LOS ANGELES COUNTY
COMMISSION ON HIV

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

COMMISSION ON HIV MEETING MINUTES

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

TELECONFERENCE SITE:
California Department of Public Health, Office of AIDS
1616 Capitol Avenue, Suite 74-616, Sacramento, CA 95814

February 14, 2019

COMMISSION MEMBERS PRESENT	COMMISSION MEMBERS PRESENT *(cont.)*	COMMISSION MEMBERS ABSENT	DPH/DHSP STAFF
Al Ballesteros, MBA, *Co-Chair*	William King, MD, JD	Joseph Cadden, MD	Kyle Baker
Grissel Granados, MSW, *Co-Chair*	Lee Kochems, MA	Aaron Fox, MPM	Muntu Davis, MD, MPH
Traci Bivens-Davis	Bradley Land	Jerry D. Gates, PhD	Jeffrey Gunzenhauser,MD, MPH
Jason Brown	Miguel Martinez, MSW, MPH	David P. Lee, MPH, LCSW	Andre Nazarians, RN, PHN
Alasdair Burton *(Alt.)*	Anthony Mills, MD	Eric Paul Leue	
Danielle Campbell, MPH	Carlos Moreno	Abad Lopez	**COMMISSION STAFF/CONSULTANTS**
Raquel Cataldo	Derek Murray	Eduardo Martinez *(Alt.)*	
Michele Daniels	Katja Nelson	Raphael Peña	Carolyn Echols-Watson, MPA
Frankie Darling-Palacios	Jazielle Newsome	Martin Sattah, MD	Dina Jauregui
Erika Davies	Mario Pérez, MPH		Dawn McClendon
Susan Forrest	Juan Preciado		Jane Nachazel
Luckie Fuller	Ricky Rosales		Doris Reed
Terry Goddard, MA	LaShonda Spencer, MD		James Stewart
Felipe Gonzalez	Kevin Stalter		Tim Vincent, MS
Bridget Gordon	Yolanda Sumpter		Sonja Wright, MS, Lac
Joseph Green	Greg Wilson		
Diamante Johnson	Russell Ybarra		

PUBLIC			
Tania Aguilar	Jenna Alarcon	Ernesto Aldana	Guadalupe Andrade
Jayshawnda Arrington	Claudia Ayala-Ramirez	Latisha Barbera	Virginia Cabrera
Liliana Campos, JD	Efren Chacon	Efren Chavez	Stevie Cole
Alfonso Coro	Dahlia Ferlito	Sherri Fuller	Thelma Garcia

PUBLIC *(cont.)*			
Kelly Gluckman	Lupe Gonzales	Kyle Gordon	Thomas Green
Steven Grey	Shawn Griffin	Joaquin Gutierrez	Karl Halfman, MS *(OA by phone)*
Becky Hardin	Lisa Hart	Alex Iling	Ronald Jackson
Damilola Jolayemi	Shellye Jones	Jeffrey King	Beck Levin
Roxanne Lewis	Dorriane Martin	Andre Molet	Ethel Morris
Brian Nillis, RN	Geo Orellana	Phuc Pham	Danny Pitts
Luis Ramos	Adrian Rodriquez	Glenn San Agustin	Natalie Sanchez
Maria Scott	Ricky Scutolo	Tenzing Sheepa	Lazell Thompson
Maribel Ulloa	Octavio Vallejo, MPH, MD	Glenda Victores	Nathan Vrohsman
Jayze Washington	Lauren White	Amiya Wilson	JavonTae Wilson

CALL TO ORDER AND ROLL CALL: Ms. Granados opened the meeting at 9:20 am.
Roll Call (Present): Bivens-Davis, Brown, Burton, Campbell, Cataldo, Daniels, Davies, Forrest, Fuller, Goddard, Gonzalez, Gordon, Green, King, Land, Martinez (Miguel), Mills, Moreno, Murray, Nelson, Newsome, Pérez, Preciado, Rosales, Spencer, Stalter, Wilson, Ybarra, Ballesteros, Granados.

I. ADMINISTRATIVE MATTERS

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

2. **APPROVAL OF MEETING MINUTES**:
MOTION #2: Approve the 1/10/2019 Commission on HIV Meeting Minutes, as presented ***(Passed by Consensus)***.

II. REPORTS

3. **EXECUTIVE DIRECTOR/STAFF REPORT**:
   - Ms. McClendon reported Cheryl Barrit, MPIA, Executive Director, was on a short family leave to care for her son and will return at the end of February. The Commission remains well staffed to continue to move work forward.
   - For questions, feel free to contact staff or Co-Chairs.

   A. Welcome and Key Presentations:
   - Ms. McClendon welcomed attendees and highlighted the day's three presentations:
     - The Executive Committee previously heard the Brown Act refresher developed by the Office of the County Counsel with a focus on areas pertinent to the Commission. The Executive Committee recommended it to the full body.
     - The panel in honor of National Black HIV/AIDS Awareness Day (NBHAAD) will discuss the disproportionate impact of HIV/AIDS in the African American community. Commissioner Greg Wilson led in coordinating the panel. Tim Vincent, MS, consultant for the Commission's stigma reduction plan, will facilitate the panel.
     - The epidemiological and programmatic overview of Sexually Transmitted Disease (STD) in Los Angeles County (LAC) was requested by the Commission in 2018. Commissioner Pérez, DHSP, will present.
   - The panel and STD overview will seek to engage and challenge Commissioners to act on strategies that help advance the Los Angeles County HIV/AIDS Strategy (LACHAS).

   B. 2018 Annual Report to the Board of Supervisors (BOS): The Commission Co-Chairs and Cheryl Barrit, MPIA, Executive Director, drafted this report over the holidays. The outline of work completed in 2018 was presented to the Executive Committee and will be submitted to the BOS shortly. The format is mandated by the BOS for all LAC Commissions.

   C. Ralph D. Brown Act Refresher:
   - Liliana Campos, JD, Senior Deputy County Counsel, Office of the County Counsel, has worked on Brown Act issues and presented to BOS commissions and committees for two years, including a PowerPoint in the packet recently presented to the Executive Committee. She noted Emily Issa, JD, Deputy County Counsel, is the Commission's Advise Counsel.

- She stressed that the entire purpose and intent of the Brown Act is to assert that, "The people of this State do not yield their sovereignty to the agencies which serve them," and ensure that the people remain "...informed so that they may retain control over the instruments they have created." The core is empowerment of the people.
- The Brown Act applies to local legislative bodies like the BOS, bodies they create like the Commission, and their standing committees, when a quorum exists and members hear, discuss, or deliberate an item within the body's subject matter jurisdiction. Particular attention is warranted for electronic communication media such as email as quorum can be reached inadvertently and quickly, e.g., by using a "reply all" email option or by serial communications.
- A quorum may attend another public meeting and respond to that meeting's items of business so long as members do not discuss the body's own work among themselves. A quorum may also attend social or ceremonial events without discussing items of the body's business but, even when not a violation, public perception should be considered. For example, a regular breakfast prior to a body's meeting may be wholly social, but still raise public concerns.
- Likewise, the best practice should a member wish to discuss a potential item of business or campaign for a position such as Co-Chair is to request staff to agendize the item for discussion at an open meeting.
- The body as a whole is held accountable legally for violations of the Brown Act. If a particular individual can be identified as the violator, and the violation was inadvertent, then the Brown Act offers retraining as one remedy.
- Social media is a complex topic. Certain elements suggest an account is truly personal, e.g., topics are personal to the account holder and the account is mainly limited to friends or family. On the other hand, an account open to the public, where other members of the body may follow the account, may result in a quorum of the body reading, discussing, or deliberating on an item of business within the body's subject matter jurisdiction. That would be a violation.
- Law is sparse, but a recent Supreme Court case on President Trump's Twitter account held that, though the intent of the account was personal, its use internationally to communicate items of business make it a limited public forum. That restricts account management, e.g., members of the public cannot be blocked nor comments deleted. Social media used in a way that opens it to the public may result in its transformation into a limited public forum or public forum.
- Several members noted routine engagement in HIV work and questioned whether, e.g., support of universal testing would be a violation. Ms. Campos replied, while each situation varies with language and placement, it is preferable to err on the side of caution. The Brown Act theme is transparency with items of business defined broadly. They should be placed on an agenda in a manner sufficient for the public to choose whether to participate at that meeting.
- Ms. Campos did not complete the PowerPoint due to meeting time limitations, but recommended review of remaining slides. Questions may be referred to her or to Commission staff.
- Ms. Granados encouraged all, beyond specific questions, to uphold the spirit and intent of the Brown Act to ensure transparent decision-making so that the community is informed about decisions which impact them.
- Mr. Ballesteros felt more guidance was needed on utilizing social media for critical educational purposes.

4. **CO-CHAIR REPORT**:

A. Meeting Management Reminders:

- Ms. Granados reminded members of Item 11. Commission New Business Items which replaced Commission Member Comment last month. This item can be used to recommend topics for a future agenda.
- Everyone was reminded to turn off cell phones or place them on silent mode.
- Public comment is limited to one two-minute period per person for non-agendized topics and one per agenda item. Time is doubled for non-English speakers using an interpreter. Public comment forms are at the sign-in table.
- Commission discussion is limited to three minutes per agenda item per Commissioner. Members may speak a second time after all have had the opportunity to speak once. A third round requires a two-thirds vote to suspend the rules.

B. Committee Co-Chair Election Updates/Reminders: The Operations Committee will elect Co-Chairs on 2/282/2019.

C. Executive At-Large Member Nominations in March: Nominations will open at the March Commission for elections in April.

D. Recognition of National Black HIV/AIDS Awareness Day (NBHAAD):

- Ms. Granados noted the following panel was to recognize NBHAAD, 2/7/2019, and Black History Month. These offer an annual opportunity to promote HIV education, testing, treatment, and community involvement in Black communities.
- It is hoped discussion will enlighten the Commission and help identify concrete actions to assist this disproportionately impacted community. She thanked Greg Wilson for helping to put together the presentation.

III. DISCUSSION

5. LOS ANGELES COUNTY HIV/AIDS STRATEGY (LACHAS):

A. Panel Discussion on the Disproportionate Impact of HIV/AIDS in the African American Community:

- Greg Wilson is an HIV+, Black, gay, man; as well as Senior Manager, In The Meantime Men's Group, Inc.; and a Commissioner. He learned he was HIV+ 14 years ago to the day.
- He and Jeffrey King, Executive Director, In The Meantime, had several discussions on community concerns about a lack of focus on NBHAAD, especially as this community is disproportionately impacted and reflected in funding streams.
- NBHAAD began in 1999 as a grass roots effort to raise awareness. He thanked the Commission for honoring the request to acknowledge it and hear the concerns of those who live, love, and work within the Black community. Allies can show support by listening, learning, and growing in unbiased perspectives. It is important to address HIV in the Black community beyond stigma including day-to-day challenges from poverty to racism and beyond. The various layers of challenges lead to the disproportionate outcomes. This panel is a great start to the necessary conversation.
- By the end of the panel, he recommends identifying in the Black community: 1. Specific strategies for the Commission to support Black leaders and community stakeholders in their efforts to end HIV; 2. HIV prevention and treatment best practices; and, 3. Specific strategies to reduce HIV stigma.
- Panelists were: Commissioners Ms. Bivens-Davis, Dr. King, and Mr. Fuller; and JavonTae Wilson, Lead HIV Tester for the Vulnerable Populations contract, In The Meantime. The video of the panel will be available.
- Mr. Vincent, facilitator, was grateful this panel was convened to help illuminate challenges faced by Black communities related to HIV. In direct service, training, and Technical Assistance (TA) for 30 years, he was glad of this opportunity.
- He called attention to data in the packet's PowerPoint as it impacts three main discussion questions.
  What is your individual perception, and what do you feel is the communities' perception, of the state of HIV in the Black community in 2019?
- *Bivens-Davis*: There are new treatment and intervention advancements, and we are in a more intergenerational place.
- At the same time, it requires addressing chronic conditions and mobilization needs of bookend communities - younger and wiser. There is still significant segmentation fueled by Social Determinants of Health (SDH) and funding that meets needs of some while leaving outliers behind. People of Color (POC), especially Black people, are impacted by substance misuse, mental health, immigration, crime - which create inequitable access to meeting the pandemic.
- Transactional sex is increasing. We work under 1980s legislation with a work force unsustainable and people isolated from services due to phobias, stigma, shame, and silence. Nor is there a history of sustaining culturally appropriate and timely interventions that target Black people, especially those who do not identify as same gender loving men. Stigma manifests as inability to change those patterns based on pre-existing ideas. Stigma also manifests internally.
- She posits questions: Where are programs for trans-identified people who do not identify as MSM? Aside from a clinic, where can women go for support and receive child watch? Not all spaces are penetrated.
- Policies are needed to protect Medicare, secure Title X, reauthorize Ryan White CARE Act, and offer access to housing with support from curb to couch. People need to stop speaking about HIV in silos because conversations need to expand outside the Commission. Elders need support and all age groups need mobilization with gatekeepers mentored.
- In summary, she felt we had come a long way over the past 15 years, yet were still at the beginning.
- *King*: He has practiced HIV medicine for 14 years at UCLA, Federally Qualified Health Centers (FQHCs), and at his own practice for eight years in the Crenshaw area about five minutes from where he grew up.
- Despite advancements in biomedical prevention and treatment, discrepancies in the Black community continue without anyone asking why. He urged a standing committee continue this discussion on positive ways to address access to care, treatment, and PrEP. PowerPoint slides in the packet reflect stratification by race/ethnicity in the Cascade of Care with African Americans less likely to be retained in care or virally suppressed. The same is true of PrEP.
- Part of the problems is not just getting patients to a physician, but to a willing physician. Not all physicians want to treat HIV, do PrEP, have sexual health conversations, or have office staff trained to provide a respectful, comfortable environment. Offices are mandated to meet cultural competency standards for language, but standards should also be mandated for those of different ethnicities as well as trans health.
- Information is available in the Crenshaw area on billboards for STD and HIV care. The same is true of social media and on television. All of that is important. Even so, the Kaiser Family Foundation report on access, perceptions, information, and knowledge reflects pretty good data for youth, but knowledge lags about PrEP, that treatment can prevent transmission, and that HIV is not transmittable, e.g., from glasses. We continue to educate physicians, but he questions whether than was translating into drawing people into their offices. That is the next step.
- Stigma is known to harm biological and mental health so culturally appropriate interventions need to be developed.

- *Fuller*: He works with the trans community, specifically trans men. The trans community is >49% more likely to become diagnosed with HIV. Numbers are similar for trans men, but that is an estimate with studies rare. A Centers of Disease Control and Prevention (CDC) review of 29 trans-specific care studies related to HIV found just five on trans men.
- Research studies are being done on trans people, but are skewed because in medical facilities trans men are counted as women. Generally, spaces like testing trucks will count a person based on visual presentation, e.g., he is often countered as a cisgender man. His organization is centered on trans men, especially trans men of color, and they often have internalized the dangerous message that trans men are not at risk and do not need condoms.
- He stressed the importance of what it looks like to be trans masculine- or nonbinary-friendly versus trans fem friendly. He has researched and found no ob-gyns in LAC that are trans masculine- or nonbinary-friendly so there is no access.
- *JavonTae Wilson*: There has been progress, but work needs to be done, especially in spreading information about advancements. He asks HIV test clients if they know about, or are taking, PrEP. Some have not heard about it but, even those who have heard about PrEP, know very little and are not taking it.
- Stigma around HIV and HIV testing in the Black community remains. It is seen as a "gay disease" in the community as a whole. It needs to be normalized as a "people disease" and conversation around it and testing needs to be normalized. *Has the Black community grasped the significance of PrEP, PEP,and TasP as viable options to reduce rates of HIV and eradicate HIV from our community?*
- *Fuller*: Medical providers need to be educated. For example, he had to go to three different clinics to access PrEP. He was told he was not at risk as a trans man although his then partner was HIV+. Trans men, especially, tend to be sexually open. Many identify as pansexual, bisexual, or gay men. He recently saw a flyer that said, "If you are a trans woman, if you are a cis woman, or if you are a male sleeping with another male, then PrEP is for you." Why shouldn't it say, "If you are sexually active, then PrEP is for you." Why exclude demographics, especially when many lack data?
- A Canadian study said the lack of research on the trans masculine community was itself a risk factor.
- *JavonTae Wilson*: Conversations with his peers reflect a need for education. For example, some using PrEP are under the impression they can take the pill just before a sexual encounter, have condomless sex, and be protected.
- *King*: He has also tried to find trans masculine-friendly ob-gyns to do pap smears, but he has to use providers contracted with the person's insurance. Sometimes he does the work as he cannot find sensitive ob-gyns. He suggested training primary care physicians to fill the gap and invited Mr. Fuller to speak at the Medical Society on the topic.
- Regarding PrEP, he felt it was often a business issue. There are different ways of bringing people who are uninsured or undocumented into PrEP, but there is still all the paperwork. Sole primary care providers or those in small group practices have to use expensive outside medical case management to process the paperwork. The economy also results in people losing or changing insurance which means doing the paperwork all over again.
- Many of his clients find him by searching for a Black PrEP provider through their insurance directory. It means a lot to his clients to see a Black physician who grew up in that community and understands them. More funding needs to flow to those doing the work on the street and who may pay staff on their credit card.
- Many of these offices also need grant writers. Someone asked at a community meeting why there was no PrEP Center of Excellence in that area. The response was, "You didn't apply." But it should have been, "How can I help you apply."
- A lot of the problem is access. Discrimination must be acknowledged, too. That includes providers who do not want to serve certain individuals because it takes too much time and the administrator wants 15 minute visits.
- *Bivens-Davis*: She and her girlfriend saw a Gilead Truvada ad on television. Her girlfriend said, "If this prevents HIV, why are we not all taking it like a multivitamin." Yet, she had not known about it. That is the bigger question. When things are done in isolation, outliers do not receive the benefit. As a Black person, she will not volunteer information to someone who she feels does not care about her experience and will not help her through it.
- Large segments of the Black community battle mistrust all the time. We do not trust institutions, physicians, or medications. One often hears, "You can't tell me a pill solves my problem." Pills are the man's way of keeping me down.
- Nothing can be done without consistency, intervention, communication, and challenging bias. A pilot cannot be started, then stopped once it is a success. Clinicians must be held accountable. PLWH may not know how HIV affects other health conditions. Trans men have trouble finding any, but cisgender women find ob-gyns who do not ask about testing for STIs or HIV because they do not want to have to respond to your having sex. Biomedical prevention is not offered during pap smears, breast exams, or prostate checks.
- There is no place for equitable conversations that affirm sex. In testing centers, people are told, "You don't know what your partner's doing." While that may be true, it is not affirming the person trying to be in a committed space. Cisgender women are most often exposed in that place where they trust the most. Couples sometimes seek out third party partners and staff need to be able to talk about it from a sex positive perspective to help the client make choices.

Where are the gaps and what are the barriers that impede our progress in outreach to, educating, and empowering the Black community to take note of the severity of the epidemic and take ownership and responsibility for the solution?

- *JavonTae Wilson*: He has the privilege of working in an intergenerational environment with older Black, gay men. He feels his peer group often lacks that historical perspective which creates a barrier to progress.
- The Black community perceives HIV and testing as more of a gay issue so the conversation needed around those topics does not occur. Given that, there is no conversation about dealing with becoming HIV+ either.
- He would like to see community events with intergenerational stakeholders to have those conversations.
- *Fuller*: HIV has a major impact on the trans community as a whole. There are now more trans specific clinics offering transitional services, PrEP, and HIV care, but there are too few safe entries to care with confident physicians able to handle the different intersectionalities relevant to those clients, especially for Black trans people.
- Trauma-informed care has to be provided with HIV care in an inclusive care model to provide a safe space.
- *King*: He could think of just eight African American HIV specialists in LAC despite some areas with highest prevalence. That reflects a disconnect. San Francisco launched rapid start. LAC could adapt its own iteration with a warm handoff and medication started as soon as a person tests HIV+. Some medications can cause a two log drop in the Viral Load (VL) within ten days and have minimal side effects.
- Another major gap is mental health services near the primary care provider that take insurance. He cannot take care of multiple other issues for clients like substance abuse, bipolar disorder, trauma, adjustment disorder due to new diagnoses. The nearest such services to him are in Downey. His patients will not go there. Managed care organizations that make a specific request for HIV specialists need to encompass everything else that comes with it, e.g., psychiatrists, psychologists, and endocrinologists that deal with gender transition as well.
- Physicians are offered incentives to ensure LDL bad cholesterol is under 100. They are offered incentives to ensure Hemoglobin A1c diabetes screenings are under 7, and ensure diabetic patients see eye and foot physicians. There should be incentives for VLs and the number of PLWH office visits, but physicians need tools to retain individuals.
- Discrimination does occur and needs to be addressed but, whenever one points a finger, three point back at oneself. African American Greek organizations need to treat this as more than one day. Funds the Greeks take in for big regional and national meetings should support partnering with local organizations to provide services. African American churches, especially megachurches, often have HIV ministries, but need support, education, and guidance through realistic conversations. They receive funding that can also be used to partner with local organizations.
- *Bivens-Davis*: This conversation reflects the reality of the Black community. It deals with more than HIV. Resources continue patterns of programming and conversations that ignore equity. We fight institutions and ourselves. We often fail to increase sustainability of indigenous organizations or fight injustices that contribute to poor health outcomes.
- As noted earlier, there must be strategy, organization, commitment, and communication. We must be strategic in efforts to fight, e.g., poverty, injustice, police brutality, racism, and mass incarceration while supporting environmental health and harm reduction. We must equip our people with skills to thrive in a society that often feels as though it is against us. That includes addressing historical trauma and substance use, but also professional development and housing. We must engage in systemic change that pushes for timely, responsive, and inclusive resources. We have to have difficult conversations on personal accountability, particularly as they relate to race.
- What is working now is that we are having this conversation but, if we do nothing later, then it did not matter.

Question/Answer and Discussion Period

- Mr. Stalter suggested Black and Brown Communities as the next Annual Meeting topic. He noted many current contracted agencies were set up in communities that are no longer as highly impacted as they once were, but they could be incentivized to establish Memorandums of Understanding (MOUs) with smaller providers in Black and Brown areas more heavily impacted today. That would facilitate services in such areas and help draw down underspent funds.
- Regarding churches, 82% of African Americans attend church at least once per month with 52% attending weekly. That is much higher than other demographic group. Attendees are also younger. He asked how best to engage churches. Dr. King will invite some church leaders to attend Commission meetings and members might also attend HIV ministries.
- Frankie Darling-Palacios commented Black community mistrust is historically valid. She asked what simple things service providers can do to help establish a trusting relationship. Ms. Bivens-Davis said, first, acknowledging the validity of the experience which shaped a culture and perspective is critical. Show up in a way that is culturally appropriate, culturally respectful, consistent, without invading or invalidating people's realities. Put your ego aside. Respect that there are indigenous people and organizations trying to encourage and inform change. Invest in them. Do not assume you know everything about another person's experience simply because you had a White or Black boyfriend.

- Ms. Sumpter noted churches were the only gathering opportunity for kinship and friendship during slavery so the tradition is hundreds of years old. The Black community is suffering. Even finding a school for her child in her community was difficult. At one school, a Black teacher met her at the door and said, "Don't bring your child here." Issues go deeper than HIV. They include SDH, education, and especially poverty. This is a very special community.
- First in importance is follow through. She has been a Commissioner for four years and, while everyone works hard, how many times have we addressed the BOS on issues facing the Black community to move policy forward to spark change, i.e., to move resources into underserved areas to support local, culturally appropriate providers.
- Second, she felt Black people were not really wanted at the table, but are here to meet specific percentages. To make change happen, she urged establishment of an African American Caucus and a Women's Caucus. She asked Mr. Pérez to speak to the lack of programming for African Americans and how to increase that programming.
- Amiya Wilson's father was a minister and she was raised in a church in Selma, Alabama. Churches here are magnificent so she was sure funding was available and suggested asking for their support. Ms. Bivens-Davis replied not everyone's experience in church is good. Not everyone's church has accepted or affirmed who they are as individuals or choices they make in the context of their lives so, probably, those who need it the most do not feel accepted or show up.
- She does go and speak about HIV, but has to be a different person at each church to meet its cultural norms.
- At the same time, Black people were brought to this country, were pushed into church, and not allowed to celebrate the religions of our ancestors. That must be acknowledged as a part of historical trauma.
- Dr. King approaches churches with an HIV ministry. Some community leaders, including pastors, gather together to discuss issues of health like HIV, diabetes, hypertension, and disparities of care. Many pastors struggle with the disconnect between what is said to be in the Bible and reality, but there are also open churches who accept everyone. Generally, megachurches are wealthy, but hard to approach; small churches lack funds, but are approachable.
- Mr. Jackson does testing and has worked with people 20 years. Many years ago, Kevin Spears worked to make waiting rooms comfortable and respectful. Today, he talks to men daily and works to re-integrate them into care but, when they get to the physician's office or agency, they do not feel respected. He asked how to ensure receiving offices are welcoming. Dr. King replied people like Richard Hamilton once walked people to care and ensured a welcome.
- Beck Levin recently moved to Los Angeles from San Francisco and was director of the Special Projects of National Significance (SPNS) initiative on HIV housing and employment. Evaluation questions were very culturally incompetent. While they advocated and achieved some improvement, generally studies say questions were tested.
- Mr. Fuller is a cultural competence trainer. "Trans" is a self-identifier. Change forms to leave the space open so the person may choose. Allow the person to choose pronouns. People often have a trans identify used against them so may choose not to use it. In California, SB 396 made the third gender law so forms must reflect that. The goal is to be compassionate so that people feel comfortable, validated, and affirmed.
- Greg Wilson thanked Jeffrey King for the panel idea and developing the questions.
- ➲ Dr. King will initiate change by working with Mr. Jackson to improve warm provider handoffs.
- ➲ Refer proposal for a time limited Black Ad Hoc Committee to the Executive Committee.

IV. BREAK

V. REPORTS

6. CALIFORNIA OFFICE OF AIDS PROGRAMS (OA) REPORT:

- Karl Halfman, MS, Chief, HIV Care Branch, noted the February 2019 OA Report in the packet for review. As the meeting was behind its time, he streamlined his report to highlight two items.
- First, the California Department of Public Health, Center of Infectious Disease (CID) , has reinstated Marisa Ramos, PhD, as Acting Chief, OA. The CID is finalizing recruitment for a permanent Chief of OA.
- Some of the AIDS Drug Assistance Program (ADAP) data requested at the January meeting was in the packet. Sandra Robinson, MBA, Chief, ADAP Branch was unable to attend, but questions can be emailed or discussed in March.
- Joseph Green asked if HIV-related heart disease medications were on the formulary or could be added to it.
- ➲ Mr. Halfman will ask Ms. Robinson about the heart disease medications and report back.

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

A. Division of HIV/STD Programs (DHSP) Report:

- Mr. Pérez, Director, DHSP, reported this year's Ryan White Program (RWP) Part A and Minority AIDS Initiative award was received and reflected an increase of approximately $530,000 compared to last year. He thanked the DHSP team and Commission for a competitive application which scored 99 out of 100 points.
- We still need to be creative and thoughtful about how to invest these resources. That work continues. California and LAC, like others, is seeing many historic RWP costs absorbed by the Affordable Care Act (ACA).
- A recommendation was shared at the 2/13/2019 Health Deputies meeting to support all 19 responders to the recent Ambulatory Outpatient Medical (AOM)/Medical Care Coordination (MCC) Request For Proposals (RFPs). That is a continuation of LAC's existing model of HIV care with some expansion of sites at a few places throughout LAC. Contracts will go into effect on 3/1/2019, the start of the new RWP year, if the BOS approves.
- There are a few other RFPs in process which he may be able to report on at the March Commission meeting.
- The National HV Prevention Conference will be 3/18-21/2019 in Atlanta, Georgia. The CDC has announced a conversation the day prior to the Conference to talk about the increase in HIV among Latino MSM and transgender Latinas. Some here today joined a call earlier this week to discuss it. The day will convene health departments where HIV prevalence among Latinos is highest along with a cross-section of community partners from those jurisdictions. California and LAC will be a part of that conversation and will report back on results of that meeting.
- DHSP continues to share with the CDC that we are not likely to make significant progress so long as conversations are limited to the CDC and do not include partners that can influence the public and private health care delivery systems. Such partners include: other parts of the National Center for HIV, STD, and Hepatitis Prevention; the Substance Abuse and Mental Health Services Administration (SAMHSA); the Centers for Medicare and Medicaid Services (CMS); the Health Resources and Services Administration (HRSA); and Health and Human Services (HHS). It is not known as yet how robust the conversation will be at the table for the day focusing on the increase of HIV among Latinos.
- Five health leaders in the federal administration are working to outline a plan to end the HIV epidemics across the country with a focus on four strategic areas. The plan is explored in a recent *JAMA* article.
- Mr. Brown asked about the transition of Casewatch into Iris. Mr. Pérez replied DPH uses two different Casewatch systems. One is an HIV Casewatch system which is mandated for all service contracts funded through the RWP. That allows DHSP to collect all information for the Ryan White Service Report which is transmitted to the federal government to justify LAC's use of RWP funds. Separately, there is an STD Casewatch system that collects information on all syphilis, gonorrhea, and Chlamydia cases along with partner and other relevant information.
- There has been a years long effort to take several distinct infectious disease related systems and collapse them into the Iris system with a multi-phase adoption. Anyone who uses STD Casewatch will eventually shift to Iris, easier to use in reporting and navigating. There will be updates as work progresses. The change will not impact HIV Casewatch.
- He noted the African American HIV specialists that DHSP was aware of in LAC were: Dr. King; Dr. Spencer; Drs. Jefferson and Jordon, Oasis Clinic; Dr. Butler, T.H.E. Clinic; Dr. Milner, AIDS Healthcare Foundation; Dr. Leo Moore, DHSP.

➲ Staff will distribute the *JAMA* article on the federal administration plan to end HIV.

(i) Sexually Transmitted Disease in Los Angeles County: An Epidemiological and Programmatic Overview:

- Mr. Pérez presented on a PowerPoint in the packet. Media have covered the rise in STDs over the past few years across the country. There was an increase in Chlamydia first, then a double-digit increase in gonorrhea, then an increase in syphilis. People started to pay close attention when all three went up by double-digits a few years ago.
- About 2 million STDs were diagnosed across the country and 95,000 in LAC in 2018. In LAC, about two-thirds were Chlamydia; 25,000, gonorrhea; and 7,000, syphilis which is further broken out into primary, secondary, early latent, and late latent. Syphilis stage is important because it pertains to who is most infectious and when intervention is advised. All three are bacterial diseases curable with antibiotics.
- Comparatively, STD funding provides about $1 for every $10 in HIV funding. Providers expend it all.
- There are 12 slides with data broken out by disease, gender, and either race/ethnicity or age group.
- DHSP was acutely aware that data was not presented by transgender Male-to-Female or Female to Male. LAC committed 20 years ago, before most areas, to collect transgender information. The system is fairly good, but relies on providers to complete the appropriate gender box. Though standard for 20 years, there are still some compliance issues in the HIV world. STD gender information for syphilis, gonorrhea, and Chlamydia was only mandated five years ago so there is a level of immaturity with the data. It is a requirement and expectation, but data has not yet met the level of maturity that would make reporting data out viable.
- There are 1,900-2,000 new HIV diagnoses per year versus 95,000 STD. The amount of STD surveillance work to ensure cases are not counted twice is immense, especially with an historically underfunded surveillance system.

- A pregnant woman may be diagnosed and treated for syphilis early in a pregnancy, limiting a baby's exposure and averting congenital syphilis, but a woman may be re-exposed and re-infected. A mother and baby diagnosed with syphilis at birth will be considered a congenital syphilis case as the mother was not treated during the 30 days prior to delivery. DHSP physicians and nurses assess many factors to identify whether a case is congenital syphilis.
- There is a rise in California to a rate of 42.4 per 100,000 live births compared to 15.7. LAC is in between the two. 2018 saw a higher proportion compared to 2017 of newborns with organ or limb deformities. Three died.
- About 62% of mothers had a history of drug use about 50% had a recent history of incarceration, typically in the past three years. There are issues around poverty, education, health care access, and no or late prenatal care. Every case is reviewed to identify what options there had been to intervene.
- LAC is not interrupting the chain of transmission fast enough. It is critical to improve early identification of cases through screening and testing in order to treat the infection before the person passes the bacteria on.
- Ms. Nelson noted DHSP received $5 million from the BOS last year and asked how the community could help this year. Mr. Pérez noted there were requests since 2006. The BOS showed leadership last year by tapping tobacco settlement funds to enhance STD services. DHSP was now completing an RFP to get those funds out on the street.
- Advocacy groups statewide were organizing around the HIV, HCV, and STD epidemics and specific funding asks. There was also a coalition of six Southern California counties trying to put together staff needs, performance expectations, and other common data points across the counties to further enhance the request for support.
- Regarding three-site testing, DHSP was trying to make it standard for gonorrhea and Chlamydia. Those providers funded by DHSP must include that as well as treat on site. DHSP is working on convincing the larger delivery system to adopt it. Drs. Sonali Kulkarni and Leo Moore have been working to enhance PrEP access and will meet with the Department of Health Services (DHS) to adopt the standard. Health plans are part of that broader conversation as is looking at the reimbursement system which may help incentivize three-site testing.
- Mr. Fuller asked about the lack of transgender data if that is being captured with STDs. Mr. Pérez replied the STD data collection system is still maturing as DHSP works with providers to improve it. Transgender persons are, nevertheless, included among target groups even though the data set is not mature as yet. Even the 20-year-old HIV data set is not yet complete though making collection mandatory helps.
- Mr. Brown noted syphilis was prioritized for disease investigation in the past. He asked about addressing all three. Mr. Pérez noted a meeting was going on that day at DHSP to refine the approach as there are insufficient Public Health Investigators (PHIs) to investigate all cases. Currently, all cases that involve HIV are investigated, along with high priority syphilis cases, and gonorrhea cases in some areas. PHIs are overwhelmed with syphilis cases now.
- Amiya Wilson asked about STD clients taking treatment to their partners. Mr. Pérez said that is a Patient Delivered Partner Therapy (PDPT) system. It is easier with Chlamydia than with gonorrhea as the latter requires a shot. Not enough providers now offer it. DHSP hopes to raise public and physician awareness because people need options.
- Mr. Burton asked if DHSP could get the number of negative tests from companies that run them. Mr. Pérez replied DHSP collects HIV testing volume with most testing sites garnering a positivity rate between 0.3-0.7. Collecting all HIV testing records would result in magnifying testing records by 200 for a total of 2,000. With STDs, the number will quickly run up to 3.3 million versus 100,000 records. Mr. Burton suggested just collecting a number. Mr. Pérez added even repeat testing is an area of opportunity. e.g., someone treated for Chlamydia should be retested in four months to ensure the infection has cleared.

8. STANDING COMMITTEE REPORTS:

A. Operations Committee:

- Ms. Bivens-Davis noted Co-Chair elections would be 2/28/2019.
- The Work Group for the Service Awards was meeting on implementation of the awards.
- The Work Group on Assessment of the Administrative Mechanism recommendation would schedule an initial meeting once the DHSP representative was appointed.

(i) Member Application for Karl Halfman, MS, Office of AIDS (OA):

MOTION #3: Approve for recommendation to Board of Supervisors, Karl Halfman, MS, membership application to the Office of AIDS representative seat, as presented ***(Passed by Consensus)***.

B. Standards and Best Practices (SBP) Committee:

(i) Revised Medical Care Coordination (MCC) Standards of Care: Mr. Land thanked reviewers including DHSP staff and community members. The standards were focused with review of the evaluation report and alignment with current MCC practices and guidelines. Subject matter expertise was solicited and it was out for public review for two months. **MOTION #4**: Approve the revised Medical Care Coordination (MCC) Standards of Care, as presented ***(Passed by Consensus)***.

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

- Mr. Brown welcomed Miguel Martinez, MSW, MPH as his new Co-Chair. The next meeting is 2/19/2019
- PP&A is developing a process for advance planning. It is working closely with DHSP to track expenditures and fully expend RWP funds, e.g., with dental implants.

D. Public Policy Committee:

- Ms. Nelson reported she had been elected to join Mr. Fox as Co-Chair.
- The Committee reviewed its Policy Priorities and will start work at the next meeting on the Legislative Docket.
- ➲ Agendize President Trump's plan to end AIDS and the National Institute of Health study on AIDS funding.

9. CAUCUS, TASK FORCE, AND WORK GROUP REPORTS:

- Mr. Green reported the Consumer Caucus would meet after the Commission. Lunch would be provided.
- Mr. Ballesteros reported Executive initiated an Older Persons and HIV Ad Hoc Committee. He will help organize it.
- Mr. Land attended the Antelope Valley Consumer Advisor Board. He will try to attend quarterly, as requested.

VI. MISCELLANEOUS

10. PUBLIC COMMENT: OPORTUNITY TO ADDRESS COMMISSION ON ITEMS OF INTEREST WITHIN COMMISSION JURISDICTION: There were no comments.

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

- ➲ Mr. Brown requested Dr. Pratt report on the mumps and measles outbreaks at the March meeting.

12. OPPORTUNITY TO ANNOUNCE COMMUNITY EVENTS, WORKSHOPS, TRAININGS, AND OTHER RELATED ACTIVITIES:

- Greg Wilson noted In The Meantime was hosting morel NBHAAD events on the next two Tuesdays. Flyers were available.

13. ADJOURNMENT AND ROLL CALL: The meeting adjourned at 1:15 pm.
Roll Call (Present): Bivens-Davis, Brown, Burton, Campbell, Cataldo, Daniels, Darling-Palacios, Davies, Forrest, Goddard, Gonzalez, Green, King, Kochems, Land, Martinez (Miguel), Mills, Moreno, Murray, Nelson, Pérez, Preciado, Rosales, Sumpter, Wilson, Ybarra, Ballesteros, Granados.

MOTION AND VOTING SUMMARY		
MOTION 1: Approve the Agenda Order, as presented.	***Passed by Consensus***	**MOTION PASSED**
MOTION 2: Approve the 1/10/2019 Commission on HIV Meeting Minutes, as presented.	***Passed by Consensus***	**MOTION PASSED**
MOTION #3: Approve for recommendation to Board of Supervisors, Karl Halfman, MS, membership application to the Office of AIDS representative seat, as presented.	***Passed by Consensus***	
MOTION #4: Approve the revised Medical Care Coordination (MCC) Standards of Care, as presented.	***Passed by Consensus***	