LOS ANGELES COUNTY
COMMISSION ON HIV

WELCOME BACK, COMMISSIONERS!

*Join us in-person for our next **EXECUTIVE COMMITTEE** meeting*

Date: Thursday, March 23, 2023

Time: 1PM - 3PM

Address: 510 S Vermont Ave, Los Angeles, CA 90020
Terrace Level Conference Room - Accessible via public transportation (Wilshire/Vermont Station)

Parking: Complimentary parking available at 523 Shatto Place, Los Angeles CA 90020

- **Please bring your smart devices!** Meeting materials will be accessible via Commission website and QR code. NO HARD COPIES of materials will be distributed in compliance with LA County's Recycle and Reuse Initiative.
- Members of the public may attend in person or virtually

Questions? Contact us!

hivcomm@lachiv.org

(213) 738-2816

LOS ANGELES COUNTY
COMMISSION ON HIV

Visit us online: http://hiv.lacounty.gov
Get in touch: hivcomm@lachiv.org
Subscribe to the Commission's Email List:
https://tinyurl.com/y83ynuzt

EXECUTIVE COMMITTEE
Meeting

Thursday, March 23, 2023
1:00pm-3:00pm (PST)

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

Validated Parking Available at 523 Shatto Place, LA 90020

Meeting will be live streamed on Facebook @hivcommissionla

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

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/r00c8b48e2f4f418215f6393173104d7d

To Join by Telephone: 1-213-306-3065
Password: EXECUTIVE Access Code: 2597 451 1972

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.*

To access meeting materials via the QR code: (1) Open your camera app on your smart device, (2) Select the rear-facing camera in Photo or Camera mode, (3) Center the QR code that you want to scan on the screen and hold your phone steady for a couple of seconds, and (4) Tap the notification that pops up to open the link.

LIKE WHAT WE DO?

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

LOS ANGELES COUNTY
COMMISSION ON HIV

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

AGENDA FOR THE REGULAR MEETING OF THE
LOS ANGELES COUNTY COMMISSION ON HIV
EXECUTIVE COMMITTEE

MONDAY, MARCH 23, 2023 | 1:00 PM – 3:00 PM

510 S. Vermont Ave
Terrace Level Conference Room A (TK11)
Los Angeles, CA 90020
Validated Parking: 523 Shatto Place, Los Angeles 90020

MEMBERS OF THE PUBLIC:
To Register + Join by Computer:
https://lacountyboardofsupervisors.webex.com/weblink/register/r00c8b48e2f4f418215f6393173104d7d
To Join by Telephone: 1-213-306-3065
Password: EXECUTIVE Access Code: 2597 451 1972

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

AGENDA POSTED: March 17, 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 and post your Public Comment in the Chat box, submit in person, 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.

I. ADMINISTRATIVE MATTERS

1.	Call to Order & Meeting Guidelines/Reminders		1:00 PM – 1:03 PM
2.	Introductions, Roll Call, & Conflict of Interest Statements		1:03 PM – 1:05 PM
3.	Assembly Bill 2449 Attendance Notification for "Emergency Circumstances"	**MOTION #1**	1:05 PM – 1:07 PM
4.	Approval of Agenda	**MOTION #2**	1:07 PM – 1:08 PM
5.	Approval of Meeting Minutes	**MOTION #3**	1:08 PM – 1:10 PM

II. PUBLIC COMMENT

1:10 PM – 1:15 PM

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

III. COMMITTEE NEW BUSINESS ITEMS

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

IV. REPORTS

8. Executive Director/Staff Report 1:15 PM – 1:30 PM

A. Commission (COH)/County Operational Updates
   (1) Reimagining COH Meetings
   (2) Ryan White Part A Conflicts of Interest

9. Co-Chair Report 1:30 PM – 1:55 PM

A. Welcome Executive At-Large Members – Danielle Campbell & Joseph Green
B. March 9, 2023 COH Meeting | FOLLOW UP + FEEDBACK
   (1) New Business: Address HIV in Native American communities
C. April 13, 2023 COH Meeting Agenda Development
   (1) Acknowledgment of National Youth HIV and AIDS Awareness Day (NYHAAD)
   (2) Unmet Needs Presentation (DHSP)
   (3) HRSA Ryan White Part A & EHE Site Visit Follow Up & Feedback (DHSP)
   (4) Executive At-Large Member Open Nominations & Elections – 3rd Seat
   (5) Jose Magaña Membership Seat Change for Approval
   (6) Oral Healthcare Service Standards for Approval
D. Conferences, Meetings & Trainings | OPEN FEEDBACK
E. Member Vacancies & Recruitment

10. Division of HIV and STD Programs (DHSP) Report 1:55 PM – 2:15 PM

A. Fiscal, Programmatic and Procurement Updates
   (1) Ryan White Program (RWP) Part A & MAI
      a. HRSA Ryan White Part A and EHE Site Visit Feedback
   (2) HIV Workforce Summit Updates & Feedback
   (3) Fiscal
   (4) Mpox | UPDATES

11. Standing Committee Report 2:15 PM – 2:40 PM

A. Operations Committee
   (1) Membership Management
      a. Seat Change | Jose Magaña to Provider Representative #1 **MOTION #4**
      b. Status on New/Pending Membership Applications
      c. Parity, Inclusivity & Reflectiveness (PIR) | Status
   (2) Policies & Procedures
      a. Policy #08.1104 –Co-Chair Elections and Terms **MOTION #5**
      b. Code of Conduct | Proposed Changes
   (3) Assessment of Administrative Mechanism | Updates
   (4) Recruitment, Retention and Engagement
B. Planning, Priorities and Allocations (PP&A) Committee
   (1) Status Neutral Training & Technical Assistance Planning
C. Standards and Best Practices (SBP) Committee
   (1) Oral Healthcare Service Standards | **MOTION #6**
   (2) Universal Service Standards Review
   (3) Medical Care Coordination Overview

11. Standing Committee Report (cont'd) 2:15 PM – 2:40 PM

D. Public Policy Committee (PPC)

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

a. 2023-2024 Legislative Docket Development
b. 2023-2024 Policy Priorities Development
c. Coordinated STD Response
d. Act Now Against Meth (ANAM) | UPDATES

12. Caucus, Task Force, and Work Group Reports: 2:40 PM – 2:50 PM

A. Aging Caucus
B. Black/AA Caucus
C. Consumer Caucus
D. Transgender Caucus
E. Women's Caucus
F. Bylaws Review Taskforce
G. Mission & Statement Workgroup
H. Policy #08.1104: Co-Chair Terms & Elections Workgroup
I. Prevention Planning Workgroup

VI. NEXT STEPS 2:50 PM – 2:55 PM

13. Task/Assignments Recap
14. Agenda development for the next meeting

VII. ANNOUNCEMENTS 2:55 PM – 3:00 PM

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

VIII. ADJOURNMENT 3:00 PM

Adjournment for the meeting of March 23, 2023

PROPOSED MOTIONS	
MOTION #1:	Approve remote attendance by members due to "emergency circumstances", per AB 2449.
MOTION #2	Approve the Agenda Order as presented or revised.
MOTION #3	Approve the meeting minutes, as presented or revised.
MOTION #4	Approve Jose Magaña seat change from Alternate to Provider Representative #1, as presented or revised, and elevate to full body for final approval at its April 13, 2023 meeting.
MOTION #5	Approve updates to Policy #08.1104 (Commission and Committee Co-Chair Elections and Terms), as presented or revised, and elevate to full body for final approval at its April 13, 2023 meeting.
MOTION #6	Approve Oral Healthcare Services Standards, as presented or revised, and elevate to full body for final approval at its April 13, 2023 meeting.

LOS ANGELES COUNTY
COMMISSION ON HIV

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

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)**

HYBRID MEETING GUIDELINES, ETTIQUETTE & REMINDERS

(Updated 3.22.23)

☐ This meeting is a **Brown-Act meeting** and is being recorded.

- The conference room speakers are *extremely* sensitive and will pick up even the slightest of sounds, i.e., whispers. If you prefer that your private or side conversations, not be included in the meeting recording which, is accessible to the public, we respectfully request that you step outside of the room to engage in these conversations.
- Turn off your ringers/notifications on your smart devices so as not to disrupt the meeting.
- Your voice is important, and we want to ensure that it is captured accurately on the record. Please be respectful of one another and minimize crosstalk.

☐ The **meeting packet** can be found on the Commission's website at https://hiv.lacounty.gov/meetings/ or accessed via the QR code provided. Hard copies of materials will not be provided in compliance with the County's green initiative to recycle and reduce waste.

☐ Please comply with the **Commission's Code of Conduct** located in the meeting packet

☐ **Public Comment** for members of the public can be submitted in person, electronically @ https://www.surveymonkey.com/r/public_comments or via email at hivcomm@lachiv.org. *For members of the public attending virtually, you may also submit your public comment via the Chat box. Should you wish to speak on the record, please use the "Raised Hand" feature or indicate your request in the Chat Box and staff will call upon and unmute you at the appropriate time. Please note that all attendees are muted unless otherwise unmuted by staff.*

☐ For individuals joining in person, to mitigate any potential streaming interference for those joining virtually, we respectfully ask that you **not simultaneously log into the virtual option of this meeting via WebEx.**

☐ Committee members invoking **AB 2449 for "Just Cause" or "Emergency Circumstances**" must communicate their intentions to staff and/or co-chairs no later than the start of the meeting. Members requesting to join pursuant to AB 2449 must have their audio and video on, at all times, and disclose whether there is a person over the age of 18 in the room in order to be counted toward quorum and have voting privileges. For members joining virtually due to "Emergency Circumstances", a vote will be conducted by the Committee/COH for approval.

☐ Members will be required to explicitly state their agency's **Ryan White Program Part A and/or CDC prevention conflicts of interest** on the record (versus referring to list in the packet). A list of conflicts can be found in the meeting packet and are recorded on the back of members' name plates, courtesy of staff.

LOS ANGELES COUNTY COMMISSION ON HIV

2023 MEMBERSHIP ROSTER| UPDATED 3.21.23

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			***Vacant***		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	Jose Magana (OPS)
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	OPS	Miguel Alvarez	No affiliation	July 1, 2022	June 30, 2024	
	TOTAL:	36						

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 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 Avenue, 14th Floor, Los Angeles CA 90020 • TEL (213) 738-2816
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DRAFT

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

EXECUTIVE COMMITTEE MEETING MINUTES

February 23, 2023

COMMITTEE MEMBERS P = Present | A = Absent			
Luckie Fuller, Co-Chair	EA	Lee Kochems, MA	P
Bridget Gordon, Co-Chair	P	Katja Nelson, MPP	EA
Al Ballesteros, MBA	P	Mario J. Peréz, MPH	P
Everardo Alvizo, LCSW	P	Kevin Stalter	A
Erika Davies	P	Justin Valero	A
Kevin Donnelly	P		
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, MPIA; Catherine Lapointe, MPH; Lizette Martinez, MPH; Dawn McClendon; Jose Rangel-Garibay, MPH; Sonja Wright, BA, MSOM, Lac, Dipl. OM, PES			
DHSP STAFF			
No DHSP staff in attendance			

*Some participants may not have been captured electronically. Attendance can be corrected by emailing the Commission.
*Members of the public may confirm their attendance by contacting Commission staff at hivcomm@lachiv.org.
*Meeting minutes may be corrected up to one year from the date of Commission approval.

Meeting agenda and materials can be found on the Commission's website at

https://assets-us-01.kc-usercontent.com/0234f496-d2b7-00b6-17a4-b43e949b70a2/c17e261c-d9e0-462c-8a55-c060ef468b50/Pkt_EXEC_022323.pdf

CALL TO ORDER-ROLL CALL-CONFLICT OF INTEREST STATEMENTS

Bridget Gordon, Commission on HIV (COH) Co-Chair, called the meeting to order at 1:13 PM. Cheryl Barrit, Executive Director, conducted roll call. Refer to meeting packet for conflict-of-interest statements.

ROLL CALL (PRESENT): B. Gordon, A. Ballesteros, E. Alvizo, E. Davies, K. Donnelly, L. Kochems, and M. Perez

I. ADMINISTRATIVE MATTERS

1. APPROVAL OF AGENDA

MOTION #1: Approve the Agenda Order, as presented or revised ✓Passed by Consensus

2. APPROVAL OF MEETING MINUTES

MOTION #2: Approve the Executive Committee minutes, as presented or revised ✓Passed by Consensus

II. PUBLIC COMMENT

3. OPPORTUNITY FOR MEMBERS OF THE PUBLIC TO ADDRESS THE COMMISSION ON ITEMS OF INTEREST THAT ARE WITHIN THE JURISDICTION OF THE COMMISSION. *No public comment.*

III. COMMITTEE NEW BUSINESS ITEMS

4. OPPORTUNITY FOR COMMITTEE 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 TAKE ACTION AROSE SUBSEQUENT TO THE POSTING OF THE AGENDA. *No committee new business items.*

IV. REPORTS

5. EXECUTIVE DIRECTOR/STAFF REPORT

A. Commission (COH)/County Operational Updates

(1) Resumption of Brown Act In-Person Meetings

- C. Barrit reported that Brown Act meetings, which consist of the full COH meeting and standing committee meetings, will convene in-person beginning in March 2023.
- C. Barrit is in the process of conducting phone calls with each commissioner to address questions or concerns regarding the resumption of in-person meetings.
- Commissioners have the option to attend meetings remotely under the provisions set by AB 2449 due to “just cause” or “emergency circumstances.” Commissioners may only join remotely under AB 2449 up to two times a year, and their camera and audio functions must be turned on for the duration of the meeting.
- Masks will be strongly recommended for those attending in-person.
- Pre-packaged meals will be provided during the full body COH meeting.
- Members of the public will be encouraged to join meetings remotely.

(2) Reimaging COH Meetings

- C. Barrit provided an overview of the 2023 Proposed Meeting Schedule; see meeting packet.
- Under the proposed schedule, several meetings would be cancelled and replaced with educational trainings and research presentations.
- Kevin Donnelly requested if the trainings/presentations can be implemented through the lens of the seven priority populations defined in the Comprehensive HIV Plan 2022-2026, particularly for mental health services for people living with HIV (PLWH) under the age of 30.
- Joe Green commented that less meetings would mean less knowledge available to consumers. Alasdair Burton concurred. K. Donnelly suggested holding expanded Consumer Caucus meetings on days when COH meetings are cancelled.
- Al Ballesteros requested if the Committee could discuss priority topics before deciding on the number of meetings to have. B. Gordon responded that the COH was asked by the Division of HIV and STD Programs (DHSP) to hold less meetings due to DHSP staff's demanding schedules.
- Lee Kochems requested if the COH's priorities could reflect those of the Public Policy Committee (PPC), including housing and aging.
- Mario Perez commented that the current structure, meeting frequency, and time demands of the COH are not consistent with changes and actionable information. He further expanded that the current COH model does not have the expected level of consumer voices or Medi-Cal representation.
- A. Ballesteros recommended holding a meeting to discuss how Ryan White Program (RWP) dollars are being used for Federally Qualified Health Centers (FQHCs).

6. CO-CHAIR'S REPORTS

A. February 9, 2023 COH Meeting | FOLLOW UP + FEEDBACK

B. Gordon noted that at the last meeting, the COH did not finish their standing committee/caucus/workgroup reports due to low attendance at the end of the meeting.

B. HRSA Site Visit | FOLLOW UP + FEEDBACK

B. Gordon reported that the series of HRSA site visits included the following:

- HRSA staff inquiries to Executive Committee members regarding bylaws, funding, and data
- A listening session with the Consumer Caucus
- A RWP community client meeting

C. March 9, 2023 COH *In-Person* Meeting Agenda Development – B. Gordon led the review of the following agenda items for the March 9 COH meeting:

(1) Meet & Greet
(2) Acknowledgement of National Women and Girls HIV/AIDS Awareness Day (NWGHAAD)
(3) Executive At-Large Member Open Nominations & Elections
(4) Member Applications for Approval
(5) (Revised) Policy #09.4205: Commission Membership Evaluation, Nomination & Approval Process for Approval
(6) Standing Reports from February 9th Meeting

K. Donnelly requested if the March COH meeting could be adjourned in honor of those who have passed away due to COVID-19.

D. Conferences, Meetings & Trainings | OPEN FEEDBACK – *No feedback provided.*

E. Member Vacancies & Recruitment

B. Gordon noted that the HRSA site visit highlighted the many vacancies on the COH, particularly for unaffiliated consumers.

F. Proposed Updates to Vision & Mission Statement

K. Donnelly recommended including language on a status-neutral approach to HIV prevention to the COH vision & mission statement to better align with the CHP. He suggested forming a workgroup to work on updating the vision and mission statement. The Committee concurred and agreed to form a Vision & Mission Statement Workgroup.

7. DIVISION OF HIV AND STD PROGRAMS (DHSP) REPORT – *M. Perez was unable to give a full DHSP report due to an urgent matter involving a fire which displaced 22 PLWH and indicated he will provide a more comprehensive report at the March COH meeting.*

A. Fiscal, Programmatic and Procurement Updates

(1) Ryan White Program (RWP) Part A & MAI
(2) HRSA Ryan White Part A and EHE Site Visit
(3) Fiscal
(4) Mpox | UPDATES

8. STANDING COMMITTEE REPORTS

A. Operations Committee

(1) Membership Management

a. Membership Applications | UPDATES

Everardo Alvizo provided the report. At their February meeting, the Operations Committee discussed membership recruitment and strategies to engage unaffiliated consumers, such as identifying medical providers who can help recruit PLWH to apply to the COH.

b. Attendance Report | UPDATES – *No update provided.*

(2) Policies & Procedures

a. Bylaws Review Planning

The Operations Committee discussed how to increase consumer stipends. E. Alvizo requested if the COH could create a Bylaws Review Planning Task Force.
MOTION #3: Approve the development of a Bylaws Review Planning Task Force to review and potentially update the Commission on HIV bylaws by the end of 2023. ✓Passed by Roll Call Vote (Yes = L. Kochems, K. Donnelly, E. Davies, E. Alvizo, A. Ballesteros, and B. Gordon; No = 0; Abstain = 0)

b. Code of Conduct | PROPOSED UPDATES – *No update provided.*

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

(1) Ryan White Program Expenditures | UPDATES

K. Donnelly and A. Ballesteros discussed the difficulties of implementing a status-neutral approach under a categorized funding system. A. Ballesteros discussed the need for improvements within the HIV workforce to provide better quality of care for PLWH.

(2) Multi-Year Contingency Planning & Maximizing Part A Funds – *No update provided.*

(3) Ryan White Program FY 23-25 Grant Application Planning – *No update provided.*

C. Standards and Best Practices (SBP) Committee

(1) Oral Healthcare Service Standards

E Davies reported that the Oral Healthcare Service Standards ended on February 3, 2023. The SBP Committee received one public comment, which was incorporated into the document.

(2) Universal Service Standards Review

The SBP Committee began its initial review of the Universal Service Standards. So far, the Committee has discussed updating the DHSP grievance program information. The review will continue at the March SBP Committee meeting. The Committee discussed potentially adding nutrition services to their standards.

D. Public Policy Committee (PPC)

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

a. 2023 Legislative Docket | UPDATE

L. Kochems provided the report. The 2023 Legislative Docket is currently being populated. The PPC will begin their review process at their March meeting.

b. 2023 Policy Priorities | UPDATES

COH staff and PPC co-chairs are in the process of revising the 2023 Policy Priorities and will discuss the changes made at their March meeting.

c. PACHA Resolution on MSM Blood Donation Deferral Policy

C. Barrit reported that the PPC is tracking updates from the Food and Drug Administration (FDA)'s blood donation deferral policy for men who have sex with men (MSM). Jose Rangel-Garibay reported that the Board of Supervisors (BOS) published a statement in support of the revised guidelines from the FDA easing restrictions on blood donations by gay and bisexual men.

d. Coordinated STD Response

The PPC will discuss the responses from the BOS' coordinated STD response at their March meeting.

e. Act Now Against Meth (ANAM) | UPDATES

The PPC is waiting for responses from the BOS on how they plan to address meth use in Los Angeles County (LAC).

9. CAUCUS, TASK FORCE, AND WORK GROUP REPORTS

A. Aging Caucus

K. Donnelly provided the report. The Aging Caucus last met on February 7th and discussed potentially having a National HIV and Aging Awareness Day event in September. The Caucus also listened to testimonials from two older adults living with HIV who are struggling to maintain secure housing and are having difficulties navigating the housing system in LAC. K. Donnelly reported that the March Aging Caucus has been cancelled. The next meeting will be on April 4th from 1-3PM.

B. Black/AA Caucus

Dawn McClendon provided the report. The Black Caucus will meet on February 23rd from 4-5PM and will discuss their 2023 workplan.

C. Consumer Caucus

Alasdair Burton provided the report. The Consumer Caucus last met on February 9th and discussed feedback on the February COH meeting and their meeting schedule for 2023. SBP Co-Chairs, E. Davies and K. Stalter, provided a presentation of the Oral Healthcare Service Standards. The Caucus plans to hold their March meeting in-person, following the COH meeting.

D. Transgender Caucus

J. Rangel Garibay provided the report. The Transgender Caucus last met on January 24th and elected Yara Tapia as one of their co-chairs. The Caucus decided to continue meeting virtually with three in-person meetings throughout the year. Their next meeting is on February 28th from 10-11:30AM.

E. Women's Caucus

D. McClendon provided the report. The Women's Caucus last met in January and decided to meet quarterly and continue meeting in a virtual format. Their next meeting will be on April 17th from 2-4PM.

F. Policy #08.1104: Co-Chair Terms & Elections Workgroup

D. McClendon provided the report. The Workgroup reviewed Policy #08.1104 as it relates to co-chair terms and elections as directed by the Executive Committee. The Workgroup made several recommendations and had them reviewed by the COH parliamentarian to ensure the recommendations aligned with Robert's Rules of Order and the Brown Act. The parliamentarian found inconsistencies within the recommendations that cannot require a candidate to be present or accept a nomination. If a candidate does not accept or decline a nomination, they still must be included in the election process. The Operations Committee will review the updated proposed changes at their next meeting for approval.

G. Prevention Planning Workgroup

The Prevention Planning Workgroup (PPW) last met on January 25th and reelected Dr. William King, Miguel Martinez, and Greg Wilson as their 2023 co-chairs; however, M. Martinez noted that he would like to end his term in June 2023. The PPW has discussed integrating prevention planning with the work of PP&A and potentially terminating as a

workgroup. The PPW cancelled their February meeting and will meet again on March 22nd from 4-5:30PM.

V. NEXT STEPS

10. TASK/ASSIGNMENTS RECAP

- COH staff will reach out to representatives from FQHCs to present at a future meeting.
- The Executive Committee and COH staff will work on a letter on behalf of the Aging Caucus to address issues regarding trainings, provider knowledge, and coordination of services for individuals accessing the housing system.

11. AGENDA DEVELOPMENT FOR THE NEXT MEETING

- Further discussions regarding reimaging COH meetings to include schedule, topics, meeting organization.

VI. ANNOUNCEMENTS

12. OPPORTUNITY FOR MEMBERS OF THE PUBLIC AND THE COMMITTEE TO MAKE ANNOUNCEMENTS. *No announcements.*

VII. ADJOURNMENT

13. ADJOURNMENT OF THE FEBRUARY 23, 2023 EXECUTIVE COMMITTEE MEETING

The meeting was adjourned by K. Donnelly at 3:26 PM.

Los Angeles County Commission on HIV
Proposed 2023 Meeting Schedule
DRAFT Version 03.16.23 – FOR DISCUSSION /IDEA GENERATION 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~~ ~~• Finish motions from Feb. 9 meeting~~ ~~• Present new meeting approach and meeting schedule to full council for feedback and public comment~~	
April	Unmet Needs Estimate presentation and discussion from DHSP	• How do we use unmet needs estimate to address the needs of priority populations and key geographic areas? • Identify key realistic action items for the Commission as result of the discussion.
May	**Cancel**	
June	Housing	• Identify discussion objectives and desired outcomes • Understand services available via RW and HOPWA (Program Overviews)

		• How can HOPWA and RW services work and complement each other to keep PLWH housed and link them to housing if experiencing homelessness? • Identify key realistic action items for the Commission as result of the discussion.
July	**Cancel**	
August	Mental Health	• Identify discussion objectives and desired outcomes • Understand services available via RW and other County-funded programs (Program Overviews) • Gain an understanding of how individuals can access mental health services. • Identify key realistic action items for the Commission as result of the discussion.
September	**Cancel**	
October	Methamphetamine and HIV/Substance Use	• Identify discussion objectives and desired outcomes • Understand services available via RW and other County-funded programs (Program Overviews) • Gain an understanding of how individuals can access services. • Identify key realistic action items for the Commission as result of the discussion.
November	**ANNUAL CONFERENCE**	Theme and topics TBD
December	**TBD or Cancel**	

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.

As defined above, do you have a Conflict of Interests: ☐ 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: ____/____/_____

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

Mandatory core trainings for all commissioners.

LOS ANGELES COUNTY
COMMISSION ON HIV

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

POLICY/PROCEDURE #08.1104	**PROPOSED REVISIONS FOR 2/23/23 OPERATIONS COMMITTEE REVIEW/APPROVAL** Commission and Committee Co-Chair Elections and Terms	Page 1 of 8

SUBJECT: **The process and scheduling for Commission and Committee Co-Chair elections.**

PURPOSE: **To outline the steps and timing for the Commission's and standing committees' Co-Chair elections.**

BACKGROUND:

- Federal Ryan White legislation mandates that all Part A jurisdictions establish local HIV planning councils to develop a comprehensive HIV plan, rank priorities and determine allocations, create standards of care, and to carry out a number of other responsibilities. The Los Angeles County Commission on HIV serves as the local Ryan White Part A HIV planning council for the Los Angeles County.

- In accordance with Ryan White rules and Ordinance 3.29 of the Los Angeles County Charter, the Commission on HIV comprises 51 voting members, meets monthly, and fulfills its various responsibilities through an open, transparent meeting process. The meetings comply with appropriate provisions of California's Ralph M. Brown Act and are run according to Robert's Rules of Order.

- Elected leadership is necessary to represent the planning council, facilitate the meetings, and oversee planning council work, among other responsibilities. The Health Resources and Services Administration (HRSA), the federal agency responsible for administering the Ryan White Program, recommends that planning councils elect Co-Chairs for these functions. The Commission on HIV has adopted HRSA's guidance with two Co-Chairs elected by the membership.

- The Commission on HIV relies on a strong committee structure to discharge its work responsibilities. Consistent with the Commission's By-Laws, the Commission organizational structure comprises five standing committees: Executive, Public Policy (PP), Operations, Priorities, Planning, and Allocations (PP&A), and Standards and Best Practices (SBP). Except for the Executive Committee (where the Commission Co-Chairs serve as the Committee Co-Chairs), the standing committees are led by two Co-Chairs elected by the Committee membership.

- The Commission Co-Chairs' duties, responsibilities, rights, and expectations are detailed in *Duty Statement, Commission Co-Chair*). The Committee Co-Chairs' duties, responsibilities, rights, and expectations are detailed in *Duty Statement, Committee Co-Chair*.

POLICY: **I would make seprate sections of the Commission Chairs, The Committee Chairs, and the Exec. Comm.**

1. The Commission Co-Chairs are elected to two-year terms, and each Co-Chair seat expires in December of alternate years. Except for the Executive Committee, each of the standing committees annually elects two Committee Co-Chairs to one-year terms that expire in February. There are no limits to the number of terms to which a Commission or committee Co-Chair can be re-elected. Co-Chairs elected to fill mid-term vacancies are elected for the remaining duration of the term, until it expires.

2. The Commission Co-Chairs are considered members of all committees and serve as Executive Committee Co-Chairs. Committee Co-Chairs cannot serve as Co-Chair to more than one Committee at a time.

3. Nominations for the vacant Commission Co-Chair seat are normally opened in August, unless unexpected circumstances arise (meeting cancellations, absence of quorum, etc.) prevent it. Nominations for the Committee Co-Chair seats are usually opened in January, following election of the Commission Co-Chairs and final committee assignments, unless otherwise delayed. Members can nominate themselves or can be nominated by other stakeholders throughout the period in which the nominations are open.

4. Except for immediate vacancies in both Co-Chair seats, nominations must be open at the monthly meeting prior to the Co-Chair elections. Unless delayed or postponed, the Co-Chair elections are held at following month's regular meeting.

5. Commission Co-Chair candidates must have at least a year's service on the Commission. At least one of them must be HIV-positive and at least one of them must be a person of color. Only Commissioners can serve as the Co-Chairs. Only Commissioners serving in their primary committee assignment may serve as Committee Co-Chairs, but at least one of the Committee Co-Chair seats must be filled by a Commissioner. Unaffiliated HIV-positive consumers are highly encouraged to seek leadership roles and run for a Commission or Committee Co-Chair seat whenever possible.

6. ~~Co-Chairs are elected through a sequential voting process until there are only one or two candidates remaining, as need dictates. The Commission/committee must approve the final candidate(s) through a consent vote of approval or through individual roll call votes~~. (Redundant, covered by Robert's) All Co- Chairs must be elected by a majority of the voting membership. ~~A~~ IF no Co-Chair candidate's ~~failure to earn~~ receives a ~~a~~ majority vote after a number of reounds of voting equal to the number of candidates, further voting is postponed until the next regular meeting ~~disqualifies that member as a Co-Chair candidate for that term, closes the election for that meeting, extends the nominations period, and postpones the election to the subsequent meeting.~~

Commented [MD1]: For Committee Consideration:

Although not the purview of the workgroup, a suggestion was made to replace "stakeholders" with "members" given only members are eligible for nominations/election.

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7. Commission and Committee Co-Chair terms are allowed to be extended to accommodate delayed meeting schedules, lack of suitable candidates, or when the body cannot determine definitive, final Co-Chair candidates. A single Co-Chair may also continue to serve, when needed, until a second Co-Chair candidate is identified and elected.

PROCEDURE(S):

1. **Terms of Office**: The Commission Co-Chairs are elected to office for staggered two-year terms. Aside from the Executive Committee, standing committee Co-Chairs are elected for two-year terms.
   a. Commission Co-Chair terms expire in alternate years to ensure leadership continuity. The Commission Co-Chairs also serve as Co-Chairs of the Executive Committee and serve in those roles for the duration of their tenure as Commission Co-Chairs.
   b. The four, remaining standing committees [Public Policy (PP), Operations, Priorities Planning and Allocations (PP&A) and Standards and Best Practices (SBP)] elect their Co-Chairs for one-year terms that expire concurrently.
   c. Commission Co-Chair terms expire in December of the calendar year, unless the November and/or December monthly Commission meeting(s) are cancelled, quorum is not achieved at the meeting at which the Co-Chair is scheduled to be elected, or by majority vote of the Commission to accommodate an extension of the Co-Chair election process.
   d. Committee Co-Chair terms expire in February of the calendar year, but may be extended, if needed, until new Co-Chairs are elected to fill the leadership positions.
   e. In the case of a mid-term vacancy in one of the Commission Co-Chair seats, the Commission Co-Chair is subsequently elected to fill the unfinished term resulting from the vacancy. Likewise, committee Co-Chairs elected to fill mid-term vacancies are elected for the respective unfinished terms.
   f. Commission Co-Chairs are considered voting members of all Committees and subcommittees but are not counted towards quorum unless present.
2. Co-Chair Nominations: ~~Outside the rare possibility of immediate vacancies in both Commission Co-Chair seats,~~ all Commission and Committee Co-Chair elections must follow a nominations period opened at the respective body's prior regular meeting. The nominations period is designed to give potential candidates the opportunity to consider standing for election and the responsibility of assuming a leadership position. Candidates may nominate themselves or participants may nominate other members. Any stakeholder may nominate Co-Chair candidates.

   Candidates can be nominated in public when the nominations are opened or any time prior to the closure of the nominations—including just prior to when the Co-Chair elections are opened at the subsequent meeting—or by contacting the Executive Director through phone, email and/or in writing at any time during the period in which nominations are open. Nominations are formally closed when the eligible candidates begin making their statements.

Commented [MD2]: Review for Accuracy/Consistency:

Inconsistent w/ current & past practices and with "Policy, Section 1" and "Procedures, Section 1(b)"

Commented [JS3R2]: This line makes no sense as the Comm Co Chairs are two years and the committee co-chairs are one. IF they are both going to be two years (wich I agree with) the line is unneeded.

Commented [MD4]: For Committee Consideration:

Although not the purview of the workgroup, a recommendation was made to require Committee Co-Chairs serve staggered two-year terms.)

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Upon being nominated, if the candidate was not present and/or did not accept or reject the nomination, staff shall notify the candidate via email and telephone within 72 hours (3 days) of the nomination. If the candidate does not acknowledge receipt of the email and/or does not accept or decline the nomination, staff shall notify current Co-Chairs at least 72 hours before the election so that the Co-Chair(s) may contact the candidate to secure their response. Should a candidate not accept or decline a nomination by the time the election is held, ~~a "no response" will be recorded, and the nomination will not move forward.~~ The members of the Commission shall be informed of the non-response or declination. ~~In the event a nomination is submitted less than one week from the date of the election, staff will notify the candidate via email and telephone.. If a response is not received by the start of the election, the candidate must be present at the time the election is held to accept the nomination and be considered for election.~~

All Commission Co-Chair candidates nominated prior to the meeting of the Co-Chair election are given the opportunity to provide a brief (single paragraph, single page) statement about their candidacy. All Co-Chair candidates should be given the opportunity to make a short oral statement about their candidacy prior to the election.

3. **Commission Co-Chair Election Process**: Normally—unless adjusted for unexpected circumstances—the Commission Co-Chair elections proceed according to the following schedule:
    a. The Co-Chairs are elected by a majority vote of Commissioners or Alternates present at a regularly scheduled Commission meeting **at least four months prior to the start date of their term**, after nominations periods opened at the prior regularly scheduled meeting.
    b. The term of office begins at the start of the calendar year. When a new Co-Chair is elected, this individual shall be identified as the Co-Chair-Elect and will have four months of mentoring and preparation for the Co-Chair role.
    c. The Co-Chairs delegate facilitation of the Co-Chair election to the Parliamentarian, Executive Director, or other designated staff, who will lead Commission voting to elect the new Commission Co-Chair
    d. Commission members who have been nominated, meet the qualifications, and who accept their nominations are presented for Commission vote.
    ~~e. The Parliamentarian (or Executive Director/staff) leads Commission voting to elect the new Commission Co-Chair.~~
    d. Following the new Co-Chair's election, the Commission Co-Chairs and the Executive Director must determine Commission members' final committee assignments by the end of December to open committee Co-Chair nominations the following month.

Commented [MD5]: Alternate language proposed: ". . . *may* not move forward."

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Commented [MD6]: For Committee Discussion:

Should a candidate be required to be present at the time the election is held if they have not acknowledged or provided a response accepting/declining their nomination. ***Seeking Parliamentarian review to ensure alignment w/ Robert's Rules of Order***

Alternate Consideration:

A list of all candidates and their nomination status will be read on the record prior to the start of the election, allowing nominees who have not yet acknowledged and/or accepted or declined their nomination to do so at that time. If a candidate does not accept or decline their nomination in writing or on the record by the start of the election, their nomination will not be considered for election.

Commented [JS7R6]: The suggested language does not comply with Robert's and violate the members rights.

Commented [MD8]: Entire section moved up from #5 to #2 for flow/organizational purposes.

Commented [JS9R8]: If there is a vacancy, a co-chair pro tem can be elected for a one or two meeting perod

Commented [MD10]: Added language from "e" for conciseness.

Commented [MD11]: Deleted & combined w/ "c" for conciseness

4. **Committee Co-Chair Election Process**: Normally—unless adjusted for unexpected circumstances—the committee Co-Chair elections proceed according to the following schedule:
    a. Aside from the Executive Committee (the Commission Co-Chairs serve as the Executive Committee Co-Chairs), the standing committees open candidate nominations for both Co-Chair seats at their January meetings (following final committee assignments).
    b. Nominations are closed the following month when Committee Co-Chair elections are opened under the Co-Chair reports.
    c. The current Co-Chairs delegate facilitation of the Co-Chair election to the Executive Director or another assigned staff representative.
    d. Committee members who have been nominated, meet the qualifications, and who accept their nominations are presented for Committee vote.
    e. The Executive Director (or other designated staff) leads Committee voting to elect the new Co-Chairs.
    f. The newly elected Co-Chairs begin service at the following committee meeting.

    As per Robert's Rules of Order, the Commission Co-Chairs should maintain a position of neutrality and not vote in Committee co-chair elections unless there is a tie vote for a position, then they may (but are not required to) vote to break the tie.

5. **Co-Chair Qualifications/Eligibility**: Only voting Commissioners may serve as Commission Co-Chairs. To ensure leadership diversity and representation, eligible Commission Co-Chair candidates must have at least one year of service and experience on the Commission. Among the two Commission Co-Chairs, at least one of the Co-Chairs must be HIV-positive, and at least one of them must be a person of color. Additionally, it is strongly preferred that at least one of the two Co-Chairs is female.

    The Commission does not impose eligibility or qualification requirements for Committee Co-Chairs, although it is strongly encouraged that nominees acquire at least one year's experience with the Committee before standing as a Co-Chair candidate.
    a. Any Committee member nominated as a Co-Chair candidate must be serving on that Committee in his/her primary Committee assignment.
    b. Only Commissioners may serve as Co-Chairs.
    c. Alternates, members serving on the Committee in secondary Committee assignments, and BOS-appointed non-Commission committee members may not serve as Co-Chairs.

Commented [MD12]: For Committee Consideration:

Although not the purview of the workgroup, a recommendation was made to update pronoun references to "they/their" for purposes of inclusivity. **Only one reference to "his/her" was found in this policy, however, recommendation applies across all policies**

6. **Co-Chair Election Voting Procedures**: Co-Chairs are elected by a majority vote:
    a. Roll call voting for elections requires each voting member to state the name of the candidate for whom he/she is voting, or to abstain, in each round of votes.

    b. If there are more than two candidates nominated for Commission Co-Chair, voting will proceed in sequential roll calls until a final candidate earns a majority of votes and is elected by a consent or roll call vote. If no candidates earn a majority of votes in a single round, the candidate earning the least number of votes will be eliminated from the subsequent round of roll call voting. The process continues until there is a majority vote for one candidate, or only one candidate remains, and the others have been eliminated. Once the final candidate has been selected, the Commission must approve that candidate for the Co-Chair seat in a consent or roll call vote.

    c. When there is only one Commission Co-Chair candidate, the vote serves as approval or rejection of the nominated candidate.
        i. A consent vote may be used to approve the final candidate(s) for the Co-Chair seat(s). A roll call vote is not necessary for a final candidate unless there are objections to the election of the candidate.

    d. If there are two Commission Co-Chair vacancies to fill, voting adheres to the process outlined above except that the final two candidates are identified as the final Co-Chair candidates. A consent vote may be used to approve both final candidates, but a subsequent roll call vote is necessary to identify which candidate will fill the longer term; the candidate earning more votes fills the seat with the longer term.
        i. A roll call vote to approve both candidates to fill the Co-Chair seats is not necessary unless there are objections to the election of one or both candidates.
        ii. When there are objections to the election of one or both candidates, each candidate must be approved by a majority through an individual roll call vote.

    e. If there are three or more candidates nominated for the two Committee Co-Chair seats, the same process described for Commission Co-Chair election voting (Procedure #4a) is followed. If there are only two Committee Co-Chair candidates, the Committee is entitled to unanimously accept the "slate of Co-Chair nominees"; otherwise, an individual roll call vote is necessary to approve the election of each candidate to a Co- Chair seat.

    f. In the case of a tie, the vote shall be retaken. ~~during the final vote, the members of the body can re-cast its their vote to accommodate changes in voting.~~ If the body cannot resolve the tie after ~~a new vote,~~ as many rounds of voting as there are candidates, the current Co- Chair(s) remain in office, voting is closed, nominations remain open until the subsequent meeting, and a new election is resumed at that meeting. The process will repeat monthly until a clear majority vote-earner is identified.

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Commented [MD13]: For Committee Consideration:

Although not under the purview of the workgroup, this is a recommendation for clarification purposes.

Commented [JS14R13]: There is no 'final' vote unless there is a stated number of rounds of voting. I suggest the number of candidates as the number of rounds

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~~g. If a majority of the voting members oppose a final candidate's/final candidates' nomination, the current Co-Chair(s) retain their seat until the subsequent meeting, nominations remain open, and a new election is held at the next meeting. The final candidates' whose nominations were opposed are no longer eligible to fill the seat in the current term. The process will repeat monthly until the body finds majority support for a final candidate(s).~~

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Commented [JS15]: As above, there is no final vote until someone is elected, or you set a limit on the number of rounds, the stated situation cannot happen

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7. **Co-Chair Election Contingencies**: A number of factors may impede the normal Co-Chair election timelines outlined in Procedures #2, #3 and #6. Following are potential challenges that can result in process delays, and how those challenges should be resolved:
    a. **Inadequate Number of Qualified Co-Chair Candidates**: The Co-Chair whose term has expired may continue in the seat with the term extended until a new Co-Chair is elected. If the Co-Chair does not choose to continue, or has resigned, a Commission or Committee Co-Chair may temporarily serve as a single Co-Chair until a second Co-Chair can be identified and elected. Co-Chair nominations will remain open indefinitely until qualified candidate(s) are identified and elected.
    b. **Cancelled Meeting(s) or Quorum(s) Not Realized**: Nominations can be opened at a subsequent meeting and/or extended to accommodate the cancelled meeting(s) or absence of quorum(s). If the meeting for which the election is scheduled is cancelled or a quorum is not present, nominations remain open an additional month and the election proceeds the following month.

NOTED AND APPROVED: Cheryl A Barrit **EFFECTIVE DATE:** September 12, 2019

Original Approval:

**Revision(s):10/19/16; 7/24/17; 9/12/19; Proposed Revisions 01/17/23*

3/13/2023

Assessment of the Administrative Mechanism (AAM)

Ryan White Program Year 31
(March1, 2020-February 28, 2021

Final Draft

LOS ANGELES COUNTY
COMMISSION ON HIV

Assessment of the Administrative Mechanism
Ryan White Program Year 31
(March 1, 2020-February 28, 2021)

Table of Contents

I. Introduction and Purpose of Report

As a Ryan White Part A planning council, the Los Angeles County Commission on HIV ("the Commission") is required by Health Resources and Services Administration (HRSA) to conduct a regular "Assessment of the Administrative Mechanism" (AAM). The AAM is meant to evaluate the speed and efficiency with which Ryan White Program funding is allocated and disbursed for HIV services in Los Angeles County. The Operations Committee of the Commission led the development, implementation, and analysis of the AAM for Ryan White Program Year 31. The purpose of this report is to present the findings of this assessment. Outlined in the sections below is the assessment methodology, and findings.

II. Assessment Methodology

The AAM covers 2 areas: 1) an assessment of the Commissioners' understanding of the priority setting and resource allocation process and 2) harnessing feedback from contracted agencies on the efficiency of Los Angeles County's administrative mechanisms (such as contracts, procurement, solicitations) to rapidly disburse funds to support HIV services in the community. The Operations Committee used an anonymous questionnaire via SurveyMonkey to elicit responses from Commissioners and contracted agencies. The Operations Committee of the Commission led the AAM and utilized the same questionnaire used for the previous AAMs as they have been tested and used in previous studies.

Online Survey of Commissioners:

Commissioners were invited to respond to the survey between April 4 to May 2022. At that time, there were 35 members (1 was on a leave of absence) and 8 alternates (1 was on a leave of absence) for a total of 41 possible respondents. Several follow-up emails were sent to ensure a high response rate. Nineteen responses were recorded at close of survey, generating a response rate of 46%.

Online Survey Contracted Providers:

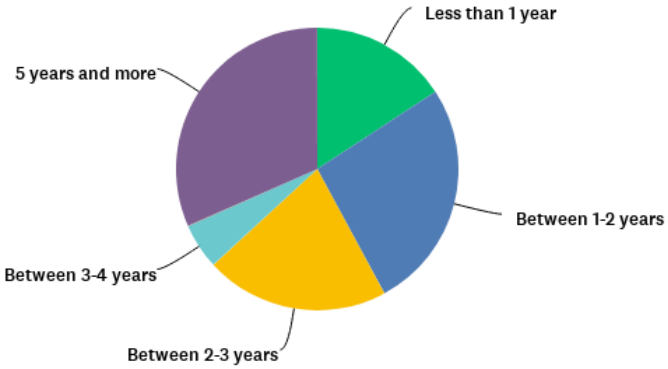
All 43 County-contracted HIV prevention and care providers were invited to participate in the AAM survey between August 18-September 15, 2022. 11 agencies completed the survey. Agencies were asked to provide one response per agency.

Limitations: The Operations Committee discussed and acknowledged the possibility of a low response rate for the Commissioner and provider surveys due to multiple local, statewide, and national surveys in circulation in 2022, including those related to the development of the federally required Integrated Plan. Another limitation of this AAM is the lag time between the program year cycle focus of the survey and the time of when the survey was released—this may have impacted memory recall of events and data presentations delivered to the Commission. Readers should not make broad interpretations with the results of the AAM but rather, use the information as a record of perceptions and responses from those individuals and agencies who completed the survey.

III. Assessment Responses

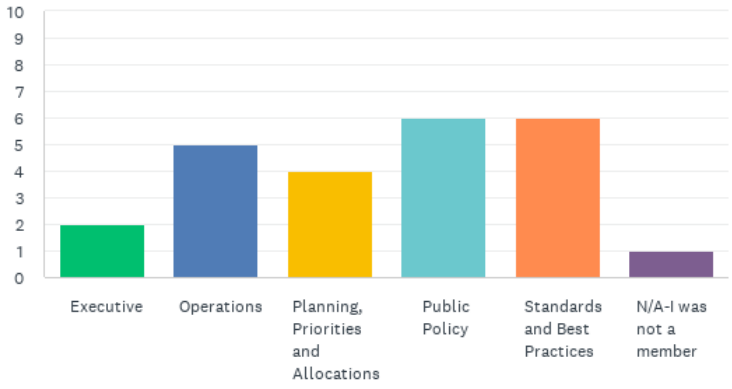
A. Survey of Los Angeles County Commission on HIV Commissioners[1]

Q1 For how long have you served as a Commissioner and/or Alternate on the Los Angeles County Commission on HIV?



Of the 19 individuals who responded to the survey, 3 indicated they have been a member of the Commission for less than a year; 5 between 1 to 2 years; 4 between 2 to 3 years; 1 between 3 to 4 years; and 6 for 5 years or more.

Q2 During the Ryan White Program Year 30 (March 1, 2020 – February 28, 2021) priority setting and resource allocation process, which committee(s) were you a member of?

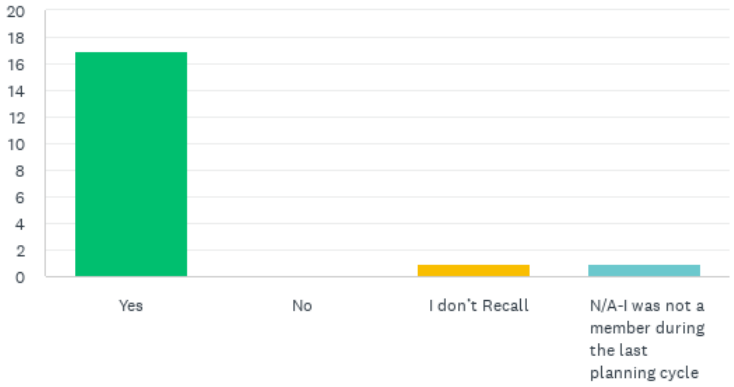


During the PY 30 priority setting and resource allocation (PSRA) process, 2 individuals indicated that they were assigned to the Executive Committee; 5 were members of Operations; 4 were members of the Planning, Priorities and Allocations; 6 were assigned to Public Policy; 6 were assigned to Standards and

[1] N=19

Best Practices; and 1 noted that they did not have a committee assignment at the time of the survey - this individual may have just been recently onboarded to the Commission and was awaiting confirmation of their committee assignment at the time that the survey was conducted.

Q3 During the Ryan White Program Year 30 (March 1, 2020 – February 28, 2021) priority setting and resource allocation planning cycle, did the Commission on HIV review/study an appropriate amount and type of data on an ongoing basis to determine community needs?

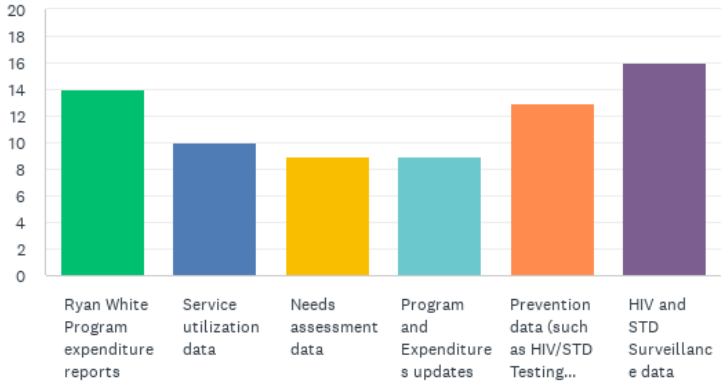


During the PY 30 PSRA planning cycle, 17 individuals who responded to the survey agreed that the Commission reviewed an appropriate amount and type of data on an ongoing basis to determine community needs; 1 indicated "I do not recall", and 1 responded that they were not a part of the planning cycle.

Comments:

- I think a greater amount of data/service resource and funding direct from the independent CA Health Jurisdictions in LA County.

Q4 During the Ryan White Program Year 30 (March 1, 2020 – February 28, 2021) planning cycle, do you recall any of the following DHSP reports being provided as a part of the priority setting and resource allocation process?

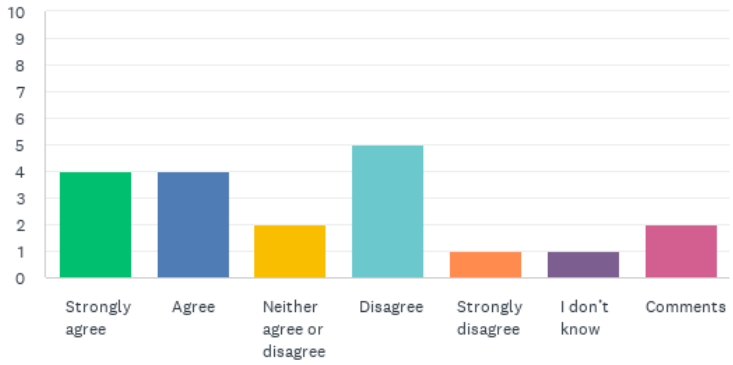


The data types most remembered by survey participants in ranked order were 1) HIV and STD surveillance (84.21%); 2) Ryan White Program expenditures report (73.68%); 3) prevention data (68.42%); 4) service utilization (52.63%); 5) needs assessment and program/expenditures updates (both at 47.37%). Prevention data included HIV/STD testing services; National HIV Behavioral Surveillance; LAC Apps-based survey; contracted biomedical services; contracted HIV education and risk reduction services; contracted vulnerable populations services).

Comments:

- Not sure on the one item. It may well have been done, I just don't remember.
- We could use more INTERSECTIONAL data on HIV HOUSING, HIV mental health, HIV SUBSTANCE USE INCLUDING HARM REDUCTION, especially related to methanol hatsmine (sp) use, AND a significant update on LGBTQI stigma/discrimination, and data that better shows the increasing needs of Seniors infected with HIV.
- I don't remember the specific reports. We were still receiving LACHAS reports and gearing up for the EHE. I don't remember a lack of data.
- Seen reports but not sure on time frame; also not sure how No 1 and 4 differ.

Q5 Please indicate the degree to which you agree with the following statement: There is adequate consumer participation and input in the planning, priority setting and resource allocation process.

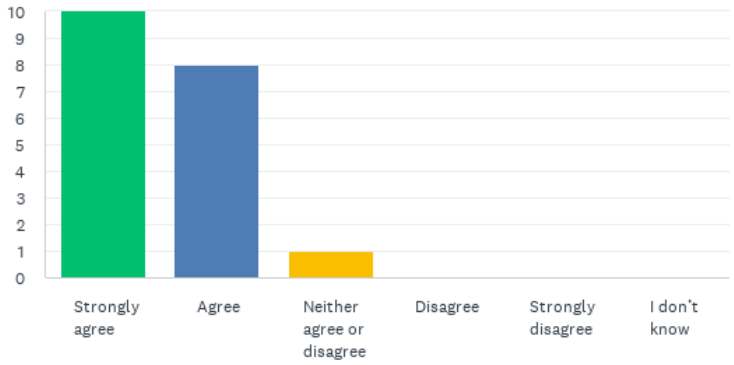


Regarding adequate consumer participation in the PSRA and planning process, 4 individuals "strongly agreed"; 4 "agreed"; 3 "neither agreed or disagreed"; 5 "disagreed"; 1 "strongly disagreed"; 1 replied "I don't know"; and 2 provided comments (listed below).

<u>Comments:</u>

- "Adequate" however is insufficient, and consumers need much more support to participate especially elderly and long-term survivors, and people of color – especially Native American Representatives
- Agree, but we could do more with consumer involvement.

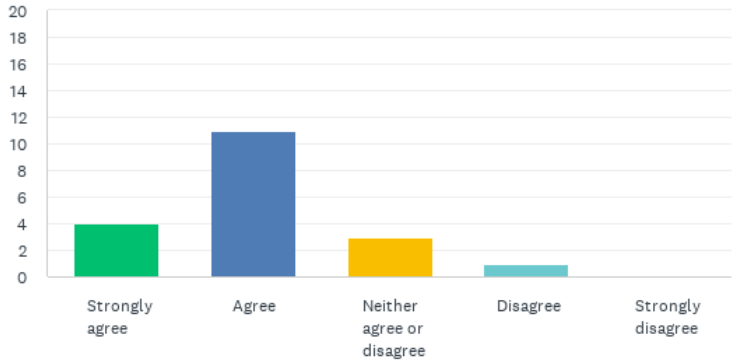
Q6 Please indicate the degree to which you agree with the following statement: During the last planning cycle, I was adequately notified of planning, priority setting and resource allocation activities and meetings.



When asked to rate their agreement/disagreement with the statement, “during the last planning cycle, I was adequately notified of planning, PSRSA activities and meetings”, 10 individuals “strongly agreed”; 8 “agreed”; and 1 neither agreed or disagreed.”

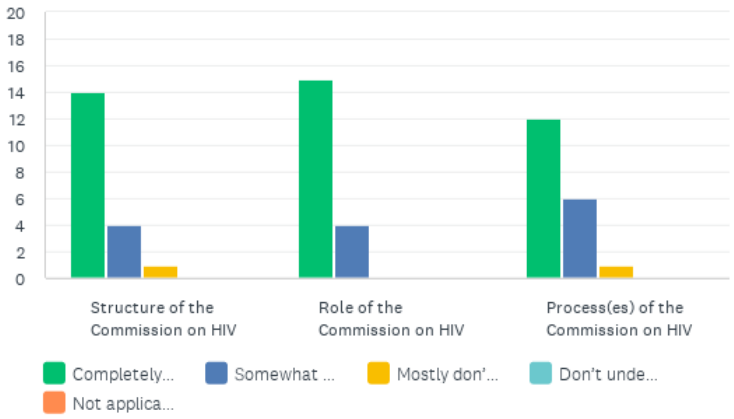
Comments: none

Q7 Please indicate the degree to which you agree with the following statement: In terms of structure and process, the Commission on HIV is effective as a planning body.



When asked to rate their agreement/disagreement with the statement, “in terms of structure and process, the Commission on HIV is effective as a planning body”, 4 individuals “strongly agreed”; 11 “agreed”; 3 “neither agreed or disagreed”; and 1 “disagreed”.

Q8 Please indicate the degree to which you understand the following:



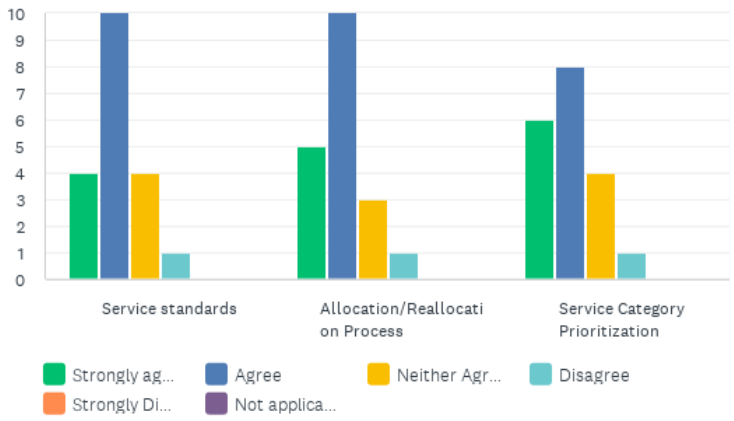
Regarding the Commissioners understanding of the structure, role and processes of the Commission, survey participants responded in the following manner:

- Structure of the Commission – 14 answered "completely understand"; 4 "somewhat understand"; and 1 "mostly don't understand"
- Role of the Commission – 15 answered completely understand" and 4 "somewhat understand";
- Process(es) of the Commission – 12 answered completely understand"; 6 "somewhat understand"; 1 "mostly don't understand"

Comments:

- We participate in creating plans. We don't lack for plans. Success in the metrics we use is incremental. We can't keep doing the same things and expect different results.
- The COH has done an excellent job helping me learn and understand my role as a commissioner.

Q9 Please indicate the degree to which you agree with the following statements: The Commission on HIV has prepared me to make decisions related to:



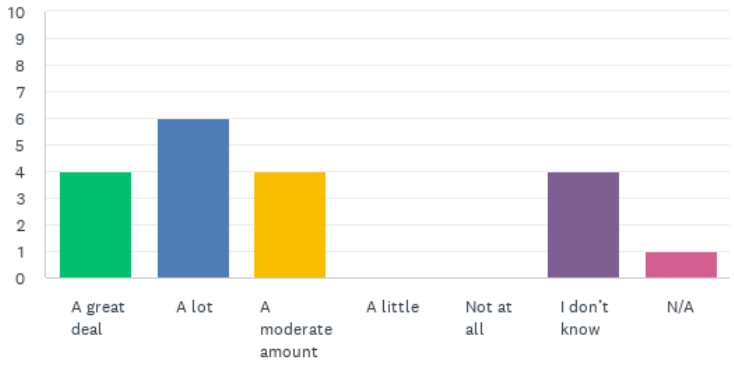
When asked to rate the degree to which the Commission has prepared members to make decisions related to service standards, PSRA and service category prioritization, survey participants responded in the following manner:

- Service standards – 4 "strongly agreed"; 10 "agreed"; 4 "neither agreed nor disagreed"; and 1 "disagreed"
- PSRA process – 5 "strongly agreed"; 10 "agreed"; 3 neither agreed nor disagreed"; and 1 "disagreed"
- Service category prioritization – 6 "strongly agreed"; 8 "agreed"; 4 neither agreed nor disagreed"; and 1 "disagreed"

<u>Comments:</u>

- As part of the Commission, I believe there is always room for improvement and increased knowledge.
- We have the knowledge and experience around the table. We need more direct consumer feedback and involvement.

Q10 Please indicate the degree to which you believe the priorities and allocations established by the Commission on HIV in the Ryan White Program Year 30 (March 1, 2020 – February 28, 2021) were followed by DHSP.



When queried to rate the degree to which the priorities and allocations established by the Commission for the Ryan White PY 30 were followed by the DHSP (the grantee), 4 responded "a great deal"; 6 " a lot"; 4 "a moderate amount; 4 "I don't know"; and 1 "N/A".

Comments: none

Observations and Recommendations

While this study has limitations such as low response rate and the likelihood of poor memory recall due to the lag in time frame from date of the priority setting meetings and the date of the study, the responses from the Commissioners offer insights on opportunities for improvement , training and learning. Key observations and recommendations are listed below:

Key Observations:

- There appears to be recognition and recall of the range of programmatic, fiscal, surveillance, service utilization and care continuum data provided to the Commission and its committees during PY 30. A participant noted that they would like to see more data that shows the intersection of HIV with morbidities such as mental, substance use, seniors and social conditions such as stigma and discrimination. More data sharing from the independent health jurisdictions (Long Beach and Pasadena) was also noted by a respondent.

- There is a need for a more robust, direct, and highly visible participation and engagement of consumers in the Commission's priority setting, resource allocation process and decision-making.

- Eighteen of the 19 respondents strongly agreed/agreed that they were "adequately notified of PSRA meetings and activities during the PY 30 planning cycle. The response may be due to the Commission's open meetings which allows for broad community participation. In addition, data presentations are disseminated in advance to the PP&A Committee and materials are posted on

the Commission's website.

- In terms of structure and process, 15 respondents indicated that they strongly agreed/agreed that the Commission is effective as a planning body; while 3 responded neither agreed or disagreed and 1 disagreed. The continues cycle of planning may also be factor in the desire to execute different approaches to community planning.

Key Recommendations:

- Facilitate a more structured collaboration process for the Operations Committee and Consumer Caucus to develop customized a training and coaching plan for consumers on how decisions are made on the Commission and make data presentations more accessible to consumers.

- In order to better prepare Commissioners with planning and decision making, the Commission should continue efforts around ongoing education and training on COH structure, role and processes. In addition, the Commission should consider periodic assessment/review of its structure, processes (such as service standards development, allocations/reallocations, and service category prioritization) and define desired outcomes and examples of what an "effective planning body" constitutes.

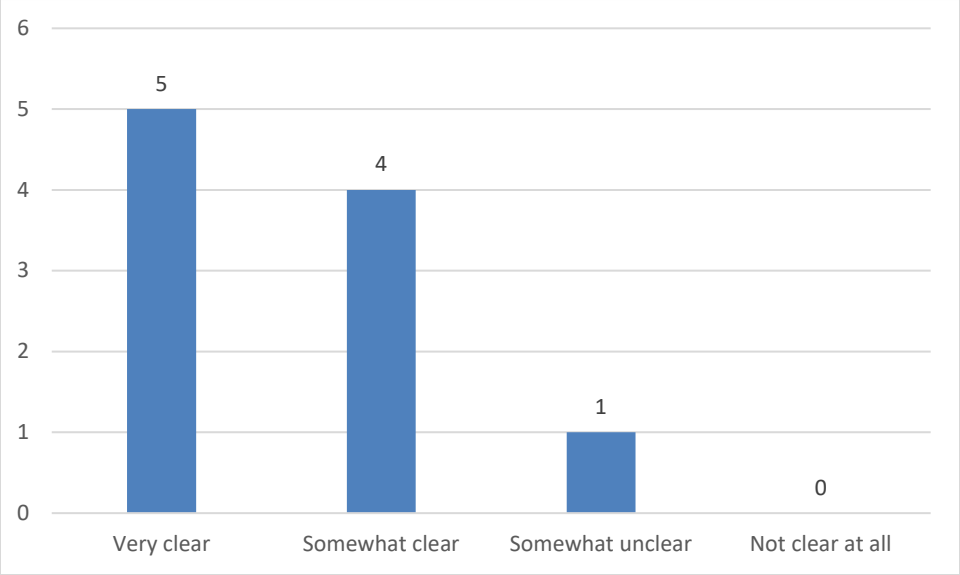
- Collaborate with the Consumer Caucus to identify strategies aimed at increasing ongoing participation of consumers in PP&A discussions, especially among consumers who identify as people of color, elderly, long-term survivors, Native Americans, and other communities disproportionately affected by HIV.

B. Assessment with Contracted Providers Responses[2]

Q1. Please describe the level of guidance you get from DHSP with respect to invoicing, budget development and budget modifications.

1. The process involves a lot of back and forth and detail that is unusual, and the spreadsheets are cumbersome.
2. Ongoing oversight on all dimensions. Usually high level of guidance provided, medium level during the COVID Era.
3. We receive sufficient guidance regarding invoicing, budget development and budget modification.
4. We've received very good, clear guidance from DHSP on budget development and modifications. They are highly responsive regarding invoicing, so there has been some lack clarify around invoicing for PFP portion of contract.
5. Our DHSP Program Managers and Finance Managers have always been accessible and more than willing to assist our program when needed.
6. Our DHSP team is most prompt and helpful when needed.
7. My project officer has been very helpful with all bud mods and invoicing
8. DHSP program managers are always available to assist and provide guidance.
9. DHSP gives adequate guidance in this area when needed.
10. Minimal
11. Guidance is generally provided when something needs to be revised. Over the years the budget process has become more tedious compared with funds that come directly from a federal source (HRSA, CDC, SAMSHA).

Q2. With respect to the process of program monitoring, how clear are you on the expectations prior to the site visit and monitoring?



Comments:

1. No information regarding audit has been provided yet.
2. Usually preparation materials are sent in advance.
3. There could have been clearer outlining of expectations prior to the site visit. Additionally, the site visit did not occur until the beginning of year 3, which was problematic.
4. Program managers convey expectations clearly prior to monitoring.
5. It seems that things are always changing. One year you get a great audit score and the next its terrible.
6. Seems like each year the expectations change. Moreover, not clear why a program that is in compliance needs to be reviewed every year. Moreover, there is a constant change in Program Managers. This creates a disconnect with understanding how a program operates. Program Managers need to go out into the field and witness programs in action.

Q3. Does DHSP regularly provide feedback on your performance? If so, is the feedback helpful? What is helpful about the feedback?

1. Feedback is always helpful. The more specific it is, the better.
2. Yes, DHSP provides feedback on performance that is helpful.
3. There is not regular feedback on the performance.
4. Our DHSP Managers regularly provide feedback on our performance. The feedback has always been helpful to improve our program policies and procedures.
5. We get regular communication from our program monitor. Updates and questions from finance are asked as needed.
6. Yes. The quarterly report is very helpful
7. Yes, DHSP provides helpful feedback to improve in areas of less strength. Also, if there is any programmatic issue, the feedback allows us to get back on track to achieve contractual goals.
8. DHSP provides feedback and about performance, goals etc.
9. No, and I think it would be nice to have a working relationship with all the program managers.
10. Feedback is generally provided in written form following a program review or if a grievance was submitted to DHSP.

Q4. Do you get feedback or technical assistance from DHSP on barriers and challenges reported on progress reports? If so, is that feedback or TA helpful? Please elaborate.

1. Yes, DHSP has been providing feedback and assisting us when we have questions. In particular, DHSP invited us to an MCC meeting where most providers were present so we could discuss our services and the referral process.
2. Needs to be on an ongoing basis. During the COVID period staff were redeployed to address the COVID Pandemic.
3. I don't recall a specific incident. However, I do believe they have been supportive regarding barriers and challenges.
4. No feedback is given on any challenges or anything specific that's reported in the monthly reports.

5. Feedback from our monthly progress reports is usually discussed during our annual program reviews. DHSP Program Managers often give examples of what other community facility programs with similar barriers and challenges are experiencing and how they are improving.
6. Our program monitor is most supportive and helpful.
7. None
8. Yes, we get feedback. DHSP always offers TA when needed, especially after a programmatic review, to address any issues identified.
9. Yes, TA is provided when requested. It has proven to be helpful taking a deeper dive into the contract expectations and clarify areas where we may have questions.
10. no- no feedback or suggestions.
11. Despite repeated requests for TA, no. One particular program continues to be challenged with reporting on one of the domains, and although we have requested TA, there has been no follow up.

Q5. With respect to the development of your DHSP contract, how would you describe the level of technical assistance and support provided by your assigned program manager and fiscal representative? (Please reference which RFP or service category you are referring to).

1. As it pertains to the fiscal portion, the process involves a lot of back and forth and detail that is unusual, and the spreadsheets are cumbersome. In addition, we had a lot of back and forth with the prior program manager. The service category is HIV Legal Services.
2. Education and Prevention-High TCM-Medium
3. Both assigned program manager and fiscal representative have been helpful. RCFCI service category.
4. N/A Were not involved in the development of the contract
5. XXXX* currently has three DHSP contracts: Medical Care Coordination Services, Ambulatory Outpatient Medical Services and Transportation Services. The transportation services contract is fairly new and was implemented during the pandemic. Unfortunately, we experienced a lack of guidance and/or communication with DHSP when trying to set up individual contracts with Metro. At the time, we didn't know who our assigned Transportation Program Manager was and could not get any response from calls and emails. We later found out that several managers had been temporarily reassigned to work on COVID-19 projects and/or were working from home. We currently have an amazing, supportive Transportation Program Manager!
6. We have an HE/RR contract and have had that contract for many years. The level of technical assistance is beneficial when needed - especially around audits.
7. I appreciate the offer of TA
8. At the beginning of 2022, we submitted our proposal for the HIV Biomedical PrEP Prevention RFP. During the application process, DHSP provided TA through webinars, provided an email address to submit any questions related to the RFP, and then posted the answers. Those tools allowed us to have a better understanding of submitting our proposal.
9. Technical assistance has been provided surrounding Benefits Specialty Services and has been helpful for frontline staff in delivering services, as well as managing the contract.
10. XXXX*- non existent but ok during audit XXXX*- minimal PH003772- great XXXX*- current is great, past was non existent XXX*- great

11. Most contracts have been in place for a number of years. Program Managers adhere to a strict definition of the contract language, but no very little how a program actually operates.

    **XXXX = used to replace contract numbers to maintain anonymity.*

Q6. Do the RFPs provide clear instructions, directions, and/or guidance? If yes, how so? If no, in what ways are they unclear? What was your role in developing the application in response to the RFP? Please elaborate.

1. We did not reply to an RFP. We were asked to assume the delegation of duties from a current contract.
2. Multiple year funding, directions have been similar over the years. Was the lead on the application, and worked with staff on all stages of the submissions.
3. I do not recall. I was part of an in-house team that responded to the last RFP.
4. Did not develop the application. Were not employed with the organization at that time.
5. To my knowledge, the RFP instructions, directions and/or guidance seem to be clear. As the Program Manager, my role includes reporting, client numbers, etc.
6. N/A We have maintained the HE/RR contract for many years.
7. The administrative guidance and task are extremely cumbersome and take way too much time from our time
8. The RFP provided clear instructions regarding the staff required to implement and roll out the program and priority populations. However, it did not explain how the goals would be calculated. It was the program manager who explained that goals are calculated based on the assigned FTEs.
9. Yes, RFPs provide clear instructions. I have provided support in developing RFP application responses.
10. The RFPs are clear. The auditing is not consistent especially in BSS and MH. I was the main contact for the response.
11. As noted above, many contracts have been in place for many years. In my capacity at our organization, I wrote most of the applications. I have found the RFP's to be generally very clear.

Q7. Do you feel the county's process of awarding contracts for services is fair? Please explain.

1. Yes. It is transparent and provides due consideration of experience with the clients and area of service.
2. Yes. I believe there is an outside, independent County review panel.
3. Yes. In my experience for RCFCI services the RFP appeared fair.
4. Don't have sufficient information to answer this question.
5. I feel the process is fair. Contracts and funding are usually awarded to those areas and SPAs that need it.
6. Understanding what difficulty it must be to streamline processes and use pre-authorized agencies, it seems fair.
7. Yes. DHSP, in this last cycle has been fair.
8. I understand there is a review committee that evaluates each proposal. However, I am unaware

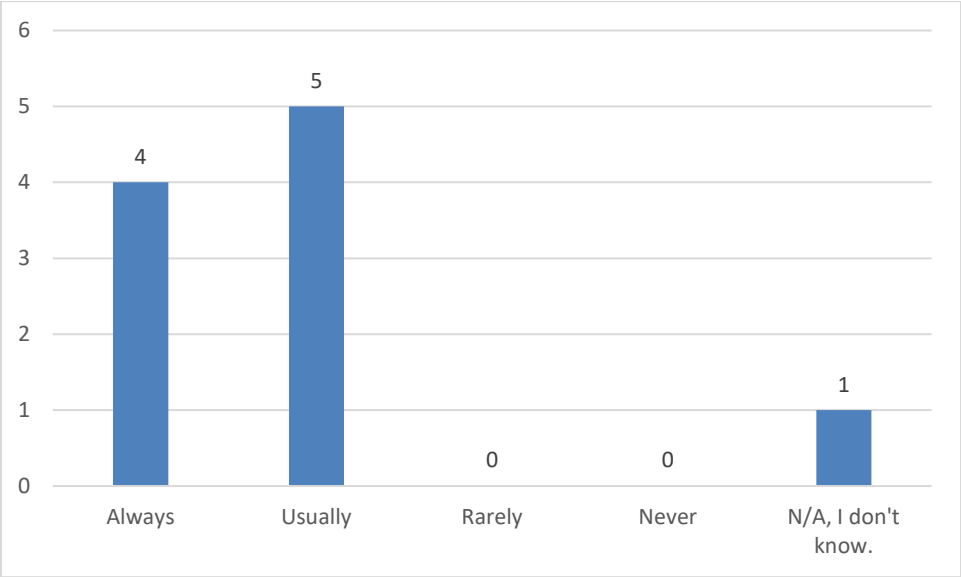
of how the review panel is chosen and how someone becomes part of it. I consider it should be more transparent to ensure there are no biases.

9. Yes, to my knowledge our agency has experienced fairness in awarding of contracts.
10. Yes
11. Yes; however, there continues to be some agencies funded that have a history of under-performing.

Q8. What are the most effective practices implemented by your agency to ensure that Ryan White program funds are spent efficiently? Please elaborate.

1. The team is established and is ready to receive referrals on trains, partners and the community.
2. Regular supervision meetings. Our award amount has remained basically the same for the past 14 years without a cost of living increase.
3. Ensuring that we have a full house and are able to bill for all available beds.
4. Internal controls on grant money spent provide a framework to ensure efficient use of program funds. These include internal approval processes, monthly financial reporting and accounts payable controls.
5. In-house audits.
6. The HE/RR contract is very specific. The guidelines are clear and reporting for both programming and financials are direct and easy to complete.
7. Targeting the right populations
8. Our agency has compliance tools that are reviewed quarterly to ensure all practices are followed, and funds are spent according to the contractual guidelines. Additionally, we submit our invoices and request feedback from the program manager or fiscal representative. If a discrepancy is identified, our accounting and program administrator correct the issue.
9. Continuous Quality Improvement efforts, through program monitoring, communication with DHSP, agency administration, management (finance, director etc) and frontline staff.
10. We have a dedicated fiscal manager. Programmatically we conduct internal audits.
11. Having finance and program administration staff who understand the contract, allowed expenses, and who work as a team to monitor expenses and respond in a timely manner with submitting budget mods.

Q9. DHSP issues payments within 30 days following submission of complete, accurate invoices, and submitted in a timely manner as stipulated by the DHSP contract.



Comments:

1. Payments are generally received in 45-60 days.
2. Much better than in the past.
3. However, it takes forever to receive an executed contract; often well-beyond the 90-days an agency is expected to "float" a program.

Q10. Are there other comments or feedback you would like to share about the County's procurement, contracting, and invoicing process? Please provide specific examples and suggestions for improvement.

1. No/None
2. Honor the agencies' individual Negotiated Indirect Cost Agreements (NICRAs). A 10% ceiling is too low.
3. N/A
4. I know that sometimes the payment takes longer than 30 days, regardless of submitting the invoice on time.
5. DHSP staff often inform an agency that they have 24-48 hours to respond to a request; however, it often takes DHSP many months to execute a contract or approve a budget modification. There have been occasions when a budget mod was approved after a contract ended. Agencies should be allowed to submit a final budget mod, with parameters, upon submission of a final invoice. DHSP staff need to go out into the field and gain an understanding of the programs they monitor. Most program staff at funded agencies returned to the office in 2021, yet DHSP staff continued to work at home. The optics of this was/is not great. This further demonstrates the disconnect with what happens in the field.

C. Key Themes

Sufficient to Very Good Guidance on Invoicing, Budget Development and Budget Modifications

With regard to the level of guidance received from DHSP around invoicing, budget development and budget modifications, comments ranged from "sufficient" to "very good" and "clear guidance." Some respondents also appreciated the accessibility and assistance from program and fiscal managers for questions and technical assistance.

Mixed Reactions around Communication of Expectations Prior to Site Visits and Program Monitoring

While some of responses noted that program managers conveyed expectations clearly prior to site visits, there were also comments that alluded to the need for clearer communication of expectations for program monitoring prior to the site visit and better explanation for changes in expectations from year to year. Some participants commented that frequent changes in program managers "create a disconnect on how a program operates."

Contractors Receive Regular Feedback on Performance and Technical Assistance (TA) on Barriers and Challenges

In general, the majority of the comments, appear to show that DHSP regularly provides feedback on contractor performance and that the feedback is helpful in improving program policies, procedures, and assisting the agencies meet their contractual goals.

Some participants noted that the TA provided by DHSP has been helpful; an example was cited where an agency was able to interact with other providers to identify solutions to challenges and barriers.

A few participants indicated that they have not received TA or feedback on challenges they have reported in progress reports at the time when the survey was conducted.

Inconsistency with the Level of TA and Support Provided by Assigned Program Manager and Fiscal Representative

While many respondents described receiving helpful TA from their program/fiscal managers, some described inconsistencies with regard to guidance and communication. Some agencies with multiple service contracts are assigned different program managers.

Experience with the County's Request for Proposals (RFP) Process

Several participants noted that their contracts have been in place for several years and remarked that the County's RFP instructions appear to be clear, however, directions regarding auditing could be more uninformed across service categories and how service target goals are calculated for contracts could be better explained to agencies.

The County's Process for Awarding Contracts for Services is Fair

Overall, the participants noted that the County's process of awarding contracts is fair and transparent.

Agencies Have Established Internal Practices to Ensure that Ryan White Program (RWP) Funds are Spent Efficiently

Based on comments provided under question #8, it appears that contracted agencies have developed organizational and administrative practices to ensure that RWP funds are utilized efficiently. These practices include internal audits and compliance tools, continuous quality improvement efforts, regular supervision meetings, and targeting the right client populations.

Payments within 30 Days Have Improved

Respondents noted that DHSP issues payments in general, within 30 days, following submission of complete and accurate invoices; one comment indicated that the payment turnaround time has improved.

Suggestions for Improvement

The survey participants offered the following suggestions for improving the County's procurement, contracting and invoicing process:

- Continue to improve payment turnaround cycles within 30 days.
- Expedite or shorten the length of time it takes to execute a contract or approve a budget modification.
- Ensure uniformity in the information communicated by program and fiscal managers to contracted agencies.
- Ensure timeliness and consistency of technical assistance provided to agencies regarding programmatic and fiscal challenges and questions.

The general comments collected from this AAM reflect the recurring themes from previous AAMs, such as consistency of information received from DHSP, setting clear expectations for audits/site visits; and lengthy RFP process. It is important to note that the lengthy RFP process cited by some survey participants is a County-wide issue. The Los Angeles County Board of Supervisors (BOS) has charged the Quality and Productivity Commission, in consultation with the Small Business Commission, and Citizen's Economy and Efficiency Commission, to seek innovative ways to streamline the County's contracting process, assist businesses, and identify potential cost savings to County operations. As a short-term response, the County's *Doing Business* site was revamped to make it more community friendly and the County hosts quarterly technical assistance events for the public and vendors. In addition, DHSP has an ongoing collaboration with the Commission on HIV's Black Caucus to address and strengthen the organizational capacity of Black-led and Black-serving agencies so that they can be better prepared to successfully compete for and maintain HIV prevention and care contracts with DHSP. Despite the bureaucratic challenges associated with a

large municipal government the size of Los Angeles County, DHSP continues to improve various administrative mechanisms to ensure that life-saving services reach people living with HIV in a timely and efficient manner.

[2] n=11 providers

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

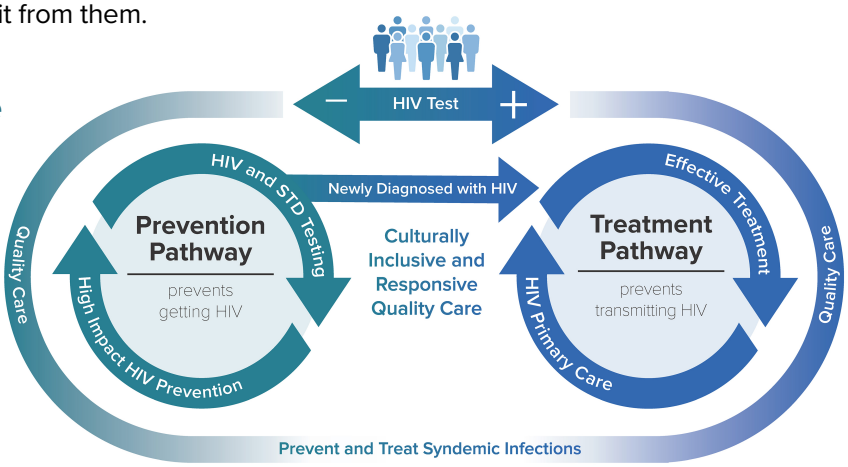
Understanding Status Neutral HIV Care

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.

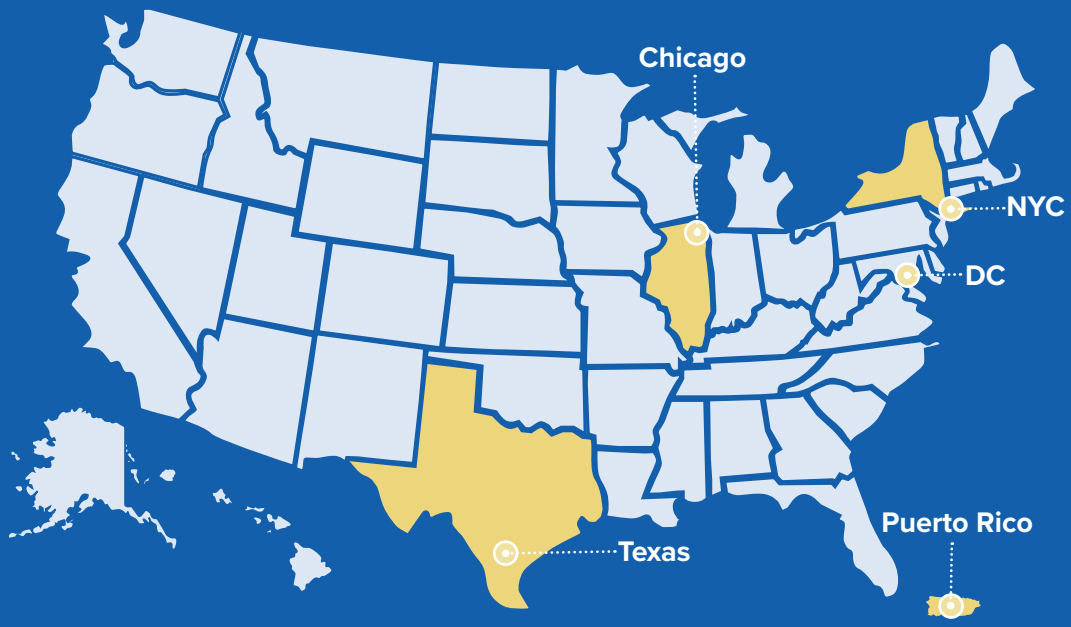
- **Supporting and enabling optimal health through continual engagement in comprehensive, "whole person" care.** By offering HIV services alongside other local health care and social support services used by the community, HIV prevention and treatment can become part of the fabric of holistic care designed 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.

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January 17, 2023

Dear Grantee:

The Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) encourage public health partners to implement status neutral approaches to HIV care and prevention. Status neutral service provision is an example of a syndemic approach to public health, weaving together resources from across infectious disease areas and incorporating social determinants of health to deliver whole-person care, regardless of a person's HIV status. Thanks to a robust toolbox that includes antiretrovirals for prevention such as pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) as well as for treatment [Treatment as Prevention (TasP) or Undetectable= Untransmittable (U=U)], and syringe service programs (SSPs), there are more tools than ever to prevent HIV. However, to realize the full potential of these tools, we need to ensure they can be accessed by every person who could benefit from them by removing barriers to services. Employing a status neutral approach and providing comprehensive care for all people, regardless of HIV status, can help reduce HIV stigma, prioritize health equity, and turn the tide on HIV-related disparities.

Historically, HIV care has often focused on specific service categories based on a person's HIV status rather than providing comprehensive services that everyone needs to get and stay healthy. A status neutral approach:

- Creates "one door" for both HIV prevention and treatment services.
- Addresses institutionalized HIV stigma by integrating prevention and care rather than supporting separate systems, which can deepen the divide between people with HIV and people who can benefit from HIV prevention services.
- Enables people to know their status by making HIV testing and subsequent actions more accessible and routine.

Furthermore, a status neutral framework encourages a comprehensive, whole-person assessment of a person's unique situation, allowing for more tailored—and therefore likely more successful—interventions.

To meet national HIV prevention goals and advance health equity, CDC and HRSA HAB recognize the importance of adopting new and innovative ways of delivering HIV prevention and care services to all who could benefit from them. This involves reframing how we think about and complement traditional HIV service models to better reach people where they are with services they need, regardless of HIV status with the goal of optimizing their health and quality of life. Implementing a status neutral framework does not require an overhaul of existing care systems. For example, incorporating status neutral approaches could include:

- Implementing HIV prevention and treatment activities in places where people seek other health services, such as sexual health services, mental health and recovery services, and transgender care.
- Making it easy for people to access care in alternative, convenient health care settings that do not require an appointment, like pharmacies and mobile health units.

For more details on how jurisdictions across the country are integrating a status neutral approach into their HIV care services, we encourage you to review CDC's issue brief on status neutral HIV care.

CDC and HRSA HAB support the use of braided funding to reduce barriers to implementation and to help extend the reach of status neutral services. Beyond CDC and HRSA, it is important to look across public and private funding streams to identify ways to also braid other funds into service delivery to achieve a more robust status neutral suite of services where feasible and appropriate. This funding approach can also increase programmatic efficiency. CDC encourages grantees to request technical assistance, if needed, on how best to braid funding from different sources.

To request technical assistance from CDC on the implementation of status neutral services:

- CDC's directly funded health department and CBO partners may request technical assistance support by submitting a request in the CBA Tracking System.
- Organizations not directly funded by CDC may contact their local health department for assistance in submitting a training request.
- For additional questions or assistance, partners may contact HIVCBA@cdc.gov.

Since HRSA's Ryan White HIV/AIDS Program (RWHAP) legislation provides grant funds to be used for the care and treatment of *people diagnosed with HIV,* thus prohibiting the use of RWHAP funds for medical services for HIV-negative clients who are at substantial risk for HIV, HRSA HAB encourages recipients to leverage the existing RWHAP infrastructure, such as risk reduction counseling and targeted HIV testing and referral, to support a status neutral approach within the parameters of the RWHAP legislation.

Similarly, HRSA's Bureau of Primary Health Care (BPHC) supports health centers to deliver comprehensive, culturally competent, high-quality primary health care services to systemically marginalized communities, including more than 200,000 people with HIV each year. HRSA BPHC encourages health centers to utilize Health Center Program funding to expand access to medication to prevent HIV (including PrEP and related services), connect people to care, and ensure services are well coordinated. Grant recipients can leverage BPHC resources and the health center network to promote, adopt, and optimize status neutral approaches while expanding access to high-quality, primary care for the communities they serve.

HRSA BPHC supported health centers seeking additional information on HIV care and treatment best practices – including how to implement a status neutral approach– can leverage the following training and technical assistance (T/TA) resources:

- HRSA's National Training and Technical Assistance Partners (NTTAPs) provide free national-level T/TA to support existing and potential health centers to improve operations and deliver comprehensive primary care services for special and vulnerable populations.
- The Health Center Resource Clearinghouse provides an up-to-date selection of high-quality TA resources relevant to health centers.
- HRSA's State/Regional Primary Care Associations (PCAs) provide T/TA based on statewide and regional needs to help health centers improve programmatic, clinical, and financial performance and operations.

HRSA and CDC are committed to developing and sharing status neutral training opportunities, resources, and tools for partners and grantees, and we look forward to continued collaboration on this effort.

Sincerely,

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National Center for HIV,
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DRAFT FOR EXECUTIVE COMMITTEE APPROVAL

SERVICE STANDARDS FOR ORAL HEALTH CARE SERVICES

LOS ANGELES COUNTY
COMMISSION ON HIV

REVIEWED AND UPDATED BY THE SBP COMMITTEE ON 10/4/22-3/6/23.

APPROVED BY THE SBP COMMITTEE ON 3/6/23.

FOR EXECUTIVE COMMITTEE APPROVAL 3/23/23

DRAFT FOR EXECUTIVE COMMITTEE APPROVAL

SERVICE STANDARDS: ORAL HEALTH CARE SERVICES

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

Human Resource Services Administration (HRSA) HIV/AIDS Bureau (HAB) Policy Clarification Notice (PCN) # 16-02 *(Revised 10/22/18)*: Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds

HRSA HAB, 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

Service standards for the Ryan White HIV/AIDS Part A Program (RWHAP) outline the elements and expectations a service provider should follow when implementing a specific service category. The standards are written for providers for guidance on what services may be offered when developing their Ryan White Part A programs. The standards set the minimum level of care Ryan White-funded agencies offer to clients, however, providers are encouraged to exceed these standards. The Los Angeles County Commission on HIV (COH) developed Oral Health Care Services standards to establish the minimum services necessary to provide oral health care services to people living with HIV. The development of the standards includes guidance from service providers, people living with HIV, the Los Angeles County Department of Public Health Division of HIV and STD Programs (DHSP), members of the Los Angeles County COH Standards and Best Practices Committee (SBP), caucuses, and the public-at-large.

SERVICE DESCRIPTION

Oral health care services are an integral part of primary medical care for all people living with HIV. Most HIV infected patients can receive routine, comprehensive oral health care in the same manner as any other person. All treatment will be administered according to published research and available standards of care. In addition, the COH developed a Dental Implants addendum to provide specific service delivery guidance to Ryan White Part A-funded agencies regarding the provision of dental implants. For more information, see the Oral Health Care Service Standard Addendum.

Service shall include (but not limited to):

- Routine dental care and oral health education and counseling
- Obtaining a comprehensive medical and oral hygiene history and consulting primary medical providers as necessary
- Providing educational, prophylactic, diagnostic and therapeutic dental services to patients with a written confirmation of HIV status

- Providing medication appropriate to oral health care services, including all currently approved drugs for HIV-related oral manifestations
- Providing or referring patients, as needed, to health specialists including, but not limited to, periodontists, prosthodontists, endodontists, oral surgeons, oral pathologists, oral medicine practitioners and registered dietitians
- Maintaining individual patient dental records in accordance with current standards
- Complying with infection control guidelines and procedures established by the California Occupation Safety and Health Administration (Cal-OSHA)

The following are priorities for HIV oral health treatment:

1. Prevention of oral and/or systemic disease where the oral cavity serves as an entry point
2. Elimination of presenting symptoms
3. Elimination of infection
4. Preservation of dentition and restoration of functioning

Recurring themes in this standard include:

- Good oral health is an important factor in the overall health management of people living with HIV.
- Treatment modifications should only be used when a patient's health status demands them.
- Comprehensive evaluation is a critical component of appropriate oral health care services.
- Treatment plans should be made in conjunction with the patient.
- Collaboration with primary medical providers is necessary to provide comprehensive dental treatment.
- Prevention and early detection should be emphasized.

GENERAL CONSIDERATIONS: **There is no justification to deny or modify dental treatment based on the fact that a patient has tested positive for HIV**. Further, the magnitude of the viral load is not an indicator to withhold dental treatment for the patient. If, however, a patient's medical condition is compromised, treatment adjustments, as with any medically compromised patient, may be necessary.

SERVICE/ORGANIZATIONAL LICENSURE CATEGORY

HIV/AIDS oral health care services shall be provided by dental care professionals who have applicable professional degrees and current California State licenses. Dental staff can include dentists, dental assistants, dental assistants in extended functions, dental hygienists, and dental hygienists in extended practice. Clinical supervision shall be performed by a licensed dentist responsible for all clinical operations.

Dentists: A dentist must complete a four-year dental program and possess a Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) degree. Additionally, dentists must pass a

three-part examination as well as the California jurisprudence exam and a professional ethics exam. Dentists are regulated by the California Dental Board (please see Dental Board of California for further information).

Registered Dental Assistants (RDA): RDAs must possess a diploma or certificate in dental assisting from an educational program approved by the California Dental Board, or 18 months of satisfactory work experience as a dental assistant. RDAs are regulated by the California Dental Board (please see Dental Board of California for further information).

Unlicensed Dental Assistants (DA): Unlicensed dental assistants are not licensed by the Dental Board of California, but they are subject to certain laws governing their conduct. Section 150.1 is the statute governing the duties that unlicensed dental assistants are allowed to perform. Unless a specific duty is listed in that regulations, the dental assistant is NOT allowed to perform that duty. A dental assistant may only expose radiographs after successful completion of a board-approved radiation safety course. Dental assistants with certain experience or educational backgrounds may qualify to apply for Registered Dental Assistant (RDA) licensure.

Registered Dental Assistants in Extended Functions (RDAEF)[1]: RDAEF holds a current licensure as a Registered Dental Assistant or has completed the requirements for licensure as a RDA, completed a Board-approved course in the application of Pit & Fissure Sealants, completed a Board-approved RDAEF program, passed a written examination administered by the Board, and submitted fingerprint clearances from both the Department of Justice and the Federal Bureau of Investigation. RDAEFs are regulated by the California Dental Board (please see Dental Board of California for further information).

Registered Dental Hygienists (RDH): RDHs must have been granted a diploma or certificate in dental hygiene from an approved dental hygiene educational program. RDHs are regulated by the California Dental Board (please see Dental Board of California for further information).

Registered Dental Hygienists in Extended Functions (RDHEF)[2]: RDHEF holds a current license as a registered dental hygienist in California, completed clinical training approved by the dental hygiene board in a facility affiliated with a dental school under the direct supervision of the dental school faculty, performed satisfactorily on an examination required by the dental hygiene board, and completed an application form and paid all application fees required by the dental hygiene board. RDHEF are regulated by the California Dental Board (please see Dental Board of California for further information).

[1] Registered Dental Assistant in Extended Functions Applicants - Dental Board of California
[2] Codes Display Text (ca.gov)

SERVICE STANDARDS

All contractors must meet the Universal Standards of Care approved by the COH in addition to the following Oral Health Care Services standards. The Universal Standards of Care can be accessed at: https://hiv.lacounty.gov/service-standards

SERVICE COMPONENT	STANDARD	DOCUMENTATION
INTAKE	Intake process will begin during first contact with client.	Intake took in client file to include (at minimum): • Documentation of HIV status • Proof of LA County residency • Verification of financial eligibility • Date of intake • Client name, home address, mailing address and telephone number • Emergency and/or next of kin contact name, home address and telephone number
	Confidentiality Policy and Release of Information will be discussed and completed.	Release of Information signed and dated by client on file and updated annually.
	Consent for Services will be completed.	Signed and dated Consent in client file.
	Client will be informed of Rights and Responsibilities and the Division on HIV and STD Programs (DHSP) Customer Support Program[3].	Signed, dated forms in client file.
EVALUATION When presenting for dental services, people living with HIV should be given a comprehensive oral	A comprehensive oral evaluation will be given to patients living with HIV and will include: • Documentation of patient's presenting complaint	Signed, dated evaluation on file in patient chart.

[3] The program aims to assist consumers of HIV and STD services who have experienced difficult accessing services from DHSP-funded providers throughout Los Angeles County.

evaluation. When indicated, diagnostic tests relevant to the evaluation of the patient should be performed and used in diagnosis and treatment planning. In addition, full medical status information from the patient's medical provider, including most recent lab work results, should be obtained, and considered by the dentist	• Caries charting • Radiographs or panoramic and bitewings and selected periapical films • Complete periodontal exam or PSR (Periodontal Screening Record) • Comprehensive head and neck exam • Complete intra-oral exam, including evaluation for HIV-associated lesions • Pain assessment	
	As indicated, diagnostic tests relevant to the evaluation will be used in diagnosis and treatment planning. Biopsies of suspicious oral lesions will be taken.	Signed, dated evaluation in patient chart to detail additional tests.
	Full medical status information will be obtained from the patient's medical provider and considered in the evaluation. The medical history and current medication list will be updated regularly to ensure all medical and treatment changes are noted.	Signed, dated evaluation in patient chart to detail medical status information.
	Obtain a thorough medical, dental, and psychosocial history to assess the patient's oral hygiene habits and periodontal stability and determine the patient's capacity to achieve dental implant success and the possibility of dental implant failure.	Client Chart/Treatment Plan/Provider Progress Notes
	Clinician, after patient assessment, will make necessary referrals to specialty programs including, but not limited to smoking cessation	

	programs; substance use treatment; medical nutritional therapy, thereby increasing patients' success rate for receiving dental implants.	
	The clinicians referring patients to specialty Oral Healthcare services will complete a referral form, educate the patient, and discuss treatment plan alternatives with patient.	
TREATMENT PLANNING In conjunction with the patient, each dental provider shall develop a comprehensive, multidisciplinary treatment plan. The patient's primary reason for the visit should be considered by the dental professional when developing the dental treatment plan. Treatment priority should be given to the management of pain, infection, traumatic injury, or other emergency conditions. Dental provider will support and reinforce patient understanding, agreement, and education in the patient's treatment plan. Ensure patient understanding that dental implants are for medical necessity (as determined by the dental provider through assessments and evaluation) and would lead to improved	A comprehensive, multidisciplinary treatment plan will be developed in conjunction with the patient.	Treatment plan dated and signed by both the provider and patient in patient file.
	Patient's primary reason for dental visit should be addressed in treatment plan.	Treatment plan dated and signed by both the provider and patient in the patient file to detail.
	Patient strengths and limitations will be considered in development of treatment plan.	Treatment plan dated and signed by both the provider and patient in patient file to detail.
	Treatment priority will be given to pain management, infection, traumatic injury, or other emergency conditions.	Treatment plan dated and signed by both the provider and patient in patient file to detail.
	Treatment plan will include consideration of the following factors: • Tooth and/or tissue supported prosthetic options • Fixed protheses, removable prostheses or combination • Soft and hard tissue characteristics and morphology, ridge relationships, occlusion and occlusal forces, aesthetics, and parafunctional habits	Treatment plan dated and signed by both the provider and patient in file to detail.

HIV health outcomes. Reinforce that Ryan White funds cannot be used to provide dental implants for cosmetic purposes.	• Restorative implications, endodontic status, tooth position and periodontal prognosis • Craniofacial, musculoskeletal relationships	
	Six-month recall schedule will be used to monitor any changes. A three-month recall schedule may be considered to limit disease progression and maintain healthy periodontal tissues in advanced cases of periodontitis or caries.	Signed, dated progress note in patient file to detail.
	Treatment plans will be updated as deemed necessary.	Signed, dated progress note in patient file to detail.
	The receiving clinician will review the referral, consider the patient's medical, dental, and psychosocial history to determine treatment plan options that offer the patient the most successful outcome based on published literature. The clinician will discuss with patient dental implant options with the goal of achieving optimal health outcomes.	Referral in Client Chart/Treatment Plan/Provider Progress Notes
	The clinician will consider the patient's perspective in deciding which treatment plan to use.	Client Chart/Treatment Plan/Provider Progress Notes
	The clinician will discuss treatment plan alternatives with the patient and collaborate with the patient to determine their treatment plan.	
	The clinician and the patient will revisit the treatment plan periodically to determine if any	

	adjustments are necessary to achieve the treatment goal.	
	The clinician will educate patients on how to maintain dental implants and the importance of routine care.	
INFORMED CONSENT Patients will sign an informed consent document for all dental procedures. This informed consent process will be ongoing as indicated by the dental treatment plan.	As part of the informed consent process, dental professionals will provide the following before obtaining consent: • Diagnostic information • Recommended treatment • Alternative treatment • Benefits and risks of treatment • Limitations of treatment	Signed, dated progress note or informed consent in patient field to detail.
	Dental providers will describe all options for dental treatment and allow the patient to be part of the decision-making process.	Signed, dated progress note or informed consent in client file to detail.
	After the informed consent discussion, patients will sign an informed consent for all dental procedures.	Signed, dated informed consent in client file.
	This informed consent process will be ongoing as indicated by the dental treatment plan.	Ongoing signed, dated informed consents in client file (as needed).
MEDICAL CONSULTATION AND PRIMARY CARE PARTICIPATION Dentists can play an important part in reminding patients of the need for regular primary medical care and CBC, CD4, viral load tests every three to six months depending on the past history of HIV infection and level of suppression achieved	Primary care physicians will be consulted when providing dental treatment.	Signed, dated progress note to detail consultations.
	Primary care physicians will be consulted when providing dental treatment depending on the medical needs of the patient. Consultation with medical providers will be: • To obtain the necessary laboratory test results • When there is any doubt about the accuracy of the	Signed, dated progress note to detail consultations.

and encouraging patients to adhere to their medication regimens. However, even the highest number of viral copies has no impact on the provision of dental care. If a patient is not under the regular care of a primary care physician, the patient should be urged to seek care and a referral to primary care will be made.	information provided by the patient • When there is a change in the patient's general health, determine the severity of the condition and the need for treatment modifications • If after evaluating the patient's medical history and the laboratory tests, the oral health provider decides that treatment should occur in a hospital setting • New medications are indicated to ensure medication safety and prevent drug/drug interactions • Oral opportunistic infections are presents	
	Dentists will encourage consistent medical care in their patients and provide referrals as necessary. Under certain circumstances, dental professionals may require further medical information to determine safety and appropriateness of care.	Signed, dated progress notes to detail referrals and discussion.
	Programs may decide to discontinue oral health services if a client has not engaged in primary medical care. Patients will be made aware of this policy at time of intake into the program.	Signed, dated progress notes to detail referrals and discussion. Policy on file at provider agency. Intake materials will also state this policy.
	Under certain circumstances, dental professionals may require further medical information to determine	Signed, dated progress notes to detail discussion.

	safety and appropriateness of care.	
PREVENTION/EARLY INTERVENTION Dental professionals will emphasize prevention and early detection of oral disease by educating patients about preventive oral health practices, including instruction in oral hygiene. In addition, dental professionals may provide counseling regarding behaviors (e.g., tobacco use, unprotected oral sex, body piercing in oral structures) and general health conditions that can compromise oral health. The impact of good nutrition on preserving good oral health should be discussed.	Dental professionals will educate patients about preventive oral health practices.	Signed, dated progress note in patient file to detail education efforts.
	Routine examinations and regular prophylaxis will be scheduled twice a year.	Signed, dated progress note or treatment plan in patient file to detail schedule.
	Dental professionals will provide basic nutritional counseling to assist in oral health maintenance. Referrals to an RD and others will be made, as needed.	Signed, dated progress note to detail nutrition discussion and referrals made.
	Root planing/scaling will be offered as necessary, either directly or by referral.	Signed, dated progress note or treatment plan in patient file to detail.
SPECIAL TREATMENT CONSIDERATIONS	As indicated, the following modifications to standard dental treatment should be considered: • Bleeding tendencies may determine whether or not to recommend full mouth scaling and root planning or multiple extractions in one visit. • In severe cases, patients may be treated more sagely in a hospital environment where blood transfusions are available. • Deep block injections should be avoided in patients with bleeding tendencies. • A pre-treatment antibacterial mouth rinse	Signed, dated process note or treatment plan in patient file to detail treatment modifications and referrals.

	should be used for those patients with periodontal disease. • Patients with salivary hypofunction should be closely monitored for caries, periodontitis, soft tissue lesions and salivary gland disease. • Fluoride supplements should be prescribed for those with increase caries and salivary hypofunction. Referral to dental professional experiences in oral mucosal and salivary gland diseases should be made in severe cases of xerostomia.	
	Routine examinations and regularly prophylaxis will be scheduled twice a year.	Signed, dated progress note or treatment plan in patient file to detail scheduled.
	Root planning/scaling will be offered as necessary, either directly or by referral.	Signed, dated progress note or treatment plan in patient file to detail.
TRIAGE, REFERRAL, COORDINATION On occasion, patients will require a higher level of oral health treatment services than a given agency is able to provide. Coordinating oral health care with primary care medical providers is vital. Regular contact with a client's primary care clinic will ensure integration of services and better client care. Train referring dental providers on how to	As needed, dental providers will refer patients to full range of oral health care providers, including: • Periodontists • Endodontists • Prosthodontists • Oral surgeons • Oral pathologists • Oral medicine practitioners	Signed, dated progress note to document referrals in patient chart.
	Providers will attempt to contact a client's primary care clinic if required or as clinically indicated to coordinate and integrate care.	Documentation of contact with primary medical clinics and providers to be placed in progress notes. In

adequately complete referral forms to allow more flexibility in treatment planning for receiving specialty dental providers.		
OUTREACH Programs providing dental care for people living with HIV will actively promote their services through known linkages and direct outreach.	Programs will promote dental services for people living with HIV through linkages or outreach.	Service promotion/outreach plan on file at provider agency.
CLIENT RETENTION	Programs shall develop a broken appointment policy to ensure continuity of service and retention of clients.	Written policy on file at provider agency.
	Programs shall provide regular follow-up procedures to encourage and help maintain a client in oral health treatment services.	Documentation of attempts to contact in signed, dated progress notes. Follow-up may include: • Telephone calls • Written correspondence • Direct contact • Text messaging
STAFFING REQUIREMENTS AND QUALIFICATIONS	Provider will ensure that all staff providing oral health care services will possess applicable professional degrees and current California state licenses.	Documentation of professional degrees and licenses on file.
	Providers shall be trained and oriented before providing oral health care services both in general dentistry and HIV specific oral health services. Training will include: • Basic HIV information • Office and policy orientation • Infection control and sterilization techniques	Training documentation on file maintained in personnel record.

	• Methods of initial evaluation of the patient living with HIV disease • Health maintenance education and counseling • Recognition and treatment of common oral manifestations and complications of HIV disease • Recognition of oral signs and symptoms of advanced HIV disease	
	Oral health care providers will practice according to California state law and the ethical codes of their respective professional organizations.	Chart review will ensure legally and ethically appropriate practice.
	Dentist in charge of dental operations shall provide clinical supervision to dental staff.	Documentation of supervision on file.
	Dental care staff will complete documentation required by program.	Periodic chart review to confirm.
	Providers will seek continuing education about HIV disease and associated oral health treatment considerations.	Documentation of trainings in employee file.

ACRONYMS

AIDS *Acquired Immune Deficiency Syndrome*
CAL-OSHA *California Occupation Safety and Health Administration*
CD4 *Cluster Designation 4*
DDS *Doctor of Dental Surgery*
DHSP *Division of HIV and STD Programs*
HBV *Hepatitis B Virus*
HIPAA *Health Insurance Portability and Accountability Act*
HIV *Human Immunodeficiency Virus*
RDA *Registered Dental Assistant*
RDAEF *Registered Dental Assistant in Extended Functions*
RDH *Registered Dental Hygienists*
RDHEF *Registered Dental Hygienist in Extended Functions*
STI *Sexually Transmitted Infection*

DEFINITIONS AND DESCRIPTIONS

Client registration and intake is the process that determines a person's eligibility for oral services.

Oral prophylaxis is a preventive dental procedure that includes the complete removal of calculus, soft deposits, plaque, and stains from the coronal portions of the tooth. This treatment enables a patient to maintain healthy hard and soft tissues.

Direct supervision is supervision of dental procedures based on instructions given by a licensed dentist who must be physically present in the treatment facility during performance of those procedures.

General supervision is the supervision of dental procedures based on instructions given by a licensed dentist, but not requiring the physical presence of the supervising dentist during the performance of those procedures.

Basic supportive dental procedures are the fundamental duties or functions which may be performed by an unlicensed dental assistant under the supervision of a licensed dentist because of their technically elementary characteristics, complete reversibility, and inability to precipitate potentially hazardous conditions for the patient being treated.

Standard precautions are an approach to infection control that integrates and expands the elements of universal precautions (human blood and certain human body fluids treated as if known to be infectious for HIV, Hepatitis B Virus (HBV) and other blood-borne pathogens). Standard precautions apply to contact with all body fluids, secretions, and excretions (except for sweat), regardless of whether they contain blood, and to contact with non-intact skin and mucous membranes.

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LOS ANGELES COUNTY
COMMISSION ON HIV

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March 13, 2022

To: Michael Green, PhD, MHSA, Chief Planning, Development and Research, Division of HIV and STD Programs, Department of Public Health, County of Los Angeles

Jesus "Chuy" Orozco, HOPWA Program Manager, City of Los Angeles Housing Department

From: Kevin Donnelly and Dr. Paul Nash, Aging Caucus Co-Chairs

Re: Housing for Older Living with HIV

As reported at the March 9, 2023 Commission on HIV meeting, the Aging Caucus heard from two long-term survivors/older adults living with HIV who shared challenges they experienced with aging and accessing housing services. We are providing a summary of their testimonies to bring to your attention the barriers clients face when accessing housing services. While these testimonies focused on the experiences of two individuals, we believe they reflect larger system issues that prevent PLWH, especially older adults, from accessing critical support services such as housing, in a timely and efficient manner.

- Both speakers spoke about having to talk to multiple case managers with different information about housing eligibility and related services—they talked about not having a clear road map of what the housing application process entails and were not provided a specific timeline for securing the services they need or information about waiting lists associated with housing programs. One speaker spoke to five case managers, the other with two.
- At the time of their attendance at the February 7 Aging Caucus meeting, there was no plan in place for long-term housing while they were in interim housing. Consequently, they were likely to be in the streets again after a few weeks of being in temporary or emergency housing.
- These two individuals have been able to maintain stable housing for over 25 years but lost their housing due to rising rents and being evicted by developers/investors. They never thought they would be in this predicament (homeless, living on the streets) as older adults living with HIV.
- Driving long distances to see their medical provider could be a challenge depending on where they find housing (temporary and/or permanent).
- Cost of living and housing affordability are major issues affecting their survival.

- They spoke about not knowing whom to talk to or where to go for mental health and other services.
- Conducting research on available services on their own was overwhelming.
- Their stories underscore that the safety net does not have a way to catch older adults with HIV when they lose stable housing. They are often given the option to live in Skid Row which does not serve their needs or may exacerbate their health conditions.
- They would like to see educational workshops on services in all places where HIV and seniors programs are offered.
- The clients expressed that it is also difficult to get proper nutrition when they do not have access to a kitchen or refrigeration, which is often the case with temporary motel housing.
- One speaker was told there is a 3 month wait for an appointment to see a psychiatrist.

We remain committed to working with you on addressing the housing crisis for people living with HIV (PLWH) and its profound impact on older adults living with HIV.

cc: Bridget Gordon
Luckie Fuller

LOS ANGELES COUNTY
COMMISSION ON HIV

****Presented by the Vision & Mission Statement Review Workgroup for the 3/23/23 Executive Committee Meeting****

(PROPOSED) VISION

An equitable system of HIV prevention and care that is comprehensive, sustainable, and accessible empowering and educating all communities to make informed decisions about their sexual health needs to maximize life expectancy and optimize quality of life.

(PROPOSED) MISSION

To plan, promote, and advocate for equitable policies, programs, and services that address the HIV epidemic in Los Angeles County. The Commission works to ensure that Los Angeles residents have access to quality sexual healthcare, including HIV prevention, testing, treatment, and support services.

The Commission strives to eliminate stigma and discrimination associated with all sexually-transmitted diseases and to promote sexual health awareness and education to the public, particularly in underserved communities. Utilizing an approach that addresses both the mental and physical health of the whole person as well as social determinants of health, the Commission collaborates with and seeks input from people with lived experience, planners, and stakeholders to coordinate efforts and leverage resources to ensure that its work is responsive to the needs of those impacted by the epidemic, regardless of socioeconomic status.