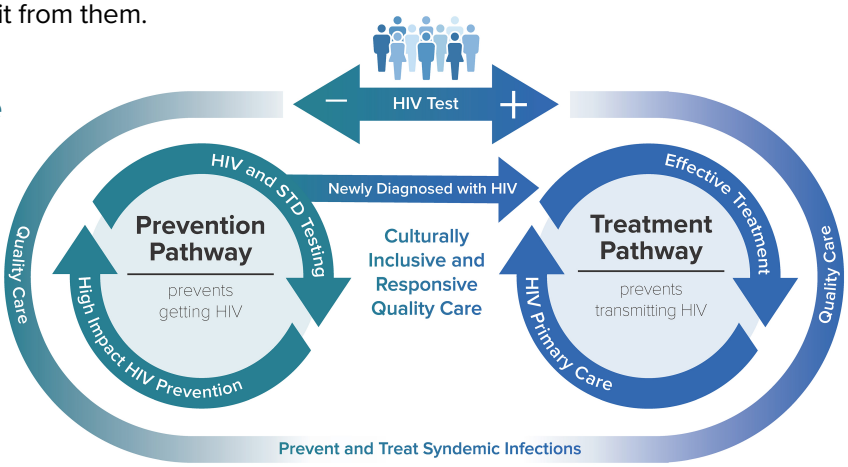
# Understanding Status Neutral HIV Care

**The status neutral framework provides care for the whole person by offering a "one-door" approach:** people with HIV and people seeking HIV prevention services can access treatment, prevention, and other critical services in the same place. Normalizing HIV treatment and prevention helps to destigmatize both. In a status neutral approach to care, a provider continually assesses and reassesses a person's clinical and social needs. The goal is to optimize a person's health through continuous engagement in treatment and prevention services without creating or deepening the divide between people with HIV and people who could benefit from prevention.

**A status neutral approach is unique because both of the harmonized pathways promote continual assessment** of each person's needs and ongoing engagement in HIV prevention and care, including access to support services, for anyone who could benefit from them.

## Status Neutral HIV Prevention and Care

People whose HIV tests are **negative** are offered powerful prevention tools like PrEP, condoms, harm reduction (e.g. SSPs), and supportive services to stay HIV negative.




People whose HIV tests are **positive** enter primary care and are offered effective treatment and supportive services to achieve and maintain viral suppression.

Follow CDC guidelines to test people for HIV. Regardless of HIV status, quality care is the foundation of HIV prevention and effective treatment. Both pathways provide people with the tools they need to stay healthy and stop HIV.

**Status neutral HIV service delivery is:**

- **Healthcare** that encompasses HIV testing, treatment, and prevention services.
- **HIV treatment and prevention** that is offered alongside other local medical healthcare services frequently used by the community—for example, sexual health, transgender and other LGBTQ-focused care, healthcare for people who use drugs, and general primary care.
- **Service delivery** that recognizes and includes broader social services that support the path to optimal HIV and other health outcomes—like housing, food, transportation, employment assistance, harm reduction services, and mental health and substance use disorder services—regardless of the HIV status of the people seeking care.
- **Culturally affirming, stigma-free HIV treatment and prevention,** delivered by supportive and accepting providers who have been trained to recognize and address implicit racial/ethnic, sexual orientation, and other biases (thoughts and feelings that providers are not consciously aware of), and provided in settings that consider and prioritize a positive experience for the person seeking services.

**Status neutral service begins with an HIV test—the pathway to prevention and treatment.** In a status neutral approach, an HIV test spurs action regardless of the result by recognizing the opportunity created by a negative or positive result for an individual to achieve better health:

- **If a person receives a negative HIV test result,** the provider engages the person in HIV prevention and offers powerful tools that prevent HIV, such as pre-exposure prophylaxis (PrEP). The prevention pathway emphasizes a consistent re-evaluation of the engaged person to match prevention and social support strategies to the individual's needs. Being engaged in such preventive services also means expedited connection to HIV care in the event of a new positive HIV test result. Condoms and harm reduction services are also an important part of this prevention pathway, especially for people who are not ready or eligible for PrEP.
- **If a person receives a positive HIV test result,** the provider offers a prescription for effective treatment to help them become virally suppressed and maintain an undetectable viral load as well as other clinical and support services to help support general health and achieve a high quality of life. Studies have shown that people with an undetectable viral load do not transmit HIV to their sexual partners, this is often referred to as "U=U."

## Why a Status Neutral Approach Is Needed

**HIV treatment and prevention services have not been fully used by all who need them:** Only 66 percent of people with diagnosed HIV in the United States are virally suppressed. PrEP remains greatly underused—just 23 percent of the estimated one million Americans who could benefit are using the intervention. Stigma and structural barriers are major obstacles that deter people from seeking HIV prevention and care. People with HIV and people who could benefit from HIV prevention are not two distinct populations, but rather one group with similar medical and social service needs. Adopting a status neutral and "whole person" approach to **people in need of prevention and care services can address these similar needs, along with HIV-related stigma.**

**Health departments implementing models of status neutral HIV care have reported benefits such as:**

- **Decreasing new HIV infections.** A status neutral approach to care and service delivery means that regardless of HIV status, people have access and support to stay on highly effective public and personal health interventions like PrEP and HIV treatment. When people are supported to fully use these interventions, the outcome is the same—HIV infections and other infections are identified, prevented, and treated. For example, New York City's status neutral approach to HIV prevention and care, first introduced in 2016, contributed to annual declines in new HIV diagnoses thereafter. New York City saw a 22% decrease in new HIV diagnoses from 2016 to 2019.

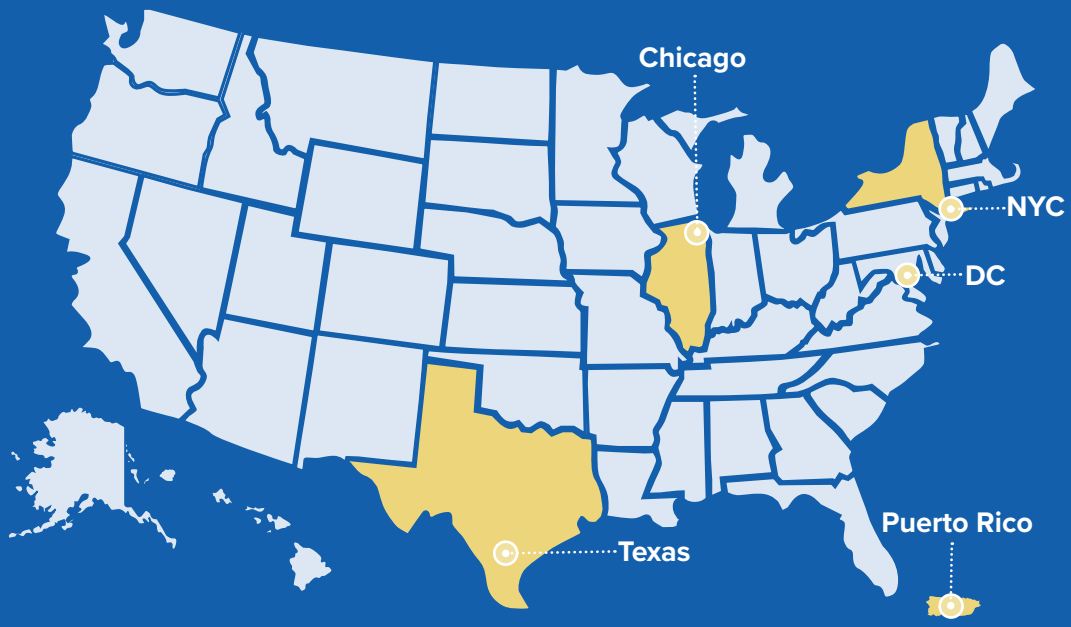
- **Supporting and enabling optimal health through continual engagement in comprehensive, "whole person" care.** By offering HIV services alongside other local health care and social support services used by the community, HIV prevention and treatment can become part of the fabric of holistic care designed to meet the needs of each person. As their needs evolve, a person can be seamlessly connected to new services. Potential outcomes include improved HIV care, as well as better overall health and social stability for every individual. For example, Chicago has created comprehensive status neutral health homes that offer the same services to people with HIV and people who could benefit from prevention services. Services include primary care, medications, care coordination, and behavioral health.

- **Opportunities for more efficient service delivery.** Parallel services and structures historically created for people with HIV or people who could benefit from prevention services can impede the most efficient use of resources. This can also inadvertently hinder connection to care by maintaining stigmatizing structures in health care. Identifying opportunities to resolve these divisions allows for more streamlined and integrated care. Washington, D.C. has seen increased capacity and improved outcomes and engagement at organizations using a status neutral approach. Using this approach has increased viral suppression rates 3% across all funded jurisdictions and increased linkage to preventive services like PrEP and harm reduction for people who tested negative for HIV.

- **Improving health equity.** The status neutral framework integrates HIV and prevention services to better address social determinants of health regardless of HIV status. The framework also encourages the delivery of culturally affirming care by ensuring providers recognize and address their implicit biases on issues like race, ethnicity, sexual orientation, or gender identity. These biases sometimes prevent people from returning for care and other services. Likewise, countering stigma is essential to ensure that people with HIV are not defined by their status, and that people seeking HIV prevention and care services are empowered to access these tools without facing judgment or being reduced to the result of a lab test. Addressing racial bias and stigma results in better care experiences for patients and increases the likelihood that they remain in care and stay healthy.

## **SPOTLIGHT:** Status Neutral HIV Care in Action

**Here's how some jurisdictions across the country are integrating a status neutral approach into their HIV care services:**




- **Chicago: Integrating all HIV and sexually transmitted infection (STI) services**. The Chicago Department of Public Health recently restructured its entire HIV services portfolio to adopt a status neutral approach. Based on feedback from its community members over a two-year community engagement process, the portfolio now integrates HIV and STI funding to deliver comprehensive care that links people to healthcare services like STI screening, substance use disorder treatment, mental health, housing, financial assistance, and psychosocial support in addition to HIV treatment and prevention. Anyone can access these services regardless of HIV status.

- **New York City: Expanding sexual health and rebranding to reduce stigma.** Stigma associated with HIV and STIs can prevent people from seeking care in STI clinics. To address this, the New York City Department of Health and Mental Hygiene rebranded its STI clinics as sexual health clinics and transformed services so that they fully meet clients' sexual health needs. These changes have resulted in more diverse populations visiting the clinic for care.

- **Puerto Rico: Delivering affirming, trauma-informed care for transgender people**. Centro Ararat in Ponce, Puerto Rico delivers integrated, tailored sexual health and primary care to the transgender community. The center's innovative clinic provides comprehensive, trauma-informed health services for transgender people alongside HIV and STI care. These services include hormone therapy and level testing, mental health services, support with name changes, and assistance finding trans-sensitive housing.

- **Texas: Improving access to social services for all people.** *Achieving Together* is the community plan to end the HIV epidemic in Texas. It lays out a vision for status neutral HIV care that supports all people in accessing services that meet their priority needs. This approach addresses social determinants of health, including housing, transportation, and food assistance, helps with insurance navigation, and increases access to mental health and substance use disorder treatment.

- **Washington, D.C.: Eliminating HIV prevention and treatment barriers early.** DC Health developed a status neutral approach through its regional early intervention services initiative, which supports engaging people early in HIV care and prevention services throughout the DC metropolitan area. The initiative has made strides in integrating prevention and treatment services, which previously operated independently, and consists of five pillars to promote equity and whole person health spanning HIV outreach, education, testing, and linkage to and retention in care.

## What CDC Is Doing to Advance Status Neutral HIV Care

**CDC is providing funding, conducting implementation science to improve programs, and partnering with organizations across the U.S. to support integrated, status neutral approaches to HIV care:**

- **Encouraging grantees to deliver integrated services.** Several of CDC's major funding programs provide flexible resources for health department and community-based organization (CBO) partners to deliver integrated HIV prevention services. Additionally, CDC encourages health departments that receive funding through CDC's flagship prevention and surveillance program to use these resources to support programs that adopt status neutral approaches to HIV prevention and treatment.

  - ***Ending the HIV Epidemic* initiative implementation:** In July 2021, CDC awarded the second major round of EHE funding — approximately $117 million — to health departments representing 57 prioritized jurisdictions to scale up focused, local efforts designed to address the unique barriers to HIV prevention in each community. CDC encourages grantees to coordinate with STD and viral hepatitis programs, LGBTQ health centers, criminal justice and correctional facilities, and other providers to deliver HIV services. In addition, the new program provides funding to a subset of jurisdictions to strengthen HIV testing, prevention, and treatment services at dedicated STD clinics.

  - **High-impact HIV prevention through CBOs and health departments:** CDC funded more than 90 CBOs to develop high-impact HIV prevention programs and partnerships, beginning in 2021. These CBOs are required to create HIV programs with the greatest potential to address social and structural determinants of health. CBOs can use CDC funding to help clients navigate essential support services. The program will also support integrated screening for STIs, viral hepatitis, and TB, and referrals for subsequent treatment.

- **Conducting implementation science.** CDC is conducting a pilot program to evaluate a project designed to deliver status neutral HIV services to transgender people. The pilot will support transgender healthcare providers and CBOs in integrating HIV, STI, viral hepatitis, and harm reduction services alongside transgender-specific healthcare. The pilot aims to establish best practices for creating a "one-door" approach for testing and other interventions that can improve the health of transgender people.

- **Building partnerships.** CDC is working with other federal agencies and organizations focused on issues that intersect with HIV and affect health outcomes, like sexual health, mental health, housing, incarceration, employment, and substance use disorder to advance status neutral approaches to HIV prevention and care. For example, the HIV National Strategic Plan incorporates the status neutral framework, creating opportunities to improve systems so they support the provision of status neutral services in the national HIV response. These partnerships will enable the sharing of knowledge and best practices that translates to better implementation science, programs, and services. These partnerships can also support better integration of programmatic efforts in communities.

## The Way Forward

**It will take time for a status neutral approach to be adopted across the country.** Federal agencies, state and local health departments, healthcare providers, and CBOs can take steps now to begin promoting and integrating this approach into their programs and service delivery models if appropriate for their organization or jurisdiction and supported by their community:

- Federal health agencies can provide training, support, and technical assistance to state and local health departments, healthcare providers, and CBOs looking to implement status neutral HIV care. They should prioritize strategies that support front-line providers in more easily creating and implementing status neutral programs. They should also promote cross-agency collaboration to integrate HIV treatment and prevention services over time with other primary care, behavioral health, and social services.

- State and local health departments can review their current funding and care delivery models to further integrate HIV into STI and primary care settings, especially community health centers, sexual health clinics, and health access points for people who use drugs. They should also identify ways to braid funding from multiple sources, and work with CBOs and other providers to gather and share best practices and lessons learned in implementing status neutral HIV care.

- Healthcare providers and CBOs can offer dynamic, supportive care that integrates culturally affirming messages and prioritizes each patients' individual needs. They can consider providing non-HIV services that can improve patients' overall health, such as STI and viral hepatitis screening, mental health care, and substance use counselling, as well as linkage to social services. They can also participate in regular trainings on recognizing and addressing implicit racial/ethnic and other biases.

## REFERENCES


1 Centers for Disease Control and Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas, 2019. HIV Surveillance Supplemental Report 2021;26(No. 2). http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published May 2021. Accessed June 2, 2021.

2 Walcott M, Kempf MC, Merlin JS, Turan JM. Structural community factors and sub-optimal engagement in HIV care among low-income women in the Deep South of the USA. Cult Health Sex. 2016;18(6):682-94.

3 Eaton LA, Driffin DD, Kegler C, et al. The role of stigma and medical mistrust in the routine health care engagement of black men who have sex with men. Am J Public Health. 2015;105(2):e75-e82.

DRAFT

LOS ANGELES COUNTY
COMMISSION ON HIV

# RYAN WHITE PROGRAM

# UNIVERSAL SERVICE STANDARDS

**Approved by COH on 2/11/21**

**DRAFT FOR PUBLIC COMMENT**

**PUBLIC COMMENT PERIOD: May 5, 2023- June 5, 2023**

**Email comments to HIVComm@lachiv.org**

LOS ANGELES COUNTY
COMMISSION ON HIV

**Service Standard Review**
**Guiding Questions for Public Comments**

The Los Angeles County Commission on HIV announces an opportunity for the public to submit comments for the draft **Universal Service Standards for HIV Care** being updated by the Standards and Best Practices Committee. We welcome feedback from consumers, providers, community members, and any HIV stakeholders interested in improving HIV care in Los Angeles County. Please distribute the document widely within you networks. The document is included below and can accessed at: **https://hiv.lacounty.gov/service-standards**

Please email comments to: HIVCOMM@LACHIV.ORG
The public comment period ends on **June 6, 2023.**

**When providing public comment, consider responding to the following:**

1. Are the Universal Service Standards presented 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? Why or why not?

3. Are the proposed Universal Services Standards client-centered? Is there anything missing related to HIV prevention and care?

LOS ANGELES COUNTY
COMMISSION ON HIV

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

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

## INTRODUCTION

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

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

## UNIVERSAL STANDARDS OVERVIEW

The objectives of the Universal Standards are to ensure agencies:

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

## 1. GENERAL AGENCY POLICIES

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

| 1.0 GENERAL AGENCY POLICIES | |
|---|---|
| **Standard** | **Documentation** |
| 1.1 Agency develops or utilizes an existing client confidentiality policy in accordance with state and federal laws to assure protection of client HIV status, behavioral risk factors, and/or use of services. | 1.1 Written client confidentiality policy on file with specific information technology safeguards for confidentiality and patient information if using telehealth service modality. |
| 1.2 Agency is responsible for informing the patient that they have the right to obtain copies of their medical and other health records maintained by the agency. | 1.2 Written policy for informing the patient of their rights to receive a copy of their medical records. The policy should contain a description of the process for obtaining records, such as a verbal or written request and a reasonable timeframe for patients to receive the information. |
| 1.3 Client determines what information of theirs can be released and with whom it can be shared. Services using telehealth modality are subject to consent by the patient. | 1.3 Completed *Release of Information Form* on file including:<br>• Name of agency/individual with whom information will be shared<br>• Information to be shared<br>• Duration of the release consent<br>• Client signature<br>For agencies and information covered by the Health Insurance Portability and Accountability Act (HIPAA), form must be HIPAA disclosure authorization compliant. The form must also be compliant with the CA Medi-Cal telehealth policy.[1] |
| 1.4 Agency develops or utilizes an existing grievance procedure to ensure clients have recourse if they feel they are being treated in an unfair manner or feel they are not receiving quality services. | 1.4 Written grievance procedure on file that includes, at minimum:<br>• Client process to file a grievance<br>• Information on the Los Angeles County Department of Public Health, Division of HIV & STD Programs (DHSP) Customer Support Program 1-800-260-8787. Additional ways to file grievances can be found at: DHSP_CSP_CustomerSupportForm_Website-ENG-Final_12.2022.pdf (lacounty.gov)<br>DHSP Customer Support Program information is posted in a visible location on site or provided to the patient at the beginning of a telehealth encounter. |

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|---|---|
| 1.5 Agency provides eligibility requirements for services available upon request. Eligibility requirements must follow guidance from Division of HIV & STD Programs (DHSP) and HRSA under Policy Clarification Notice #16- 02.[4] | 1.5 Written eligibility requirements on file. |
| 1.6 All client files are stored in a secure and confidential location, and electronic client files are protected from unauthorized use. Protection of client files and information must cover use of electronic medical records, phones, text messages, email, and telehealth modalities. | 1.6 Client files must be locked and/or password protected with access provided only to appropriate personnel. Agencies must establish written procedures and IT policies for message encryption and restrictions on staff access to protect client information. |
| 1.7 Agency maintains progress notes of all communication between provider and client. | 1.7 Legible progress notes maintained in individual client files that include, at minimum:<br>• Date of communication or service<br>• Service(s) provided<br>Recommended referrals linking clients to needed services (See Section 6: Referrals and Case Closure) |
| 1.8 Agency develops or utilizes an existing crisis management policy. | 1.8 Written crisis management policy on file that includes, at minimum:<br>• Mental health crises<br>• Dangerous behavior by clients or staff |
| 1.9 Agency develops a policy on utilization of Universal Precaution Procedures https://www.cdc.gov/niosh/topics/bbp/universal.html<br>• Staff members are trained in universal precautions. | 1.9 Written policy or procedure on file. Documentation of staff training in personnel file. |
| 1.10 Agency ensures compliance with Americans with Disabilities Act (ADA) criteria for programmatic accessibility (e.g. building and design accessibility, parking, etc.). For agencies with multiple sites, all sites must comply with the ADA requirements. | 1.10 ADA criteria on file at all sites. |
| 1.11 Agency complies with all applicable state and federal workplace and safety laws and regulations, including fire safety. | 1.11 Signed confirmation of compliance with applicable regulations on file. |

## 2. CLIENT RIGHTS AND RESPONSIBILITIES

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

| **2.0 CLIENT RIGHTS AND RESPONSIBILITIES** | |
|---|---|
| **Standard** | **Documentation** |
| 2.1 Agency ensures services are available to any individual who meets the eligibility requirements for the specific service category. | 2.1 Written eligibility requirements on file. Client utilization data made available to funder. |
| 2.2 Agency includes input from people living with HIV/AIDS in the design and evaluation of services to ensure care is client centered. | 2.2 Written documentation of how input was received to inform service planning and evaluation in regular reports. Lists may include:<br>• Consumer Advisory Board meetings<br>• Participation of people living with HIV in HIV program committees or other planning bodies<br>• Needs assessments<br>• Anonymous patient satisfaction surveys. Discreet drop off boxes should be available in various sites throughout the agency and/or anonymous electronic follow-up surveys emailed to patients after their appointment.<br>• Focus groups |
| 2.3 Agency ensures that clients receive information technology support and training on how to use telehealth services. | 2.3 Written checklists and/or "how to" guides are provided to patients prior to their telehealth appointment. Materials may be emailed to patient and/or posted on the agency website.<br>The document should contain at least the following information:<br>• Instructions on how to use telehealth tools (i.e., phone, laptop, tablets, etc.) in plain language and available in the patient's preferred language.<br>• Telephone number for technical support or trouble shooting available before, during and after the telehealth appointment. |

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| 2.4 Agency ensures that clients retain the right to accept or decline a telehealth visit. The ultimate decision on the mode of service delivery, whether in-person or telehealth, must be determined by the client first before an appointment is made. | 2.4 Written procedures and telehealth acceptance or denial form completed by patients prior to the appointment. |
| 2.5 Agency provides each client a copy of the *Patient & Client Bill of Rights & Responsibilities (Appendix B)* document that informs them of the following:<br>• Confidentiality policy<br>• Expectations and responsibilities of the client when seeking services<br>• Client right to file a grievance<br>• Client right to receive no-cost interpreter services<br>• Client right to access their file (if psychotherapy notes cannot be released per clinician guidance, agency should provide a summary to client within 30 days)<br>• Reasons for which a client may be removed from services and the process that occurs during involuntary removal | 2.5 *Patient and Client Bill of Rights* document is signed by client and kept on file. |

## 3. STAFF REQUIREMENTS AND QUALIFICATIONS

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

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

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

## 4. CULTURAL AND LINGUISTIC COMPETENCE

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

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

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

Federal and State language access laws require health care facilities that receive federal or state funding to provide competent interpretation services to limited English proficiency patients at no cost, to ensure equal and meaningful access to health care services. Interpretation refers to verbal communication where speech is translated from a speaker to a receiver in a language that the receiver can understand. Translation refers to the conversion of written material from one language to another.

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

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

## 5. INTAKE AND ELIGIBILITY

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

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

## 6. REFERRALS AND CASE CLOSURE

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

| **6.0 REFERRALS AND CASE CLOSURE** | |
|---|---|
| **Standard** | **Documentation** |
| 6.1. Agency will maintain a comprehensive list of providers for full spectrum HIV-related and other service referrals<br>a. Staff will provide referrals to link clients to services based on assessments and reassessments | 6.1 Identified resources for referrals at provider agency (e.g. lists on file, access to websites)<br>a. Written documentation of recommended referrals in client file |
| 6.2 If needed, staff will engage additional providers for specific support services (e.g. behavioral health, substance use, housing) | 6.2 Agency establishes partnerships with agencies for referrals as needed. Memoranda of Understanding (MOU) on file. |
| 6.3 For clients with missed appointments or pending case closure, staff will attempt to contact client.<br>a. Cases may be closed if the client:<br>• Relocates out of the service area<br>• Is no longer eligible for the service<br>• Discontinues the service<br>• No longer needs the service<br>• Puts the agency, service provider, or other clients at risk<br>• Uses the service improperly or has not complied with the services agreement<br>• Is deceased<br>• Has had no direct agency contact, after repeated attempts, for a period of 12 months. | 6.3 Attempts to contact client and mode of communication documented in file.<br>a. Justification for case closure documented in client file |
| 6.4 Agency has a transition procedure in place that is implemented for clients leaving services to ensure a smooth transition. | 6.4 Completed transition summary in file, signed by client and supervisor (if possible). Summary should include reason for case closure; and a plan for transition to other services, if applicable, with confirmation of communication between referring and referral agencies, or between client and agency. |

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| 6.5 Agency develops or utilizes existing due process policy for involuntary removal of clients from services; policy includes a series of verbal and written warnings before final notice and case closure. | 6.5 Due process policy on file as part of transition, and case closure policy described in the *Patient & Client Bill of Rights* document. (Refer to Appendix B). |

## APPENDIX A: RYAN WHITE PART A SERVICE CATEGORIES

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

### SERVICE CATEGORIES

| CORE MEDICAL SERVICES | SUPPORT SERVICES |
|---|---|
| Outpatient/Ambulatory Health Services | Non-Medical Case Management Services |
| AIDS Drug Assistance Program Treatments | Child Care Services |
| AIDS Pharmaceutical Assistance | Emergency Financial Assistance |
| Oral Health Care | Food Bank/Home Delivered Meals |
| Early Intervention Services (EIS) | Health Education/Risk Reduction |
| Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals | Housing |
| Home Health Care | Other Professional Services |
| Home and Community-Based Services | Linguistic Services |
| Hospice Services | Medical Transportation |
| Mental health Services | Outreach Services |
| Medical Nutrition Therapy | Psychosocial Support Services |
| Medical Case Management, including Treatment Adherence | Referral for Health Care and Support Services |
| Substance Abuse Outpatient Care | Rehabilitation Services |
| | Respite Care |
| | Substance Abuse Services (residential) |

## APPENDIX B: PATIENT & CLIENT BILL OF RIGHTS AND RESPONSIBILITIES

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

**A. Respectful Treatment and Preventative Services**

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

**B. Competent, High-Quality Care**

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

**C. Participate in the Decision-making Treatment Process**

1. Receive complete and up-to-date information in words you understand about your diagnosis, treatment options, medications (including common side effects and complications) and prognosis that can reasonably be expected.
2. Participate actively with your provider(s) in discussions about choices and options available for your treatment.
3. Make the final decision about which treatment option is best for you after you have been given all relevant information about these choices and the clear recommendation of your provider.
4. Have access to patient-specific education resources and reliable information and training about patient self-management.
5. Refuse any and all treatments recommended and be told of the effect that not taking the treatment may have on your health, be told of any other potential consequences of your refusal and be assured that you have the right to change your mind later.
6. Be informed about and afforded the opportunity to participate in any appropriate clinical research studies for which you are eligible.
7. Refuse to participate in research without prejudice or penalty of any sort.

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

**D. Confidentiality and Privacy**

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

**E. Billing Information and Assistance**

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

**F. Patient/Client Responsibilities**

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

1. Participate in the development and implementation of your individual treatment or service plan to the extent that you are able.
2. Provide your providers, to the best of your knowledge, accurate and complete information about your current and past health and illness, medications and other treatment and services you are receiving, since all of these may affect your care. Communicate promptly any changes or new developments.
3. Communicate to your provider whenever you do not understand information you are provided.
4. Follow the treatment plan you have agreed to and understand the consequences of failing to adhere to the recommended course of treatment or of using alternative treatments.
5. Understand that cases may be closed if the client:
    i. Relocates out of the service area
    ii. Is no longer eligible for the service(s)
    iii. Discontinues the service(s)
    iv. No longer needs the service(s)
    v. Puts the agency, service provider, or other clients at risk
    vi. Uses the service(s) improperly or has not complied with the services agreement
    vii. Is deceased
    viii. Has had no direct agency contact, after repeated attempts, for a period of 12 months
6. Keep your appointments and commitments at this agency or inform the agency promptly if you cannot do so.
7. Keep your provider or main contact informed about how to reach you confidentially by phone, mail, or other means.

8. Follow the agency's rules and regulations concerning patient/client care and conduct.
9. Be considerate of your providers and fellow clients/patients and treat them with the respect you yourself expect.
10. Refrain from the use of profanity or abusive or hostile language; threats, violence, or intimidations; carrying weapons of any sort; theft or vandalism; sexual harassment and misconduct.
11. If you are a person living with a Substance Use Disorder, please be open and honest with your provider about your substance use so that any issues can be properly addressed.

**For More Help or Information**

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

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

**APPENDIX C: TELEHEALTH RESOURCES**

- **Federal and National Resources:**
  - HRSA's Ryan White HIV/AIDS Program Expanding HIV Care Through Telehealth CARE Action Newsletter October 2019: https://hab.hrsa.gov/sites/default/files/hab/Publications/careactionnewsletter/telehealth.pdf
- **Telehealth Discretion During Coronavirus:**
  - AAFP Comprehensive Telehealth Toolkit: https://www.aafp.org/dam/AAFP/documents/practice_management/telehealth/2020-AAFP-Telehealth-Toolkit.pdf
  - ACP Telehealth Guidance & Resources: https://www.acponline.org/practice-resources/business-resources/telehealth
  - ACP Telemedicine Checklist: https://www.acponline.org/system/files/documents/practice-resources/health-information-technology/telehealth/video_visit_telemedicine_checklist_web.pdf
  - AMA Telehealth Quick Guide: https://www.ama-assn.org/practice-management/digital/ama-telehealth-quick-guide
  - CMS Flexibilities for Physicians: https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf - "Under the CARES Act, CMS is waiving the requirements of section 1834(m)(1) of the ACT and 42 CFR § 410.78(a)(3) for use of interactive telecommunications systems to furnish telehealth services, to the extent they require use of video technology, for certain services. This waiver allows the use of audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services, and behavioral health counseling and educational services."
  - CMS Flexibilities for RHCs and FQHCs: https://www.cms.gov/files/document/covid-rural-health-clinics.pdf - "Medicare telehealth services generally require an interactive audio and video telecommunications system that permits real-time communication between the practitioner and the patient. (During the PHE, some telehealth services can be furnished using audio-only technology.)"
  - CMS Fact Sheet on Virtual Services: https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
  - Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency
  - Using Telehealth to Expand Access to Essential Health Services during the COVID-19 Pandemic

LOS ANGELES COUNTY
COMMISSION ON HIV

2023-2024 Legislative Docket | Approval Date: Approved by PPC on 04/05/23. Approved by EC on 04/27/23.

POSITIONS: SUPPORT | OPPOSE | SUPPORT w/AMENDMENTS | OPPOSE unless AMENDED | WATCH

| BILL | TITLE | DESCRIPTION / COMMENTS | RECOMMENDED POSITION | STATUS |
|---|---|---|---|---|
| ACA 5 (Low) | Marriage Equality | ACA= Assembly Constitutional Amendment<br>The California Constitution declares that defending life and liberty, acquiring, possessing, and protecting property, and pursuing and obtaining safety, happiness, and privacy are inalienable rights, and that a person may not be deprived of life, liberty, or property without due process of law or equal protection of the laws.<br>This measure would express the intent of the Legislature to amend the Constitution of the State relating to marriage equality.<br><br>https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240ACA5 | *Support* | 15-FEB-23<br>May be heard in committee March 17. |
| ACA 8 (Wilson) | Slavery | The California Constitution prohibits slavery and prohibits involuntary servitude, except as punishment to a crime. This measure would instead prohibit slavery in any form, including forced labor compelled by the use or threat of physical or legal coercion.<br><br>https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240ACA8 | *Support with follow-up questions* | 18-FEB-23<br>May be heard in committee March 20. |
| AB 4 (Arambula) | Covered California: Expansion | This bill would revise those provisions by deleting the requirement that limits coverage for the described individuals to the California qualified health plans. Contingent upon federal approval of the waiver, specified requirements for applicants eligible for the coverage described in the bill would become operative on January 1, 2025, for coverage effective for qualified health plans beginning January 1, 2026.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB4 | *Support with follow-up questions* | 13-MAR-23<br>Re-referred to Com. on HEALTH |

| BILL | TITLE | DESCRIPTION / COMMENTS | RECOMMENDED POSITION | STATUS |
|---|---|---|---|---|
| AB 5 (Zbur) | The Safe and Supportive Schools Program | This bill would require the State Department of Education, on or before July 1, 2025, to finalize the development of an online training delivery platform and an online training curriculum to support LGBTQ cultural competency training for teachers and other certificated employees, as specified. The bill would delete the above-described encouragement and instead would require, commencing with the 2025–26 school year, each school operated by a school district or county office of education and each charter school serving pupils in grades 7 to 12, inclusive, to use the online training delivery platform and curriculum, or an in-service alternative, to provide at least 4 hours of training at least once every 3 years to teachers and other certificated employees at those schools, as provided. By imposing additional duties on local educational agencies, the bill would impose a state-mandated local program. The bill would require the department to ensure a 95% completion rate of the training required pursuant to these provisions within each 3-year training period and would require the department to report specified completion data to the Legislature, as provided. The bill would require these provisions to be known as the Safe and Supportive Schools Act.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB5&search_keywords=transgender | *Support* | 27-MAR-23<br>Re-referred to Com. on ED.<br><br>(Education) |
| AB 223 (Ward) | Change of gender and sex identifier | This bill would require any petition for a change in gender and sex identifier or a petition for change of gender, sex identifier, and name filed by a person under 18 years of age, and any paper associated with the proceeding, to be filed under seal.<br><br>It is the best interest for the public to seal these records form the public to ensure the privacy and safety of transgender and nonbinary youth. Transgender and nonbinary youth are 2 to 2.5 times as likely to experience depressive symptoms, seriously consider suicide, and attempt suicide compared of their cisgender LGBQ peers. Being outed is a traumatic event for any individual, especially for individuals under 18 years of age. Allowing our children to choose when and how they decided to share their personal details is vital in protecting their mental and physical health.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB223&search_keywords=transgender | *Support* | 23-MAR-23<br><br>In Senate. Read first time. To Com. on RLS. for assignment.<br><br>(Rules) |

| BILL | TITLE | DESCRIPTION / COMMENTS | RECOMMENDED POSITION | STATUS |
|---|---|---|---|---|
| AB 254 (Bauer-Kahan) | Confidentiality of Medical Information Act: reproductive or sexual health application information | This bill would revise the definition of "medical information" to include reproductive or sexual health application information, which the bill would define to mean information related to a consumer's reproductive or sexual health collected by a reproductive or sexual health digital device. The bill would make a business that offers a reproductive or sexual health digital service to a consumer for the purpose of allowing the individual to manage the individual's information, or for diagnosis, treatment, or management of a medical condition of the individual, a provider of health care subject of the requirements of the Confidentiality of medical Information Act (CMIA). Because the bill would expand the scope of a crime, it would impose a state-mandated local program.<br><br>CMIA prohibits a provider of health care, a health care service plan, a contractor, or a corporation and its subsidiaries and affiliates form intentionally sharing, selling, using for marketing, o otherwise using any medical information, as defined, for any purpose not necessary to provide health care services to a patient, except as provided.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB254&search_keywords=sexual+health | *Support* | 13-MAR-23<br><br>From committee: Do pass and re-refer to Com on P. & C.P. (Ayes 13. Noes 0.) (March 14). Re-referred to Com. on R. & C.P.<br><br>(Privacy and Consumer Protection) |

| BILL | TITLE | DESCRIPTION / COMMENTS | RECOMMENDED POSITION | STATUS |
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| AB 352 (Bauer-Kahan) | Health Information | This bill would require specified businesses that electronically store or maintain medical information on the provision of sensitive services on behalf of a provider of health care, health care service plan, pharmaceutical company, contractor, or employer to develop capabilities, policies, and procedures, on or before July 1, 2024, to enable certain security features, including limiting user access privileges and segregating medical information related to sensitive services, as specified. The bill would additionally prohibit a provider of health care, health care service plan, contractor, or employer from cooperating with any inquiry or investigation by, or from providing medical information to, an individual, agency, or department from another state or, to the extent permitted by federal law, to a federal law enforcement agency that would identify an individual or that is related to an individual seeking or obtaining an abortion or abortion-related services that are lawful under the laws of this state, unless the request for medical information is authorized in accordance with specified existing provisions of law. Because the bill would expand the scope of an existing crime, it would impose a state-mandated local program. This bill would require the advisory group, as part of the above-described information, to identify policies and procedures to ensure appropriate safeguards to prevent electronic health information related to the provision of sensitive services from automatically being disclosed, transmitted, or transferred to, shared with, or accessed by, individuals and entities in another state. The bill would exempt health information related to sensitive services from that real time health information sharing requirement, to the extent not in conflict with federal law, until the previously described policies and procedures are implemented. The bill would define "sensitive services" for these purposes to mean all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB352&search_keywords=sexual+health | *Support with follow-up questions* | 27-MAR-23<br>Re-referred to Com. on HEALTH |
| AB 367 (Maienschein) | Controlled Substances: Enhancements | This bill, until January 1, 2029, would state that, for purposes of this enhancement, a person inflicts great bodily injury when they sell, furnish, administer, or give away fentanyl or an analog of fentanyl and the person to whom the substance was sold, furnished, administered, or given suffers a significant or substantial physical injury from using the substance. The bill would specify that this provision does not apply to juvenile offenders.<br><br>https://leginfo.legislature.ca.gov/faces/billHistoryClient.xhtml?bill_id=202320240AB367 | *Watch* | 23-MAR-23<br><br>In committee: Hearing postponed by committee. |

| BILL | TITLE | DESCRIPTION / COMMENTS | RECOMMENDED POSITION | STATUS |
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| AB 470 (Valencia) | Continuing medical education: physicians and surgeons | This bill would specify that these educational activities may also include activities that are designed to improve the quality of physician-patient communication. This bill would require the advisory group to be informed of federal and state threshold language requirements, as specified, and would require the authorized updated to be for the purpose of meeting the needs of California's changing demographics and properly addressing language disparities, as they emerge.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB470 | *Support* | 28-MAR-23<br><br>From committee: Do Pass and re-refer to Com. on APPR. With recommendation: To Consent Calendar. (Ayes 18. Noes 0) (March 28). Re-referred to Com. on APPR.<br><br>(Appropriations) |
| AB 598 (Wicks) | Sexual health education and human immunodeficiency virus (HIV) prevention education: school climate and safety: California Health Kids Survey | This bill would revise the information included in this instruction related to local resources and abortion, as specified, and would require that pupils received a physical or digital resource detailing local resources upon completion of the applicable instruction. This bill would require the State Department of Education to ensure the California Health Kids Survey includes questions about sexual and reproductive care as a core survey module for pupils in grades 7,9 and 11. The bill would require each school district serving pupils in any grades 5,7,9 or 11 to administer the California Health Kids Survey to pupils in the applicable grades, as provided.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB598&search_keywords=HIV | *Support* | 12-MAR-23<br><br>Re-referred to Com. on ED. |
| AB 719 (Boerner Horvath) | Medi-Cal benefits | This bill would require the department to require managed care plans to contract with public transit operators for the purpose of establishing reimbursement rates for nonmedical and nonemergency medical transportation trips provided by a public transit operator. The bill would require the rates reimbursed by the managed care plan to the public transit operates to be based on the department's fee-for-service rates for nonmedical and nonemergency medical transportation service.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB719&search_keywords=HIV | *Support* | 23-FEB-23<br>Referred to Com. on HEALTH. |

| BILL | TITLE | DESCRIPTION / COMMENTS | RECOMMENDED POSITION | STATUS |
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| AB 760 (Wilson) | California State University and University of California: records: affirmed name and gender identification | This bill would additionally require the Trustees of the California State University and would request the Regents of the University of California, to implement a system by which current students, staff, and faculty can declare an affirmed name, gender, or both name and gender identification, as provided. The bill would, commencing with the 2024-25 academic year, require California State University campus systems, and would request University of California campus systems, to be fully capable of allowing current students, staff, or faculty to declare an affirmed name, gender, or both name and gender identification.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB760&search_keywords=gender | *Support with Amendments (require the bill to apply to the University of California as well)* | 23-FEB-23 Referred to Com. on HIGHER ED. |
| AB 793 (Bonta) | Privacy: reverse demands | This bill would prohibit any government entity from seeking, or any court from enforcing, assisting, or supporting, a reverse-keyword or reverse-location demand, as defined, issued by a government entity or court in this state or any other state. The bill would prohibit a person or California entity from complying with a reverse-keyword or reverse-location demand. The bill would authorize a court to suppress any information obtained or retained in violation of these provisions, the United States Constitution, or California Constitution. The bill would authorize the Attorney General to commence a civil action for compliance with these provisions.<br>The bill would require a government entity to immediately notify any person whose information was obtained in violation of these provisions of the violation and of the legal recourse available, as specified. The bill would authorize an individual whose information was obtained, or a service provider or other recipient of the reverse-keyword or reverse-location demand to file a petition to void or modify the demand or order the destruction of information obtained in violation of these provisions. The bill would authorize an individual whose information was obtained by a government entity in violation of these provisions to bring a civil suit against the government entity for damages, injunctive or declaratory relief, or other relief that the court deems proper.<br><br>https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB793 | *Support with Amendments* | 20-MAR-23 Re-referred to Com. on PUB. S.<br><br>(Public Safety) |
| AB 920 (Bryan) | Discrimination: housing status | This bill would also prohibit discrimination based upon housing status, as defined. “Housing status” refers to the status of experiencing homelessness, as defined in paragraph (2) of subdivision (a) of Section 50675.15 of the Health and Safety Code.<br><br>https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB920 | *Support* | 28-MAR-23 From committee: Do pass and re-refer to Com. on APPR. (Ayes 7. Noes 2.) (March 28). Re-referred to Com. On APPR. |

| BILL | TITLE | DESCRIPTION / COMMENTS | RECOMMENDED POSITION | STATUS |
|---|---|---|---|---|
| AB 957 (Wilson) | Family law: gender identity | This bill would require the court to strongly consider that affirming the minor's identity is in the best interest of the child if a nonconsenting parent objects to a name change to conform to the minor's gender identity. This bill would require a court, when determining the best interests of a child, to also consider a parent's affirmation of the childe's gender identity.<br><br>https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB957 | *Support* | 22-MAR-23<br><br>Read second time. Ordered to third reading. |
| AB 1022 (Mathis) | Medi-Cal: Program of All-Inclusive Care for the Elderly | This bill, among other things relating to the Program of All-Inclusive Care for the Elderly (PACE) would require those capitation rates to also reflect the frailty level and risk associated with those populations. The bill would also expand an approved PACE organization's authority to use video telehealth to conduct all assessments, as specified.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1022&search_keywords=HIV | *Support* | 02-MAR-23<br>Referred to Com. on HEALTH. |
| AB 1078 (Jackson) | Instructional materials: removing instructional materials and curriculum: diversity | The bill would require the state board to develop, by July 1, 2024, a policy for local educational agencies to follow before removing any instructional materials or ceasing to teach any curriculum […] This bill would revise the list of culturally and racially diverse groups to instead include materials that accurately portray the contributions of people of all gender expressions and the role and contributions of LGBTQ+ Americans. The bill would also require that every instructional material adopted by a governing board include proportional and accurate representation of California's diversity in the categories of race, gender, socioeconomic status, religion, and sexuality. By imposing new obligations on local educational agencies, the bill would impose a state-mandated local program.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1078&search_keywords=transgender | *Support* | 02-Mar-23<br><br>Referred to Com. On ED<br><br>(Education) |
| AB 1163 (Luz Rivas) | State forms: gender identity | This bill would require specified state agencies and departments to revise their public-use forms, by January 1, 2025, to be more inclusive of individuals who identify as transgender, gender nonconforming, or intersex. This bill would require the agencies to revise their forms to allow individuals to provide their accurate gender identification. This bill would also require the impacted agencies and departments to collect data pertaining to the specific needs of the transgender, gender nonconforming, or intersex community, including, but not limited to, information relating to medical care, mental health disparities, and population size.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1163&search_keywords=transgender | *Support* | 21-MAR-23<br>Re-referred to Com. on A. & A.R.<br><br>(Accountability and Administrative Review) |

| BILL | TITLE | DESCRIPTION / COMMENTS | RECOMMENDED POSITION | STATUS |
|---|---|---|---|---|
| *AB 1314 (Essayli and Gallagher)* | *Gender identity: parental notification* | *This bill would, notwithstanding the consent provisions described above, provide that a parent or guardian has the right to be notified in writing within 3 days from the date any teacher, counselor, or employee of the school becomes aware that a pupil is identifying at school as a gender that does not align with the child's sex on their birth certificate, other official records, or sex assigned at birth, using sex-segregated school programs and activities, including athletic teams and competitions, or using facilities that do not align with the child's sex on their birth certificate, other official records, or sex assigned at birth. The bill would state legislative intent related to these provisions. By imposing additional duties on public school officials, the bill would impose a state-mandated local program.*<br><br>*https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB1314* | | *13-MAR-23 Referred to Com. on ED.*<br><br>*(Education)* |
| AB 1431 (Zbur) | Housing: the California Housing Security Act | This bill would, upon appropriation of the Legislature, establish the California Housing Security Program to provide a housing subsidy to eligible persons, as specified, to reduce housing insecurity and help Californians meet their basic housing needs. To create the program, the bill would require the Department of Housing and Community Development to establish a 2-year pilot program in up to 4 counties, as specified. The bill would require the department to issue guidelines to establish the program that include, among other things, the amount of the subsidy that shall be the amount necessary to cover the portion of a person's rent to prevent homelessness but shall not exceed $2,000 per month. Under the bill, the subsidy would not be considered income for purposes of determining eligibility or benefits for any other public assistance program, nor would participation in other benefits exclude a person from eligibility for the subsidy. Under the bill, an undocumented person, as specified, who otherwise qualifies for the subsidy would be eligible for the subsidy. The bill would require the department to submit a report on the program to the Legislature, as described.<br><br>"Adult with a disability" means an individual or head of household who is 18 years of age or older and is experiencing a condition that limits a major life activity, including, but not limited to, one of the following:<br>(5) A chronic illness, including, but not limited to, HIV.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1431&search_keywords=HIV | *Support* | 27-MAR-23<br><br>Re-referred to Com. on H. & C.D.<br><br>(Housing and Community Development) |

| BILL | TITLE | DESCRIPTION / COMMENTS | RECOMMENDED POSITION | STATUS |
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| AB 1432 (Carrillo) | Health insurance: policy | This bill additionally would subject a policy or certificate of group health insurance that is marketed, issued, or delivered to a California resident to any provisions of the Insurance Code requiring coverage of abortion, abortion-related services, and gender-affirming care, regardless of the situs of the contract or master group policyholder.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1432 | *Support* | 09-MAR-23 Referred to Com. on HEALTH. |
| AB 1549 (Wendy Carrillo) | Medi-Cal: federally qualified health centers and rural health clinics | This bill would, among other things, require that per-visit rate to account for the costs of the FQHC or RHC that are reasonable and related to the provision of covered services, including the specific methods and processes used by the FQHC and RHC to deliver those services. The bill would also require the rate for any newly qualified health center to include the cost of care coordination services provided by the health center, as specified.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1549&search_keywords=HIV | *Support* | 27-MAR-23<br><br>Re-referred to Com. on HEALTH. |
| AB 1645 (Zbur) | Health care coverage: cost sharing | This bill would prohibit a group or individual no grandfathered health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2024, from imposing a cost-sharing requirement for office visits for the above-described preventive care services and screenings and for items or services that are integral to their provision. The bill would prohibit those contracts and policies from imposing a cost-sharing requirement, utilization review, or other specified limits on a recommended sexually transmitted infections screening, and from imposing a cost-sharing requirement for any items and services integral to a sexually transmitted infections screening, as specified. The bill would require a plan or insurer to directly reimburse a nonparticipating provider or facility of sexually transmitted infections screening that meets specified criteria its median contracted rate in the general geographic region for screening tests and integral items and services rendered and would prohibit a nonparticipating provider from billing or collecting a cost-sharing amount for a sexually transmitted infections screening from an enrollee or insured. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1645&search_keywords=sexual+health | *Support* | 21-MAR-23 Re-referred to Com. on HEALTH. |

| BILL | TITLE | DESCRIPTION / COMMENTS | RECOMMENDED POSITION | STATUS |
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| SB 36 (Skinner) | Out-of-state criminal charges: prosecution related to abortion, contraception, reproductive care, and gender-affirming care | The bill would prohibit a magistrate form issuing a warrant for the arrest of an individual whose alleged offense or conviction is for the violation of law of another state that authorizes a criminal penalty to an individual performing, receiving, supporting, or aiding in the performance or receipt of an abortion, contraception, reproductive care, or gender-affirming care if the abortion, contraception, reproductive care, or gender-affirming care is lawful under the laws of this state, regardless of the recipient's location. […] This bill would additionally prohibit an officer or employee of a state or local law enforcement agency from providing information or assistance to specified entities regarding services constituting legally protected health care activity, including but not limited to, abortion, contraception, reproductive care, and gender-affirming care, if those services would be lawful if they were provided entirely within this state.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB36&search_keywords=gender | *Support* | 14-MAR-23<br>From committee: Do pass and re-refer to Com. on JUD. (Ayes 4. Noes 0.) (March 14). Re-referred to Com. on JUD. |
| SB 37 (Caballero) | Older Adults and Adults with Disabilities Housing Stability Act | This bill would, upon an appropriation by the Legislature for this express purpose, require the California Department of Housing and Community Development, commencing January 1, 2024, to begin developing the Older Adults and Adults with Disabilities Housing Stability Program. The bill would require the department, in administering the program, to offer competitive grants to nonprofit community-based organizations, continuums of care, public housing authorities, and area agencies on aging, as specified, to administer a housing subsidy program for older adults and adults with disabilities who are experiencing homelessness or at risk of homelessness, as defined.<br><br>a) "Adult with a disability" means an individual or head of household who is 18 years of age or older and is experiencing a condition that limits a major life activity, including, but not limited to, the following:<br>a. A "physical disability," as defined in subdivision (m) of Section 12926 of the Government Code.<br>b. A "mental disability," as defined in subdivision (j) of Section 12926 of the Government Code, except it shall also include a substance use condition.<br>c. A "medical condition," as defined in subdivision (i) of Section 12926 of the Government Code.<br>d. A "developmental disability," as defined in subdivision (a) of Section 4512 of the Welfare and Institutions Code.<br>e. A chronic illness, including, but not limited to, HIV.<br>f. A traumatic brain injury.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB37&search_keywords=HIV | *Support* | 27-MAR-23<br>Set for hearing April 24. |

| BILL | TITLE | DESCRIPTION / COMMENTS | RECOMMENDED POSITION | STATUS |
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| SB 339 (Wiener) | HIV preexposure prophylaxis | This bill would authorize a pharmacists to furnish up to a 90-day course of preexposure prophylaxis, or preexposure prophylaxis beyond a 90-day course if specified conditions are met. The bill would require the California State Board of Pharmacy to adopt emergency regulations to implement these provisions by July 1, 2024. This bill would require a health care service plan and health insurer to cover preexposure prophylaxis and postexposure prophylaxis furnished by a pharmacists, including costs for the pharmacist's services and related testing ordered by the pharmacists, and reimburse pharmacists services at 100% of the fee schedule for physician services. The bill would include preexposure prophylaxis furnished by a pharmacist as pharmacist services on the Medi-Cal schedule of benefits. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB339&search_keywords=HIV | *Support* | 14-MAR-23<br><br>From committee with author's amendments. Read second time and amended. Re-referred to Coms. On B., P. & E. D.<br><br>(Business, Professions and Economic Development) |
| SB 372 (Menjivar) | Department of Consumer Affairs: licensee and registrant records: name and gender changes | This bill would require a board to update a licensee's or registrant's records, including records contained within an online licenses verification system, to include the licensee's or registrant's legal name or gender has been changed. The bill would require the board to remove the licensee's or registrant's former name, or gender form its online license verification system and treat this information as confidential. The board would be required to establish a process to allow a person to request and obtain this information, as prescribed. The bill would require the board, if requested by a licensee or registrant, to reissue specified documents conferred upon, or issued to, the licensee or registrant with their updated legal name or gender. The bill would prohibit a board form charging a higher fee for reissuing a document with corrected document with a corrected or updated legal name or gender than the fee it charges for reissuing a document with other corrected or updated information.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB372&search_keywords=gender | *Support* | 27-MAR-23<br>From committee: Do pass and re-refer to Com. on JUD. (Ayes 8. Noes 2.) (March 27). Re-referred to Com. on JUD.<br><br>(Judiciary) |

| BILL | TITLE | DESCRIPTION / COMMENTS | RECOMMENDED POSITION | STATUS |
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| SB 427 (Portantino) | Health care coverage: antiretroviral drugs, devices, and products | This bill would prohibit a health care service plan or health insurer from subjecting antiretroviral drugs, devices, or products that are either approved by the United States Food and Drug Administration (FDA) or recommended by the federal Centers for Disease Control and Prevention (CDC) for the prevention of AIDS/HIV to prior authorization or step therapy, but would authorize prior authorization or step therapy if at least one therapeutically equivalent version is covered without prior authorization or step therapy and the insurer provides coverage for a noncovered therapeutic equivalent antiretroviral drug, device, or product without cost sharing pursuant to an exception request.<br><br>The bill would prohibit a non-grandfathered or grandfathered health care service plan contract or health insurance policy from imposing any cost-sharing or utilization review requirements for antiretroviral drugs, devices, or products that are either approved by the FDA or recommended by the CDC for the prevention of AIDS/HIV. The bill would require a grandfathered health care service plan contract or health insurance policy to provide coverage for those drugs, devices, or products, and would require a plan or insurer to provide coverage under the outpatient prescription drug benefit for those drugs, devices, or products, including by supplying participating providers directly with a drug, device, or product, as specified. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB427&search_keywords=HIV | *Watch* | 21-MAR-23<br><br>From Committee with author's amendments. Read second time and amended. Re-referred to Com. on RLS.<br><br>(Rules) |

| BILL | TITLE | DESCRIPTION / COMMENTS | RECOMMENDED POSITION | STATUS |
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| SB 524 (Caballero) | Pharmacists: testing and treatment | This bill, with respect to the conditional performance of tests approved or authorized by the FDA and classified as waived pursuant to the CLIA, would instead authorize a pharmacist to order, perform, and report those tests. The bill would authorize a pharmacist to furnish prescription medications that are furnished pursuant to the result from a test performed by the pharmacist that is used to guide diagnosis or clinical decision-making, as specified. The bill would require a pharmacist, in providing these patient care services, to utilize specified evidence-based clinical guidelines or other clinically recognized recommendations. The bill would require the pharmacist to document, to the extent possible, the testing services provided, as well as the prescription medications furnished, to the patient pursuant to the test result, in the patient's record in the record system maintained by the pharmacy.<br><br>This bill would expand the Medi-Cal schedule of benefits to include ordering, performing, and reporting any test approved or authorized by the FDA that is classified as waived pursuant to the CLIA, as authorized by existing law, that is used to guide diagnosis or clinical decision-making. The bill would also expand the schedule of benefits to include furnishing prescriptions pursuant to the result from a test, as authorized by the bill's provisions, that is used to guide diagnosis or clinical decision-making.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB524&search_keywords=HIV | *Support* | 20-MAR-23<br>From committee with author's amendments. Read second time and amended. Re-referred to Com. on RLS.<br><br>(Rules) |
| SB 525 (Durazo) | Minimum wage: health care workers | This bill would require a health care worker minimum wage of $25 per hour for hours worked in covered health care employment, as defined, subject to adjustment, as prescribed. The bill would provide that the health care worker minimum wage would be enforceable by the Labor Commissioners or by a covered worker through a civil action, through the same means and with the same relief available for violation of any other state minimum wage requirement. By establishing a new minimum wage, the violation of which would be a crime, the bill would impose a state-mandated local program.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB525&search_keywords=%22health+care%22 | *Support with Amendments* | 28-MAR-23<br><br>From committee with author's amendments. Read second time and amended. Re-referred to Com. on L., P.E. & R.<br><br>(Labor, Public Employment, and Retirement) |

| BILL | TITLE | DESCRIPTION / COMMENTS | RECOMMENDED POSITION | STATUS |
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| SB 541 (Menjivar) | Sexual Health: contraceptives: Immunization | This bill would, in order to prevent and reduce unintended pregnancies and sexually transmitted infections, on or before the start of the 2024–25 school year, require each public school, including schools operated by a school district or county office of education and charter schools, to make internal and external condoms available to all pupils free of charge, as provided. The bill would require these public schools to, at the beginning of each school year, inform pupils through existing school communication channels that free condoms are available and where the condoms can be obtained on school grounds. The bill would, commencing with the- 2024–25 school year, require each public school to post at least one notice regarding these requirements in a prominent and conspicuous location on the school campus, as specified.<br><br>The bill would require this notice to include certain information, including, among other information, information about how to use condoms properly. The bill would require each public school to allow the distribution of condoms during the course of, or in connection to, educational or public health programs and initiatives, as provided. By imposing additional duties on public schools, the bill would impose a state-mandated local program.<br><br>The bill would provide that school-based health center sites located on school campuses maintaining any combination of classrooms from grades 7 to 12, inclusive, may not be prohibited from making internal and external condoms available and easily accessible at the school-based health center site to all pupils free of charge.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB541&search_keywords=HIV | *Support* | 20-MAR-23<br>From committee with author's amendments. Read second time and amended. Re-referred to Com. on ED. |

** The bill was not approved by the Commission on HIV*
*** Commission on HIV recommended bill for the Legislative docket*

*Footnotes:*
*(1) Bills introduced in the first year of the regular session that do not become carry-over bills shall be returned to the Chief Clerk of the Assembly or the Secretary of the Senate.*

*Notes:*
*Items italicized in blue indicate a new status or a bill for consideration for inclusion in the docket.*

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave, 14th Floor • Los Angeles, CA 90020 • TEL (213) 738-2816 • FAX (213) 637-4748
HIVCOMM@LACHIV.ORG • https://hiv.lacounty.gov

# Dr. Wilbert C. Jordan, MD, MPH

The Commission on HIV expresses its profound sorrow at the passing of Dr. Wilbert C. Jordan, a distinguished member of the former Los Angeles County Commission on AIDS (currently the Los Angeles County Commission on HIV) from 1988 to 1995, who served as its Chair from 1993 to 1995. He was also an inaugural member of the Los Angeles County HIV Prevention Planning Committee. Dr. Jordan's tireless and unapologetic efforts to raise HIV and AIDS awareness in the Black/African American community and his pioneering work in treating patients with HIV have earned him numerous accolades, including the distinguished United States Surgeon General's Award in 2000.

Dr. Jordan, a distinguished academic, earned his bachelor's degree from Harvard University in 1966 before attending Case Western Reserve University Medical School, where he obtained his medical degree in 1971. He commenced his training at Harvard's Beth Israel Hospital as an intern and junior resident before transferring to UCLA. There, he successfully completed the esteemed Robert Wood Johnson Clinical Scholars program and earned his Master of Public Health degree in addition to completing residencies in internal medicine and infectious diseases.

As a visionary leader, Dr. Jordan was the first provider to report a heterosexual case of HIV in Los Angeles County in 1983. Additionally, he founded the AIDS Clinic at King-Drew Medical Center, now known as the OASIS Clinic. His unwavering dedication to health equity and social justice has left an indelible mark on the HIV care landscape and serves to inspire all those who continue to fight the HIV epidemic.

Dr. Jordan received numerous accolades for his exceptional contributions in the medical field, including the Black AIDS Institute Hero in the Struggle award in 2001, the Bishop Leontine T.C. Kelly Award for Courage in 2013, the Better Brothers Los Angeles Advocate Award in 2015, and the CDU Legacy Leaders award in 2017. He has been recognized by the Los Angeles Sentinel and the Student National Medical Association, who established the Dr. Wilbert C. Jordan Research Forum in his honor. Additionally, he has been named Doctor of the Year three times by the Charles R. Drew Medical Society. In 2002, he was the inaugural recipient of the B.E.T. Community Service Pioneers Award.

As we mourn his loss, we honor Dr. Jordan's legacy and stand on his majestic shoulders by strengthening our commitment to end HIV once and for all. We call on the Community to join us in this vital mission and pay tribute to a trailblazer whose impact will be felt for generations to come.

We send our deepest sympathies to Dr. Jordan’s family, friends, and patients; our communities, and our colleagues at Charles Drew University, Drew Cares and MLK Oasis Clinic during this difficult time.

Rest in Power, Dr. Jordan.

**From:** Luckie Alexander
**To:** Executive Team
**Subject:** TRANSMASCULINE PEOPLE NEED YOUR HELP!!!!
**Date:** Tuesday, May 2, 2023 3:42:23 PM
**Attachments:** Jastice For Banko.png
Banko Brown - ITM (1).mp4

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Invisible Men was founded to address the severe lack of resources available for transmasculine individuals. Tragically, the recent killing of a young transmasculine person named Banko Brown in San Francisco, highlights the urgency of our mission. This young person was killed because he was hungry and homeless. We are the **ONLY** organization in LA County and **one of 4** in all California to specifically serve transmasculine individuals. Most orgs that serve the "trans community" don't mean us! Funding & grant opportunities very seldom include our community. We are heartbroken and enraged.

For years, our transfemme community has had access to resources such as specialized housing, medical care, and support organizations tailored to their unique needs. As a transmasculine community, we also require similar resources that address our unique needs. We are often forgotten and excluded from conversations about issues that affect us, such as abortion rights, HIV prevention and treatment, and social services.

**This is a call to action to increase awareness of the systemic issues that transmasculine individuals, particularly those who are Black and lack resources, face. We need funding & resources such as emergency housing, reproductive and fertility care, sexual assault assistance, HIV prevention and treatment, and more. We are asking for changes in policies, attitudes, and social services to allow for transmasc folks to have safe housing facilities among other resources, funding transmasculine orgs, and supporting transmasculine people by providing much needed services.**

Sadly, incidents like Banko's death often go unnoticed due to the erasure and misgendering of our community in media reports and other outlets. The lack of support and outcry perpetuates the cycle of invisible violence, stigma, and discrimination that transmasculine individuals face. It is crucial that we come together as a community to advocate for our siblings and demand the resources and support we deserve.

***ASKS:***
Housing transmasc folks in men's facilities poses a significant safety risk, while placing them in women's facilities also puts individuals at risk of mental harm. There are currently no safe and affirming housing facilities for trans masculine folkes to be placed.
**Ask:** We need specialized SAFE housing that considers the unique needs and safety concerns of transmasc individuals.

Furthermore, access to food and funding is critical to addressing food insecurity among transmasc individuals. Community resources seldomly encourage transmasc folks or are met with "we only provide services for trans femm folks"
**Ask:** Many in our community face significant barriers to accessing these resources, and we need your support to ensure that everyone has access to safe and nourishing food.

It is also essential to include transmasc individuals in reproductive services and abortion rights

advocacy. Transmac folks also fear the loss of abortion access and gendered language create barriers to care and erasure.
**Ask:** As birth givers, we need access to safe and affirming reproductive health services, and we must be included in conversations and policy-making regarding our reproductive rights.

Another critical issue that transmasc individuals face is a lack of non-gendered medical care. Gendered language further perpetuates erasure and creates barriers to access.
**Ask**: We need policies that explicitly include transmasc folks to ensure that our unique needs and experiences are considered.

Finally, it's essential to recognize that resources that serve the "trans community" don't always serve transmasc folks.
**Ask:** We need policies and programs that explicitly include us and address the specific challenges we face.

I urge you to take these concerns seriously and work with our community to develop policies and programs that support and uplift transmasc individuals in our community.

**IMMEDIATE Actions to take:**

- ***Raise awareness: Educate others about the issues facing transmasc folks, including the discrimination, harassment, and violence they face on a daily basis.***
- ***TAG, SHARE, UPLIFT TRANSMASC FOLKS on social media, listen to our stories***
- ***Work, Support, Fund advocacy groups to organize events and campaigns that raise awareness and promote understanding.***
- ***Support transmasc-led organizations and transmasc serving organizations: Donate to and volunteer with organizations that advocate for and serve the rights of transmasc folks. These groups often work on the ground to provide support, resources, and advocacy for trans individuals. Note not orgs that serve "trans community" serve transmasc folks including some trans led orgs.***
- ***Speak out against transmasc erasure: When you hear comments or observe folks engage in exclusionary behavior, speak up and call it out. Use your voice to advocate for the inclusion of transmasc folks.***

Together, we can create a world where all individuals have access to basic necessities like food and shelter, and where transmasculine individuals are valued and protected. This is a global issue, not just an American one. Join us in raising awareness and showing support for the transmasculine community wherever you are in the world.

Please remember to **TAG allies** & **SHARE to amplify the message & DONATE to his burial fund and orgs that are doing this work.**

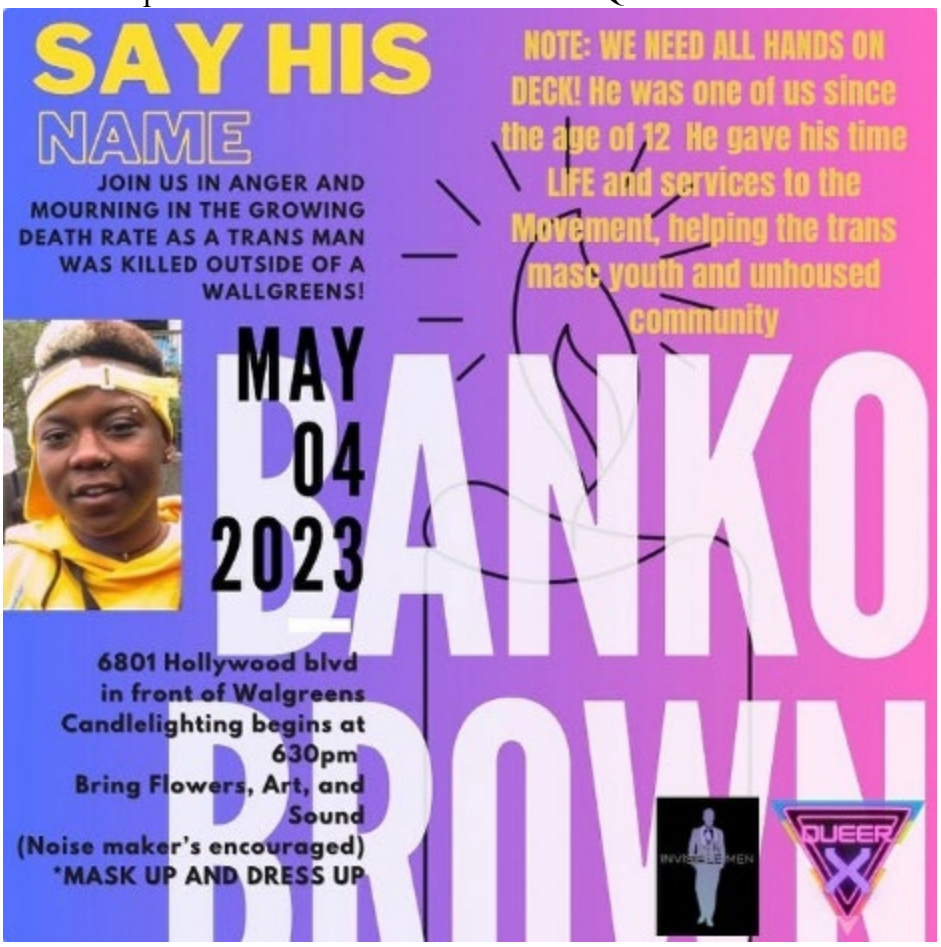
Banko Brown GoFundMe - https://gofund.me/1a9db982

**ORGS IN SAN FRANCISCO SUPPORTING WITH BANKO'S BURIAL:**

* BROTHERHOOD510 (transmasc)
* PYRAMID KINGS (transmasc)

* YOUNG WOMEN'S FREEDOM CENTER

#JusticeForBanko #SayTheirName #TransMasc #thishastostop
#TransMasc #Transmasculine #InvisibleMen #JusticeForBanko #SayTheirName
#TransRightsAreHumanRights #HousingJustice #ReproductiveJustice #HealthcareForAll
#EndTransphobia #EndTransViolence #LGBTQIA #SocialJustice #ThisHasToStop




Luckie Alexander
Pronouns: He.Him.Superman (Why this Matters?)
Founder - Invisible Men
InvisbleTMen.com
Instructor: Trans Theory - Antioch University
Artist: LuckieAlexander.com
2023 Co Chair: LA County HIV Commission
2023 Co Chair: CHIPTS CAB
Artist: All Black Lives Matter Mural Hollywood
(213)528-0482
linktr.ee/Luckiealexander
Schedule w/me:
calendly.com/luckiealexander/meeting