LOS ANGELES COUNTY
COMMISSION ON HIV

Visit us online: http://hiv.lacounty.gov
Get in touch: hivcomm@lachiv.org
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COMMISSION ON HIV MEETING

Thursday, April 10, 2025
9:00am-12:00pm (PST)

****CHANGE IN MEETING VENUE****
ST. ANNE'S CONFERENCE & EVENT CENTER
FOUNDATION ROOM
155 N. OCCIDENTAL BLVD., LOS ANGELES 90026

Parking Instructions: All attendees should enter the Large Overflow Parking Lot off Glassell St. and walk across to the Conference Center. Attendants will be on-site to assist. If attendees requires an accessible parking space, it will be located in the Main Parking Lot off of Occidental Blvd. **Map/Directions**

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

Register Here to Join Virtually

https://lacountyboardofsupervisors.webex.com/weblink/register/r1324073018f213dd608115ffef1ddeaf

Notice of Teleconferencing Sites

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

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

Public Comments

You may provide public comment in person, or alternatively, you may provide written public comment by:

- Emailing hivcomm@lachiv.org
- Submitting electronically at https://www.surveymonkey.com/r/PUBLIC_COMMENTS

** Please indicate your name, the corresponding agenda item, and whether you would like to state your public comment during the meeting. All public comments will be made part of the official record.*

Accommodations

Requests for a translator, reasonable modification, or accommodation from individuals with disabilities, consistent with the Americans with Disabilities Act, are available free of charge with at least 72 hours' notice before the meeting date by contacting the Commission office at hivcomm@lachiv.org or 213.738.2816.

Scan QR code to download an electronic copy of the meeting packet. Hard copies of materials will not be available in alignment with the County's green initiative to recycle and reduce waste. If meeting packet is not yet available, check back prior to meeting; meeting packet subject to change. Agendas will be posted 72 hours prior to meeting per Brown Act.

together.

WE CAN END HIV IN OUR COMMUNITIES ONCE & FOR ALL

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

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

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

THURSDAY, APRIL 10, 2025 | 9:00 AM – 12:00 PM

****CHANGE IN LOCATION****
ST. ANNE'S CONFERENCE & EVENT CENTER
FOUNDATION ROOM
155 N. OCCIDENTAL BLVD., LOS ANGELES 90026

Parking Instructions: All attendees should enter the Large Overflow Parking Lot off Glassell St. and walk across to the Conference Center. Attendants will be on-site to assist. If attendees requires an accessible parking space, it will be located in the Main Parking Lot off of Occidental Blvd. **Map/Directions**

NOTICE OF TELECONFERENCING SITES
California Department of Public Health, Office of AIDS
1616 Capitol Ave, Suite 74-61, Sacramento, CA 95814

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

MEMBERS OF THE PUBLIC: TO JOIN VIRTUALLY, REGISTER HERE:
HTTPS://LACOUNTYBOARDOFSUPERVISORS.WEBEX.COM/WEBLINK/REGISTER/R1324073018F213DD608115FFEF1DDEAF
JOIN BY PHONE: +1-213-306-3065 Access code: 2530 259 8471

AGENDA POSTED: April 4, 2025

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, email your Public Comment to hivcomm@lachiv.org or submit electronically HERE. All Public Comments will be made part of the official record.

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

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

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

1. ADMINISTRATIVE MATTERS

A.	Call to Order, Roll Call/COI & Meeting Guidelines/Reminders		9:00 AM – 9:03 AM
B.	Approval of Agenda	**MOTION #1**	9:03 AM – 9:05 AM
C.	County Land Acknowledgment		9:05 AM – 9:07 AM
D.	Consent Calendar	**MOTION #2**	9:07 AM – 9:10 AM
E.	Approval of Meeting Minutes	**MOTION #3**	9:10 AM – 9:12 AM

2. PUBLIC & COMMISSIONER COMMENTS

A. Public Comment *(Opportunity for members of the public to address the Commission on items of interest that are within the jurisdiction of the Commission. For those who wish to provide public comment may do so in person, electronically HERE, or by emailing hivcomm@lachiv.org. If providing oral public comments, comments may not exceed 2 minutes per person.)* 9:12 AM – 9:20 AM

B. Commissioner Comment *(Opportunity for Commission members to address the Commission on items of interest that are within the jurisdiction of the Commission. Comments may not exceed 2 minutes per member.)* 9:20 AM – 9:25 AM

3. RYAN WHITE PROGRAM YEAR 35 ALLOCATION CONTINGENCY PLANNING 9:25AM – 11:30 AM

The Commission will engage in a facilitated discussion and make key decisions on contingency planning in response to significant proposed budget cuts to the Ryan White Program, with a focus on data driven prioritization strategies. **MOTION #4**

4. MANAGEMENT/ADMINISTRATIVE REPORTS – I

A. Executive Director/Staff Report 11:30 AM – 11:35 AM

5. STANDING COMMITTEE REPORTS – I 11:35 AM – 11:45 AM

A. Standards and Best Practices (SBP) Committee
(1) Housing Services Standards | **MOTION #5**

B. Public Policy Committee (PPC)
(1) 2025 COH Legislative Docket | **MOTION #6**

C. Caucus, Task Force, and Work Group Reports:
(1) Transgender Caucus
- Statement of Solidarity| **MOTION #7**

5. MISCELLANEOUS

A. Public Comment 11:45 AM – 11:50 AM

(Opportunity for members of the public to address the Commission of items of interest that are within the jurisdiction of the Commission. For those who wish to provide public comment may do so in person, electronically HERE, or by emailing hivcomm@lachiv.org. If providing oral public comments, comments may not exceed 2 minutes per person.)

B. Commission New Business Items 11:50 AM – 11:55 AM

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

C. Announcements 11:55 AM – 12:00 PM

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

D. Adjournment and Roll Call 12:00 PM

Adjournment of the regular April 10, 2025, Commission meeting.

PROPOSED MOTION(S)/ACTION(S)	
MOTION #1	Approve meeting agenda, as presented or revised.
MOTION #2	Approve meeting minutes, as presented or revised.
MOTION #3	Approve Consent Calendar, as presented or revised.
MOTION #4	Approve the Ryan White Program Year 35 Allocation Contingency Plan and grant the Division of HIV and STD Programs (DHSP) the authority to adjust allocations by up to ten percent (10%) per service category, as needed —without returning to the full Commission for additional approval.
CONSENT CALENDAR	
MOTION #5	Approve Housing Service Standards, as presented or revised.
MOTION #6	Approve the 2025 Legislative Docket, as presented or revised.
MOTION #7	Approve Transgender Caucus Statement of Solidarity, as presented or revised.

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION ON HIV MEMBERS			
Danielle Campbell, PhDc, MPH, Co-Chair	*Joseph Green, Co-Chair*	Dahlia Alé-Ferlito	Miguel Alvarez
Jayda Arrington	Al Ballesteros, MBA	Alasdair Burton	Mikhaela Cielo, MD
Lilieth Conolly (LOA)	Sandra Cuevas	Mary Cummings	Erika Davies
Kevin Donnelly	Kerry Ferguson (*Alternate)	Arlene Frames (LOA)	Arburtha Franklin
Rita Garcia (**Alternate)	Rev. Gerald Green (**Alternate)	Felipe Gonzalez	Bridget Gordon
Joaquin Gutierrez (**Alternate)	Karl Halfman, MA	Dr. David Hardy	Ismael Herrera
Terrance Jones	William King, MD, JD, AAHIVS	Lee Kochems, MA (LOA)	Leonardo Martinez-Real
Leon Maultsby, MHA, DBH	Vilma Mendoza	Jeremy Mitchell aka Jet Findley (**Alternate)	Andre Moléttе
Dr. Paul Nash, CPsychol, AFBPsS FHEA	Katja Nelson, MPP	Byron Patel, RN	Mario J. Pérez, MPH
Aaron Raines (**Alternate)	Dechelle Richardson	Erica Robinson	Daryl Russell
Ismael Salamanca	Sabel Samone-Loreca (**Alternate)	Harold Glenn San Agustin, MD	Martin Sattah, MD
DeeAna Saunders	LaShonda Spencer, MD	Kevin Stalter	Lambert Talley (*Alternate)
Justin Valero, MPA	Carlos Vega-Matos (**Alternate)	Jonathan Weedman	Russell Ybarra
MEMBERS:		**44**	
QUORUM:		**23**	

LEGEND:

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

LOS ANGELES COUNTY
COMMISSION ON HIV

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

VISION

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

MISSION

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

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Approved by COH 6/8/23

CODE OF CONDUCT

The Commission on HIV welcomes commissioners, guests, and the public into a space where people of all opinions and backgrounds are able to contribute. In this space, we challenge ourselves to be self-reflective and committed to an ongoing understanding of each other and the complex intersectionality of the lives we live. We create a safe environment where we celebrate differences while striving for consensus in the fights against our common enemies: HIV and STDs. We build trust in each other by having honest, respectful, and productive conversations. As a result, the Commission has adopted and is consistently committed to implementing the following guidelines for Commission, committee, and associated meetings.

All participants and stakeholders should adhere to the following:

1) **We approach all our interactions with compassion, respect, and transparency.**
2) **We respect others' time by starting and ending meetings on time, being punctual, and staying present.**
3) **We listen with intent, avoid interrupting others, and elevate each other's voices.**
4) **We encourage all to bring forth ideas for discussion, community planning, and consensus.**
5) **We focus on the issue, not the person raising the issue.**
6) **Be flexible, open-minded, and solution-focused.**
7) **We give and accept respectful and constructive feedback.**
8) **We keep all issues on the table (no "hidden agendas"), avoid monopolizing discussions and minimize side conversations.**
9) **We have no place in our deliberations for racist, sexist, homophobic, transphobic, and other discriminatory statements, and "-isms" including misogyny, ableism, and ageism.**
10) **We give ourselves permission to learn from our mistakes.**

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

LOS ANGELES COUNTY
COMMISSION ON HIV

HYBRID MEETING GUIDELINES, ETTIQUETTE & REMINDERS

(Updated 7.15.24)

☐ This meeting is a **Brown-Act meeting** and is being recorded.
- 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. *Please indicate your name, the corresponding agenda item, and whether you would like to state your public comment during the meeting; if so, staff will call upon you appropriately. Public comments are limited to two minutes per agenda item. All public comments will be made part of the official record.*

☐ 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 for the entire duration of the meeting 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.

If you experience challenges in logging into the virtual meeting, please refer to the WebEx tutorial HERE or contact Commission staff at hivcomm@lachiv.org.

OVERVIEW OF THE COUNTYWIDE LAND ACKNOWLEDGMENT

AS ADOPTED BY THE BOARD OF SUPERVISORS ON NOVEMBER 1, 2022

The County of Los Angeles recognizes that we occupy land originally and still inhabited and cared for by the Tongva, Tataviam, Serrano, Kizh, and Chumash Peoples. We honor and pay respect to their elders and descendants—past, present, and emerging—as they continue their stewardship of these lands and waters. We acknowledge that settler colonization resulted in land seizure, disease, subjugation, slavery, relocation, broken promises, genocide, and multigenerational trauma. This acknowledgment demonstrates our responsibility and commitment to truth, healing, and reconciliation and to elevating the stories, culture, and community of the original inhabitants of Los Angeles County. We are grateful to have the opportunity to live and work on these ancestral lands. We are dedicated to growing and sustaining relationships with Native peoples and local tribal governments, including (in no particular order) the:

- Fernandeño Tataviam Band of Mission Indians
- Gabrielino Tongva Indians of California Tribal Council
- Gabrieleno/Tongva San Gabriel Band of Mission Indians
- Gabrieleño Band of Mission Indians – Kizh Nation
- San Manuel Band of Mission Indians
- San Fernando Band of Mission Indians

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

WHAT IS A LAND ACKNOWLEDGMENT?

A land acknowledgment is a statement that recognizes an area's original inhabitants who have been forcibly dispossessed of their homelands and is a step toward recognizing the negative impacts these communities have endured and continue to endure, as a result.

"THIS IS A FIRST STEP IN THE COUNTY OF LOS ANGELES ACKNOWLEDGING PAST HARM TOWARDS THE DESCENDANTS OF OUR VILLAGES KNOWN TODAY AS LOS ANGELES...THIS BRINGS AWARENESS TO STATE OUR PRESENCE, *E'QUA'SHEM*, WE ARE HERE."

—Anthony Morales, Tribal Chairman of the Gabrieleno/Tongva San Gabriel Band of Mission Indians

HOW WAS THE COUNTYWIDE LAND ACKNOWLEDGMENT DEVELOPED?

JUNE 23, 2020

The Board of Supervisors (Board) approves a motion, authored by LA County Supervisor Hilda L. Solis, to adopt the Countywide Cultural Policy.

JULY 13, 2021

The Board supports a motion to acknowledge and apologize for the historical mistreatment of California Native Americans by Los Angeles County.

OCTOBER 5, 2021

The Board directs the LA County Department of Arts and Culture (Arts and Culture) and the LA City/County Native American Indian Commission (LANAIC) to facilitate meetings with leaders from local Tribes to develop a formal land acknowledgment for the County.

"THE SPIRIT OF OUR ANCESTORS LIVES WITHIN US. THE TRUE DESCENDANTS OF THIS LAND HAVE BECOME THE TIP OF THE SPEAR AND WILL CONTINUE TO SEEK RESPECT, HONOR, AND DIGNITY, ALL OF WHICH WERE STRIPPED FROM OUR ANCESTORS. IT IS OUR MOST SINCERE GOAL TO WORK TOGETHER AS WE BEGIN TO CREATE THE PATH FORWARD TOWARD ACKNOWLEDGMENT, RESTORATION, AND HEALING."

—Donna Yocum, Chairwoman of the San Fernando Band of Mission Indians

NOVEMBER 2021 – MARCH 2022

With help from an outside consultant, Arts and Culture and LANAIC conduct extensive outreach to 22 tribal governments, with generally 5 tribal affiliations, that have ties to the LA County region, as identified by the California Native American Heritage Commission. Five Tribes agree to participate on a working group.

MARCH 30 – SEPTEMBER 30, 2022

Over five facilitated sessions, the working group contributes recommendations, guidance, and historic and cultural information that informs the development of the County's land acknowledgment.

OCTOBER 18, 2022

LANAIC Commissioners approve a recommendation for the Board to adopt the Countywide Land Acknowledgment.

NOVEMBER 1, 2022

The Board adopts the Countywide Land Acknowledgment.

DECEMBER 1, 2022

The Countywide Land Acknowledgment begins to be verbally announced and displayed visually at the opening of all Board meetings.

"TRUTH IS THE FIRST STEP TO THE RECOVERY OF OUR STOLEN LAND AND BROKEN PROMISES…WE ARE STILL HERE."

—Robert Dorame, Tribal Chair of the Gabrielino Tongva Indians of California

POLICY/PROCEDURE #08.2107	Consent Calendar	Page 1 of 3

NO PROPOSED CHANGES, 4/10/2008

ADOPTED, 1/10/2008

SUBJECT: **"Consent Calendar" procedures at Commission and other meetings.**

PURPOSE: **To provide instructions for the "Consent Calendar" procedures at the Los Angeles County Commission on HIV and other, related Commission meetings.**

BACKGROUND:

- The Commission regularly takes action on multiple items at its monthly meetings. As a result, the Commission is pressured to give complex actions adequate consideration and due diligence, but must rush through motions in order to conclude the meetings on time.

- At the November 2, 2007 Commission meeting, members suggested using a Consent Calendar to expedite the motions that have unanimous support and do not necessitate discussion or debate. The Executive Committee formally endorsed the Consent Calendar practice at its December 3, 2007 meeting.

POLICY:

1) The "Consent Calendar" is a procedural mechanism to expedite Commission business by allowing the body to approve all motions on the consent calendar collectively without debate or dialogue.

2) Commission members or members of the public may set aside (or "pull") an item from the Consent Calendar for any reason in order for the body to discuss and/or vote on it at its appointed time on the agenda. Reasons for setting aside an item include an accompanying presentation, a desire to discuss, address and/or review the item, to register a contrary or opposing vote, and/or to propose an amendment to the motion.

3) Any item that would generate an opposing vote must be removed from the Consent Calendar and returned to its normal place on the agenda.

4) Those items that remain on the Consent Calendar (that have not been "pulled") will be approved collectively in the single Consent Calendar motion. The Consent Calendar motion must be approved unanimously by quorum of the voting membership that is present.

5) The motions that have been set aside will be addressed according to their order on the agenda. Removing an item from the Consent Calendar does not preclude a later vote on that item, nor its approval at a later point on the agenda.

6) Voting members are allowed to register their abstentions from individual items on the Consent Calendar during the Consent Calendar vote.

PROCEDURE(S):

1. **Consent Calendar**: All "action" motions on the Commission's (or other meetings') agendas are automatically placed on the Consent Calendar. "Procedural" motions (e.g., approval of the agenda, approval of the minutes) are not part of the Consent Calendar.

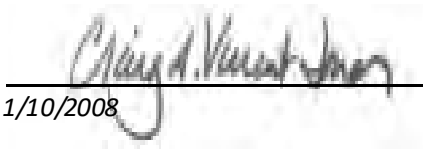
2. **Setting Aside Consent Calendar Items**: An item may be "pulled" from the Consent Calendar by any Commission member, member of the public, or staff member for any reason. The most common reasons for setting aside a Consent Calendar item are:
   a) There is a presentation that accompanies the item.
   b) The member has a question or would like information about the item.
   c) The member would like to see to discuss the item or see it discussed.
   d) The member would like to amend/substitute the motion.
   e) There is an opposing vote.

3. **Items Removed from the Consent Calendar**: "Pulling" an item from the Consent Calendar does not preclude that motion from being considered at a later point on the agenda:
   a) Setting aside a Consent Calendar item returns that item to its regular place on the agenda, where it is addressed at its appointed time.
   b) That motion will be voted on, in agendized order, unless the body chooses to postpone, amend or substitute it when it is considered.

4. **Approving the Consent Calendar**: The Consent Calendar approval vote must be unanimous.
   a) There is no discussion about the Consent Calendar approval, except to pull specific items.
   b) As with all Commission motions, a quorum must be present to vote on it.
   c) As a vote without objections, the Consent Calendar motion does not necessitate a roll call.
   d) Items that generate an opposing vote for the Consent Calendar approval must be removed from the Consent Calendar for later consideration on the agenda.
   e) Voting members may register "abstentions" for individual items on the Consent Calendar.

DEFINITIONS:

- **Abstain/Abstention**: when a voting member acknowledges his/her presence, but declines to vote "aye" or "no" on a motion.
- **"Action" Item/Motion**: a motion that leads to action by the Commission. In the context of this policy, "action" motions are placed on the Consent Calendar.
- **Consent Calendar**: a procedural vehicle for a public voting body to collectively approve all of its "action" motions that do not require discussion or debate.
- **Motion**: the proposed decision or action that the Commission formally moves and votes on.
- **"Procedural" Item/Motion**: a motion necessary for meeting procedural requirements (approving the agenda or minutes). In the context of this policy, "procedural" motions are not placed on the Consent Calendar.
- **"Pull" (an Item/Motion)**: removing or setting aside an item/motion from the Consent Calendar and returning it to its original place on the agenda for discussion/consideration.

NOTED AND APPROVED:  **EFFECTIVE DATE:** January 10, 2008

Original Approval: 1/10/2008 *Revision(s):*

LOS ANGELES COUNTY COMMISSION ON HIV

2025 MEMBERSHIP ROSTER| UPDATED 4.8.25

SEAT NO.	MEMBERSHIP SEAT	Commissioners Seated	Committee Assignment	COMMISSIONER	AFFILIATION (IF ANY)	TERM BEGIN	TERM ENDS	ALTERNATE
1	Medi-Cal representative			***Vacant***		July 1, 2023	June 30, 2025	
2	City of Pasadena representative	1	EXC|SBP	Erika Davies	City of Pasadena Department of Public Health	July 1, 2024	June 30, 2026	
3	City of Long Beach representative	1	PP&A	Ismael Salamanca	Long Beach Health & Human Services	July 1, 2023	June 30, 2025	
4	City of Los Angeles representative	1	SBP	Dahlia Ale-Ferlito	AIDS Coordinator's Office, City of Los Angeles	July 1, 2024	June 30, 2026	
5	City of West Hollywood representative	1	PP&A	Dee Saunders	City of West Hollywood	July 1, 2023	June 30, 2025	
6	Director, DHSP **Non Voting*	1	EXC	Mario Pérez, MPH	DHSP, LA County Department of Public Health	July 1, 2024	June 30, 2026	
7	Part B representative	1	PP&A	Karl Halfman, MA	California Department of Public Health, Office of AIDS	July 1, 2024	June 30, 2026	
8	Part C representative	1	OPS	Leon Maultsby, DBH, MHA	Charles R. Drew University	July 1, 2024	June 30, 2026	
9	Part D representative	1	SBP	Mikhaela Cielo, MD	LAC + USC MCA Clinic, LA County Department of Health Services	July 1, 2023	June 30, 2025	
10	Part F representative	1	SBP	Sandra Cuevas	Pacific AIDS Education and Training - Los Angeles Area	July 1, 2024	June 30, 2026	
11	Provider representative #1			***Vacant***		July 1, 2023	June 30, 2025	
12	Provider representative #2	1	SBP	Andre Molette	Men's Health Foundation	July 1, 2024	June 30, 2026	
13	Provider representative #3	1	PP&A	Harold Glenn San Agustin, MD	JWCH Institute, Inc.	July 1, 2023	June 30, 2025	
14	Provider representative #4	1	PP&A	LaShonda Spencer, MD	Charles Drew University	July 1, 2024	June 30, 2026	
15	Provider representative #5	1	SBP	Byron Patel, RN	Los Angeles LGBT Center	July 1, 2023	June 30, 2025	
16	Provider representative #6	1	EXC|OPS	Dechelle Richardson	No affiliation	July 1, 2024	June 30, 2026	
17	Provider representative #7	1	SBP	David Hardy	LAC-USC Rand Schrader Clinic	July 1, 2023	June 30, 2025	
18	Provider representative #8	1	SBP	Martin Sattah, MD	Rand Shrader Clinic, LA County Department of Health Services	July 1, 2024	June 30, 2026	
19	Unaffiliated representative, SPA 1			***Vacant***		July 1, 2023	June 30, 2025	Kerry Ferguson (SBP)
20	Unaffiliated representative, SPA 2	1	SBP	Russell Ybarra	*Unaffiliated representative*	July 1, 2024	June 30, 2026	
21	Unaffiliated representative, SPA 3	1	OPS	Ish Herrera	*Unaffiliated representative*	July 1, 2023	June 30, 2025	Joaquin Gutierrez (OPS)
22	Unaffiliated representative, SPA 4			***Vacant***		July 1, 2024	June 30, 2026	Lambert Talley (PP&A)
23	Unaffiliated representative, SPA 5	1	EXC|SBP	Kevin Stalter	*Unaffiliated representative*	July 1, 2023	June 30, 2025	
24	Unaffiliated representative, SPA 6	1	OPS	Jayda Arrington	*Unaffiliated representative*	July 1, 2024	June 30, 2026	
25	Unaffiliated representative, SPA 7	1	OPS	Vilma Mendoza	*Unaffiliated representative*	July 1, 2023	June 30, 2025	
26	Unaffiliated representative, SPA 8	1	EXC|PP&A	Kevin Donnelly	*Unaffiliated representative*	July 1, 2024	June 30, 2026	Carlos Vega-Matos (PP&A)
27	Unaffiliated representative, Supervisorial District 1	1	PP	Leonardo Martinez-Real	*Unaffiliated representative*	July 1, 2023	June 30, 2025	
28	Unaffiliated representative, Supervisorial District 2	1	EXC|OPS	Bridget Gordon	*Unaffiliated representative*	July 1, 2024	June 30, 2026	Aaron Raines (OPS)
29	Unaffiliated representative, Supervisorial District 3	1	SBP	Arlene Frames ***(LOA)***	*Unaffiliated representative*	July 1, 2023	June 30, 2025	Sabel Samone-Loreca (SBP)
30	Unaffiliated representative, Supervisorial District 4			***Vacant***		July 1, 2024	June 30, 2026	
31	Unaffiliated representative, Supervisorial District 5	1	PP&A	Felipe Gonzalez	*Unaffiliated representative*	July 1, 2023	June 30, 2025	Rita Garcia (PP&A)
32	Unaffiliated representative, at-large #1	1	PP&A	Lilieth Conolly ***(LOA)***	*Unaffiliated representative*	July 1, 2024	June 30, 2026	Gerald Green (PP&A)
33	Unaffiliated representative, at-large #2	1	PPC	Terrance Jones	*Unaffiliated representative*	July 1, 2023	June 30, 2025	Jeremey Mitchell (Jet Finley) (PPC)
34	Unaffiliated representative, at-large #3	1	EXC|PP&A	Daryl Russell, M.Ed	*Unaffiliated representative*	July 1, 2024	June 30, 2026	
35	Unaffiliated representative, at-large #4	1	EXC	Joseph Green	*Unaffiliated representative*	July 1, 2023	June 30, 2025	
36	Representative, Board Office 1	1	PP&A	Al Ballesteros, MBA	JWCH Institute, Inc.	July 1, 2024	June 30, 2026	
37	Representative, Board Office 2	1	EXC	Danielle Campbell, PhDC, MPH	T.H.E Clinic, Inc. (THE)	July 1, 2023	June 30, 2025	
38	Representative, Board Office 3	1	EXC|PP	Katja Nelson, MPP	APLA	July 1, 2024	June 30, 2026	
39	Representative, Board Office 4	1	EXC|OPS	Justin Valero, MA	No affiliation	July 1, 2023	June 30, 2025	
40	Representative, Board Office 5	1	PP&A	Jonathan Weedman	ViaCare Community Health	July 1, 2024	June 30, 2026	
41	Representative, HOPWA			***Vacant***		July 1, 2023	June 30, 2025	
42	Behavioral/social scientist	1	EXC|PP	Lee Kochems, MA ***(LOA)***	*Unaffiliated representative*	July 1, 2024	June 30, 2026	
43	Local health/hospital planning agency representative			***Vacant***		July 1, 2023	June 30, 2025	
44	HIV stakeholder representative #1	1	EXC|OPS | PP	Alasdair Burton	No affiliation	July 1, 2024	June 30, 2026	
45	HIV stakeholder representative #2	1	PP	Paul Nash, CPsychol AFBPsS FHEA	University of Southern California	July 1, 2023	June 30, 2025	
46	HIV stakeholder representative #3	1	OPS	Erica Robinson	Health Matters Clinic	July 1, 2024	June 30, 2026	
47	HIV stakeholder representative #4	1	PP	Arburtha Franklin	Translatin@ Coalition	July 1, 2023	June 30, 2025	
48	HIV stakeholder representative #5	1	PP	Mary Cummings	Bartz-Altadonna Community Health Center	July 1, 2024	June 30, 2026	
49	HIV stakeholder representative #6			***Vacant***		July 1, 2023	June 30, 2025	
50	HIV stakeholder representative #7	1	PP&A	William D. King, MD, JD, AAHIVS	W. King Health Care Group	July 1, 2024	June 30, 2026	
51	HIV stakeholder representative #8	1	EXC|OPS	Miguel Alvarez	No affiliation	July 1, 2024	June 30, 2026	
	TOTAL:	**43**						

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: 52

LOS ANGELES COUNTY
COMMISSION ON HIV

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

COMMITTEE ASSIGNMENTS

Updated: April 2, 2025
Assignment(s) Subject to Change

EXECUTIVE COMMITTEE		
Regular meeting day: 4th Thursday of the Month **Regular meeting time: 1:00-3:00 PM** **Number of Voting Members= 14 | Number of Quorum= 8**		
COMMITTEE MEMBER	**MEMBER CATEGORY**	**AFFILIATION**
Danielle Campbell, PhDc, MPH	**Co-Chair, Comm./Exec.***	**Commissioner**
Joseph Green	**Co-Chair, Comm./Exec.***	**Commissioner**
Alasdair Burton	At-Large	Commissioner
Erika Davies	Co-Chair, SBP	Commissioner
Kevin Donnelly	Co-Chair, PP&A	Commissioner
Arlene Frames *(LOA)*	Co-Chair, SBP	Commissioner
Bridget Gordon	At-Large	Commissioner
Arburtha Franklin	Co-Chair, Public Policy	Commissioner
Katja Nelson, MPP	Co-Chair, Public Policy	Commissioner
Dèchelle Richardson	At-Large	Commissioner
Erica Robinson	Co-Chair, Operations	Commissioner
Darryl Russell	Co-Chair, PP&A	Commissioner
Justin Valero, MA	Co-Chair, Operations	Commissioner
Mario Pérez, MPH	DHSP Director	Commissioner

OPERATIONS COMMITTEE		
Regular meeting day: 4th Thursday of the Month **Regular meeting time: 10:00 AM-12:00 PM** **Number of Voting Members= 10 | Number of Quorum= 6**		
COMMITTEE MEMBER	**MEMBER CATEGORY**	**AFFILIATION**
Erica Robinson	**Committee Co-Chair***	**Commissioner**
Justin Valero	**Committee Co-Chair***	**Commissioner**
Jayda Arrington	*	Commissioner
Miguel Alvarez	*	Commissioner
Alasdair Burton	At-Large	Commissioner
Bridget Gordon	At-Large	Commissioner
Joaquin Gutierrez *(alternate to Ish Herrera)*	*	Alternate
Ismael Herrera	*	Commissioner
Leon Maultsby, DBH, MHA	*	Commissioner
Vilma Mendoza	*	Commissioner
Aaron Raines *(alternate to Bridget Gordon)*	*	Alternate
Dèchelle Richardson	At-Large	Commissioner

PLANNING, PRIORITIES & ALLOCATIONS (PP&A) COMMITTEE		
Regular meeting day: 3rd Tuesday of the Month **Regular meeting time: 1:00-3:00 PM** **Number of Voting Members= 16| Number of Quorum= 9**		
COMMITTEE MEMBER	**MEMBER CATEGORY**	**AFFILIATION**
Kevin Donnelly	**Committee Co-Chair***	Commissioner
Daryl Russell, M.Ed	**Committee Co-Chair***	Commissioner
Al Ballesteros, MBA	*	Commissioner
Lilieth Conolly *(LOA)*	*	Commissioner
Rita Garcia *(alternate to Felipe Gonzalez)*	*	Alternate
Felipe Gonzalez	*	Commissioner
Reverend Gerald Green *(alternate to Lilieth Conolly)*	*	Alternate
William D. King, MD, JD, AAHIVS	*	Commissioner
Rob Lester	*	Committee Member
Miguel Martinez, MPH	*	Committee Member
Harold Glenn San Agustin, MD	*	Commissioner
Ismael Salamanca	*	Commissioner
Dee Saunders	*	Commissioner
LaShonda Spencer, MD	*	Commissioner
Lambert Talley	*	Commissioner
Carlos Vega-Matos *(alternate to Kevin Donnelly)*	*	Alternate
Jonathan Weedman	*	Commissioner
Michael Green, PhD	DHSP staff	DHSP

PUBLIC POLICY (PP) COMMITTEE		
Regular meeting day: 1st Monday of the Month **Regular meeting time: 1:00-3:00 PM** **Number of Voting Members= 9 | Number of Quorum= 5**		
COMMITTEE MEMBER	**MEMBER CATEGORY**	**AFFILIATION**
Arburtha Franklin	**Committee Co-Chair***	Commissioner
Katja Nelson, MPP	**Committee Co-Chair***	Commissioner
Mary Cummings	*	Commissioner
Jet Finley *(alternate to Terrance Jones)*	*	Alternate
OM Davis	*	Committee Member
Terrance Jones	*	Commissioner
Lee Kochems ***(LOA)***	*	Commissioner
Leonardo Martinez-Real	*	Commissioner
Paul Nash, CPsychol AFBPsS FHEA	*	Commissioner

STANDARDS AND BEST PRACTICES (SBP) COMMITTEE		
Regular meeting day: 1st Tuesday of the Month **Regular meeting time: 10:00AM-12:00 PM** **Number of Voting Members = 15 | Number of Quorum = 8**		
COMMITTEE MEMBER	**MEMBER CATEGORY**	**AFFILIATION**
Arlene Frames ***(LOA)***	**Committee Co-Chair***	**Commissioner**
Erika Davies	**Committee Co-Chair***	**Commissioner**
Dahlia Alè-Ferlito	*	Commissioner
Mikhaela Cielo, MD	*	Commissioner
Sandra Cuevas	*	Commissioner
Caitlyn Dolan	*	Committee Member
Kerry Ferguson	*	Alternate
Lauren Gersh	*	Committee Member
David Hardy, MD	*	Commissioner
Sabel Samone-Loreca *(alternate to Arlene Frames)*	*	Alternate
Mark Mintline, DDS	*	Committee Member
Andre Molette	*	Commissioner
Byron Patel, RN, ACRN	*	Commissioner
Martin Sattah, MD	*	Commissioner
Kevin Stalter	*	Commissioner
Russell Ybarra	*	Commissioner

AGING CAUCUS

Regular meeting day/time: 2nd Tuesday Every Other Month @ 1pm-3pm
Co-Chairs: Kevin Donnelly & Paul Nash
Open membership

CONSUMER CAUCUS

Regular meeting day/time: 2nd Thursday of Each Month; Immediately Following Commission Meeting
Co-Chairs: Damone Thomas, Lilieth Conolly & Ismael (Ish) Herrera
Open membership to consumers of HIV prevention and care services

BLACK CAUCUS

Regular meeting day/time: 3rd Thursday of Each Month @ 4PM-5PM (Virtual)
Co-Chairs: Leon Maultsby & Dechelle Richardson
Open membership

TRANSGENDER CAUCUS

Regular meeting day/time: 3rd Thursday Quarterly @ 10AM-11:30 AM
Co-Chairs: Rita Garcia & Chi Chi Navarro
Open membership

WOMEN'S CAUCUS

Regular meeting day/time: Virtual - 3rd Monday Bi-monthly @ 2-3:00pm
The Women's Caucus Reserves the Option of Meeting In-Person Annually
Co-Chairs: Shary Alonzo & Dr. Mikhaela Cielo
Open membership

HOUSING TASKFORCE

Regular meeting day/time: Virtual – 4th Friday of Each Month @ 9AM – 10AM
Co-Chairs: Katja Nelson & Dr. David Hardy
Open membership

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 3/28/25

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ALE-FERLITO	**Dahlia**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
ALVAREZ	**Miguel**	No Affiliation	No Ryan White or prevention contracts
ARRINGTON	**Jayda**	Unaffiliated representative	No Ryan White or prevention contracts
BALLESTEROS	**Al**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & Linked Referral…(CSV)
			STD Screening, Diagnosis, and Treatment
			High Impact HIV Prevention
			Mental Health
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
			Data to Care Services
BURTON	**Alasdair**	No Affiliation	No Ryan White or prevention contracts
CAMPBELL	**Danielle**	T.H.E. Clinic, Inc.	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Biomedical HIV Prevention
			Transportation Services
CIELO	**Mikhaela**	Los Angeles General Hospital	Biomedical HIV Prevention
CONOLLY	**Lilieth**	No Affiliation	No Ryan White or prevention contracts
CUEVAS	**Sandra**	Pacific AIDS Education and Training - Los Angeles	No Ryan White or prevention contracts
CUMMINGS	**Mary**	Bartz-Altadonna Community Health Center	Community Engagement/EHE

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DAVIS (PPC Member)	**OM**	Asian American Drug Abuse Program (AADAP)	High Impact HIV Prevention
			HIV Testing and Viral Hepatitis Services in Los Angeles County
DOLAN (SBP Member)	**Caitlyn**	Men's Health Foundation	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
			Data to Care Services
DONNELLY	**Kevin**	Unaffiliated representative	No Ryan White or prevention contracts
FERGUSON	**Kerry**	ViiV Healthcare	No Ryan White or prevention contracts
FINLEY	**Jet**	Unaffiliated representative	No Ryan White or prevention contracts
FRAMES	**Arlene**	Unaffiliated representative	No Ryan White or prevention contracts
FRANKLIN*	**Arburtha**	Translatin@ Coalition	Vulnerable Populations (Trans)
GARCIA	**Rita**	No Affiliation	No Ryan White or prevention contracts
GERSH (SBP Member)	**Lauren**	APLA Health & Wellness	High Impact HIV Prevention
			Benefits Specialty
			Nutrition Support
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Residential Care Facility - Chronically Ill
			Intensive Case Management
GONZALEZ	**Felipe**	Unaffiliated representative	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated representative	No Ryan White or prevention contracts
GREEN	**Gerald**	Minority AIDS Project	Benefits Specialty
GREEN	**Joseph**	Unaffiliated representative	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
GUTIERREZ	**Joaquin**	Connect To Protect LA/CHLA	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
HARDY	**David**	LAC-USC Rand Schrader Clinic	No Ryan White or prevention contracts
HERRERA	**Ismael "Ish"**	Unaffiliated representative	No Ryan White or prevention contracts
JONES	**Terrance**	Unaffiliated representative	No Ryan White or prevention contracts
KOCHEMS	**Lee**	Unaffiliated representative	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
LESTER (PP&A Member)	**Rob**	Men's Health Foundation	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
			Data to Care Services
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
MARTINEZ-REAL	**Leonardo**	Unaffiliated representative	No Ryan White or prevention contracts
MAULTSBY	**Leon**	Charles R. Drew University	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MENDOZA	**Vilma**	Unaffiliated representative	No Ryan White or prevention contracts
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MOLETTE	**Andre**	Men's Health Foundation	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
			Oral Healthcare Services
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention
			Community Engagement/EHE
			Oral Healthcare Services
NELSON	**Katja**	APLA Health & Wellness	High Impact HIV Prevention
			Benefits Specialty
			Nutrition Support
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Residential Care Facility - Chronically Ill
			Case Management

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
PATEL	**Byron**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			High Impact HIV Prevention
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
RAINES	**Aaron**	No Affiliation	No Ryan White or prevention contracts
RICHARDSON	**Dechelle**	No Affiliation	No Ryan White or prevention contracts
ROBINSON	**Erica**	Health Matters Clinic	No Ryan White or prevention contracts
RUSSEL	**Daryl**	Unaffiliated representative	No Ryan White or prevention contracts
SALAMANCA	**Ismael**	City of Long Beach	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			HIV Testing & Sexual Networks
SAMONE-LORECA	**Sabel**	Minority AIDS Project	Benefits Specialty
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	No Ryan White or prevention contracts

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
			High Impact HIV Prevention
			Mental Health
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
			Data to Care Services
SAUNDERS	**Dee**	City of West Hollywood	No Ryan White or prevention contracts
SPENCER	**LaShonda**	Oasis Clinic (Charles R. Drew University/Drew CARES)	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
STALTER	**Kevin**	Unaffiliated representative	No Ryan White or prevention contracts
TALLEY	**Lambert**	Grace Center for Health & Healing	No Ryan White or prevention contracts
VALERO	**Justin**	No Affiliation	No Ryan White or prevention contracts
VEGA-MATOS	**Carlos**	Men's Health Foundation	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
			Data to Care Services
WEEDMAN	**Jonathan**	ViaCare Community Health	Biomedical HIV Prevention
YBARRA	**Russell**	Capitol Drugs	No Ryan White or prevention contracts

Division of HIV and STDs Contracted Community Services

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

Service Category	Organization/Subcontractor
Mental Health	
Medical Specialty	
Oral Health	
AOM	
Case Management Home-Based	Libertana Home Health
	Caring Choice
	The Wright Home Care
	Cambrian
	Care Connection
	Envoy
Nutrition Support (Food Bank/Pantry Service)	AIDS Food Store
	Foothill AIDS Project
	JWCH
	Project Angel
Oral Health	Dostal Laboratories
STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)	
STD-Ex.C	
Biomedical HIV Prevention Services	
Case Management Home-Based	Envoy
	Caring Choice
	Health Talent Strategies
	Hope International
Mental Health	
Vulnerable Populations (YMSM)	TWLMP
Nutrition Support (Food Bank/Pantry Service)	
Vulnerable Populations (Trans)	CHLA
	SJW
HTS - Storefront	LabLinc Mobile Testing Unit Contract
Vulnerable Populations (YMSM)	

Service Category	Organization/Subcontractor
AOM	
Vulnerable Populations (YMSM)	APAIT
	AMAAD
HTS - Storefront	Center for Health Justice
	Sunrise Community Counceling Center
STD Prevention	
HERR	

AOM	
STD Infertility Prevention and District 2	
Linkage to Care Service forr Persons Living with HIV	EHE Mini Grants (MHF; Kavich- Reynolds; SJW; CDU; Kedren Comm Health Ctr; RLA; SCC
	EHE Priority Populations (BEN; ELW; LGBT; SJW; SMM; WLM; UCLA LAFANN
	Spanish Telehealth Mental Health Services
	Translation/Transcription Services
	Public Health Detailing
	HIV Workforce Development
Vulnerable Populations (YMSM)	Resilient Solutions Agency
Mental Health	Bienestar
Oral Health	USC School of Dentistry
Biomedical HIV Prevention Services	

Service Category	Organization/Subcontractor
Community Engagement and Related Services	AMAAD
	Program Evaluation Services
	Community Partner Agencies
Housing Assistance Services	Heluna Health
AOM	Barton & Associates
Vulnerable Populations (YMSM)	Bienestar
	CHLA
	The Walls Las Memorias
	Black AIDS Institute
Vulnerable Populations (Trans)	Special Services for Groups
	Translatin@ Coalition
	CHLA
AOM	AMMD (Medical Services)
Biomedical HIV Prevention Services	
Vulnerable Poplulations (YMSM)	
Sexual Health Express Clinics (SHEx-C)	AMMD - Contracted Medical Services
Case Management Home-Based	Caring Choice
	Envoy
AOM	
Mental Health	
STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)	

Service Category	Organization/Subcontractor
Residential Facility For the Chronically Ill (RCFCI)	
Transitional Residential Care Facility (TRCF)	
HTS - Social and Sexual Networks	Black AIDS Institute
AOM	
Case Management Home-Based	Envoy
	Cambrian
	Caring Choice
Oral Health	Dental Laboratory
AOM	
HTS - Storefront	
HTS - Social and Sexual Networks	
AOM	New Health Consultant
Case Management Home-Based	Always Right Home
	Envoy
Mental Health	
Oral Health-Endo	
Oral Health-Gen.	
Oral Health-Endo	Patient Lab - Burbank Dental Lab, DenTech
	Biopsies - Pacific Oral Pathology
Oral Health-Gen.	Patient Lab Services
AOM	UCLA
Benefit Specialty	UCLA
Medical Care Coordination	UCLA
Oral Health	

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

Commission member presence at meetings is recorded based on the attendance roll call. Only members of the Commission on HIV are accorded voting privileges. Members of the public may confirm their attendance by contacting Commission staff. Approved meeting minutes are available on the Commission's website and may be corrected up to one year after approval. Meeting recordings are available upon request.

COMMISSION ON HIV (COH)
March 13, 2025 MEETING MINUTES

THE CALIFORNIA ENDOWMENT
Conference Room: Beatriz Solis A
1000 N. Alameda Street, Los Angeles, CA 90012
CLICK HERE FOR MEETING PACKET

TELECONFERENCE SITES:
California Department of Public Health, Office of AIDS
1616 Capitol Ave, Suite 74-61, Sacramento, CA 95814

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

COMMISSION MEMBERS P=Present | VP=Virtually Present | A=Unexcused Absence | EA=Excused Absence									
Dahlia Alè-Ferlito	P	Miguel Alvarez	P	Jayda Arrington	P	Al Ballesteros, MBA	EA	Alasdair Burton	P
Dr. Danielle Campbell, PhDc, MPH	P	Dr. Mikhaela Cielo, MD	P	Lilieth Conolly	EA (LOA)	Sandra Cuevas	A	Mary Cummings	P
Erika Davies	P	Kevin Donnelly	P	Kerry Ferguson	P	Jet Finley	A	Arlene Frames	AB2449
Arburtha Franklin	EA	Rita Garcia	EA	Reverend Gerald Green	P	Joe Green	P	Bridget Gordon	A
Karl Halfman, MS	P	Dr. David Hardy, MD	P	Ish Herrera	P	Terrance Jones	P	Dr. William King, JD	EA
Lee Kochems	EA (LOA)	Leonardo Martinez-Real	P	Dr. Leon Maultsby	P	Vilma Mendoza	P	Andre Molette	P
Katja Nelson	P	Byron Patel	P	Mario Perez, MPH	P	Aaron Raines	A	Dechelle Richardson	A

Erica Robinson	P	Daryl Russell	P	Ismael Salamanca	P	Dr. H. Glenn San Augustin	EA	Dr. Martin Sattah	EA
Dee Saunders	P	Dr. LaShonda Spencer	EA	Kevin Stalter	A	Lambert Talley	P	Justin Valero	EA
Carlos Vega-Matos	P	Jonathan Weedman	P	Russell Ybarra	P				
COMMISSION STAFF & CONSULTANTS									
Cheryl Barrit, MPIA; Lizette Martinez, MPH; Sonja Wright, DACM; Jose Rangel-Garibay, MPH; Jim Stewart, AJ King (Next Level Consulting)									

1. ADMINISTRATIVE MATTERS

A. CALL TO ORDER, ROLL CALL/COI & MEETING GUIDELINES/REMINDERS

Joe Green, Commission on HIV (COH) Co-Chair, called the meeting to order at 9:05 AM, and reviewed meeting guidelines and reminders; see packet. Jim Stewart, Parliamentarian, conducted roll call.

ROLL CALL (PRESENT): D. Ale-Ferlito, M. Alvarez, J. Arrington, A. Burton, M. Cielo, M. Cummings, E. Davies, K. Donnelly, K. Ferguson, A. Frames, G. Green, F. Gonzalez, K. Halfman, I. Herrera, T. Jones, L. Martinez-Real, L. Maultsby, V. Mendoza, A. Molette, B. Patel, M. Perez, E. Robinson, D. Russell, I. Salamanca, S. Samone-Loreca, D. Saunders, L. Spencer, K. Stalter, L. Talley, C. Vega-Matos, J. Weedman, R. Ybarra, D. Campbell, and J. Green.

B. COUNTY LAND ACKNOWLEDGEMENT

J. Green read the County's Land Acknowledgement to recognize the land originally and still inhabited and cared for by the Tongva, Tataviam, Kizh, and Chumash Peoples; see meeting packet for full statement.

C. APPROVAL OF AGENDA

MOTION #1: Approve meeting agenda, as presented or revised. √ Passed by Consensus

D. APPROVAL OF MEETING MINUTES

MOTION #2: Approve meeting minutes, as presented or revised. √ Passed by Consensus

E. APPROVAL OF CONSENT CALENDAR

MOTION #3: Approve consent calendar, as presented or revised. √ Passed by Consensus

2. PUBLIC & COMMISSIONER COMMENTS

A. **Public Comment**

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

- Chi Chi Navarro, the newly elected Transgender Caucus Co-Chair, introduced themselves to the Commission attendees.

B. **Commissioner Comment**

Opportunity for Commission members to address the Commission on items of interest that are within the jurisdiction of the Commission.

- Ish Herrera made a passionate plea for the consideration of consumer stipend increases.

3. MANAGEMENT/ADMINISTRATIVE REPORTS – I

A. Executive Director/ Staff Report

Executive Director, Cheryl Barrit, extended accolades and recognition to the Commission for their work in 2024 and provided the following report:

(1) 2024 Annual Report

The 2024 Annual Report was submitted to Commission Services, Health Deputies, and the Executive Office on March 5th. The report is available on the COH website under the "Our Work" tab.

(2) 2025 COH Meeting Schedule | Updated

The 2025 COH meeting schedule will prioritize data presentations from the Division of HIV and STD Programs (DHSP) to ensure that the planning council receives data to help inform its planning efforts. The schedule is reviewed monthly by the Executive Committee and is subject to change.

(3) Budget Uncertainty in Ryan White Program (RWP) Year 35

- There was uncertainty across all County departmental budget reviews held by the Board of Supervisors (BOS) during the last week of February due to severely strained financial resources compounded by federal and state budget restraints.
- All County departments, including commissions, were directed to look for ways to cut operational costs.
- The BOS asked commissions to review their functions and determine relevancy and potential cost savings and efficiencies that might be gained. The review aligns with the COH's current restructuring efforts.
- The COH is developing its Program Year (PY) 35 budget in conjunction with the Executive Office. Difficult but necessary choices will have to be made to adjust the COH's business operations and practices to align with the limited budgetary resources available.
- The COH budget is reviewed by the Executive Committee and approved by DHSP.

B. Co-Chairs' Report.

(1) Welcome New Members

Co-Chair J. Green welcomed: Ismael Salamanca, Carlos Vega-Matos, Reverend Gerald Green, Rob Lester, Caitlin Dolan, Jet Finley, Aaron Raines, and OM Davis.

(2) 2025 Executive Committee At-Large Member Seats | Open Nominations

The following commissioners were nominated: Miguel Alvarez (nomination accepted), Lambert Talley (self-nominated), Alasdair Burton(self-nominated), and Dechelle Richardson (nominated via email).

(3) February 13, 2025 COH Meeting | Follow-up & Feedback

No follow-up or feedback.

(4) Conferences, Meetings, & Trainings

Commissioner Leon Maultsby shared he is on the host committee for the National African American Leadership Conference on Health Disparities and Social Justice (NAESM) event happening June 25-29, 2025, at the Sheraton Gateway Los Angeles Hotel near LAX. There are two openings available for anyone who would like to attend.

(5) Acknowledgment of National HIV/AIDS Awareness Days

- March 10, 2025: National Women & Girls HIV/AIDS Awareness Day #NWGHAAD is dedicated to raising awareness about the impact of HIV on women, girls, and transgender women. NWGHAAD advocates for prevention, education, and support.
  **See addendum for poem read by Dr. Mikhaela Cielo in honor of NWGHAAD.*
- March 20, 2025: National Native American HIV/AIDS Awareness Day (NNHAAD) aims to raise awareness about the impact of HIV/AIDS in Native American, Alaska Native, and Native Hawaiian communities.
- March 31, 2025: Transgender Day of Visibility (TDOV) is dedicated to celebrating transgender and non-binary people, raising awareness, and fighting for their rights and equality.

4. COMPREHENSIVE EFFECTIVENESS REVIEW & RESTRUCTURING PROJECT

C. Barrit shared that: (1) critique of the COH is important for improvements and evolution and reminded all that the COH has gone through changes before, (2) commissioners, community and County partners have provided feedback on the capacity, effectiveness and structure of the COH since it became an integrated prevention and care planning body in 2013, and in 2023-2024, members started drafting changes to the bylaws, (3) additional areas of improvement emerged from the 2023 Health Resources and Services Administration (HRSA) administrative site visit and 2024 HRSA TA site visit, and (4) the COH is partnering with Next Level Consulting and Collaborative Research(CR) to facilitate a thoughtful and inclusive process for restructuring as it will be one of the key priorities for the COH in 2025.

AJ King, Next Level Consulting, provided the following update and common themes from the February Commission meeting break out groups discussions: (1) most seemed open to the restructuring process, (2) the vast majority acknowledged that the COH does good work but there are ways to become more efficient and effective, (3) ensure that the membership is reflective of those that need to be at the table, especially youth living with HIV, (4) maintain consumer voices, (5) continue and improve upon community engagement, (6)

improve upon HIV prevention care planning, and (7) strengthen core planning activities (i.e., needs assessment data, recommend specific strategies stemming from the needs assessment data, and assessing the outcomes of the implementation strategies).

The last thought is whether July's timeline is feasible, taking into consideration other moving parts such as the bylaws changes. The Commission, in partnership with Next Level Consulting and Collaborative Research, will convene five restructuring work groups from March 19th to 21st, two on Wednesday and Thursday from 9:30 am to 11:30 am and 1:30 pm to 3:30 pm, and one on Friday from 9:30 am to 11:30 am. The work groups will delve deeper into the restructuring process and are open to commissioners, community partners, and the public.

AJ King opened the floor for questions:

- Mario Perez expressed the following concerns: (1) the feedback and recommendations provided by DHSP outlining what planning should consist of, is not reflected, (2) too many meetings are being held, and (3) service providers, academic partners, and funders should be included in the restructuring work group discussions to retain a system that responds to the growing needs of the communities served.
- Concern was expressed about the $25 gift cards being issued from the COH budget to community participants, although they may not have participated in any previous planning efforts and may not understand or have background or historical information to base their feedback and recommendations on. AJ King and staff reported that the gift cards are not coming from the COH operating budget.
- A request was made to incorporate a virtual component to the work group meetings.

5. STANDING COMMITTEE REPORTS – I

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

Co-Chair Kevin Donnelly provided the following report:

- During its February meeting, the PP&A Committee reviewed the Antelope Valley HIV Care Continuum data that was shared by DHSP during the Antelope Valley World AIDS Day event. The data review helped inform the Program Year 35-37 Directives.
- The Committee conducted a final review of the Ryan White Program Year 35-37 (PY35-37) Directives before formally approving. The directives were then approved by the Executive Committee on February 27th and are up for final approval by the full body at the March 13th Commission on HIV meeting.
- DHSP staff provided a Program Year 34 (PY34) Expenditures report to the committee. The report focused on Part A and Minority AIDS Initiative (MAI) expenditures. The report highlighted PY34 service priorities, allocations per funded service category, year-to-date expenditures (through the month of November 2024), and projected final spending through the end of the program year (February 28, 2025). The report shows most service categories are exceeding allocated expenditures.
- Projected Part A expenditures are expected to exceed current allocations by approximately $3.8 million, and MAI expenditures are projected to exceed current allocations by approximately $2 million. Additional services that were previously allocated and funded in Program Year 33 but are currently funded by other

funding sources, including Outreach (Linkage and Re-engagement Program (LRP), Emergency Rental Assistance (ERA), and Home-Delivered Meals, are also projected to exceed funding by $2.6 million.

- Discussions were held on ways to minimize overspending in PY35. DHSP recommended that if the Committee would like to maintain the current level of investments, the Committee would need to reallocate funds to better align with current expenditures. DHSP noted that they no longer have significant carryover of EHE and other resources that they were able to shift into Ryan White Program service categories to cover overspending of the grant to continue to support RWP service categories in the past.
- After discussion regarding the RWP PYs 35-37 Directives, they were voted on and passed by the full Commission body. Please refer to the Motion #4 voting summary in the table below.
- The next PP&A Committee meeting will be on Tuesday, March 18th, from 1 pm-3 pm at the Vermont Corridor. Commissioners should review the PP&A meeting minutes from February and attend PP&A Committee meetings to stay informed of current funding challenges, to develop a deeper understanding of the priority setting and allocation process, and to observe how data is used to inform decision-making.
- The link to the February PP&A meeting packet can be found HERE.

B. Operations Committee

Co-Chair Erica Robinson provided the following report:

- The Operations Committee met on February 27th and reviewed the most recent iteration of the membership reflectiveness table against incoming members. The Committee underscored the importance of doing more targeted community outreach to recruit youth and transgender individuals. Operations explored key events to attend, such as the UCLA-CFAR CAB conference, June Pride events, and youth groups and TGI groups affiliated with local HIV service organizations. Awarding school credits was a strategy discussed to encourage youth to attend COH meetings to incentivize their engagement.
- The Committee reviewed members' attendance records to ensure all members are getting the support they need to perform their duties.
- The Operations Committee is conducting the annual Assessment of the Efficiency of the Administrative Mechanism (AEAM) and promoting the mandatory 2025 trainings with their fellow Commissioners. The Ryan White Care Legislative Overview and Membership Structure and Responsibilities training was rescheduled to April 2nd, from 12 pm – 1 pm. The updated training schedule, the February training slides, and the link to the quiz are on the Commission's website.
- The Operations Committee will continue to agendize the Commission Restructuring Debrief conversation as a standing agenda item.
- The next Operations Committee meeting is on March 27th, from 10 am – 12 pm at the Vermont Corridor.
- Please register for and attend all mandatory commissioner trainings and complete the required quizzes to receive your certificate of completion.
- The 2025 training schedule is on the COH website. Registration links are embedded in the training schedule.
- The link to the Operations Committee meeting packet can be found HERE.

C. Standards and Best Practices (SBP) Committee

Co-Chair Erika Davies reported the following:

- The Committee reviewed public comment received for the "Housing Services" service standards and approved the documents. The documents will be elevated to the Executive Committee for review and approval at their March 20, 2025, meeting.
- The Committee began review of the Transitional Case Management service standards. This document will encompass service standards for the following populations: Youth, Justice-Involved, and Older Adults (50+) as recommended by DHSP, for older adults who might be transferring from Ryan White Medicare and Medicaid to other health care options.
- The committee will continue its review at its next Committee meeting.
- The next SBP Committee meeting will be on Tuesday, April 1, 2025, from 10 am-12 pm at the Vermont Corridor, 14th floor. Committee members, Commissioners, and members of the public planning on attending the meeting must check in with the security guards on the 9th floor lobby and wait for a COH staff member to escort them to the 14th floor.
- The Committee encourages consumers to participate in the service standards development process.
- The link to the March 11, 2025, meeting packet can be found **HERE.**

D. Public Policy Committee (PPC)

Co-Chair Katja Nelson reported the following:

- Arburtha Franklin was elected as PPC co-chair for 2025.
- Reviewed state bills listed on the 2025-26 Legislative Docket and held deliberations to determine the position the PPC will recommend the Board of Supervisors (BOS) to take on the proposed legislation. The PPC approved the document and elevated it to the Executive Committee for review and approval at their March 20, 2025, meeting.
- The Committee is considering taking time off and re-convening when more information is available at the federal and state levels.
- The next PPC meeting will be on Monday, April 7, 2025, from 10 am-12 pm at the Vermont Corridor. The Committee requests all to review the 2025-26 Legislative Docket and submit any questions, concerns, and suggestions to the PPC. A copy of the document is included in the March 3, 2025, meeting packet.
- The link to the March 3, 2025, meeting packet can be found **HERE.**

E. Caucus, Task Force, and Work Group Reports:

(1) Aging Caucus

Co-Chair K. Donnelly reported the following:

- The Aging Caucus met virtually on March 11, 2025, from 1 pm to 2 pm, and finalized their 2025 key priorities and began planning for a cross-caucus collaborative event, slated for September, to address HIV and aging across intersectional identities and age groups.

- K. Donnelly shared that despite the stereotypes, people over 50 are amongst the happiest out there, often reporting being happier than when they were younger. This is accompanied with reduced stress, greater coping strategies and arguably better sex, according to the U Curve of Happiness.
  - The Caucus requests that all stay informed of resources regarding Medicaid and Medicare, which are critical resources for low-income, older adults, and people with disabilities.
    - How Medicaid Funding Caps Would Harm Older Adults
    - Lambda Legal Help Desk
    - Facing the Future Together: FAQs, Guidance, & Resources for Older Adults
  - The next Aging Caucus virtual meeting on May 13, 2025, from 1 pm to 2 pm.
  - The link to the March 11, 2025 meeting packet can be found **HERE.**

(2) Black/AA Caucus

Co-Chair Leon Maultsby provided the following report:

- The Black Caucus did not meet in February and instead held a Community Game Night in commemoration of National Black HIV/AIDS Awareness Day (NBHAAD).
- In honor of NBHAAD, the Caucus released an infographic highlighting preliminary findings from the Faith-Based, Black Immigrant & Non-U.S.-Born, Women, and Same-Gender Loving Men community listening sessions.
- The next Black Caucus meeting will be held virtually on March 20, 2025, focusing on: (1) planning for the remaining community listening sessions, (2) advancing the organizational needs assessment of Black-led and Black-serving organizations in Los Angeles County (LAC), and (3) conducting another round of nominations and elections for a second co-chair.
- The Caucus requests all to attend their March 20, 2025, virtual meeting and to support outreach efforts to ensure broad community participation.

(3) Consumer Caucus

Co-Chair Ish Herrera reported the following:

- The Consumer Caucus did not meet in February but successfully hosted a Consumer Resource Fair, which attracted over 200 community members and 60+ vendors. The event received overwhelmingly positive feedback from both consumers and vendors, with ongoing responses highlighting its impact.
- The next Consumer Caucus meeting will be held following the March 13, 2025, COH meeting, where members will: (1) elect the 2025 co-chairs, (2) receive a presentation from DHSP's Client Quality Management Program, led by consultant Michael Hager, and (3) review the Housing Services Standards.
- In lieu of its April 10, 2025, meeting, the Caucus is planning a Ryan White Program Dental Services Listening Session; you may access the flyer HERE.
- The Caucus requests people to attend the March 13, 2025, Consumer Caucus meeting, participate in co-chair elections, review the Housing Services Standards, and help promote the Ryan White Program Dental Services Listening Session.

(4) Transgender Caucus

Co-Chair Chi Chi Navarro provided the following report:

- Commission on HIV (COH) staff provided an overview of the structure and functions of the COH and shared that the COH is undergoing restructuring. A copy of the presentation materials is included in the February 25, 2025, meeting packet.
- COH staff shared that there will be opportunities for the caucus to participate in upcoming need assessments and community listening sessions as the COH prepares to draft the 2026-2030 Comprehensive HIV Plan (CHP).
- The Caucus discussed the possibility of drafting a statement of solidarity in response to the transphobic rhetoric and policies enacted by the President and Congress. Sunitha Menon, Executive Director of the LGBTQ+ Commission, shared that the LGBTQ+ Commission is writing a letter to the Board of Supervisors (BOS) and suggested the caucus and COH consider co-signing the letter to make a stronger statement. COH staff will follow up with Sunitha and the LGBTQ+ Commission co-chairs to discuss opportunities for collaboration.
- The next Transgender Caucus meeting will be held virtually on Tuesday, March 25, 2025, from 10 am-12 pm. The Caucus will continue its discussion of the 2025 Strategic Priorities and decide on next steps for the "Call to Action" agenda item.
- The Caucus requests all to continue to promote the Transgender Caucus within your networks and invite community members to attend future meetings.
- The link to the February 25, 2025, meeting packet can be found **HERE.**

(5) Women's Caucus

Co-Chair Dr. Mikhaela Cielo reported the following:

- The Women's Caucus (WC) did not meet in February.
- The next virtual Women's Caucus meeting will be on Monday, March 17th from 2 pm-3 pm via Webex. The caucus will continue planning for women's listening sessions, including a review of proposed discussion questions, enlisting key partners to assist with recruitment and facilitation, and identifying potential listening session locations.
- The Caucus requests all to continue to promote the WC within your networks and identify potential partners and locations to assist with planning and hosting future listening sessions.
- Link to the January Women's Caucus meeting packet can be found **HERE.**

(6) Housing Task Force (HTF)

Co-Chair K. Nelson reported the following:

- The HTF met on February 28, 2025, to review their workplan, which led to a spirited discussion about the lack of good data that speaks to the needs of people living with HIV (PLWHA) in LAC (not just those who are RWP clients) and the siloed housing systems to address homelessness. The HTF will develop a housing-specific needs assessment and plan for a convening of representatives from various housing players in the County and neighboring cities to understand the multiple pathways to housing that may be leveraged and coordinated with RW-funded services for expanded access and impact.

- The HTF asks all to share data and/or studies specific to PLWH who are experiencing homelessness or at risk for homelessness with the HTF to help paint a clearer picture of documentable needs of PLWH in LAC, in addition to those who are in the RW care system. The HTF asks all to join the next HTF meeting via Webex on March 28, 2025, from 9 am to 10:30 am.
- The link to the February 28, 2025, meeting packet can be found **HERE.**

6. MANAGEMENT/ADMINISTRATIVE REPORTS - II

A. Los Angeles County Department of Public Health Report

Mario J. Perez, Director, Division of HIV and STP Programs (DHSP), highlighted the following: (1) DHSP is trying to maintain a continuum of services in an era of substantial stress, (2) DHSP has shared their current contract levels and revenue streams with PP&A, (3) DHSP has invited currently contracted HIV care service providers to join them for a conversation on March 25th to solicit feedback on how to maintain quality care and services to the communities served despite funding cutbacks and current spending patterns, and (4) the presentation will display how DHSP allocated resources in response to the core medical services, Request for Proposals (RFP), Ambulatory Outpatient Medical (AOM) services and Medical Care Coordination (MCC) services, and their approach to the funding level decisions that was approved by the Board of Supervisors offices.

M. Perez added that the House approved a continuing resolution to fund the federal government through the end of September 2025 and approved budget language outlining how much money can be spent; however, the House did not report language which specifically identifies how much money should be spent in particular areas (ex: how much funding should go to the Centers For Disease Control, how much should go to the Health Resources and Services Administration, etc.).The concern lies in how budgets are approved that do not have a level of specificity; as such, DHSP will keep a watchful eye on what is happening at the federal level.

At this time, DHSP does not have information regarding full funding for the current Ryan White program year (PY 35) that started March 1st.

M. Perez introduced DHSP staff Sona Oksuzyan, MD, PhD, MPH and Janet Cuanas, MPH, who presented the Ryan White Program Utilization Summary, Program Year 33 as follows:

- There are separate reports for core and support services categories to better inform activities.
- The report was restructured to track utilization across the priority populations: Latinx Men Who Have Sex With Men (MSM), Black MSM, Cisgender Women of Color, Transgender Persons, Youth (29 years and younger), 50+ PLWH, Persons Who Inject Drugs (PWID), and Unhoused RWP Clients.
- Core Service Categories: AOM, MCC, oral health (general and specialty), Home-Based Case Management (HBCM), and mental health.
- Support Services: Emergency Financial Assistance (EFA), housing services, Non-Medical Case Management (NMCM), and nutritional services.

- RWP Report Framework, Data Sources: HIV Casewatch, HIV surveillance, and DHSP expenditure reports
- RWP Report Framework, Outcomes: engagement in care, retention in care, and viral suppression
- Starting with Program Year 30, utilization has stayed consistent. There was a slight dip in Program Year 32 and in Program Year 33, the numbers started to increase. In PY 33, approximately 9,300 clients used RW services quarterly. Overall, 15,822 clients used RW services in PY 33.
- Many clients were identified as male, over half were Latinx , and 2 out of 5 were 50 years and older.
- RWP expenditures by source funding for PY 29-33: total expenditures increased overall, Part A expenditures gradually increased, MAI expenditures varied due to carryover strategies, Part B was stable, and other expenditures varied.
- The costliest RWP service category was housing, and the least costly was NMCM.
- Summary of the responses to the questions asked: (1) information is collected via RWP clients self-reporting, (2) collection of information on gender and sex at birth is standardized by the Department of Public Health (DPH) of Los Angeles County (LAC) and DPH developed guidelines for standard collection and reporting of sexual orientation and gender identity (SOGI) in 2022, (3) gender identity is reported as: male, female, transgender male, transgender female, Gender Non-conforming, and prefer not to answer, (4) sexual orientation is reported as: sexual orientation should be reported as: gay or lesbian, bisexual, straight or heterosexual, something else:_____, don't know, or prefer not to state, (5) DHSP does not follow-up on a client's gender identity, however, providers will update gender identity or if a client expresses their identity needs to be changed it will be updated, and (6) current RW legislation does not say anything about qualification for services based on immigration status; if a client meets eligibility criteria they can receive RWP services.
- Please refer to the meeting packet for the complete presentation.

B. California Office of AIDS (OA) Report (Part B Representative)

(1) **OA Voice Newsletter Highlights.** Karl Halfman directed all to the report in the meeting packet and reported that the OA is expecting their new data system to roll out on April 7th. K. Halfman stated that he would share the Medicaid data mentioned in today's meeting with division leadership.

(2) California Planning Group (CPG). No report provided.

C. Housing Opportunities for People Living with AIDS (HOPWA) Report

Matthew Muhonen provided the HOPWA report as follows:

- In reference to last month's comment regarding trans youth and the lack of services available to them, HOPWA is talking with their service providers about ways to focus on this population and the senior population, such as using current contracts and not having to issue an RFP to form new programs, scattered site master leasing, and other supportive services.
- Due to federal budget cuts, HOPWA has lost all its technical assistance support through the HUD Exchange website. HOPWA is working to obtain an emergency sole source by the next program year that begins July 1st, to have its technical assistance reinstated.
- HOPWA will expand its scattered site leasing and Tenant-Based Rental Assistance (TBRA) programs and the

supportive services that go along with these programs at the beginning of the next program year.

- HOPWA is finishing its program audits and the monitoring of its contractors.
- HOPWA is expected to receive current program year funding in May.
- A request was made for HOPWA to present monthly data, such as the number of people who were housed, versus yearly data.

D. Ryan White Program (RWP) Parts C, D, and F Report

Part C: Dr. L. Maultsby reported that Charles Drew University's (CDU) Ryan White Program Services Report (RSR) is due March 30th. A well-attended CFAR CAB was held on March 4th, great feedback was received, and they are anticipating holding another CAB event next year. Additionally, Dr. Maultsby recommended using Project Officers as a source of information.

Part D: Dr. M. Cielo reported that they are preparing for an upcoming HRSA site visit and shared that the funding for UCLA's peer support program, Friends Helping Friends, is ending; they will continue to file claims through April.
Part F: No report provided.

E. Cities, Health Districts, Service Planning Area (SPA) Reports.

City of Los Angeles: Dahlia Alé-Ferlito reported that the City of L.A. received additional mid-year budget reductions but was able to identify internal resources to preserve services. Additionally, the city was notified of 77 federal grants in 7 departments that have been canceled, and 27 federal grants in 5 departments that have been postponed.

City of Long Beach: Ismael Salamanca reported that the Long Beach Comprehensive HIV Planning Group has a PrEP and PEP work group and a Transgender Wellness work group that meets quarterly, and a monthly Syringe Services PrEP work group. Long Beach has a Harm Reduction program that provides free Narcan testing strips, and they are working to provide vending machines. Long Beach's Trans Day of Visibility is on March 30th at Bixby Park, and the Long Beach PRIDE is being held May 17th – 18th.

City of West Hollywood: D. Saunders reported: (1) the City of West Hollywood is holding its HIV-prevention providers meeting on April 23rd, (2) RFPs open in April and close in June, and (3) vendor applications are being accepted for WeHo PRIDE.

City of Pasadena: E. Davies reported Pasadena is closing its satellite site at Bethel Church in March. Outreach services will continue for various at-risk populations through the combined efforts of the Pasadena Outreach Team, mental health promoters, and city prevention counselors. Additionally, Nathan Press has been hired as the new division manager for social-mental health services.

7. MISCELLANEOUS

D. Public Comment. ***(Opportunity for members of the public to address the Commission of items of interest that are within the jurisdiction of the Commission. For those who wish to provide public comment may do so in person, electronically HERE, or by emailing hivcomm@lachiv.org. If providing oral public comments, comments may not exceed 2 minutes per person.)***

- K. Donnelly attended the SPA 2 Provider Consortium. Gilead liaison, Michael Barajas, provided an update about their prevention portfolio. The SPA 2 consortium is going strong.
- A. Burton attended the E5 Conference along with other commissioners. A. Burton encouraged commissioners to speak more about the value of research.
- Lambert Talley provided words of encouragement to overcome adversities and challenges.

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

No Commission New Business Items.

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

- Session 5 of the Confessions podcast is now available.
- Andre Molette shared that Men's Health Foundation is holding a brunch on Saturday March 29th from 11 am -2: 30 pm, Rise Up Women Together, in honor of NWGHAAD.
- C. Navarro announced the following: (1) Mariachi Fiesta on March 13th in West Hollywood at Plummer Park, starting at 6:30 pm, (2) Qiki Gala X Art Show on March 16th, from 6 pm – 10 pm at the Transgender Empowerment Center, (3) the Queer Mercado on March 15th, from 10 am – 4 pm at the East L.A. Civic Center, and (4) Puteria on March 15th at 357 S. Broadway, starting at 9 pm.

G. Adjournment and Roll Call: Adjournment for the meeting of March 13, 2025.

The meeting adjourned at 11:56 AM. Jim Stewart conducted roll call.

ROLL CALL (PRESENT): D. Ale-Ferlito, M. Alvarez, J. Arrington, A. Burton, M. Cielo, M. Cummings, E. Davies, K. Donnelly, K. Ferguson, A. Frames, F. Gonzalez, D. Hardy, K. Halfman, I. Herrera, L. Martinez-Real, L. Maultsby, V. Mendoza, K. Nelson, B. Patel, M. Perez, E. Robinson, D. Russell, I. Salamanca, S. Samone-Loreca, D. Saunders, L. Spencer, K. Stalter, L. Talley, C. Vega-Matos, J. Weedman, R. Ybarra, D. Campbell, and J. Green.

MOTION AND VOTING SUMMARY		
MOTION 1: Approve meeting agenda, as presented or revised.	Passed by Consensus.	**MOTION PASSED**
MOTION 2: Approve the August 8, 2024, Commission on HIV meeting minutes, as presented or revised.	Passed by Consensus.	**MOTION PASSED**
MOTION 3: Approve Consent Calendar, as presented or revised.	Passed by Consensus.	**MOTION PASSED**
MOTION 4: Approve Ryan White Program PY 35-37 Directives, as presented or revised.	Summary of votes: Yes: D. Ale-Ferlito, M. Alvarez, A. Burton, D. Campbell, M. Cielo, M. Cummings, E. Davies, K. Donnelly, K. Ferguson, J. Green, F. Gonzalez, L. Martinez-Real, L. Maultsby, V. Mendoza, D. Saunders, J, Weedman, R. Ybarra No: None. Abstain: J. Arrington, G. Green, A. Frames, K. Halfman, I. Herrera, T. Jones, A. Molette, B. Patel, E. Robinson, D. Russell, I. Salamanca, L. Talley.	**MOTION PASSED**

MOTION AND VOTING SUMMARY		
MOTION 5: Approve 2025 Public Policy Priorities, as presented or revised.	Passed by Consent Calendar.	**MOTION PASSED**

Addendum to Agenda Item # 3B (5)
National Women and Girls' HIV/AIDS Awareness Day (NWGHAAD)

Leslé Honoré Poetry

This is for the women
With 9 to 5s
And 7 to 3s
First shifts
And graveyard
With full times
And part times
Who have more month left
Than money
But still make rent
With passports
With no stamps
With vision boards
Of destinations
They are saving to see
With dreams they tuck away
Pull out late at night
Or early in the morning
While the babies are still sleep
Turn it over in their hands
Then shelve it again for safe keep
This is for the women
Without titles without pensions
With some college
A lot of loans
With late night classrooms
Online studies
Who won't give up
Who run the world
On grit and perseverance
This is for the women
Who are anything but
Ordinary
But the world sees as regular
This is for the magicians
Who weave spells of hope
For their children
While putting their hopes on pause
This is for the over the counter
Beauty Queens
With Wet and Wild Lips
And Walgreens legs

And Suave smelling hair
For the women who look in the mirror
To see some one familiar
Because they rarely see reflections
Anywhere
For the hustlers
With tired feet
And tired backs
With spirits whispering
Keep moving
We are almost there
For the women who know
Liberation isn't found in the clothes they wear
The shoes on their feet
But the dignity in their souls
This is a song for you
Resourceful
And resilient
Moving mountains for your family
I see you
Stunning and Strong
I see you
Brilliant and beautiful
I see you
Making a life
Out of thin air
Today is for you
An ordinary day
Unmarked on the calendar
No songs to commemorate
Just an ordinary day
Full of promise
Full of possibilities
Full of hope
Full of magic
Just like you
You who pushes on
You who doesn't give up
You who bends but doesn't break
You
This is for you
You with the stars in your hair
Sun on your lips
Moonlit cheeks

Addendum to Agenda Item # 3B (5)
National Women and Girls' HIV/AIDS Awareness Day (NWGHAAD)

This is for you
You are anything but regular
You are the
UNIVERSE

PRIORITY SETTING AND RESOURCE ALLOCATION (PSRA) KEY POINTS AND REMINDERS

LOS ANGELES COUNTY
COMMISSION ON HIV

The Commission's Responsibility

- Priority setting and resource allocations
  - The Commission allocates Ryan White funds to specific service categories.

- DHSP is responsible for awarding, managing, and monitoring contracts.

Ryan White is a payor of last resort.

What is Priority Setting and Resource Allocation (PSRA)?

- The most important decision-making responsibility for Commissioners
- Led by the Planning, Priorities and Allocations Committee (PP&A).
- Decisions on priority setting and resource allocations must be based on data and *not* anecdotal information, impassioned pleas or personal and/or agency agendas.
- Serve the greatest number of PLWH possible, given the available resources.

LOS ANGELES COUNTY
COMMISSION ON HIV

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

POLICY/ PROCEDURE:	NO. 09.5203	Priority Setting and Resource Allocations (PSRA) Framework and Process

APPROVED 7.11.24

SUBJECT: The Commission's Priority Setting and Resource Allocations (PSRA) framework, process and specifics.

PURPOSE: To outline the Commission's service prioritization and resource allocations process, as mandated by the Ryan White Treatment Modernization Act (Ryan White) and Los Angeles County Charter Code 3.29.

BACKGROUND:

- Service prioritization and resource allocations are two of the Part A planning councils' chief responsibilities, detailed specifically in Ryan White legislation and confirmed in County Charter Code.

- In accordance with Health Resources and Services Administration (HRSA) guidance, the Commission sets service priorities based on consumer need and determines allocations from priorities and other factors such as service capacity, other sources of funding, service utilization and cost-effectiveness.

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

POLICY:

- This policy outlines the Priority Setting and Resource Allocation (PSRA) process used to

- prioritize services and allocate resources—in accordance with governing Ryan White and County code legislation—encompassing the specific partners, responsibilities, steps, tasks, and timelines associated with the process.

- The PSRA process is led by the Commission's Planning, Priorities and Allocations (PP&A) Committee. The Division of HIV and STD Programs (DHSP) provides critical information; consumer input is collected through the Comprehensive HIV Plan and other assessments; and provider input is collected through focus forums, surveys, and Commission participation.

- The policy details the expectations and timing of stakeholder involvement in the multi-year Ryan White Part A funding cycle determined by the HRSA Ryan White HIV/AIDS Program (RWP). The process allows for ongoing stakeholder input at several key junctures. Multi-year allocations are intended to conclude prior to the submission of the RWP Part A application. Allocations are reviewed annually to ensure alignment with and responsiveness to community needs and funding requirements.

A. **Priorities and allocations are data based**. Decisions are based on the data, not on personal preferences. Commissioners should avoid presenting anecdotal information or personal experiences during the decision making, focusing on needs assessments, and cost/service utilization data rather than a single person's experience.

B. **Conflicts of interest are stated and followed.** Commission members must state areas of conflict according to the approved Conflict of Interest Policy at the beginning of meetings. As stated in the RWHAP Part A Manual, X. Ch 8. Conflict of Interest, p. 147, Conflict of Interest can be defined as an actual or perceived interest by the member in an action that results or has the appearance of resulting in a personal, organizational, or professional gain. The definition may cover both the member and a close relative, such as a spouse, domestic partner, sibling, parent, or child. This actual or perceived bias in the decision-making process is based on the dual role played by a planning council member who is affiliated with other organizations as an employee, a board member, a member, a consultant, or in some other capacity. Any funded RWHAP Part A provider must declare all funded service categories (e.g., areas of conflict of interest) at the beginning of the meeting(s). They can participate in discussions, answer questions directed by other members, and can vote on priorities and allocations presented as a slate.

C. The data provide the basis for changes in **priorities or allocations from the previous year**. The data indicate changes in service needs/gaps and availability based on information from the various data sources.

D. **Needs of specific populations and geographic areas** are an integral part of the discussion in the data presentations and the decision making. They may also lead to recommendations to the Recipient on how best to meet the priorities.

E. **Final vote** on the complete priorities and allocations will be presented by the Planning, Priorities and Allocations Committee Co-Chairs to the full planning council for a roll-call vote. Commissioners must complete the required annual Priority Setting and Resource Allocation training prior to voting. Commissioners must notify staff once training is complete and a record of the completed training will be kept on file by Commission staff. Commissioners who have not completed the training are not eligible to vote. *Planning, Priorities and Allocations Committee-only members must also complete the annual Priority Setting and Resource Allocation training. Training materials can be found on the Commission website at: https://hiv.lacounty.gov/events-training/.

F. **Paradigms and operating values** are selected and used by the PP&A Committee to help guide their decision-making in setting service priorities and resource allocations. The PP&A Committee reviews the paradigms and operating values selected and approved from the previous year as the foundation for current year PSRA process or reallocations. (Attachment 1)

G. **The Commission's Status Neutral HIV and STI Delivery System framework** is used by the PP&A Committee to ensure that service priorities and resources allocations emphasizes high-quality care to engage and retain people in services regardless of if the services are for HIV treatment or prevention. This approach continually addresses the healthcare and social service needs of all people affected by HIV so that they can achieve and maintain optimal health and well-being. (Attachment 2)

H. Decisions should help to ensure **parity in access to care**, for all Ryan White-eligible HIV/AIDS population groups and for PLWH/A regardless of where they live in the County.

I. Discussions and decisions should have a major focus on **improving performance on the HIV Care Continuum/Treatment Cascade,** focusing on areas of concern – such as linkage to care or retention in care. Reducing unmet need (the number of people who know they are HIV-positive but are not in care) requires deciding how many "new" or "lost to care" clients should be identified, estimating the mix of services they will need from RWHAP Part A, and allocating funds sufficient to meet those needs. Where a choice needs to be made between providing a wider range of services to more individuals and getting additional people into care, the Planning Council will give priority to getting more people key services (among them primary care and medications).

J. The Commission members will keep in mind current goals, objectives, and priorities from its **Comprehensive HIV Plan (CHP)** to be sure they receive appropriate attention in decision making.

PROCEDURE(S):

1. The priority setting process should consider services needed to provide and/or support a continuum of care, regardless of how these services are being funded and the extent of unmet demand for these services. Funding availability and unmet needs associated with these service priorities are considered during the resource allocation process.

2. The list of HRSA fundable service categories (core and support) and the definitions of these services will be presented by the Commission staff.

3. The list of HIV prevention categories from the most recently approved Prevention Service Standards will be presented by the Commission staff.

4. DHSP compiles service utilization reports (including, but not limited to, clients served, priority populations, expenditures per client), anticipated service delivery goals/objectives, expenditures reports, surveillance reports, prevention data (including, but not limited to, counseling and testing and PrEP and PEP utilization), and programmatic and fiscal challenges and opportunities for service improvements.

5. The PP&A Committee will consult with all Caucuses prior to the start of the annual priority setting and resource allocation process to:
   a) Gather opinions from consumers on which services should be prioritized and how resources should be allocated;
   b) go over the main points from the latest Ryan White Program Service Utilization Reports and HIV prevention data provided by DHSP;
   c) Look at the most recent financial reports on HIV prevention and care from DHSP;
   d) Examine the main goals, objectives, and measures from important documents like the Comprehensive HIV Plan and Ending the HIV Epidemic Plan:

6. The PP&A Committee formally organizes focus groups at various provider stakeholder meetings or conducts provider surveys as needed to inform the PSRA process.

7. During July-August, the PP&A Committee deliberates and prioritizes services categories in rank order (highest need is #1 priority). The principal data and information used for priority-setting are the Comprehensive HIV Plan, relevant needs assessment, the HIV epidemiology report, fiscal and programmatic reports, and service utilization reports.
   a) The PP&A Committee only ranks service priorities once—regardless of funding scenario—as they indicate the services most needed regardless of changes in the funding picture or in which different resources available.
   b) The PP&A Committee compiles and/or reviews the data and feedback it has collected from DHSP, community listening sessions and/or surveys and reviews it in June, prior to service prioritization.

8. During July-August after the service categories have been ranked and prioritized, the PP&A Committee determines resource allocations for services:
   a) Allocations can be made by actual amounts or percentages based on specific expenditure proposals, although percentages allow more flexibility to respond to variances in the funding awards.
   b) Allocations may change in each of the selected funding scenarios.
   c) It is strongly encouraged that stakeholders who suggest funding allocations for specific service categories also present accompanying recommendations to advise how the continuum of care will accommodate those suggested modifications to funding levels.
   d) Additional streams of funding are identified in each service category, with amounts locally dedicated for HIV services where the information is available.
   e) The PP&A Committee, in collaboration with DHSP, compiles a resource inventory for allocation-setting, and uses it to help determine capacity and other resources when allocating funds.

9. The PP&A Committee recommends and secures approval for service priorities and funding allocations at the August or September Commission meeting, prior to the RWP Part A grant application submission deadline and/or annual report and program terms report.

10. When a reallocation of funds is necessary, adequate data to support the movement of funds between service categories will be presented, considered, and fully documented in the minutes of the meeting during which the reallocation of funds is approved. Proposed re-allocations must be submitted to the Commission for approval. All changes in allocations must be accompanied with a written justification detailing the reasons for the modifications. Reallocations should occur in June or July with a presentation of recommendations and memorandum from DHSP explaining the reasons for the reallocations. In alignment with County policy, the Commission grants authority to DHSP to make adjustments of 10% greater or lesser than the approved allocations amount, as expenditure categories dictate, without returning to the Commission for approval.

11. During the month (30 days) following the approval of resource allocations by Commission, the PP&A Committee will consider appeals regarding its PSRA process. Appeals must be presented to the PP&A Committee at its monthly meeting immediately following the Commission meeting in which the allocations were adopted. The following two types of appeals will be considered:
   a) new factual information that may have led to different decisions if the information had been available during the PSRA process, and/or
   b) questions or complaints about decision-making that did not conform to the process as outlined.

12. In September-November, the PP&A Committee compiles information and suggestions made throughout the PSRA process to further elaborate on its priority and allocation decisions by developing “directives.”

a) These "directives" are framed as "guidance", "recommendations", and/or "expectations" and are intended to detail "how best to meet the need" or as "other factors to be considered" to be forwarded to DHSP the Commission and/or its various committees, and/or other stakeholders, as appropriate.
b) The guidance, recommendations and expectations further define minimum quality of care standards, implementation practices and/or mechanisms to respond to specific operational or system needs.
c) Once completed and approved by the PP&A Committee, the directives are forwarded to the Executive Committee and the Commission for approval.
d) The approved directives are transmitted to DHSP for consideration and implementation if deemed to be feasible by DHSP. DHSP will review the directives and provide a written response to the PP&A Committee which recommendations are feasible with a timeline for implementation.
e) DHSP shall provide periodic updates at PP&A Committee meetings.

13. In addition to its other business, the PP&A Committee devotes the intervening months between each year's PSRA process to further study identified service categories, populations and/or related planning issues, and implements committee activities accordingly to compile the necessary data.

NOTED AND APPROVED: _____ **EFFECTIVE DATE:** _____

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
PARADIGMS AND OPERATIONG VALUES
(Amended Draft - PP&A 04/20/2021)

PARADIGMS (Decision-Making)

- Equity: Allocate resources in a manner that address avoidable or curable differences among groups of people, whether those groups are defined by ethnicity, socially, economically, demographically, or geographically. (1)
- ***Compassion: response to suffering of others that motivates a desire to help.*** (2)

OPERATING VALUES

- Efficiency: accomplishing the desired operational outcomes with the least use of resources
- Quality: the highest level of competence in the decision-making process
- Advocacy: addressing the asymmetrical power relationships of stakeholders in the process
- Representation: ensuring that all relevant stakeholders/constituencies are adequately represented in the decision-making process
- Humility: Acknowledging that we do not know everything and ***willingness to listen carefully to others***. (3)

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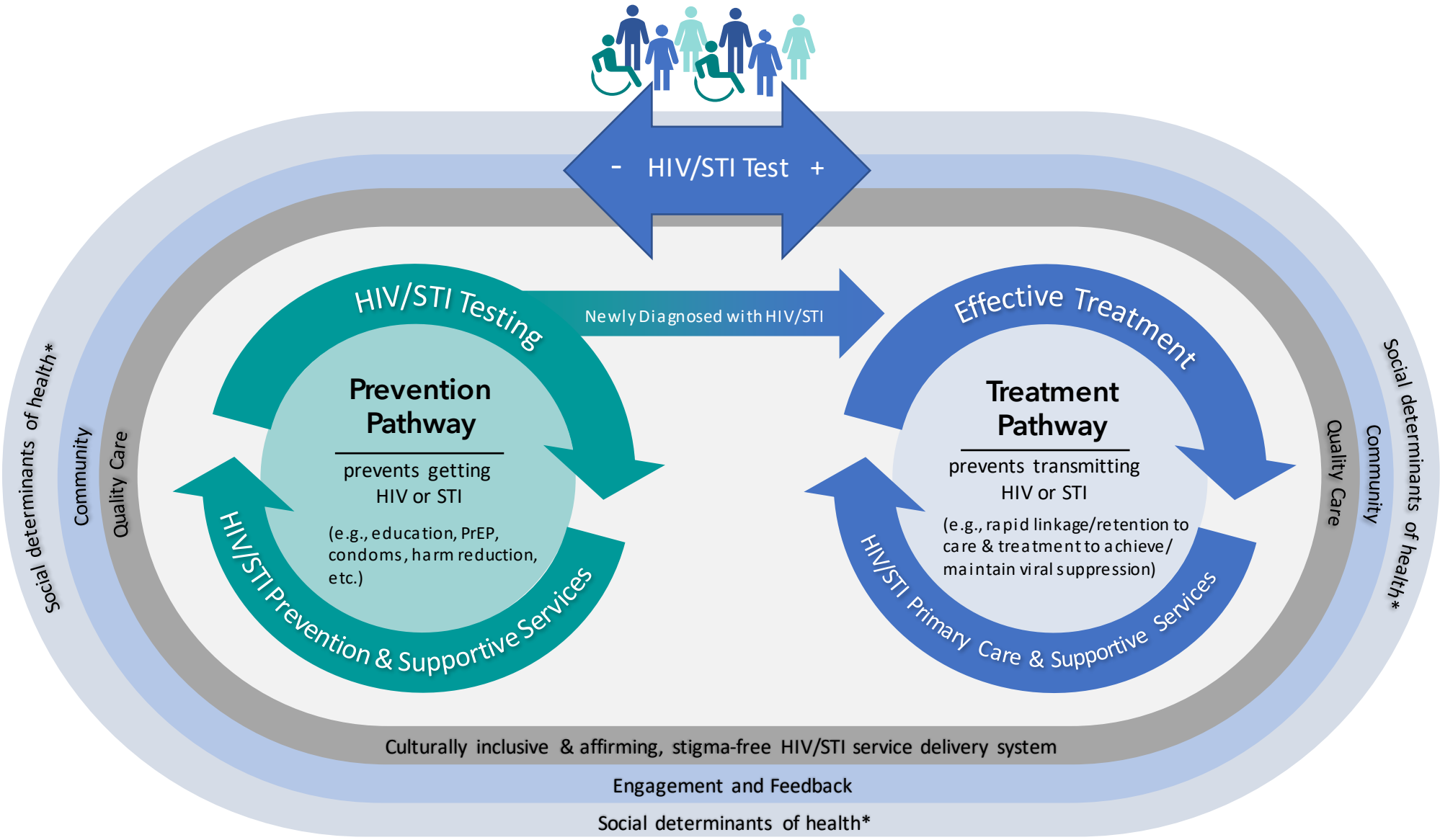
1 Based on the World Health Organization's (WHO) definition of equity.
2 Compassion moved to second position per April 20, 2021 committee meeting decision.
3 Wording change per April 20, 2021 committee meeting decision.

Status Neutral HIV and STI Service Delivery System



LOS ANGELES COUNTY COMMISSION ON HIV

Revised 10/18/23

* Social determinants of health include economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.

See Healthy People 2030 for more details on the social determinants of health.

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
PARADIGMS AND OPERATING VALUES
(Approved - PP&A 11/19/2024, Approved – COH 2/13/25)

PARADIGMS (Decision-Making)

- **Equity:** Allocate resources in a manner that address avoidable or curable differences among groups of people, whether those groups are defined by ethnicity, socially, economically, demographically, or geographically.
- **Compassion:** Response to suffering of others that motivates a desire to help.
- **Restorative Justice**: correction of past inequities[1].

OPERATING VALUES

- **Efficiency**: Accomplishing the desired operational outcomes with the least use of resources.
- **Quality**: The highest level of competence in the decision-making process.
- **Advocacy**: Addressing the asymmetrical power relationships of stakeholders in the process.
- **Representation**: Ensuring that all relevant stakeholders/constituencies are adequately represented in the decision-making process.
- **Humility**: Acknowledging that we do not know everything and willingness to listen carefully to others.
- **Access**: Assuring access to the process for all stakeholders and/or constituencies.

1. *Restorative justice seeks to examine the harmful impact of a crime and then determines what can be done to repair that harm while holding the person who caused it accountable for his or her actions. Accountability for the offender means accepting responsibility and acting to repair the harm done.*

Ryan White Program Year (PY) 35 Service Rankings and Allocations Table - Scenario #2

$8 million partial award for Part A and MAI plus $5 million for Part B = $13m Total [1]

					FY 2025 (PY 35) [2]
Service Type	**Service Ranking**	**Service Category**	**Estimated Part A & MAI PY34 Expenditures $**	**Estimated Part B PY34 Expenditures $**	**Part A, MAI, & Part B %**
Core	**6**	Medical Case Management (Medical Care Coordination)	**$ 11,660,438.00**	**$ -**	**32.30%**
Core	**8**	Oral Health	**$ 8,751,232.00**	**$ -**	**0.00%**
Core	**20**	Outpatient/Ambulatory Medical Health Services (Ambulatory Outpatient Medical)	**$ 6,860,111.00**	**$ -**	**52.31%**
Core	**11**	Early Intervention Services (Testing Services)	**$ 2,332,127.00**	**$ -**	**0.00%**
Core	**17**	Home and Community-Based Health Services	**$ 2,345,241.00**	**$ -**	**0.00%**
Support	**2**	Emergency Financial Assistance	**$ 1,539,288.00**	**$ -**	**0.00%**
Support	**7**	Nutrition Support (Food Bank/Home-delivered Meals)	**$ 2,783,905.00**	**$ -**	**0.00%**
Support	**5**	Non-Medical Case Management			
		Benefits Specialty Services	**$ 1,517,835.00**	**$ -**	**11.54%**
		Transitional Case Management - Jails	**$ 26,720.00**	**$ -**	**0.00%**
Support	**10**	Medical Transportation	**$ 715,013.00**	**$ -**	**3.85%**
Support	**23**	Legal Services	**$ 1,049,695.00**	**$ -**	**0.00%**
Support	**1**	Housing		**$ 5,287,873.00**	
		Housing Services RCFCI/TRCF (Home-Based Case Management)	**$ 571,410.00**	**$ -**	**0.00%**
		Housing for Health	**$ 5,375,220.00**	**$ -**	**0.00%**
Core	**3**	Mental Health Services	**$ 85,420.00**	**$ -**	**0.00%**
Core	**9**	AIDS Drug Assistance Program (ADAP) Treatments	$ -	$ -	0.00%
Core	**22**	Local AIDS Pharmaceutical Assistance Program (LPAP)	$ -	$ -	0.00%
Core	**15**	Health Insurance Premium & Cost Sharing Assistance	$ -	$ -	0.00%
Core	**16**	Home Health Care	$ -	$ -	0.00%
Core	**28**	Hospice Services	$ -	$ -	0.00%
Core	**26**	Medical Nutritional Therapy	$ -	$ -	0.00%
Core	**12**	Substance Abuse Services Outpatient	$ -	$ -	0.00%
Support	**18**	Child Care Services	$ -	$ -	0.00%
Support	**13**	Health Education/Risk Reduction	$ -	$ -	0.00%

Los Angeles County Commission on HIV
Contingency Plan - $13 million (Approved by COH on 4/10/25)

Support	**27**	Linguistic Services (Language Services)	$ -	$ -	0.00%
Support	**14**	Outreach Services (LRP)	$ -	$ -	0.00%
Support	**4**	Psychosocial Support Services	$ -	$ -	0.00%
Support	**24**	Referral	$ -	$ -	0.00%
Support	**25**	Rehabilitation	$ -	$ -	0.00%
Support	**21**	Respite Care	$ -	$ -	0.00%
Support	**19**	Substance Abuse Residential	$ -	$ -	0.00%
		Overall Total	**$ 45,613,655.00**	**$ 5,287,873.00**	**100.00%**

Footnotes:

(1) DHSP recommended PP&A Committee to consider $5 million in Part B funds into allocations
(2) Factors taken into consideration for proposed allocations include:

- Expenditure Reports
- Utilization Reports – greatest good for the greatest number of people
- Identification of other payor sources for various funded services
- Preservation of core services, namely those unique to the Ryan White Program
- Alignment with statutory requirement of 75% of program expenditures dedicated to core services and 25% of program expenditures dedicated to support services

Ryan White Program Year (PY) 35 Service Rankings and Allocations Table (Approved by COH on 9/26/24)

			FY 2025 (PY 35) [1]	
Service Type	**Service Ranking**	**Service Category**	**Part A %**	**MAI %**
Core	**6**	Medical Case Management (Medical Care Coordination)	**29.00%**	**0.00%**
Core	**8**	Oral Health	**21.30%**	**0.00%**
Core	**20**	Outpatient/Ambulatory Medical Health Services (Ambulatory Outpatient Medical)	**17.11%**	**0.00%**
Core	**11**	Early Intervention Services (Testing Services)	**0.00%**	**0.00%**
Core	**17**	Home and Community-Based Health Services	**6.50%**	**0.00%**
Support	**2**	Emergency Financial Assistance	**8.00%**	**0.00%**
Support	**7**	Nutrition Support (Food Bank/Home-delivered Meals)	**7.79%**	**0.00%**
Support	**5**	Non-Medical Case Management		
		Patient Support Services	0.00%	0.00%
		Benefits Specialty Services	**3.95%**	**0.00%**
		Transitional Case Management - Jails	**1.58%**	**0.00%**
Support	**10**	Medical Transportation	**1.84%**	**0.00%**
Support	**23**	Legal Services	**2.00%**	**0.00%**
Support	**1**	Housing		
		Housing Services RCFCI/TRCF (Home-Based Case Management)	**0.91%**	**0.00%**
		Housing for Health	**0.00%**	**100.00%**
Core	**3**	Mental Health Services	**0.02%**	**0.00%**
Core	**9**	AIDS Drug Assistance Program (ADAP) Treatments	0.00%	0.00%
Core	**22**	Local AIDS Pharmaceutical Assistance Program (LPAP)	0.00%	0.00%
Core	**15**	Health Insurance Premium & Cost Sharing Assistance	0.00%	0.00%
Core	**16**	Home Health Care	0.00%	0.00%
Core	**28**	Hospice Services	0.00%	0.00%
Core	**26**	Medical Nutritional Therapy	0.00%	0.00%
Core	**12**	Substance Abuse Services Outpatient	0.00%	0.00%
Support	**18**	Child Care Services	0.00%	0.00%
Support	**13**	Health Education/Risk Reduction	0.00%	0.00%
Support	**27**	Linguistic Services (Language Services)	0.00%	0.00%
Support	**14**	Outreach Services (LRP)	0.00%	0.00%
Support	**4**	Psychosocial Support Services	0.00%	0.00%
Support	**24**	Referral	0.00%	0.00%
Support	**25**	Rehabilitation	0.00%	0.00%
Support	**21**	Respite Care	0.00%	0.00%
Support	**19**	Substance Abuse Residential	0.00%	0.00%
		Overall Total	**100.00%**	**100.00%**

Footnotes:

(1) Approved by PP&A Committee on 9/17/24; approved by Exec. Committee on 9/26/24: Exe. approved due to lack of quorum @ COH meeting on 9/12/24)

Green font indicates allocation increase from PY34

Red font indicates allocation decrease from PY34

Division on HIV and STD Programs Program year 34 (PY34) Expenditure Report - Part A Expenditures

Priority #	Service Category	YR 34 Allocation Percentages	Year 34 Commission Allocations	YTD Actual	Full Year Estimate	Estimated Year 34 Expenditure Percentages	Variance Full Year Estimate vs. COH Allocations
			[1]	*[2]*	*[3]*	*[4]*	*[1-3]*
	CORE SERVICES						
3	OUTPATIENT/AMBULATORY MEDICAL CARE	17.11%	6,500,000	$ 4,543,129	$ 6,860,111	18.05%	$ (360,111)
13	ORAL HEALTH CARE	20.79%	7,900,000	6,068,278	8,751,232	23.03%	$ (851,232)
18	HOME AND COMMUNITY-BASED HEALTH SERVICES	6.50%	2,470,000	2,093,866	2,345,241	6.17%	$ 124,759
6	MEDICAL CASE MANAGEMENT SERVICES (MCC)	27.15%	10,316,352	9,754,986	11,660,438	30.69%	$ (1,344,086)
7	MENTAL HEALTH SERVICES	0.29%	110,000	81,352	85,420	0.22%	$ 24,580
23	MEDICAL NUTRITION THERAPY	0.00%	-	-	-	0.00%	$ -
10	EARLY INTERVENTION SERVICES (PH STD Clinic)	6.58%	2,500,000	1,947,287	2,332,127	6.14%	$ 167,873
	CORE SERVICES TOTAL	**78.41%**	**$ 29,796,352**	**$ 24,488,898**	**$ 32,034,569**	**84.31%**	**$ (2,238,217)**
	SUPPORTIVE SERVICES						
14	CHILD CARE SERVICES	0.00%	-	-	-	0.00%	$ -
2	CASE MANAGEMENT SERVICES NON-MEDICAL (BSS)	3.95%	1,500,000	1,322,942	1,517,835	3.99%	$ (17,835)
22	LINGUISTIC SERVICES	0.00%	-	664	664	0.00%	$ (664)
11	MEDICAL TRANSPORTATION SERVICES	1.63%	620,000	617,243	715,013	1.88%	$ (95,013)
12	FOOD BANK (NSS)[2]	5.79%	2,200,000	2,473,565	2,783,905	7.33%	$ (583,905)
1	HOUSING SERVICES (TRCF/RCFCI) (THAS)	0.91%	344,000	557,738	571,410	1.50%	$ (227,410)
15	LEGAL SERVICES	1.42%	538,000	962,220	1,049,695	2.76%	$ (511,695)
4	EMERGENCY FINANCIAL ASSISTANCE (EFA)[3]	6.32%	2,400,000	1,539,288	1,539,288	4.05%	$ 860,712
2	NMCM (TCM Jails) 6 medical case workers and 1 HPA I	1.58%	600,000	6,680	26,720	0.07%	$ 573,280
8	OUTREACH SERVICES (LRP)	0.00%	-	-	-	0.00%	$ -
	SUPPORTIVE SERVICES TOTAL	**21.59%**	**8,202,000**	**7,480,340**	**8,204,530**	**21.59%**	**(2,530)**
	DIRECT SERVICES TOTAL	**100.00%**	**37,998,351**	**28,083,483**	**40,239,099**	**105.90%**	**(2,240,748)**
	QUALITY MANAGEMENT	0.00%	500,001	911,161	1,251,836	2.93%	$ (751,835)
	ADMINISTRATIVE SERVICES (includes Planning Council/A	10.00%	4,277,594	7,410,098	4,277,594	10.00%	$ -
	QM & ADMIN TOTAL	**10.00%**	**4,777,595**	**8,321,259**	**5,529,430**	**12.93%**	**(751,835)**
	PART A GRAND TOTAL	**110.00%**	**42,775,946**	**40,290,497**	**45,768,529**	**118.82%**	**(2,992,583)**

Notes:

(1) Allocation based on priorities set by HIV Commission. Actual YR 34 grant award is **$42,775,946**

(2) Home-delivered Meals for Year 34 funded through HRSA EHE

(3) EFA expenditures shown represent March 1, 2024 - May 31, 2024. Additional funding for Emergency Rental Assistance through HRSA EHE

Division on HIV and STD Programs Program year 34 (PY34) Expenditure Report - Minority AIDS Initiative (MAI) Expenditures

Priority #	Service Category	YR 34 Allocation Percentages	Year 34 Commission Allocations	YTD Actual	Full Year Estimate	Estimated Year 34 Expenditure Percentages	Variance Full Year Estimate vs. COH Allocations
			[1]	*[2]*	*[3]*	*[4]*	*[1-3]*
	CORE SERVICES						
3	OUTPATIENT/AMBULATORY MEDICAL CARE	0.00%	-	$ -	$ -	0.00%	$ -
13	ORAL HEALTH CARE	0.00%	-	-	-	0.00%	$ -
18	HOME AND COMMUNITY-BASED HEALTH SERVICES	0.00%	-	-	-	0.00%	$ -
6	MEDICAL CASE MANAGEMENT SERVICES (MCC)	0.00%	-	-	-	0.00%	$ -
7	MENTAL HEALTH SERVICES	0.00%	-	-	-	0.00%	$ -
23	MEDICAL NUTRITION THERAPY	0.00%	-	-	-	0.00%	$ -
10	EARLY INTERVENTION SERVICES (PH STD Clinic)	0.00%	-	-	-	0.00%	$ -
					-		
	CORE SERVICES TOTAL	**0.00%**	**$ -**	**$ -**	**$ -**	**0.00%**	**$ -**
	SUPPORTIVE SERVICES						
14	CHILD CARE SERVICES	0.00%	-	-	-	0.00%	$ -
2	CASE MANAGEMENT SERVICES NON-MEDICAL (BSS)	0.00%	-	-	-	0.00%	$ -
22	LINGUISTIC SERVICES	0.00%	-	-	-	0.00%	$ -
11	MEDICAL TRANSPORTATION SERVICES	0.00%	-	-	-	0.00%	$ -
12	FOOD BANK (NSS)	0.00%	-	-	-	0.00%	$ -
1	HOUSING SERVICES (Transitional Housing)	100.00%	3,305,358	4,031,415	5,375,220	162.62%	$ (2,069,862)
15	LEGAL SERVICES	0.00%	-	-	-	0.00%	$ -
4	EMERGENCY FINANCIAL ASSISTANCE (EFA)	0.00%	-	-	-	0.00%	$ -
2	NMCM (TCM Jails) 6 medical case workers and 1 HPA I	0.00%	-	-	-	0.00%	$ -
8	OUTREACH SERVICES (LRP)	0.00%	-	-	-	0.00%	$ -
	SUPPORTIVE SERVICES TOTAL	**100.00%**	**3,305,358**	**4,031,415**	**5,375,220**	**162.62%**	**(2,069,862)**
	DIRECT SERVICES TOTAL	**100.00%**	**3,305,358**	**4,031,415**	**5,375,220**	**162.62%**	**(2,069,862)**
	ADMINISTRATIVE SERVICES	10.00%	367,569	416,179	367,292	10.00%	$ 277
	MAI ADMIN TOTAL	**10.00%**	**367,569**	**416,179**	**367,292**	**10.00%**	**277**
	PART A GRAND TOTAL	**110.00%**	**3,672,927**	**4,447,594**	**5,742,512**	**172.62%**	**(2,069,585)**

Notes:

(1) Allocation based on priorities set by HIV Commission. Actual YR 34 grant award is **$3,672,927**

Division on HIV and STD Programs Program year 34 (PY34) Expenditure Report - Part B Expenditures

Priority #	Service Category	YTD Actual	Full Year Estimate
	CORE SERVICES		
3	OUTPATIENT/AMBULATORY MEDICAL CARE	$ -	$ -
13	ORAL HEALTH CARE	-	-
18	HOME AND COMMUNITY-BASED HEALTH SERVICES	-	-
6	MEDICAL CASE MANAGEMENT SERVICES (MCC)	-	-
7	MENTAL HEALTH SERVICES	-	-
23	MEDICAL NUTRITION THERAPY	-	-
10	EARLY INTERVENTION SERVICES (PH STD Clinic)	-	-
			-
	CORE SERVICES TOTAL	**$ -**	**$ -**
	SUPPORTIVE SERVICES		
14	CHILD CARE SERVICES	-	-
2	CASE MANAGEMENT SERVICES NON-MEDICAL (BSS)	-	-
22	LINGUISTIC SERVICES	-	-
11	MEDICAL TRANSPORTATION SERVICES	-	-
12	FOOD BANK (NSS)	-	-
1	HOUSING SERVICES (Substance Use Transitional Housing)	812,475	891,175
1	HOUSING SERVICES (RCFCI/TRCF)	4,027,286	4,396,698
15	LEGAL SERVICES	-	-
4	EMERGENCY FINANCIAL ASSISTANCE (EFA)	-	-
2	NMCM (TCM Jails) 6 medical case workers and 1 HPA I	-	-
8	OUTREACH SERVICES (LRP)	-	-
	SUPPORTIVE SERVICES TOTAL	**4,839,761**	**5,287,873**
	DIRECT SERVICES TOTAL	**4,839,761**	**5,287,873**
	ADMINISTRATIVE SERVICES	419,997	576,134
	Part B ADMIN TOTAL	**419,997**	**576,134**
	PART B GRAND TOTAL	**5,259,758**	**5,864,007**

Division on HIV and STD Programs Program year 34 (PY34) Expenditure Report - HRSA Ending the HIV Epidemic (EHE) Expenditures

Service Category	YTD Actual	Full Year Estimate
	[2]	*[3]*
STREET MEDICINE PROGRAM	$ 2,388,566	$ 2,388,566
MENTAL HEALTH SERVICES (Spanish Telehealth Mental Health)	269,143	269,143
EARLY INTERVENTION SERVICES (Partner Services, HIV Rapid Tests)	1,703,447	1,703,447
EHE INNOVATION AWARDS	1,656,394	1,656,394
EHE MINI GRANTS	110,365	110,365
EHE PRIORITY POPULATIONS	3,189,074	3,189,074
MEDICAL TRANSPORTATION SERVICES	17,678	17,678
HOME DELIVERED MEALS (NSS)	1,241,912	1,241,912
FOOD BANK GIFT CARDS	1,417,344	1,417,344
EMERGENCY RENTAL ASSISTANCE	1,228,161	1,228,161
FLEX (Guaranteed Gift Cards)	3,659,160	3,659,160
DARE2Care (Data-to-Care)	727,393	875,241
RAPID AND READY (Linkage-to-Care)	324,924	324,924
OUTREACH SERVICES (LRP)	836,247	836,247
DIRECT SERVICES TOTAL	**18,769,808**	**18,917,656**
e2LA DATA SYSTEM	564,323	564,323
THIRD-PARTY ADMINISTRATOR (EHE Services)	2,475,915	2,475,915
RYAN WHITE SERVICES MEDIA CAMPAIGN	1,334,546	1,334,546
OTHER COSTS	**4,374,784**	**4,374,784**
ADMINISTRATIVE/PLANNING 7 EVALUATION SERVICES	1,835,430	1,835,430
HRSA EHE ADMIN/PLANNING & EVAL TOTAL	**1,835,430**	**1,835,430**
HRSA EHE GRAND TOTAL	**24,980,022**	**25,127,870**

ASSESSMENT OF FULL YEAR ESTIMATE COMPARED TO GRANT AMOUNT AVAILABLE FOR DIRECT SERVICES

Grant	Grant Amount Available for Direct Services	Year End Estimate for Direct Services	Variance
Part A	$37,998,351	$40,239,099	$2,240,748
MAI	$3,305,358	$5,375,220	$2,069,862
Part B	$5,287,873	$5,287,873	$0
HRSA EHE*	$16,244,557	$23,144,592	$6,900,035
Total	$62,836,139	$74,046,784	**$11,210,645**

**includes FY 2020 - 2023 carryover of $9,536,247 and FY 2024 available services funding of $6,708,310.*

HIV Care and Treatment Services Investments 2025-2026

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

April 10, 2025

Meeting Agenda

I. Welcome and Opening Remarks
II. Anticipated Resources for 2025-2026
III. Financial Overview
- Service Expenditures vs. Available Resources
- Contract Obligations and Financial Commitments

IV. RWP Client Data and Service Expenditures for YR 33 (FY 2023-2024)
V. Summary Discussion

Welcome: Adapting and Coalescing in Uncertain Times

Overview of and HIV Care and Treatment and HIV and STD Prevention Resources

FY 2023 and FY 2024 and Projected FY 2025 Overall DHSP Funding for Contractual and Direct Prevention and HIV Care and Treatment Services

	FY 2023	FY 2024	FY 2025
PREVENTION	$31.6 M	$29.9 M	$0 M- $25 M
RWP CARE AND TREATMENT	$49.5 M	$52.7 M	$13.4 M- $59.9 M

Overview of HIV Care and Treatment Resources

FY 2025 RWP Care and Treatment Services Funding Sources

Federal

HRSA
Health Resources & Services Administration

Part A/MAI
EHE

State

CDPH
California Department of Public Health

Part B

Local

County of Los Angeles Public Health

HIV NCC

FY 2025 Federal Funding Overview

HRSA
Health Resources & Services Administration

RWP Part A/MAI
Resources for Contractual and Direct Services:
$7M - $43 M

RWP Part A/Minority AIDS Initiative

- 3 separate awards
  - Formula
  - Supplemental
  - MAI
- 3-year funding cycle
- Competitive application
- Funds can only be used for PCN 16-02 service categories
- DHSP's largest source of revenue
- Stable funding over the past decade

FY 2025 State Funding Overview

Part B Resources for Contractual and Direct Services: $6.4 M

Part B

- Funds can only be used for PCN 16-02 service categories
- Historically supported Fee-for-Service contracts such as AOM, RCFCI, TRCF, SU Treatment Residential, etc.

FY 2025 RWP Care and Treatment Services Funding Status

- Great uncertainty from federal agencies
- Currently have **partial** notices of awards for HRSA Part A Formula, MAI
- Availability and amount for HRSA Part A Supplemental award unknown
- Received a one time increase in RWP Part B award (OA)

Resource Allocation and Contingency Planning

Resource Allocation

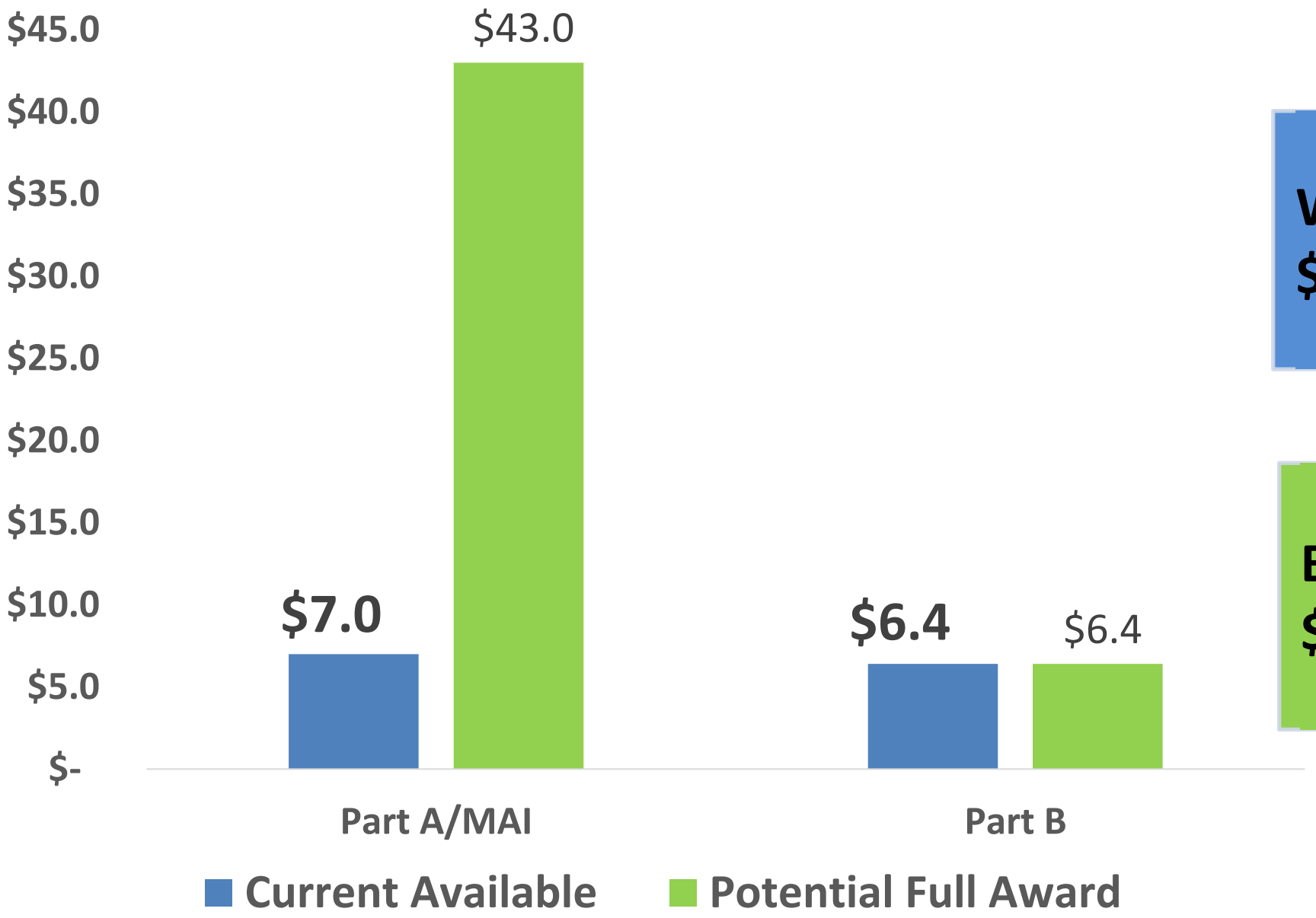
Local planning council (Commission on HIV) is legislatively mandated by HRSA to allocate RWP Part A/MAI resources annually

Commission on HIV allocates a **percentage** of the RWP Part A/MAI award to each RWP service category listed in Policy Clarification Notice (PCN) 16-02

The Commission on HIV is currently undergoing contingency planning and developing multiple allocation scenarios for various funding levels

2025-2026 HIV Care and Treatment Anticipated Resources

FY 2025-2026 Amounts for COH Resource Allocation



Worst Case Scenario: $13.4 M

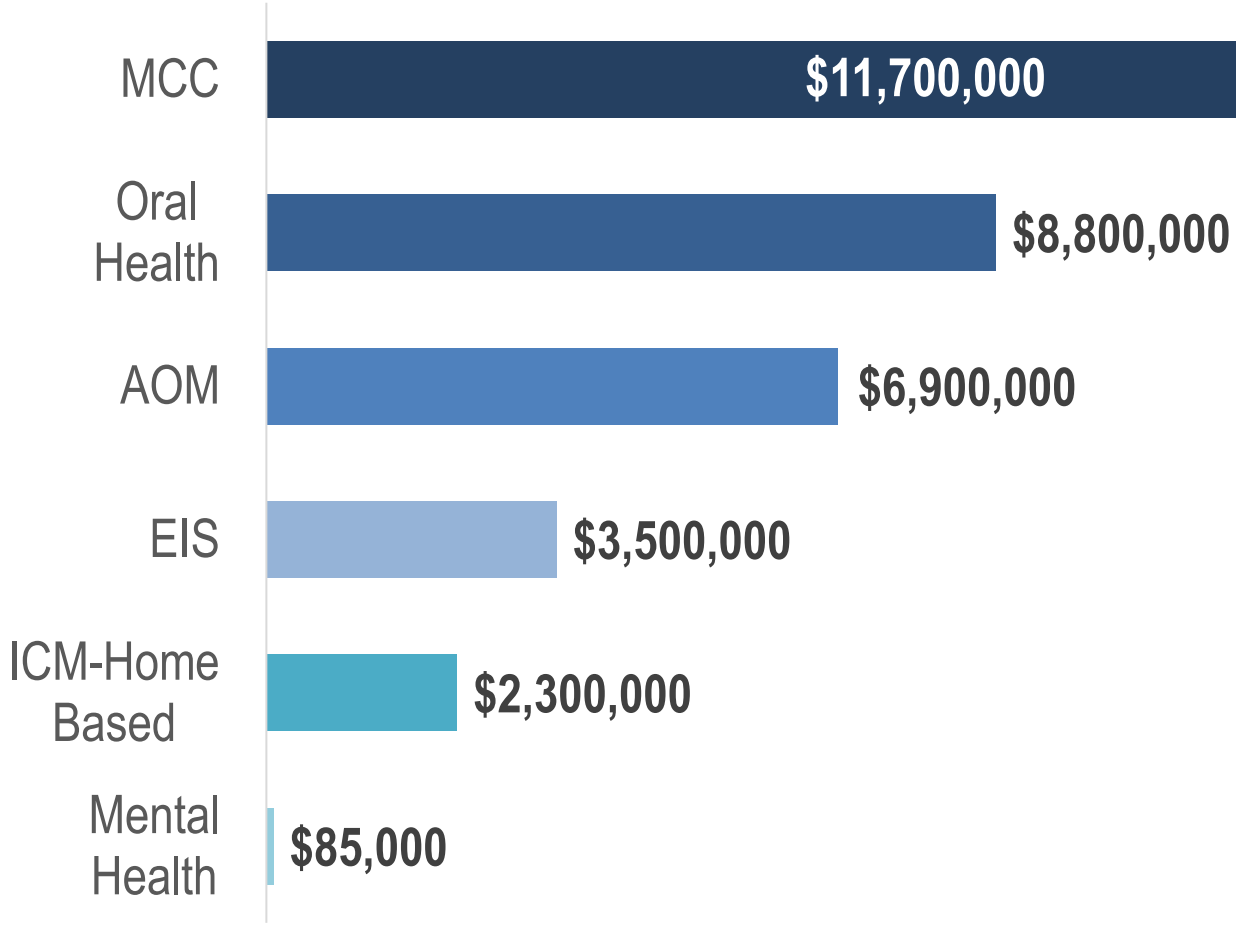
Best Case Scenario: $49.4 M

Financial Overview: Review of 2024 RWP HIV Care and Treatment Expenditures

Estimated FY 2024 RWP HIV Care and Treatment Direct Services Expenditures

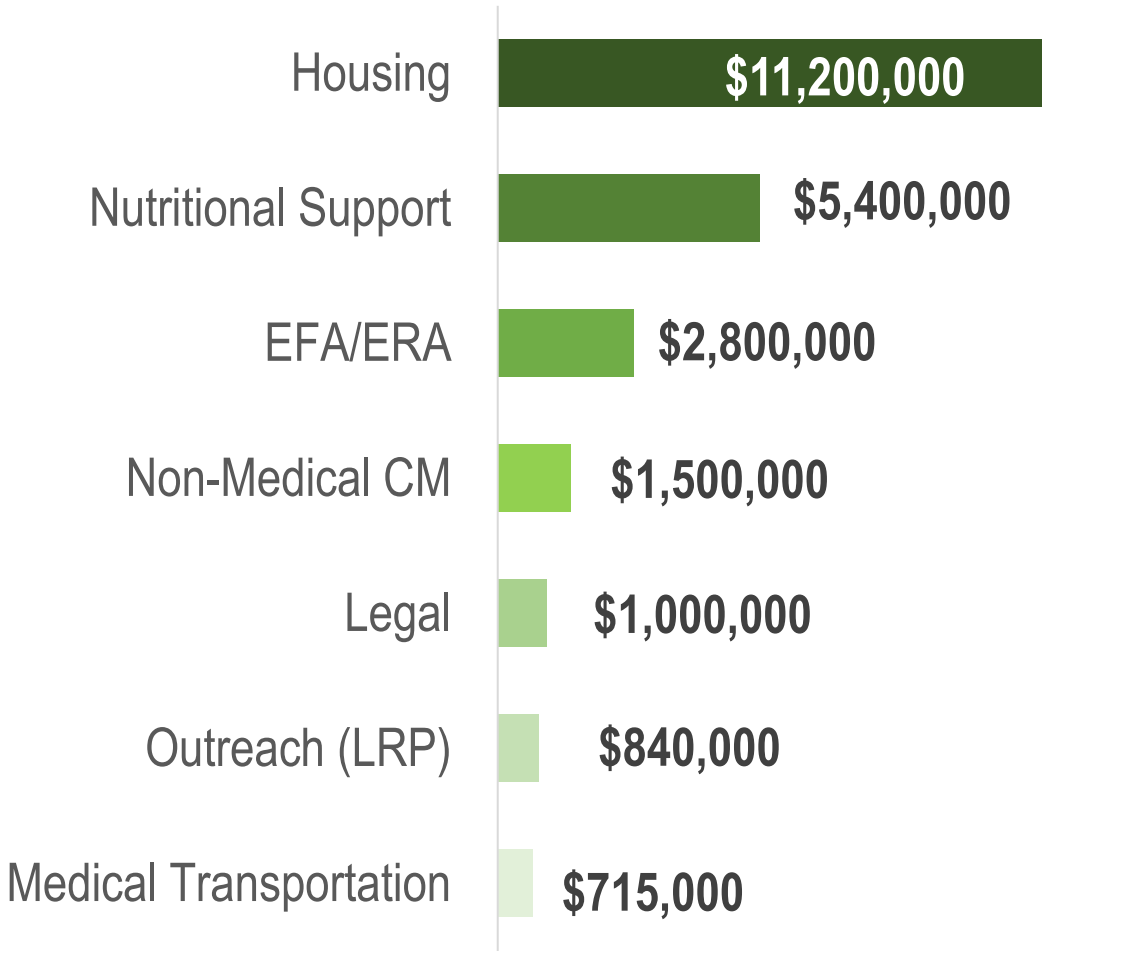
RWP Core Services Estimated Expenditures

Total $33.3 million (58.6%)

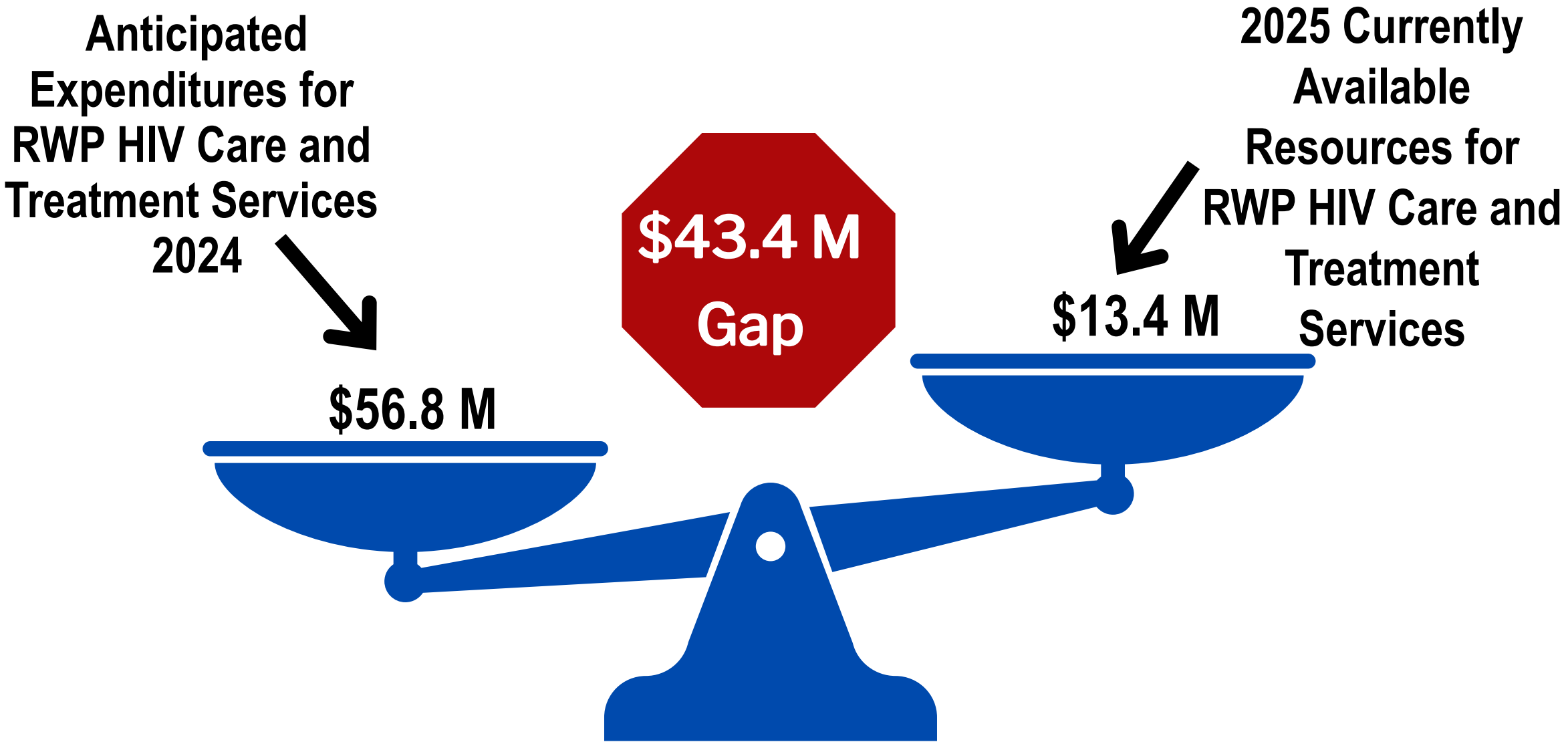


RWP Support Services Estimated Expenditures

Total $23.5 million (41.4%)



2024 Expenditures vs. 2025 Current Available Resources



Financial Overview: 2025-2026 HIV Care and Treatment Contract Obligations and Direct Service Commitments

FY 2025 RWP HIV Care and Treatment Contract and Direct Services

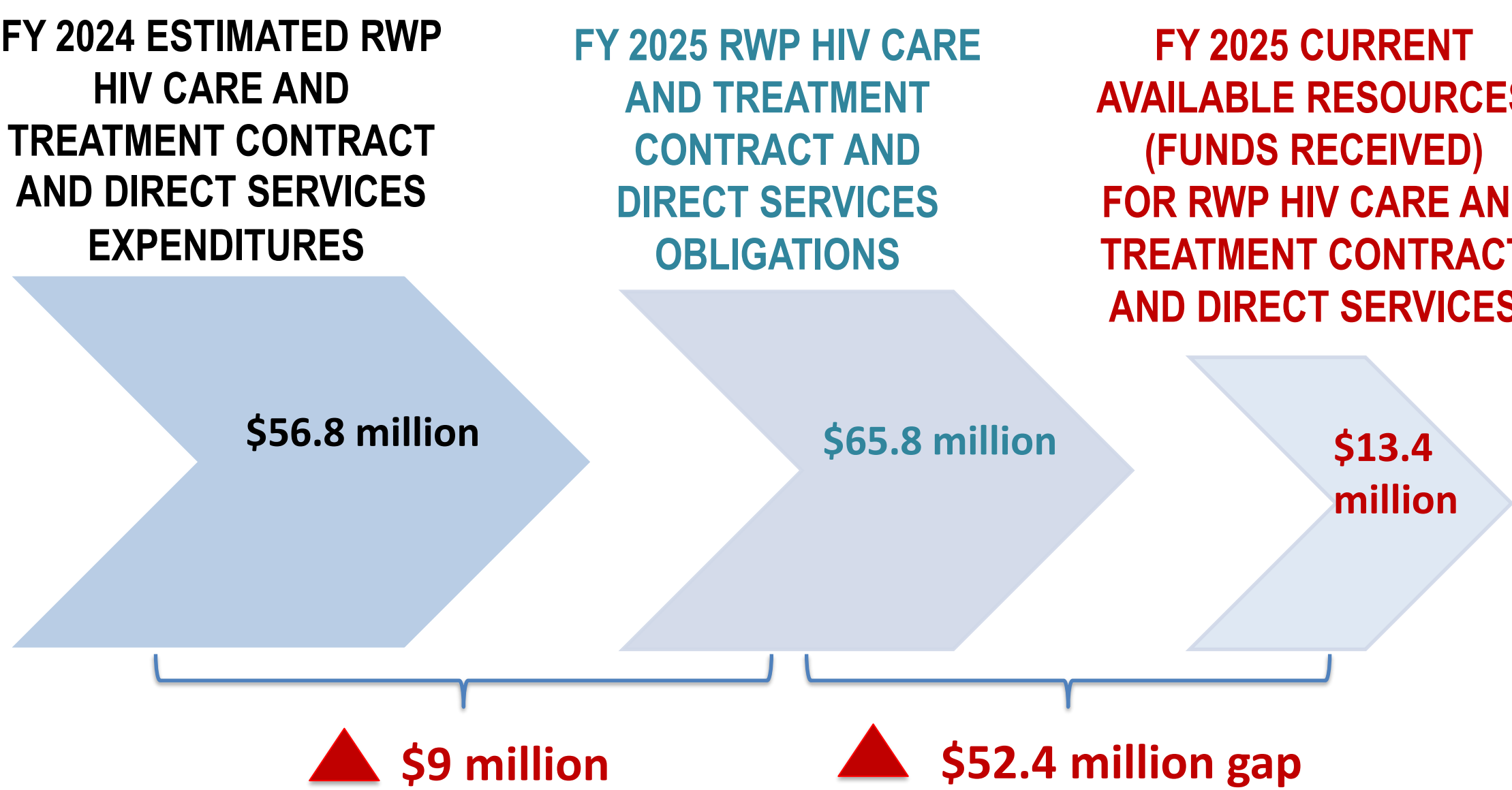
Core Services

- Core Medical Services (AOM, MCC, PSS)
- Oral Health
- Mental Health
- Intensive Case Management-Home Based
- EIS (Partner Services, HIV Testing in PH STD Clinics)

Support Services

- NMCM (BSS, TCM-Jails)
- Housing (RCFCI, TRCF, SU Transitional, Transitional-MAI)
- EFA/ERA
- Nutritional Support (Food Bank, Home Delivered Meals)
- Legal
- Medical Transportation
- Outreach (LRP)

FY 2025 RWP Service Obligations and Available Resources



How did we get here?

Changes in Revenue

- Some grants ended in 2024/early 2025 contributing to a loss of revenue
- Decrease in grant awards
- No EHE or MAI carryover funds from FY 2024 for FY 2025

How did we get here? (continued)

Grant Administration Factors

- Grant awards have not increased at the same rate as inflation
- Federal grant awards must be spent each year or resources will be lost. Only a portion of the HRSA MAI award can be carried over into the next year.
- Historically not all subrecipient contracts were fully maximized or expended, so DHSP intentionally awards contracts 10-13% in excess of grant resources to maximize spending in each grant year.

How did we get here? (continued)

Cost of Services

- Increased reimbursement rate for AOM services in July 2022
- DHSP approved some augmentations to contracts because of increases in service costs tied to inflation and wage increases
- DHSP approved some budget modifications enabling subrecipients to maximize contracts

How did we get here? (continued)

COVID Pandemic Response

- Additional Nutritional Support Services ($ 703,545)
- New EFA Services ($2.5 million)
- Increase in AOM FFS rates

How did we get here? (continued)

Post-COVID Pandemic Peak

- Increased allocations to legal services to meet the needs of consumers because the eviction moratorium was lifted ($900,000)
- Implemented new ERA program because other rental assistance programs (i.e. State) had ended ($2,350,447)
- Increased allocation to nutritional support services through the provision of $100 gift cards in 2024 and early 2025 ($77,600)
- **DHSP did not reduce any services/contracts after the County public health emergency for COVID-19 ended (2023)**

How did we get here? (continued)

Projected Impact of Medi-Cal Expansion

- Based on RWP Utilization data, DHSP anticipated a reduction in the number of clients and expenditures for AOM services due to expansion of Medi-Cal initiated in May 2022 and January 2024

- Taking into account aging and provision of full scope Medi-Cal to immigrants aged 26-49 beginning in January 2024, DHSP estimated that 1,878 clients would exit RWP AOM services in 2024 and access Medi-Cal.

- **DHSP forecasted $3.1 million in AOM cost savings in 2024**
  (1,878 clients x 2.5 visits x $662 per visit)

How did we get here? (continued)

Actual AOM Service Utilization and Expenditures Increased!

	2022	2023	2024
NUMBER OF CLIENTS	3,478	3,604	Pending
EXPENDITURES	$5,884,932	$7,479,143	$6,900,000

Utilization of RWP Services: Year 33

Overview of RWP YR 33 Service Utilization and Expenditures

County of Los Angeles Public Health

Service Category	Number of clients	Expenditures	Average per Client
Housing Services	270	**$8,354,482**	***$30,943***
Home-Based Case Management	120	$2,866,908	***$23,891***
Linkage Re-Engagement Program	40	$923,044	***$23,076***
Substance Abuse Services Residential - Transitional	84	$725,000	*$8,631*
Emergency Financial Assistance	617	$2,614,115	*$4,237*
Medical Outpatient (AOM)	3,604	**$7,479,143**	*$2,075*
Oral Health	**4,332**	**$7,805,282**	*$1,802*
Nutrition Support	2,461	$3,882,464	*$1,578*
Medical Care Coordination	**6,942**	**$10,687,814**	*$1,540*
Mental Health	151	$109,422	*$725*
Non-Medical Case Management	**6,553**	$1,813,126	*$277*

RWP Subservice Categories, Year 33

County of Los Angeles Public Health

Service and Subservice Category	Number of clients	Expenditures	Average per Client
Housing Services	270	$8,354,482	*$30,943*
Residential Care Facilities for the Chronically Ill	70	$3,668,495	***$52,407***
Transitional Residential Care Facilities	32	$844,699	*$26,397*
Permanent Supportive Housing (H4H)	173	$3,841,288	*$22,204*
Oral Health	4,332	$7,805,282	*$1,802*
Specialty OH	999	$2,052,755	*$2,055*
General OH	4,064	$5,752,527	*$1,415*
Nutrition Support	2,461	$3,882,464	*$1,578*
Delivered Meals	453	$1,337,818	*$2,953*
Food Bank	2,133	$2,544,646	*$1,193*
Non-Medical Case Management	6,553	$1,787,095	*$273*
Transitional Care - Jails	472	$322,116	*$682*
Benefit Specialty	6,121	$1,491,010	***$244***

Moving Forward: Financial Shortfall and Program Implications

Next Steps

- Ongoing meetings with DPH and County leadership
- Reviewing all DHSP internal functions and will make workforce adjustments based on revenue
- Identifying other payor sources to support services
- Continue planning with the Commission on HIV
  - Do they revisit your core principles?
  - Do they reprioritize and/or reallocate?
- Continue planning activities including funding reduction scenarios incorporating provider input
- Advocacy

Questions and Summary Discussion

Thank you

Ryan White Program Utilization Summary, Year 33 (March 1, 2023-February 29, 2024)

Sona Oksuzyan, Supervising Epidemiologist

Janet Cuanas, Research Analyst III

Monitoring and Evaluation Unit

Division of HIV and STD Programs

March 13, 2025

Overview

- Background
- Methods
- Results
- Key Takeaways
- Next Steps
- Questions/Discussion

Background

- Ryan White Program (RWP) Funding
- RWP Report Updates
- RWP Service Categories

County of Los Angeles Public Health

RWP Funding and Report Updates

Ryan White Program (RWP) Annual Funding to DHSP

- Source: Health Resources and Services Administration HIV/AIDS Bureau (HRSA-HAB)

Commission on HIV (COH) RWP DHSP Report

- Utilization Report informs service planning and resource allocation activities

RWP Utilization Report Updates

- Separate reports for core and support service categories to better inform activities
- The report is restructured to track utilization across the priority populations identified in the Los Angeles County (LAC) Ending the HIV Epidemic (EHE) Strategic Plan and the LAC Integrated Comprehensive HIV Plan
- **While not identified as a priority population in the above plans, persons experiencing homelessness (unhoused people) are included in the utilization report**

PRIORITY POPULATIONS

Latinx Men Who Have Sex with Men (MSM)

Black MSM

Cisgender Women of Color

Transgender Persons

Youth (29 years and younger)

PLWH Age ≥ 50

Persons Who Inject Drugs (PWID)

Unhoused RWP Clients

RWP Service Categories

Core Service Categories

- Ambulatory Outpatient Medical (AOM)
- Medical Care Coordination (MCC)
- Oral Health
  - General Oral Health
  - Specialty Oral Health
- Home-Based Care Management (HBCM)
- Mental Health

Support Service Categories

- Emergency Financial Assistance (EFA)
- Housing Services
  - Housing Services (RCFCI)
  - Housing Services (TRCF)
  - Permanent Supportive Housing (H4H)
- Non-Medical Case Management (NMCM):
  - Benefits Specialty
  - Transitional Incarceration
- Nutritional Services
  - Food Bank
  - Delivered Meals
- Substance Abuse Services Residential
- Outreach (LRP)

Methods

- RWP Report Framework
- Evaluation Framework

County of Los Angeles Public Health

RWP Report Framework

Year 33: March 1, 2023-February 29, 2024

Data Sources

- HIV Casewatch: Client characteristics and service use
- HIV Surveillance: Viral load, CD4 and genotype tests
- DHSP Expenditure Reports

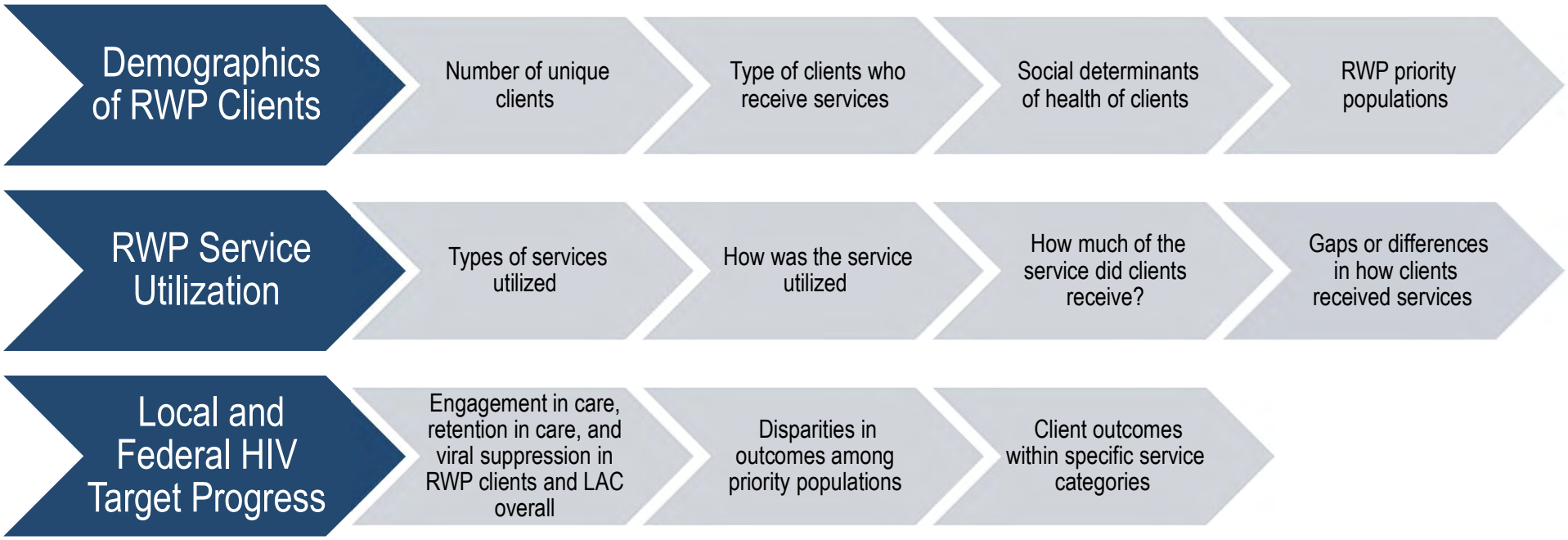
Utilization Indicators

- Total service units = **Number of services units** paid for by DHSP (includes hours, visits, procedures, days, and sessions)
- Total Expenditures = **Total dollar amount** paid by DHSP
- Service units per client = Total number of service units / number of clients
- Expenditures per client = Total dollar amount / number of clients

Outcomes

- Engagement in care
- Retention in care
- Viral suppression

Evaluation Framework



Results: Year 33

- Service Utilization
- RWP Client Demographics
- RWP Priority Populations
- HIV Care Continuum Outcomes

County of Los Angeles Public Health

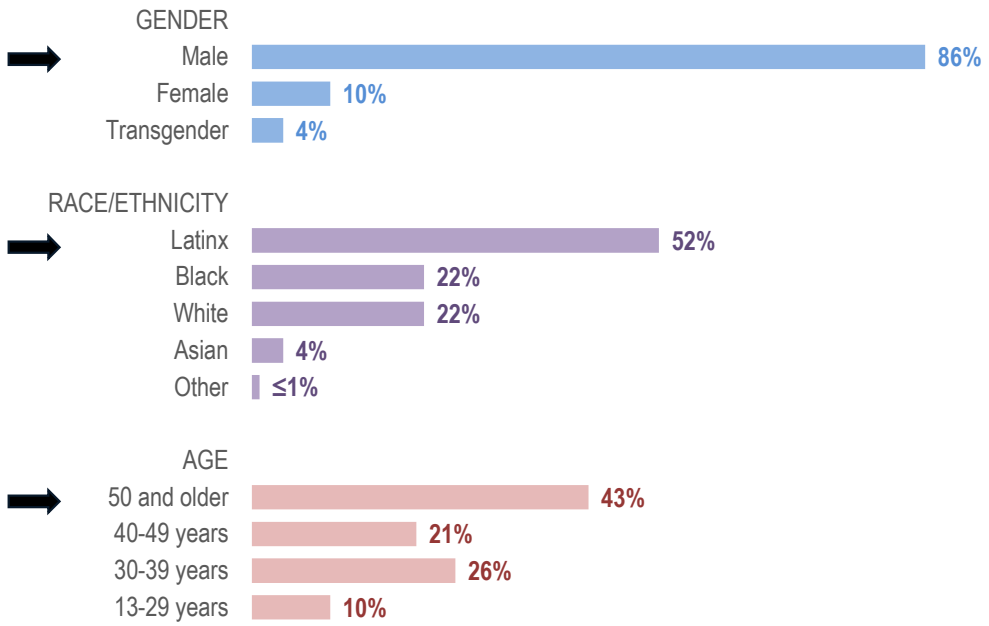
Utilization remains consistent among contracted providers over the past four years.

Quarterly RWP Utilization at Funded Agencies, Years 30-33

In Year 33 most RWP clients identified as male, over half were Latinx, and three out of five were under aged 50.

County of Los Angeles Public Health

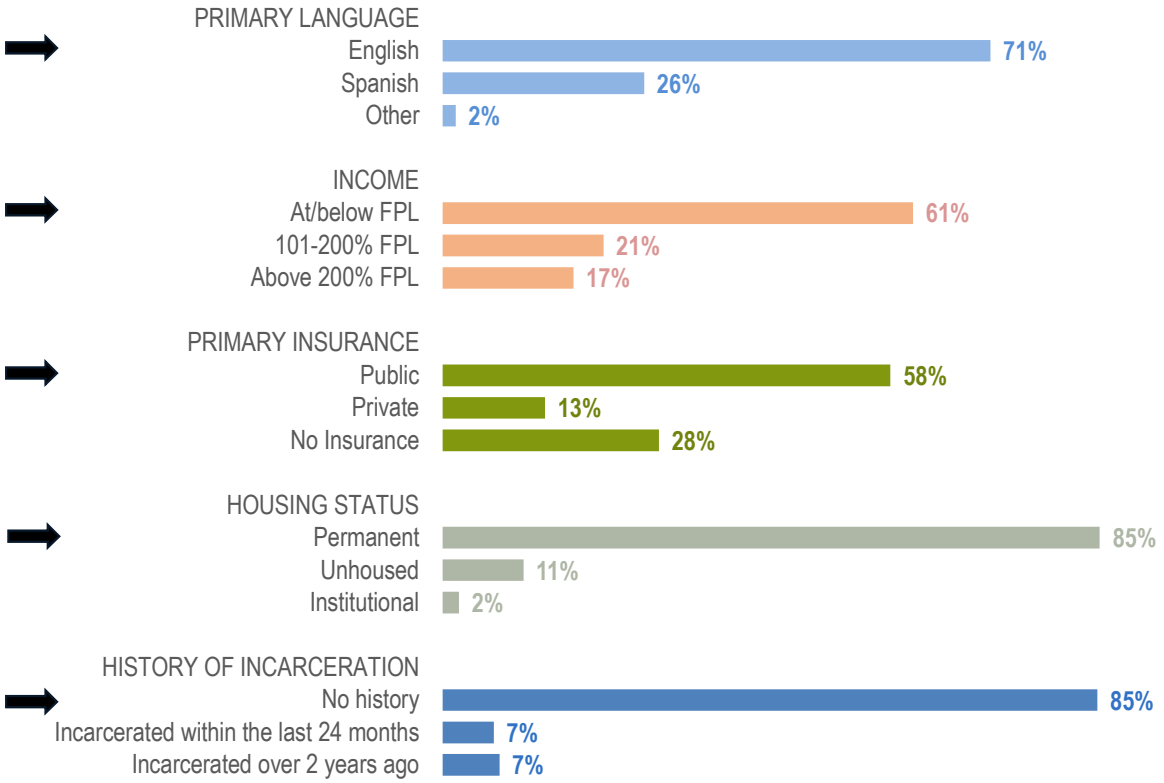
RWP Client Demographics, Year 33 (N=15,882)



Most RWP clients were English-speakers, lived ≤ FPL, had public health insurance, had permanent housing status and no history of incarceration.

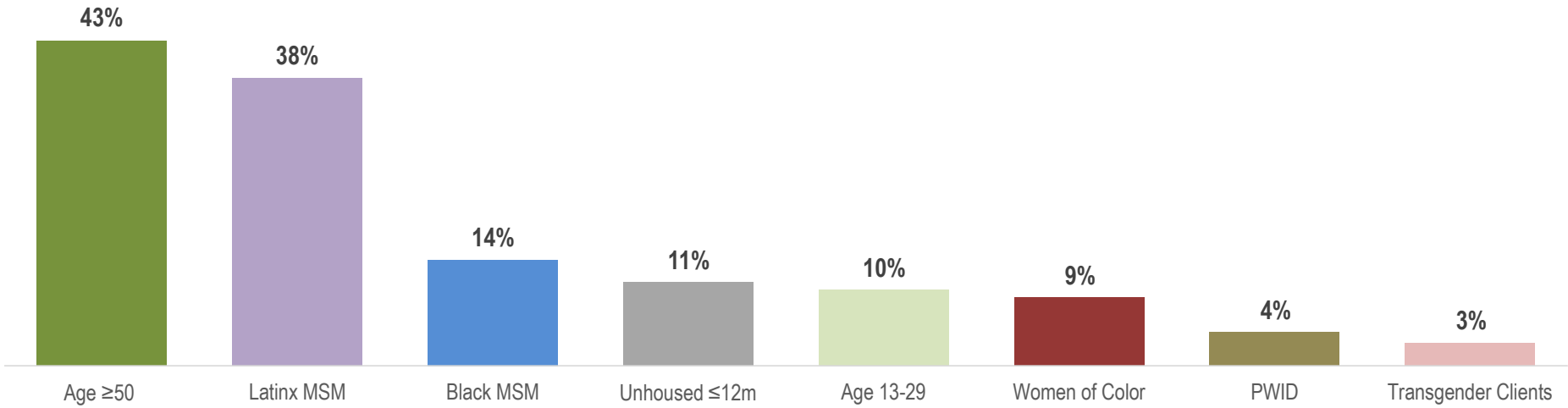
County of Los Angeles Public Health

RWP Client Social Determinants of Health, Year 33, (N=15,882)



RWP is reaching clients in LAC priority populations, Year 33

The majority of clients (43%) were 50 years of age or older, followed by Latinx MSM.*



*Priority population groups are not mutually exclusive, they overlap.

Comparison of LAC Priority Populations[a] for RWP Utilization, Year 33

Population *(% of row population)*	Trans-identified Clients[b]	Latinx MSM[c]	Black MSM[c]	Women of Color	Age 13-29	Age ≥ 50	PWID	Unhoused ≤12m
Trans-identified Clients[b]	***535 (3% of RWP)***	253 47%	88 16%	-	89 17%	161 30%	12 2%	120 22%
Latinx MSM[c]	253 4%	***6,055 (38% of RWP)***	-	-	658 11%	2,303 38%	152 3%	520 9%
Black MSM[c]	88 4%	-	***2,255 (14% of RWP)***	-	292 13%	731 32%	62 3%	327 15%
Women of Color	-	-	-	***1,436 (9% of RWP)***	105 7%	765 53%	37 3%	140 10%
Age 13-29	89 6%	658 43%	292 19%	105 7%	***1,539 (10% of RWP)***	-	36 2%	243 16%
Age ≥ 50	161 2%	2,303 34%	731 11%	765 11%	-	***6,872 (43% of RWP)***	351 5%	450 7%
PWID	12 2%	152 23%	62 9%	37 6%	36 5%	351 53%	***660 (4% of RWP)***	146 22%
Unhoused ≤12m	120 7%	520 31%	327 20%	140 8%	243 15%	450 27%	146 9%	***1,668 (11% of RWP)***

Data source: HIV Casewatch as of 5/2/2024, HIV Surveillance data as of 5/8/2024

[a]Populations not mutually exclusive

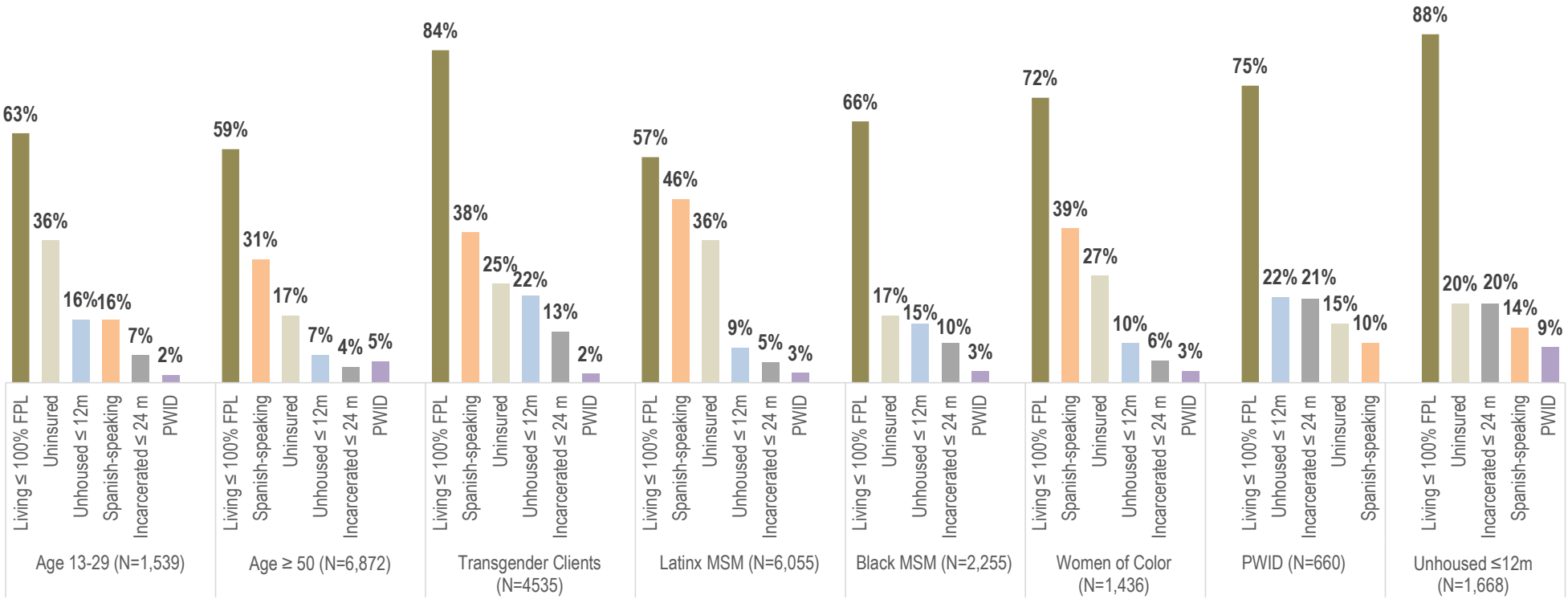
[b]Includes 497 transgender women and 38 transgender men

[c]MSM defined by primary HIV risk category

[d]Reported as unhoused within the 12 months reporting period.

Poverty and having no insurance impacted the highest percent of clients across priority populations, however the other SDOH impacted each population differently.

Social Determinants among LAC Priority Populations, Year 33

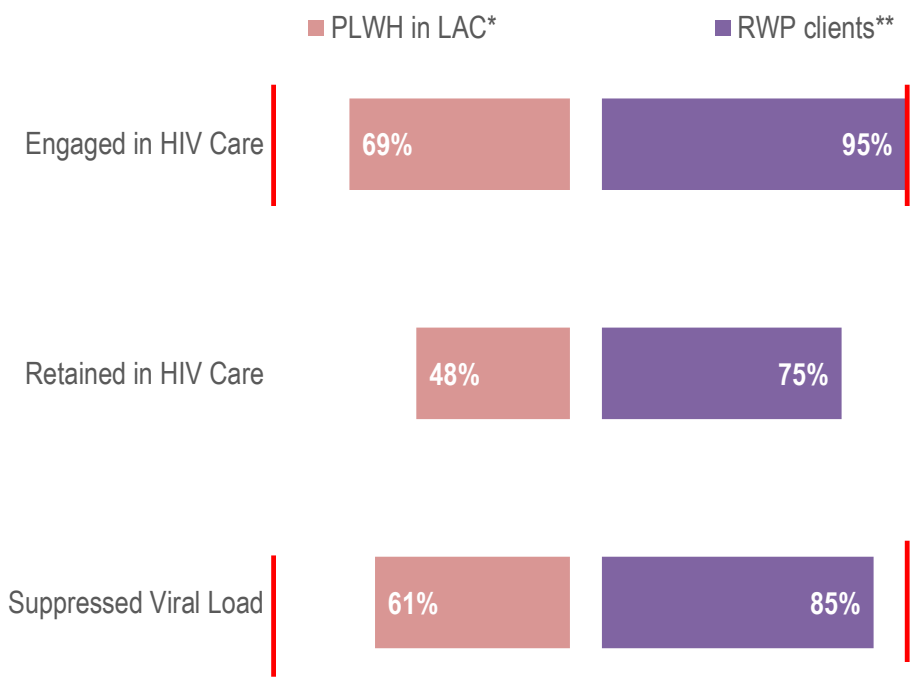


Utilization of RWP Services by LAC Priority Populations[a], Year 33

Service Category	Age 12-29	Age ≥ 50	Transgender Clients	Women of Color	Latinx MSM	Black MSM	PWID	Unhoused ≤12m
SUD Residential (n=84)	10%	17%	8%	1%	38%	19%	14%	55%
HBCM (n=120)	-	87%	-	13%	20%	8%	4%	2%
MH Services (n=151)	13%	17%	5%	7%	58%	11%	-	7%
Housing Services (n=270)	9%	45%	6%	13%	37%	15%	7%	45%
EFA (n=617)	5%	51%	2%	11%	28%	24%	5%	7%
Nutrition Support (n=2,461)	3%	64%	4%	11%	35%	13%	6%	14%
AOM (n=3,604)	13%	21%	3%	7%	54%	8%	2%	6%
Oral Health (n=4,332)	3%	58%	3%	11%	43%	11%	4%	6%
NMCM (n=6,553)	10%	43%	2%	9%	40%	13%	4%	7%
MCC (n=6,942)	12%	34%	5%	6%	39%	18%	5%	17%

HIV Care Continuum in LAC and in RWP clients, Year 33 (N=15,882)

- Engagement[a], retention in care[b] and viral load suppression[c] percentages were higher for RWP clients compared to PLWH in LAC, Year 33.
- RWP overall did not meet the EHE target of 95% for viral suppression or local targets for engagement and retention in care (95%).



[a]**Engagement in Care** defined as 1 ≥ viral load, CD4 or genotype test reported in the 12-month period based on HIV laboratory data as of 5/8/2024
[b]**Retention in care** defined as 2 ≥ viral load, CD4 or genotype test reported >30 days apart in the 12-month period based on HIV laboratory data as of 5/8/2024
[c]**Viral suppression** defined as most recent viral load test <200 copies/mL in the 12-month period based on HIV laboratory data as of 5/8/2024

* Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022. http://publichealth.lacounty.gov/dhsp/Reports/HIV/Annual_HIV_Surveillance_Report_2022_LAC_Final.pdf

** Data source: HIV Casewatch as of 5/2/2024

HIV Care Continuum (HCC) Outcomes among Priority Populations, Year 33

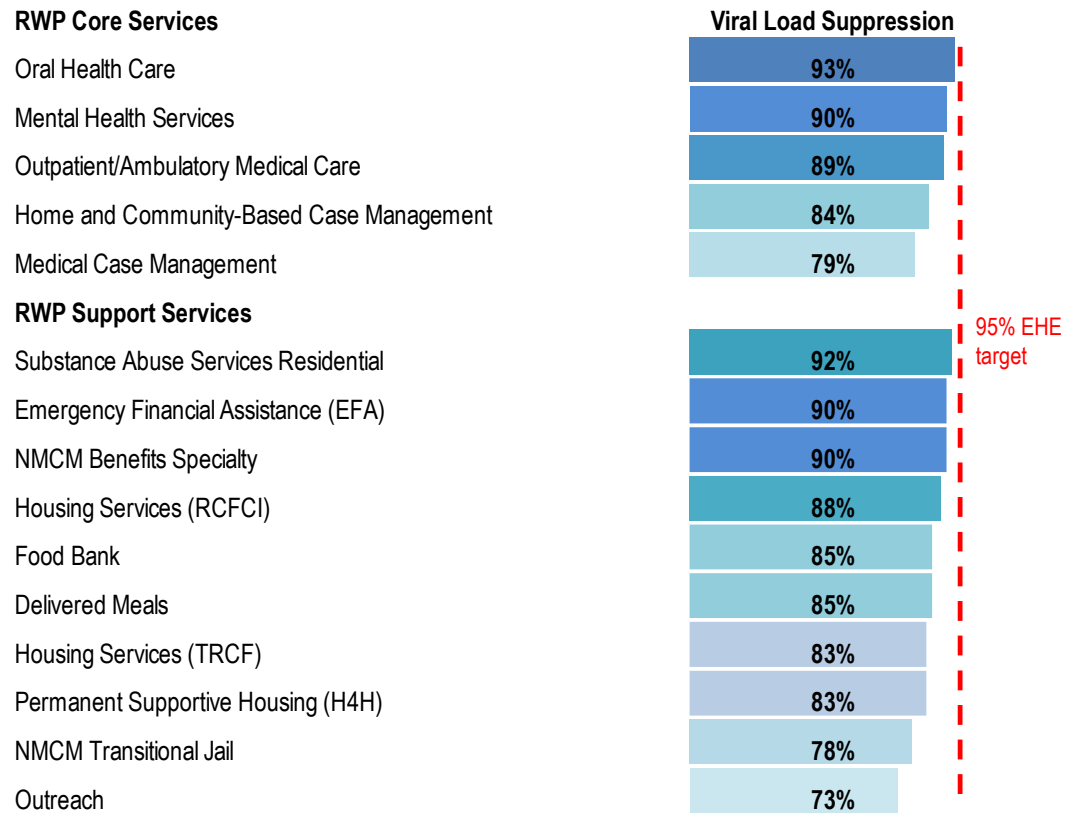
- RWP clients **aged 50 and older had the highest engagement, retention in care and viral suppression.**
- RWP clients **experiencing homelessness had the lowest engagement and retention in care and viral suppression.**
- RWP clients **aged 50 and older, Latinx MSM and Women of color met the target of 95% for engagement in care.**
- None of other LAC priority populations met the EHE or local targets for HCC outcomes.

Priority Population	***No.***	***% of RWHAP Population***	**Engaged in Care**	**Retained in Care**	**Virally Suppressed**
50 years of age or older	6,872	43%	**96%**	**81%**	**89%**
Latinx MSM[c]	5,790	36%	**96%**	77%	87%
Women of color	1,663	10%	**95%**	76%	85%
Transgender Persons[b]	535	3%	95%	76%	79%
Youth (29 years and younger)	1,539	10%	94%	64%	79%
Black MSM[c]	2,105	13%	94%	68%	79%
Persons Who Inject Drugs (PWID)	660	4%	93%	74%	82%
People experiencing homelessness	1,668	11%	**91%**	**64%**	**72%**

[a]Limited to membership in two priority populations; a client could be in more than two priority populations as population definitions are not mutually exclusive
[b]Includes 497 transgender women and 38 transgender men
[c]MSM defined as PLWH who reported male sex at birth, sex with men as primary HIV risk category and non-White race/ethnicity

Viral Suppression among RWP and by Service Category, Year 33 (N=15,882)

- Among RWP clients, **85% were virally suppressed**
- **Neither** the RWP overall **nor any** of the service categories **met the EHE viral suppression target of 95%**



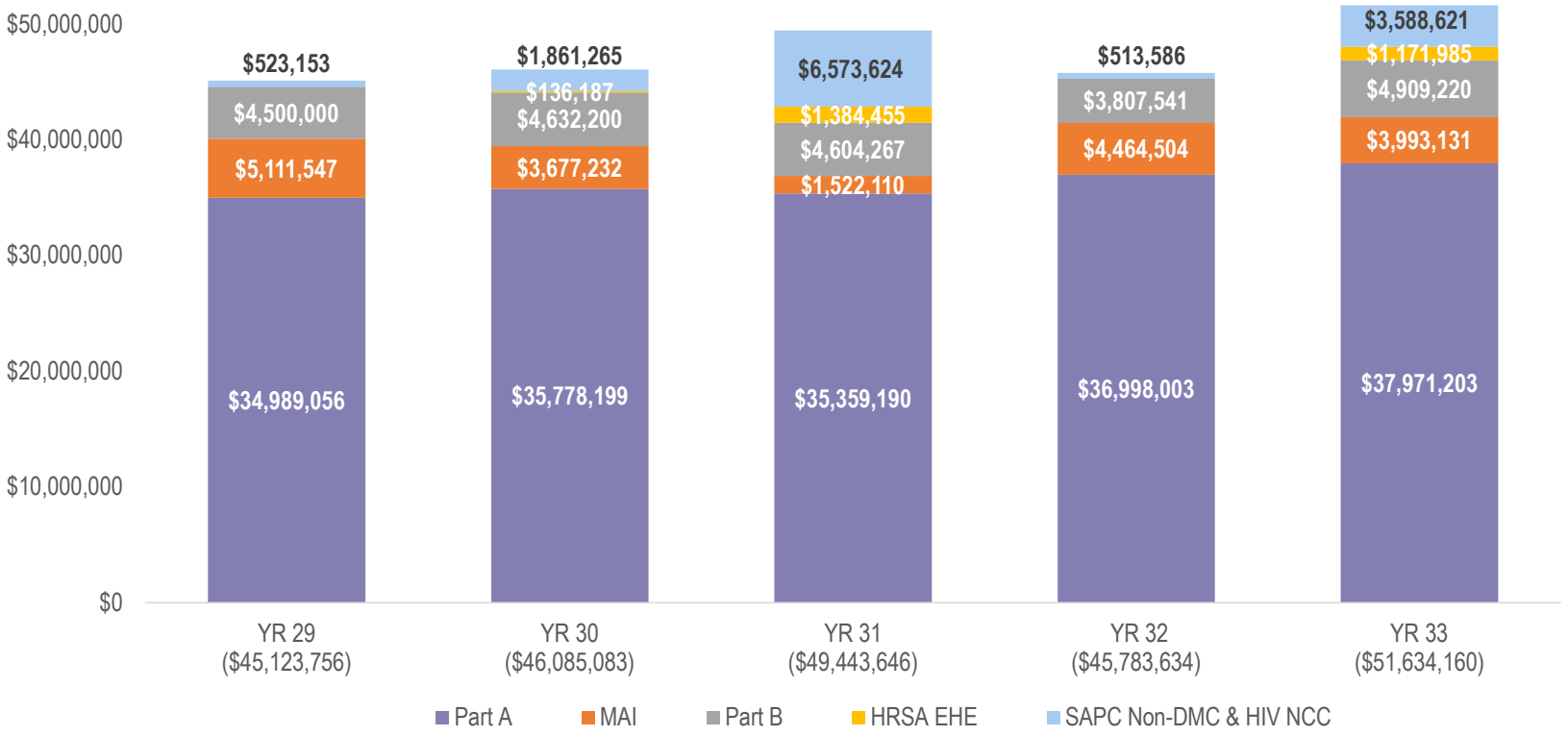
Expenditures

- Expenditures by Funding Source
- Expenditures by Service Category
- Expenditures per Client

County of Los Angeles Public Health

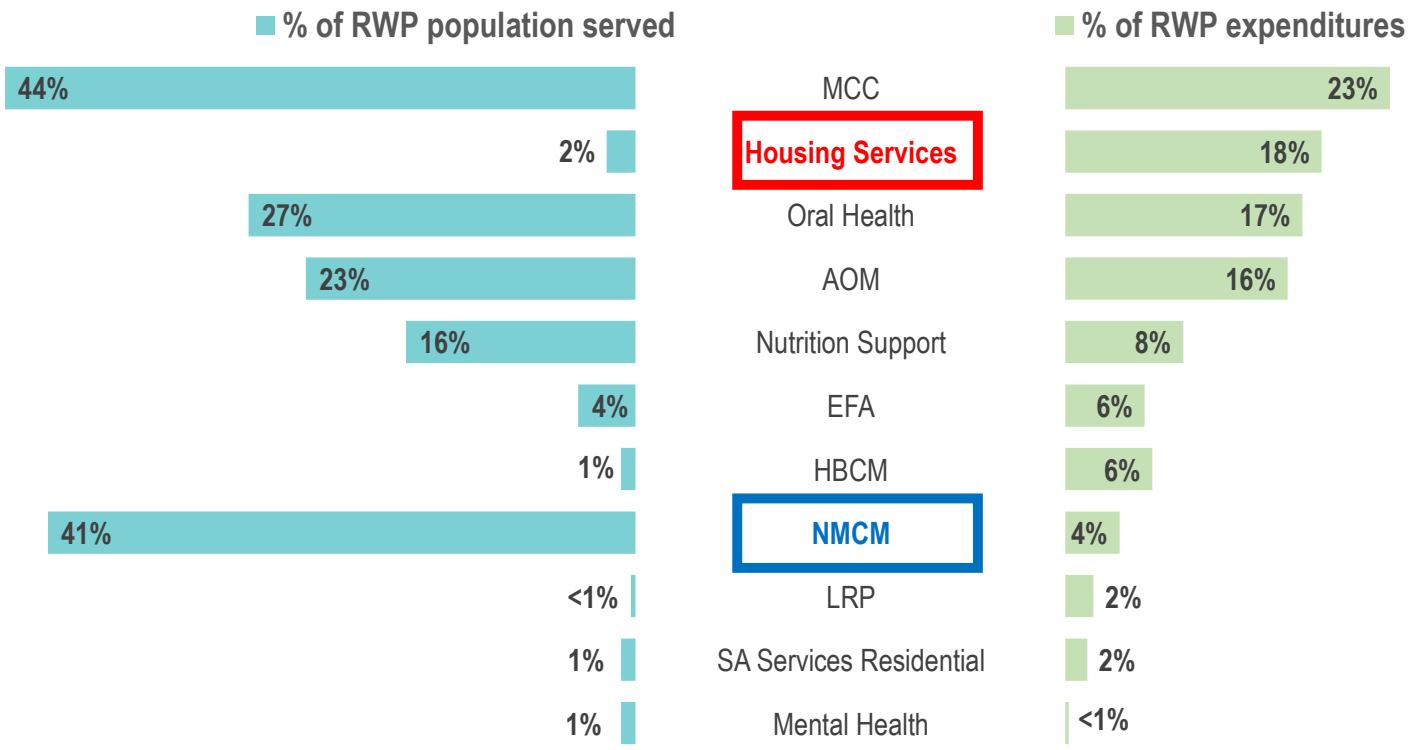
RWP Expenditures by Source of Funding, Years 29-33

Total expenditures increased: Part A expenditures gradually increased, MAI expenditures varied due to carryover strategies, Part B was stable, other expenditures varied.



The costliest RWP service category compared to the percent of RWP population served was **Housing;** the least costly service was **NMCM**.

RWP Population Served vs Total Expenditures, Year 33



RWP Service Category Expenditures, Year 33

- **The highest expenditures per client** were spent **for Housing Services**, followed by HBCM and LRP.
- **The lowest expenditures per client** were spent for **NMCM, Mental Health and MCC.**

Service Category	Number of clients	Expenditures YR 33	Expenditures per client YR 33
Housing Services	270	$8,440,602	***$31,261***
Home-Based Case Management	120	$2,866,908	*$23,891*
Linkage Re-Engagement Program	40	$923,044	*$23,076*
Substance Abuse Services Residential - Transitional	84	$725,000	*$8,631*
Emergency Financial Assistance	617	$2,614,115	*$4,237*
Medical Outpatient	3,604	$7,322,339	*$2,032*
Oral Health	4,332	$7,805,282	*$1,802*
Nutrition Support	2,461	$3,882,464	*$1,578*
Medical Care Coordination	6,942	$10,688,014	*$1,540*
Mental Health	151	$109,422	*$725*
Non-Medical Case Management	6,553	$1,787,095	***$273***

Key Takeaways

- **Utilization of RWP services remains consistent** across community-based agencies
- Most of RWP clients are **male, Latinx, aged 50 and older, English-speakers, living at or below FPL, with public health insurance, with permanent housing and without incarceration history**
- The RWP is **reaching and serving LAC priority populations**

Key Takeaways – Priority Populations

- Service utilization among LAC priority populations is consistent relative to their size with the **highest among RWP clients aged 50 and older, Latinx MSM and Black MSM.**

- While poverty impacts all of the LAC priority populations, they are **differentially impacted by SDOH**:
  - The majority of RWP clients from each priority population lived at or below FPL.
  - High percentage of priority populations were Spanish-speakers and uninsured.
  - Recent incarceration (≤24m), drug use and unstable housing were more prevalent among RWP clients aged 13-29, unhoused and PWID.

Key Takeaways - Expenditures

- **Part A expenditures gradually increased, MAI expenditures varied, and Part B was stable over 5 years.** The percentage of expenditures from other sources increased over the years.

- Although **Housing served one of the lowest percentage of RWP clients**, **it had the highest expenditures per client.**

- Although **NMCM and MCC served the largest percentage of RWP clients, per client expenditures for NMCM and MCC were the lowest**.

Next Steps

- Present to SMT and COH on two major service clusters
  - Core Services (AOM, MCC, Oral Health, HBCM, Mental Health)
  - Support Services (EFA, Housing, NMCM, Nutrition Support, LRP, Substance Use Residential)
- Examine detailed utilization of RWP services within each LAC priority populations
- Examine RWP by priority population over time

Questions/Discussion

Thank you!

- **Acknowledgements**
  - Monitoring and Evaluation – Wendy Garland, Siri Chirumamilla
  - PDR – Victor Scott, Michael Green
  - Surveillance – Virginia Hu, Kathleen Poortinga
  - CCS – Paulina Zamudio and the RWP program managers
  - RWP agencies and providers
  - RWP clients

https://www.dhcs.ca.gov/services/medi-cal/Pages/Benefits_services.aspx#top

Essential Health Benefits

Medi-Cal provides a comprehensive set of health benefits which may be accessed as medically necessary.

Outpatient (Ambulatory) Services

- Physician services
- Hospital outpatient & outpatient clinic services
- Outpatient surgery (Includes anesthesiologist services.)
- Podiatry
- Chiropractic
- Allergy care
- Treatment therapies (chemotherapy, radiation therapy, etc.)
- Dialysis/hemodialysis

Emergency Services

- Emergency Room services
- All inpatient and outpatient services that are necessary for the treatment of an emergency medical condition, including dental services, as certified by the attending physician or other appropriate provider.
- Ambulance services

Hospitalization

- Inpatient hospital services
- Anesthesiologist services
- Surgical services (bariatric, reconstructive surgery, etc.)
- Organ & tissue transplantation

Maternity and Newborn Care

- Prenatal care
- Delivery and postpartum care

- Breastfeeding education
- Nurse midwife services
- Licensed midwife services
- Doula services

Mental health and Substance Use Disorder (SUD) Services

- Outpatient mental health services
- Outpatient specialty mental health services
- Inpatient specialty mental health services
- Outpatient substance use disorder services
    - Residential treatment services
- Voluntary inpatient detoxification
- Medi-Cal Peer Support Services (select counties)

Prescription Drugs

- Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class.
- Members may receive up to a 100-day supply of many medications.

Dental

The Medi-Cal Dental Program (/services/Pages/DHCS-CalAIM-Dental.aspx) provides free or low-cost dental services to children and adults who receive Medi-Cal. Services covered by Medi-Cal Dental include:

- Diagnostic and preventive dental hygiene (e.g., exams, x-rays, and teeth cleanings, molar sealants)
- Orthodontics for children who qualify
- Tooth extractions
- Sedation for dental services
- Fillings and crowns
- Root canal treatments (anterior/posterior)
- Scaling and root planning
- Complete and partial dentures, and relines

For more information on covered benefits, please visit the Smile, California (https://smilecalifornia.org/covered-services/) website.

Programs such as physical and occupational therapy (known as Rehabilitative & Habilitative Services) and devices

- Physical therapy
- Speech therapy / Audiology
- Occupational therapy
- Acupuncture
- Cardiac rehabilitation
- Pulmonary rehabilitation
- Skilled nursing facility services (90 days)
- Disposable Medical supplies (Continuous Glucose Monitoring "CGM" Systems and Disposable Insulin Delivery Systems for diabetics, Self-monitoring blood pressure devices and blood pressure cuffs)
- Equipment and appliances (including implanted hearing devices)
- Durable medical equipment
- Orthotics/prostheses
- Hearing aids
- Home Health Services

Laboratory Services

- Outpatient laboratory and X-ray services
    - Various advanced imaging procedures are covered based on medical necessity.

Preventive and Wellness Services and Chronic Disease Management

- United States Preventive Services Task Force A & B recommended preventive services
- Advisory Committee for Immunization Practices recommended vaccines
- Health Resources and Service Administration's Bright Futures recommendations
- Preventive services for women recommended by The Institute of Medicine
- Family planning services
- Smoking cessation services
- Behavior health treatment for children under 21

Pediatric Services Including Oral and Vision Care

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a Medi-Cal benefit for individuals under the age of 21 who have full-scope Medi-Cal eligibility. EPSDT provides periodic screenings to determine health care needs and, in addition to the standard Medi-Cal benefits, a member under the

age of 21 may receive extended services as medically necessary. Members under the age of 21 also have access to preventive dental care and vision care.

Other

Vision

- Routine eye exam once in 24 months
- Eyeglasses and contact lenses

Enhance Care Management (ECM)

ECM provides comprehensive care management to select high-need Medi-Cal members.

Community Health Workers (CHW) Services

Medi-Cal covers CHW services as a preventive benefit to: help members prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health.

Transportation Services

Medi-Cal offers transportation (/services/medi-cal/Pages/Transportation.aspx) to and from appointments for services covered by Medi-Cal. This includes transportation to medical, dental, mental health, or substance use disorder appointments, and to pick up prescriptions and medical supplies.

Nonemergency Transportation Services: Transportation by ambulance, litter van, or wheelchair van only when ordinary public or private conveyance is medically contra-indicated and transportation is required for a Medi-Cal benefit.

Nonmedical Transportation Services: Transportation by private or public vehicle for people who do not have another way to get to their appointment.

Long Term Services and Supports

- Skilled Nursing Facility services (91+ days)
- Personal Care Services
- Self-Directed Personal Assistance Services
- Community First Choice Option
- Home and Community Based Services

Get Help in Your Language (/Language-Resources/Pages/home.aspx)

العربية (/Language-Resources/Pages/Ara-home.aspx) | Հայերեն (/Language-Resources/Pages/Arm-home.aspx) | ខ្មែរ (/Language-Resources/Pages/Cam-home.aspx) | 繁體中文 (/Language-Resources/Pages/TCH-Home.aspx) | فارسی (/Language-Resources/Pages/Far-home.aspx) | हिंदी (/Language-Resources/Pages/Hin-home.aspx) | Hmoob (/Language-Resources/Pages/Hmo-home.aspx) | 日本語 (/Language-Resources/Pages/Jp-home.aspx) | 한국어 (/Language-Resources/Pages/Kor-Home.aspx) | ລາວ (/Language-Resources/Pages/lao-home.aspx) | Mienh waac (/Language-Resources/Pages/Mei-home.aspx) | ਪੰਜਾਬੀ (/Language-Resources/Pages/Pun-home.aspx) | Русский (/Language-Resources/Pages/Rus-home.aspx) | Español (/Language-Resources/Pages/Es-Home.aspx) | Tagalog (/Language-Resources/Pages/Tag-Home.aspx) | ภาษาไทย (/Language-Resources/Pages/Tha-home.aspx) | Українська (/Language-Resources/Pages/Ukr-home.aspx) | Tiếng Việt (/Language-Resources/Pages/VIE-Home.aspx)

myMedi-Cal

How to Get the Health Care You Need

CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Table of Contents

DHCS On Social Media

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California Department of Health Care Services

DHCS_CA

Health Coverage in California

"My Medi-Cal: How to Get the Health Care You Need" tells Californians how to apply for Medi-Cal for no-cost or low-cost health insurance. You will learn what you must do to qualify. This guide also tells you how to use your Medi-Cal benefits. It tells you when to report changes. You should keep this guide and use it when you have questions about Medi-Cal.

California offers two ways to get health coverage. They are "Medi-Cal" and "Covered California." Both programs use the same application.

What Is Medi-Cal?

Medi-Cal is California's version of the Federal Medicaid program. Medi-Cal offers no-cost and low-cost health coverage to eligible people who live in California.

The Department of Health Care Services (DHCS) oversees the Medi-Cal program.

Your local county office manages most Medi-Cal cases for DHCS. You can reach your local county office online at ***www.benefitscal.com***. You can also call your local county office.

To get the phone number for your local county office, go to:
http://dhcs.ca.gov/mymedi-cal

or call 1-800-541-5555
(TTY 1-800-430-7077)

The local county offices use many facts to determine what type of help you can get from Medi-Cal. They include:

- How much money you make
- Your age
- The age of any children on your application
- Whether you are pregnant, blind or disabled
- Whether you receive Medicare

Did you know?

It is possible for members of the same family to qualify for both Medi-Cal and Covered California. This is because the Medi-Cal eligibility rules are different for children and adults.

For example, coverage for a household of two parents and a child could look like this:

Parents—eligible for a Covered California health plan and receive tax credits and cost sharing to reduce their costs

Child—eligible for no-cost or low-cost Medi-Cal

Most people who apply for Medi-Cal can find out if they qualify based on their income. For some types of Medi-Cal, people may also need to give information about their assets and property. To learn more, see the Medi-Cal Program Comparison on page 5.

What Is Covered California?

Covered California is the State's health insurance marketplace. You can compare health plans from brand-name insurance companies or shop for a plan. If your income is too high for Medi-Cal, you may qualify to purchase health insurance through Covered California.

Covered California offers "premium assistance." It helps lower the cost of health care for individuals and families who enroll in a Covered California health plan and meet income rules. To qualify for premium assistance, your income must be under the Covered California program income limits.

Did you know?

If you qualify for Supplemental Security Income (SSI), you automatically qualify for SSI-linked Medi-Cal.

Your local county office can help with some SSI Medi-Cal related problems. They will tell you if you need to contact a Social Security office to solve the problem.

Covered California has four levels of coverage to choose from: Bronze, Silver, Gold, and Platinum. The benefits within each level are the same no matter which insurance company you choose. Your income and other facts will decide what program you qualify for.

To learn more about Covered California, go to ***www.coveredca.com*** or call **1-800-300-1506 (TTY 1-888-889-4500)**.

What Are the Requirements to Get Medi-Cal?

To qualify for Medi-Cal, you must live in the state of California and meet certain rules. You must give income and tax filing status information for everyone who is in your family and is on your tax return. You also may need to give information about your property.

You do not have to file taxes to qualify for Medi-Cal. For questions about tax filing, talk to the Internal Revenue Service (IRS) or a tax professional.

All individuals who apply for Medi-Cal must give their Social Security Number (SSN) if they have one. Every person who asks for Medi-Cal must give information about his or her immigration status. Immigration status given as part of the Medi-Cal application is confidential. The United States Citizenship and Immigration Services cannot use it for immigration enforcement unless you are committing fraud.

Adults age 19 or older may qualify for limited Medi-Cal benefits even if they do not have a Social Security Number (SSN) or cannot prove their immigration status. These benefits cover emergency, pregnancy-related and long-term care services.

You can apply for Medi-Cal for your child even if you do not qualify for full coverage.

In California, immigration status does not affect Medi-Cal benefits for children under age 19. Children may qualify for full Medi-Cal benefits, regardless of immigration status.

To learn more about Medi-Cal program rules, read the Medi-Cal Program Comparison on the next page.

Medi-Cal Program Comparison

MAGI vs. Non-MAGI

The Modified Adjusted Gross Income (MAGI) Medi-Cal method uses Federal tax rules to decide if you qualify based on how you file your taxes and your countable income.

Non-MAGI Medi-Cal includes many special programs. Persons who do not qualify for MAGI Medi-Cal may qualify for Non-MAGI Medi-Cal.

Who is eligible:

- Children under 19 years old
- Parents and caretakers of minor children
- Adults 19 through 64 years old
- Pregnant individuals

- Adult aged 65 years or older
- Child under 21
- Pregnant individual
- Parent/Caretaker Relative of an age-eligible child
- Adult or child in a long-term care facility
- Person who gets Medicare
- Blind or have a disability

Property rules:

No property limits.

- Must report and give proof of property such as vehicles, bank accounts, or rental homes
- Limits to the amount of property in the household

For both MAGI and Non-MAGI:

- The local county office will check your application information. You may need to give more proof.
- You must live in California.
- U.S. citizens or lawfully-present applicants must provide their SSN.
- You must apply for any income that you might qualify for such as unemployment benefits and State Disability Insurance.
- You must comply with medical support enforcement* which will:
  - Establish paternity for a child or children born outside of marriage.
  - Get medical support for a child or children with an absent parent.

  If you think you have a good reason not to follow this rule, call your local county office.

How Do I Apply?

You can apply for Medi-Cal at any time of the year by mail, phone, fax, or email. You can also apply online or in person.

You can only apply for Covered California coverage on certain dates. To learn when you can apply, go to ***www.coveredca.com*** or call **1-800-300-1506 (TTY 1-888-889-4500)**.

Apply by mail:

You can apply for Medi-Cal and Covered California with the Single Streamlined Application. You can get the application in English and other languages at: ***http://dhcs.ca.gov/mymedi-cal***. Send completed applications to your local county office.

Find your local county office address at:
http://dhcs.ca.gov/mymedi-cal

You can also send applications to:
Covered California
P.O. Box 989725
West Sacramento, CA 95798-9725

Apply by phone, fax, or email:

Call your local county office. You can find the phone number on the web at ***http://dhcs.ca.gov/mymedi-cal*** or call Covered California at **1-800-300-1506**.

Apply online at:

www.benefitscal.com

OR

www.coveredca.com

In person:

Find your local county office at ***http://dhcs.ca.gov/mymedi-cal***.
You can get help applying.

You can also find a Covered California Certified Enrollment Counselor or Insurance Agent at ***www.CoveredCA.com/get-help/local/***.

How Long Will it Take for My Application to Be Processed?

It may take up to 45 days to process your Medi-Cal application. If you apply for Medi-Cal based on disability, it may take up to 90 days. Your local county office or Covered California will send you an eligibility decision letter. The letter is called a "Notice of Action." If you do not get a letter within the 45 or 90 days, you may ask for a "State Fair Hearing." You may also ask for a hearing if you disagree with the decision. To learn more, read "Appeal and hearing rights" on page 19.

How Do I Use My Medi-Cal Benefits?

Medi-Cal covers most medically necessary care. This includes doctor and dentist appointments, prescription drugs, vision care, family planning, mental health care, and drug or alcohol treatment. Medi-Cal also covers transportation to these services. Read more in "Covered Benefits" on page 12.

Once you are approved, you can use your Medi-Cal benefits right away. New beneficiaries approved for Medi-Cal get a Medi-Cal Benefits Identification Card (BIC). Your health care and dental providers need your BIC to provide services and to bill Medi-Cal. New beneficiaries and those asking for replacement cards get the new BIC design showing the California poppy. Both BIC designs shown here are valid:

Please contact your local county office if:

- You did not get your BIC
- Your BIC is lost
- Your BIC has wrong information
- Your BIC is stolen

Once you are sent a new BIC, you cannot use your old BIC.

You can get the phone number for your local county office at:

http://dhcs.ca.gov/mymedi-cal

or call:

1-800-541-5555 (TTY 1-800-430-7077)

How Do I See a Doctor?

Most people who are in Medi-Cal see a doctor through a Medi-Cal managed care plan. The plans are like the health plans people have with private insurance. Read more about managed care plans starting on the next page.

It may take a few weeks to assign your Medi-Cal managed care plan. When you first sign up for Medi-Cal, or if you have special situations, you may need to see the doctor through "Fee-for-Service Medi-Cal."

What Is Fee-for-Service Medi-Cal?

Fee-for-Service is a way Medi-Cal pays doctors and other care providers. When you first sign up for Medi-Cal, you will get your benefits through Fee-for-Service Medi-Cal until you are enrolled in a managed care health plan.

Before you get medical or dental services, ask if the provider accepts Medi-Cal Fee-for-Service payments. The provider has a right to refuse to take Medi-Cal patients. If you do not tell the provider you have Medi-Cal, you may have to pay for the medical or dental service yourself.

How Are Medical or Dental Expenses Paid on Fee-for-Service Coverage?

Your provider uses your BIC to make sure you have Medi-Cal. Your provider will know if Medi-Cal will pay for a medical or dental treatment. Sometimes you may have to pay a "co-payment" for a treatment. You may have to pay $1 each time you get a medical or dental service or prescribed medicine. You may have to pay $5 if you go to a hospital emergency room when you do not need an emergency service. Those beneficiaries enrolled in a managed care plan do not have to pay co-payments.

There are some services Medi-Cal must approve before you may get them. See page 9 for more information.

How Do I Get Medical or Dental Services When I Have to Pay a Share of Cost (SOC)?

Some Non-MAGI Medi-Cal programs require you to pay a SOC. The Notice of Action you get after your Medi-Cal approval will tell you if you have a SOC. It will also tell the amount of the SOC. Your SOC is the amount you must pay or promise to pay to the provider for health or dental care before Medi-Cal starts to pay.

The SOC amount resets each month. You only need to pay your SOC in months when you get health and/or dental care services. The SOC amount is owed to the health or dental care provider. It is not owed to Medi-Cal or the State. Providers may allow you to pay for the services later instead of all at once. In some counties, if you have a SOC you cannot enroll in a managed care plan.

If you pay for health care services from someone who does not accept Medi-Cal, you may count those payments toward your SOC. You must take the receipts from those health care expenses to your local county office. They will credit that amount to your SOC.

You may be able to lower a future month's SOC if you have unpaid medical bills. Ask your local county office to see if your bills qualify.

What Is Medi-Cal Managed Care?

Medi-Cal Managed Care is an organized system to help you get high-quality care and stay healthy.

> **"Medi-Cal Managed Care health plans help you find doctors, pharmacies and health education programs."**

Most people must enroll in a managed care plan, unless you meet certain criteria or qualify for an exemption. Your health plan options depend on the county you live in. If your county has multiple health plans, you will need to choose the one that fits your and your family's needs.

Every Medi-Cal managed care plan within each county has the same services. You can get the directory of managed care plans at ***http://dhcs.ca.gov/mymedi-cal***. You can choose a doctor who works with your plan to be your primary care physician. Or your plan can pick a primary care doctor on your behalf. You may choose any Medi-Cal

family planning provider of your choice, including one outside of your plan. Contact your managed care plan to learn more.

Managed care health plans also offer:

- Care coordination
- Referrals to specialists
- 24-hour nurse advice telephone services
- Customer service centers

Medi-Cal must approve some services before you may get them. The provider will know when you need prior approval. Most doctors' services and most clinic visits are not limited. They do not need approval. Talk with your doctor about your treatment plan and appointments.

How Do I Enroll in a Medi-Cal Managed Care Plan?

If you are in a county with more than one plan option, you must choose a health plan within 30 days of Medi-Cal approval. You will get an information packet in the mail. It will tell you the health plan(s) available in your county. The packet will also tell you how to enroll in the managed care plan you choose. If you do not choose a plan within 30 days of getting your Medi-Cal approval, the State will choose a plan for you.

Please wait for your health plan information packet in the mail.

> **"If your county only has one health plan, the county chooses the plan for you."**

If you live in **San Benito County**, there is only one health plan. You may enroll in this health plan. Or you may choose to stay in Fee-for-Service Medi-Cal.

If your county has more than one health plan, you will need to choose the one that fits your and your family's needs.

To see what plans are in your county, go to *https://www.healthcareoptions.dhcs.ca.gov/*

How Do I Disenroll, Ask for an Exemption from Mandatory Enrollment, or Change My Medi-Cal Managed Care Plan?

Most Medi-Cal beneficiaries must enroll in a Medi-Cal managed care plan. If you enrolled in a health care plan **by choice**, you may disenroll at any time. To disenroll, call Health Care Options at **1-800-430-4263.**

When your county has more than one plan, you can call Health Care Options if you want to change your managed care health plan.

If you are getting treatment now from a Fee-for-Service Medi-Cal provider, you may qualify for a temporary exemption from mandatory enrollment in a Medi-Cal managed care plan. The Fee-for-Service provider cannot be part of a Medi-Cal managed care plan in your county. The provider must be treating you for a complex condition that could get worse if you have to change providers.

Ask your provider if he or she is part of a Medi-Cal managed care plan in your county. If your provider is not part of a Medi-Cal managed care plan in your county, have your provider fill out a form with you to ask for an exemption from enrolling in a Medi-Cal managed care plan.

Your provider will need to sign the form, attach required proof, and mail or fax the form to Health Care Options. They will review it and decide whether you qualify for a temporary exemption from enrollment in a Medi-Cal managed care plan. You can find the form and instructions at ***http://dhcs.ca.gov/mymedi-cal***.

If you have questions, call **1-800-430-4263.**

What if I Have Other Health Insurance?

Even if you have other health coverage such as health insurance from your work, you may still qualify for Medi-Cal. If you qualify, Medi-Cal will cover allowable costs not paid by your primary insurance. Under federal

law, Medi-Cal beneficiaries' private health insurance must be billed first before billing Medi-Cal.

Medi-Cal beneficiaries are required by federal and state law to report private health insurance. To report or change private health insurance, go to ***http://dhcs.ca.gov/mymedi-cal*** or call **1-800-541-5555 (TTY 1-800-430-7077)**. Outside of California, call **1-916-636-1980.**

You also must report it to your local county office and your health care provider. If you fail to report any private health insurance coverage that you have, you are committing a misdemeanor crime.

Can I Get Medi-Cal Services When I Am Not in California?

When you travel outside California, take your BIC or proof that you are enrolled in a Medi-Cal health care plan. Medi-Cal can help in some cases, such as an emergency due to accident, injury or severe illness. Except for emergencies, your managed care plan must approve any out-of-state medical services before you get the service. If the provider will not accept Medicaid, you will have to pay medical costs for services you get outside of California. Remember: there may be many providers involved in emergency care. For example, the doctor you see may accept Medicaid but the x-ray department may not. Work with your managed care plan to limit what you have to pay. The provider should first make sure you qualify by calling **1-916-636-1960.**

If you live near the California state line and get medical service in the other state, some of these rules do not apply. To learn more, contact your Medi-Cal managed care plan.

> **"You will not get Medi-Cal if you move out of California. You may apply for Medicaid in the state you move to."**

If you are moving to a new county in California, you also need to tell the county you live in or the county you are moving to. This is to make sure you keep getting Medi-Cal benefits. You should tell your local county office within 10 days of moving to a new county.

What Should I Do if I Can't Get an Appointment or Other Care I Need?

The Medi-Cal Managed Care Office of the Ombudsman helps solve problems from a neutral standpoint. They make sure you get all necessary required covered services.

The Office of the Ombudsman:

- Helps solve problems between Medi-Cal managed care members and managed care plans without taking sides
- Helps solve problems between Medi-Cal beneficiaries and county mental health plans without taking sides
- Investigates member complaints about managed care plans and county mental health plans
- Helps members with urgent enrollment and disenrollment problems
- Helps Medi-Cal beneficiaries access Medi-Cal specialty mental health services
- Offers information and referrals
- Identifies ways to make the Medi-Cal managed care program more effective
- Educates members on how to navigate the Medi-Cal managed care and specialty mental health system

To learn more about the Office of the Ombudsman, you can call:

1-888-452-8609

or go to:

http://dhcs.ca.gov/mymedi-cal

How Does Medi-Cal Work if I also Have Medicare?

Many people who are 65 or older or who have disabilities qualify for both Medi-Cal and Medicare. If you qualify for both programs, you will get most of your medical services and prescription drugs through Medicare. Medi-Cal provides long-term services and supports such as nursing home care and home and community-based services.

> **“Medi-Cal covers some benefits that Medicare does not cover.”**

Medi-Cal may also pay your Medicare premiums.

What Is the Medicare Premium Payment Buy-In Program?

The Medicare Premium Payment Program, also called Medicare Buy-In, allows Medi-Cal to pay Medicare Part A (Hospital Insurance) and/or Part B (Medical Insurance) premiums for Medi-Cal members and others who qualify for certain Medi-Cal programs.

What Is the Medicare Savings Program (MSP)?

Medicare Savings Programs may pay Medicare Part A and Medicare Part B deductibles, co-insurance and co-payments if you meet certain conditions. When you apply for Medi-Cal, your county will evaluate you for this program. Some people who do not qualify for full-scope Medi-Cal benefits may still qualify for MSP.

If I Use a Medicare Provider, Will I Have to Pay Medicare Co-Insurance?

No. If eligible to MSP you will not have to pay any co-insurance or deductibles. If you get a bill from your Medicare provider, contact your Medi-Cal managed care plan or call **1-800-MEDICARE.**

If I Have Medicare, Do I Have to Use Doctors and Other Providers Who Take Medi-Cal?

No. You can use any Medicare provider, even if that provider doesn't take Medi-Cal or isn't part of your Medi-Cal managed care plan. Some Medicare providers may not accept you as a patient.

Did you know?

Medi-Cal provides breastfeeding education as part of Maternity and Newborn Care.

You are eligible for routine eye exams once every 24 months.

To learn more about what's offered, visit: ***http://dhcs.ca.gov/mymedi-cal***

Medi-Cal Covered Benefits

Medi-Cal offers a full set of benefits called Essential Health Benefits. To find out if a service is covered, ask your doctor or health plan. Essential Health Benefits include:

- Outpatient services, such as a checkup at a doctor's office
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health services
- Substance use disorder services, such as treatment for drug or alcohol addiction
- Prescription drugs
- Laboratory services, such as blood tests
- Programs such as physical therapy (called rehabilitative and habilitative services) and medical supplies and devices such as wheelchairs and oxygen tanks
- Preventive and wellness services
- Chronic disease management
- Children's (pediatric) services, including oral and vision care
- In-home care and other long-term services and supports

Substance Use Disorder Program

Medi-Cal offers inpatient and outpatient settings for drug or alcohol abuse treatment. This is also called substance use disorder treatment. The setting depends on the types of treatment you need. Services include:

- Outpatient Drug Free Treatment (group and/or individual counseling)
- Intensive Outpatient Treatment (group counseling services provided at least three hours per day, three days per week)
- Residential Treatment (rehabilitation services provided while living on the premises)
- Narcotic Replacement Therapy (such as methadone)

Some counties offer more treatment and recovery services. Tell your doctors about your condition so they can refer you to the right treatment. You may also refer yourself to your nearest local treatment agency. Or call the Substance Use Disorder non-emergency treatment referral line at **1-800-879-2772.**

Medi-Cal Dental Program

Dental health is an important part of overall health. The Medi-Cal Dental Program covers many services to keep your teeth healthy. You can get dental benefits as soon as you are approved for Medi-Cal.

You can see the dental benefits and other resources at ***http://dhcs.ca.gov/mymedi-cal***. Or, you can call **1-800-322-6384 (TTY 1-800-735-2922)** Monday through Friday between 8:00 a.m. and 5:00 p.m.

How Do I Get Medi-Cal Dental Services?

The Medi-Cal Dental Program gives service in two ways. One is Fee-for-Service Dental and you can get it throughout California. Fee-for-Service Dental is the same as Fee-for-Service Medi-Cal. Before you get dental services, you must show your BIC to the dental provider and make sure the provider takes Fee-for-Service Dental.

The other way Medi-Cal gives dental services is through Dental Managed Care (DMC). DMC is only offered in Los Angeles County and Sacramento County. DMC plans cover the same dental services as Fee-for-Service Dental. DHCS uses three managed care plans in Sacramento County. DHCS also contracts with three prepaid health plans in Los Angeles County. These plans provide dental services to Medi-Cal beneficiaries.

If you live in Sacramento County, you must enroll in DMC. In some cases, you may qualify for an exemption from enrolling in DMC.

To learn more, go to Health Care Options at ***http://dhcs.ca.gov/mymedi-cal***.

In Los Angeles County, you can stay in Fee-for-Service Dental or you can choose the DMC program. To choose or change your dental plan, call Health Care Options.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

If you or your child are under 21 years old, Medi-Cal covers preventive services, such as regular health check-ups and screenings. Regular checkups and screenings look for any problems with your medical, dental, vision, hearing, and mental health, and any substance use disorders. You can also get vaccinations to keep you healthy. Medi-Cal covers screening services any time there is a need for them, even if it is not during your regular check-up. All of these services are at no cost to you.

Checkups and screenings are important to help your health care provider identify problems early. When a problem is found during a check-up or screening, Medi-Cal covers the services needed to fix or improve any physical or mental health condition or illness. You can get the diagnostic and treatment services your doctor, other health care provider, dentist, county Child Health and Disability Prevention program (CHDP), or county mental or behavioral health provider says you need to get better. EPSDT covers these services at no cost to you.

Your provider will also tell you when to come back for the next health check-up, screening, or medical appointment. If you have questions about scheduling a medical visit or how to get help with transportation to the medical visit, Medi-Cal can help. Call your Medi-Cal Managed Care Health Plan (MCP). If you are not in a MCP, you can call your doctor or other provider or visit ***http://dhcs.ca.gov/mymedi-cal*** for transportation assistance.

For more information about EPSDT you may call **1-800-541-5555**, go to ***http://dhcs.ca.gov/mymedi-cal***, contact your county CHDP Program, or your MCP. To learn more about EPSDT Specialty Mental Health or Substance Use Disorder services, contact your county mental or behavioral health department.

Transportation Services

Medi-Cal can help with rides to medical, mental health, substance use, or dental appointments when those appointments are covered by Medi-Cal. The rides can be either nonmedical transportation (NMT) or non-emergency medical transportation (NEMT). You can also use NMT if you need to pick up prescriptions or medical supplies or equipment.

If you can travel by car, bus, train, or taxi, but do not have a ride to your appointment, NMT can be arranged.

If you are enrolled in a health plan, call your Member Services for information on how to get NMT services.

If you have Fee-for-Service, you can do the following:

- Call your county Medi-Cal office to see if they can help you get an NMT ride.
- To set up a ride, you should first call your Fee-for-Service medical provider and ask about a transportation provider in your area. Or, you can call one of the approved NMT providers in your area listed at ***http://dhcs.ca.gov/mymedi-cal***.

If you need a special, medical vehicle to get to your appointment, let your health care provider know. If you are in a health plan, you can also contact your plan to set up your transportation. If you are in Fee-for-Service, call your health care provider. The plan or provider can order NEMT such as a wheelchair van, a litter van, an ambulance, or air transport.

Be sure to ask for a ride as soon as you can before an appointment. If you have frequent appointments, your health care provider or health plan can request transportation to cover future appointments.

Go to ***http://dhcs.ca.gov/mymedi-cal*** for more information about rides arranged by approved NMT providers.

Specialty Mental Health Services

If you have mental illness or emotional needs that your regular doctor cannot treat, specialty mental health services are available. A Mental Health Plan (MHP) provides specialty mental health services. Each county has an MHP.

Specialty mental health services may include, but are not limited to, individual and group therapy, medication services, crisis services, case management, residential and hospital services, and specialized services to help children and youth.

To find out more about specialty mental health services, or to get these services, call your county MHP. Your MHP will determine if you qualify for specialty mental health services. You can get the MHP's telephone number from the Office of the Ombudsman at **1-888-452-8609** or go to ***http://dhcs.ca.gov/mymedi-cal***.

Other Health Programs & Services

California offers other programs for your medical needs. You can apply for some through the same local county office that handles Medi-Cal.

From Your Local County Office

You can ask for the programs below from the same local county office where you apply for Medi-Cal. You can get the phone number for your county at ***http://dhcs.ca.gov/mymedi-cal*** or call **1-800-541-5555 (TTY 1-800-430-7077)**.

Former Foster Youth

If you were in foster care on your 18th birthday or later, you may qualify for free Medi-Cal. Coverage may last until your 26th birthday. Income does not matter. You do not need to fill out a full Medi-Cal application or give income or tax information when you apply. For coverage right away, contact your local county office.

Confidential Medical Services

You can apply for confidential services if you are under age 21. To qualify, you must be:

- Unmarried and living with your parents, or
- Your parent must be financially responsible for you, such as college students

You do not need parental consent to apply for or get coverage. Services include family planning and pregnancy care, and treatment for drug or alcohol abuse, sexually transmitted diseases, sexual assault, and mental health.

250% Working Disabled Program

The Working Disabled Program gives Medi-Cal to adults with disabilities who have higher income than most Medi-Cal recipients. If you have earned disability income through Social Security or your former job, you may qualify. The program requires a low monthly premium, ranging from $20 to $250 depending on your income. To qualify, you must:

- Meet the Social Security definition of disability, have gotten disability income, and now be earning some money through work
- Meet program income rules for earned and unearned income
- Meet other program rules

Medi-Cal Access Program (MCAP)

MCAP gives low-cost comprehensive health insurance coverage to pregnant individuals. MCAP has no copayments or deductibles for its covered services. The total cost for MCAP is 1.5% of your Modified Adjusted Gross Income. For example, if your income is $50,000 per year, your cost would be $750 for coverage. You can pay all at once or in monthly installments over 12 months. If you are pregnant and in Covered California coverage, you may be able to switch to MCAP. Babies born to individuals enrolled in MCAP qualify for the Medi-Cal Access Infant Program or for Medi-Cal. To qualify for MCAP, you must be:

- A California resident
- Not enrolled in no-cost Medi-Cal or Medicare Part A and Part B at time of application

- Not covered by any other health insurance plan
- Within the program income guidelines

To learn more about MCAP, go to ***http://dhcs.ca.gov/mymedi-cal*** or call **1-800-433-2611**.

In-Home Supportive Services (IHSS) Program

IHSS helps pay for services so you can remain safely in your own home. If you qualify for Medi-Cal, you may also qualify for IHSS. If you do not qualify for Medi-Cal, you may still qualify for IHSS if you meet other eligibility criteria. If you have Medi-Cal with no SOC, it will pay for all your IHSS services. If you have Medi-Cal with a SOC, you must meet your Medi-Cal SOC before any IHSS services are paid. To qualify, you must be at least **one** of the following:

- Age 65 and older
- Blind
- Disabled (including disabled children)
- Have a chronic, disabling condition that causes functional impairment expected to last at least 12 consecutive months or expected to result in death within 12 months

IHSS can authorize services such as:

- Domestic services such as washing kitchen counters or cleaning the bathroom
- Preparation of meals
- Laundry
- Shopping for food
- Personal care services
- Accompaniment to medical appointments
- Protective supervision for people who are mentally ill or mentally impaired and cannot remain safely in their home without supervision
- Paramedical services

To learn more, go to ***http://www.cdss.ca.gov/In-Home-Supportive-Services***.

Other State Health Services

The programs below have a different application process from Medi-Cal's. You can apply or learn more about the program using the contact information listed.

Breast and Cervical Cancer Treatment Program

The Breast and Cervical Cancer Treatment Program gives cancer treatment and related services to low-income California residents who qualify. They must be screened and/or enrolled by the Cancer Detection Program, Every Woman Counts, or by the Family Planning, Access, Care and Treatment programs. To qualify, you must have income under the limit and need treatment for breast or cervical cancer. To learn more, call **1-800-824-0088** or email ***BCCTP@dhcs.ca.gov***.

Home and Community-Based Services

Medi-Cal allows certain eligible seniors and persons with disabilities to get treatment at home or in a community setting instead of in a nursing home or other institution. Home and Community-Based Services include but are not limited to case management (supports and service coordination), adult day health services, habilitation (day and residential), homemaker, home health aide, nutritional services, nursing services, personal care, and respite care. You must qualify for full-scope Medi-Cal and meet all program rules. To learn more, call DHCS, Integrated Systems of Care Division at **1-916-552-9105**.

California Children's Services (CCS) Program

The CCS program gives diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 who have CCS-eligible medical conditions. CCS-eligible medical conditions are those that are physically disabling or require medical, surgical or

rehabilitative services. Services authorized by the CCS program to treat a Medi-Cal enrolled child's CCS-eligible medical condition are not services that most health plan's cover. The Medi-Cal health plan still provides primary care and preventive health services not related to the CCS-eligible medical condition.

To apply for CCS, contact your local county CCS office. To learn more, go to ***http://dhcs.ca.gov/mymedi-cal*** or call **1-916-552-9105**.

Genetically Handicapped Person's Program (GHPP)

GHPP gives medical and administrative case management and pays for medically-necessary services for persons who live in California, are over age 21, and have GHPP-eligible medical conditions. GHPP-eligible conditions are inherited conditions like hemophilia, cystic fibrosis, Phenylketonuria, and sickle cell disease that have major health effects. GHPP uses a system of Special Care Centers (SCCs). SCCs give comprehensive, coordinated health care to clients with specific eligible conditions. If the service is not in the health plan's covered benefits, GHPP authorizes yearly SCC evaluations for Medi-Cal enrolled adults with a GHPP-eligible medical condition.

To apply for GHPP, complete an application. Fax it to **1-800-440-5318**. To learn more, call **1-916-552-9105** or go to ***http://dhcs.ca.gov/mymedi-cal***.

Retroactive Medi-Cal

If you have unpaid medical or dental bills when you apply for Medi-Cal, you can ask for retroactive Medi-Cal. Retroactive Medi-Cal may help pay medical or dental bills in any of the three months before the application date.

For example, if you applied for Medi-Cal in April, you may be able to get help with bills for medical or dental services you got in January, February and March.

To get retroactive Medi-Cal you must:

- **Qualify for Medi-Cal in the month you got the medical services**
- **Have received medical or dental services that Medi-Cal covers**
- **Ask for it within one year of the month in which you received the covered services**
- **You must contact your local county office to request retroactive Medi-Cal**

For example, if you were treated for a broken arm in January 2017 and applied for Medi-Cal in April 2017, you would have to request retroactive Medi-Cal by no later than January 2018 to pay the medical bills.

If you already paid for medical or dental service you got during the three months of the retroactive period, Medi-Cal may also help you get paid back. You must submit your claim within one year of the date of service, or within 90 days after approval of your Medi-Cal eligibility, whichever is longer.

To file a claim, you must call or write to:

Department of Health Care Services
Beneficiary Services
P.O. Box 138008
Sacramento, CA 95813-8008
1-916-403-2007 (TTY 1-916-635-6491)

For Medical, Mental Health, Substance Use Disorder, and In-Home Support Services Claims

Medi-Cal Dental Beneficiary Services
P.O. Box 526026
Sacramento, CA 95852-6026
1-916-403-2007 (TTY 1-916-635-6491)

For Dental Claims.

Updating & Renewing My Medi-Cal

You must report any household changes within 10 days to your local county office. You can report changes in person, online, by phone, email or fax. Changes can affect your Medi-Cal eligibility.

You must report if you:

- Get married or divorced
- Have a child, adopt or place a child for adoption
- Have a change in income or property (if applicable)
- Get any other health coverage including through a job or a program such as Medicare
- Move, or have a change in who is living in your home
- Have a change in disability status
- Have a change in tax filing status, including change in tax dependents
- Have a change in citizenship or immigration status
- Are incarcerated (jail, prison, etc.) or released from incarceration
- Have a change in American Indian or Alaska Native status or change your tribal status
- Change your name, date of birth or SSN
- Have any other changes that may affect your income or household size

What if I Move to Another County in California?

If you move to another California county, you can have your Medi-Cal case moved to the new county. This is called an Inter-County Transfer (ICT). You must report your change of address to either county within 10 days from the change. You can report your change of address online, in person, by phone, email, or fax. Your managed care plan coverage in your old county will end on the last day of the month. You will need to enroll in a managed care plan in your new county.

When you leave the county temporarily, your Medi-Cal will not transfer. This includes a child going to college or when you take care of a sick relative. Contact your local county office to report the household member's temporary address change to a new county. The local county office will update the address so the household member can enroll in a health plan in the new county.

How Do I Renew My Medi-Cal Coverage?

To keep your Medi-Cal benefits, you must renew at least once a year. If your local county office cannot renew your Medi-Cal coverage using electronic sources, they will send you a renewal form. You will need to give information that is new or has changed. You will also need to give your most current information. You can return your information online, in person, or by phone or other electronic means if available in your county. If you mail or return your renewal form in person, it must be signed.

If you do not give the needed information by the due date, your Medi-Cal benefits will end. Your local county office will send you a Notice of Action in the mail. You have 90 days to give your local county office all the missing information without having to re-apply. If you give the missing information within 90 days and still qualify for Medi-Cal, your local county office will reinstate your Medi-Cal with no gaps in coverage.

Rights & Responsibilities

When you apply for Medi-Cal, you will get a list of your rights and responsibilities. This includes the requirement to report changes in address or income, or if someone is pregnant or gave birth. You can call your local county office or find the most up-to-date list of your rights and responsibilities online at:

http://dhcs.ca.gov/mymedi-cal

Appeal and Hearing Rights

Health Care Services and Benefits

You have the right to ask for an appeal if you disagree with the denial of a health care service or benefit.

If you are in a Medi-Cal managed care plan and you get a Notice of Action letter telling you that a health care service or benefit is denied, you have the right to ask for an appeal.

You must file an appeal with your plan within 60 days of the date on the Notice of Action. After you file your appeal, the plan will send you a decision within 30 days. If you do not get a decision within 30 days or are not happy with the plan's decision, you can then ask for a State Fair Hearing. A judge will review your case. **You must first file an appeal with your plan before you can ask for a State Fair Hearing.** You must ask for a State Fair Hearing within 120 days of the date of the plan's written appeal decision.

If you are in Fee-for-Service Medi-Cal and you get a Notice of Action letter telling you that a health service or benefit has been denied, you have the right to ask for a State Fair Hearing right away. You must ask for a State Fair Hearing within 90 days of the date on the Notice of Action.

You also have the right to ask for a State Fair Hearing if you disagree with what is happening with your Medi-Cal application or eligibility. This can be when:

- You do not agree with a county or State action on your Medi-Cal application
- The county does not give you a decision about your Medi-Cal application within 45 or 90 days
- Your Medi-Cal eligibility or Share of Cost changes

Eligibility Decisions

If you get a Notice of Action letter telling you about an eligibility decision that you disagree with, you can talk to your county eligibility worker and/or ask for a State Fair Hearing. If you cannot solve your disagreement through the county, you must request a State Fair Hearing within 90 days of the date on the Notice of Action. You can ask for a State Fair Hearing by contacting your local county office. You can also call or write to:

California Department of Social Services
Public Inquiry and Response
PO Box 944243, M.S. 9-17-37
Sacramento, CA 94244-2430
1-800-743-8525, (TTY 1-800-952-8349)

You can also file a hearing request online at:

http://www.cdss.ca.gov/

If you believe you have been unlawfully discriminated against on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can make a complaint to the DHCS Office of Civil Rights.

You can learn how to make a discrimination complaint in "Federally Required Notice Informing Individuals About Nondiscrimination and Accessibility Requirements" on page 21.

About State Fair Hearings

The State will tell you it got your hearing request. You will get a notice of the time, date and place of your hearing. A hearing representative will review your case and try to resolve your issue. If the county/State offers you an agreement to solve your issue, you will get it in writing.

You can give permission in writing for a friend, family member or advocate to help you at the hearing. If you cannot fully solve your issue with the county or State, you or your representative must attend the State Fair Hearing. Your hearing can be in person or by phone. A judge who does not work for the county or Medi-Cal program will hear your case.

You have the right to free language help. List your language on your hearing request. Or tell the hearing representative you would like a free interpreter. You cannot use family or friends to interpret for you at the hearing.

If you have a disability and need reasonable accommodations to fully take part in the Fair Hearing process, you may call 1-800-743-8525 (TTY 1-800-952-8349). You can also send an email to *SHDCSU@DSS.ca.gov*.

To get help with your hearing, you can ask for a legal aid referral. You may get free legal help at your local legal aid or welfare rights office.

Third Party Liability

If you suffer an injury, you may use your Medi-Cal to get medical services. If you file an insurance claim or sue someone for damages because of your injury, you must notify the Medi-Cal Personal Injury (PI) program within 30 days of filing your claim or action. You must tell both your local county office and the PI program.

To notify the Medi-Cal PI program, please complete the "Personal Injury Notification (New Case)" form. You can find it on the website below. If you do not have internet access, please ask your attorney or insurance company representative to notify the Medi-Cal PI program on your behalf. You can find notification and update forms at: ***http://dhcs.ca.gov/mymedi-cal***.

If you hire a lawyer to represent you for your claim or lawsuit, your lawyer is responsible for notifying the Medi-Cal PI program and giving a letter of authorization. This authorization allows Medi-Cal staff to contact your lawyer and discuss your personal injury case. Medi-Cal does not provide representation or attorney referrals. Staff can offer information that can help the lawyer through the process.

Estate Recovery

The Medi-Cal program must seek repayment from the estates of certain Medi-Cal members who have died. Repayment is limited to payments made, including managed care premiums, for nursing facility services, home and community based services, and related hospital and prescription drug services when the beneficiary:

- Was an inpatient in a nursing facility, or
- Received home and community based services on or after his or her 55th birthday

If a deceased member does not leave an estate subject to probate or owns nothing when they die, nothing will be owed.

To learn more, go to *http://dhcs.ca.gov/er* or call 1-916-650-0590

Medi-Cal Fraud

Beneficiary responsibilities

A beneficiary must always present proof of Medi-Cal coverage to providers before getting services. If you are getting treatment from more than one doctor or dentist, you should tell each doctor or dentist about the other doctor or dentist providing your care.

It is your responsibility not to abuse or improperly use your Medi-Cal benefits. It is a **crime** to:

- Let other people use your Medi-Cal benefits
- Get drugs through false statements to a provider
- Sell or lend your BIC to any person or give your BIC to anyone other than your service providers as required under Medi-Cal guidelines

Misuse of BIC/Medi-Cal benefits is a crime. It could result in negative actions to your case or criminal prosecution. If you suspect Medi-Cal fraud, waste or abuse, make a confidential report by calling **1-800-822-6222**.

Federally Required Notice Informing Individuals About Nondiscrimination and Accessibility Requirements

DHCS complies with applicable federal and state civil rights laws. DHCS does not unlawfully discriminate on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation. DHCS does not unlawfully exclude people or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation. DHCS:

- Provides free aids and services to people with disabilities to communicate effectively with DHCS, such as:
  - Qualified sign language interpreters
  - Written information in other formats such as large print, audio, accessible electronic formats and other formats
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call the Office of Civil Rights, at **1-916-440-7370, (Ext. 711, California State Relay)** or email ***CivilRights@dhcs.ca.gov***.

If you believe DHCS has failed to provide these services or you have been discriminated against in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation, you can file a grievance at:

Office of Civil Rights
PO Box 997413, MS 0009
Sacramento, CA 95899-7413
1-916-440-7370, (Ext. 711, CA State Relay)
Email: *CivilRights@dhcs.ca.gov*

If you need help filing a grievance, the Office of Civil Rights can help you. Complaint forms are available at:

http://www.dhcs.ca.gov/Pages/Language_Access.aspx

Important Resources

ONLINE

Main Medi-Cal Site:
http://dhcs.ca.gov/mymedi-cal

Get the myMedi-Cal smartphone app to help you learn more about coverage, find local help, and more!

PHONE NUMBERS

Medi-Cal Members & Providers:
1-800-541-5555

Medi-Cal Managed Care:
1-800-430-4263
(TTY 1-800-430-7077)

Office of the Ombudsman:
1-888-452-8609

State Fair Hearing:
1-800-743-8525
(TTY 1-800-952-8349)

Covered California:
1-800-300-1506

Medi-Cal Dental Program:
1-800-322-6384

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. You can file electronically through the Office for Civil Rights Complaint Portal at ***https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*** or you can file by mail or phone at:

U.S. Department of Health
and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, TTY 1-800-537-7697

You can get a complaint form at:

http://www.hhs.gov/ocr/office/file/index.html

This document meets Section 508 accessibility standards. This publication can also be made available in Braille, large print, and other electronic formats in response to a reasonable accommodation request made by a qualified individual with a disability. To ask for a copy of this publication in another format, call the Medi-Cal Eligibility Division at **1-916-552-9200 (TTY 1-800-735-2929)** or email ***MCED@dhcs.ca.gov***.

Language Assistance

Attention: If you speak English, you can call 1-800-541-5555 (TDD 1-800-430-7077) for free help in your language. Call your local county office for eligibility issues or questions. (English)

تنبيه: إذا كنت تتحدث العربية، فيمكنك الاتصال برقم 1-800-541-5555 (TDD 1-800-430-7077) للمساعدة المجانية بلغتك. اتصل بمكتب المقاطعة المحلي للمشكلات أو الأسئلة المتعلقة بالتأهل. (Arabic)

Ուշադրություն: Եթե Դուք հայերեն եք խոսում, կարող եք զանգահարել 1-800-541-5555 (TDD 1-800-430-7077) և անվճար օգնություն ստանալ Ձեր լեզվով: Իրավասության հետ կապված խնդիրների կամ հարցերի դեպքում զանգահարեք Ձեր շրջանային գրասենյակ: (Armenian)

សម្គាល់៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ អ្នកអាចទូរសព្ទទៅលេខ 1-800-541-5555 (TDD 1-800-430-7077) សម្រាប់ជំនួយដោយឥតគិតថ្លៃ ជាភាសារបស់អ្នក។ ទូរសព្ទទៅកាន់ការិយាល័យខោនធីក្នុងមូលដ្ឋានរបស់អ្នកសម្រាប់បញ្ហាទាក់ទងនឹងសិទ្ធិទទួលបានសេវា ឬក្នុងករណីមានសំណួរណាមួយ។ (Cambodian)

注意： 如果您使用中文，請撥打1-800-541-5555 (TDD 1-800-430-7077) 免費獲得以您所用語言提供的協助。關於資格的爭議或問題請致電您所在縣的辦事處。 (Chinese)

توجه: اگر به زبان فارسی صحبت می کنید، می توانید برای دریافت کمک رایگان به زبان خود با شماره 1-800-541-5555 (TDD 1-800-430-7077) تماس بگیرید. برای مسائل مربوط به صلاحیت یا سؤالات، با دفتر محلی شهرستان خود تماس بگیرید. (Farsi)

ध्यान दें: यदि आप हिंदी भाषी हैं, तो आप अपनी भाषा में निःशुल्क सहायता के लिए 1-800-541-5555 (TDD 1-800-430-7077) पर कॉल कर सकते हैं। योग्यता संबंधी समस्याओं या प्रश्नों के लिए अपने स्थानीय काउंटी कार्यालय को कॉल करें। (Hindi)

Lus Ceeb Toom: Yog tias koj hais lus Hmoob, koj tuaj yeem hu rau tus xov tooj 1-800-541-5555 (TDD 1-800-430-7077) kom tau kev pab koj dawb ua koj hom lus. Hu rau lub chaw lis dej num hauv koj lub nroog txog cov teeb meem kev tsim nyog tau txais kev pab los yog cov lus nug. (Hmong)

注意：ご希望により、1-800-541-5555 (TDD 1-800-430-7077) へお電話いただければ日本語で対応いたします。有資格問題または質問などは、地域の代理店までお電話ください。 (Japanese)

주의: 한국어를 말하면, 1-800-541-5555 (TDD 1-800-430-7077) 번으로 무료로 도움을 받으실 수 있습니다. 적격 문제 또는 질문은 해당 지역 카운티 사무소에 문의하십시오. (Korean)

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ທ່ານສາມາດໂທຫາເບີ 1-800-541-5555 (TDD 1-800-430-7077) ເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອຟຣີໃນພາສາຂອງທ່ານ. ໂທຫາຫ້ອງການເຂດໃນທ້ອງຖິ່ນຂອງທ່ານເພື່ອສອບຖາມກ່ຽວກັບເງື່ອນໄຂໃນການມີສິດໄດ້ຮັບ ຫຼື ມີຄຳຖາມອື່ນໆ. (Laotian)

Waac-mbungh: Se gorngv meih gongv mien waac nor, maaiv zuqc cuotv nyaanh gunv korh waac mingh taux 1-800-541-5555 (TDD 1-800-430-7077) yiem wuov maaih mienh tengx faan waac bun meih hiuv duv. Gunv korh waac taux meih nyei kaau dih nyei mienh, Se gorngv meih oix hiuv taux, meih maaih fai maaiv maaih ndaam-dorng leiz puix duqv ziqv nyei buanc. (Mien)

ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਸੀਂ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮੁਫ਼ਤ ਸਹਾਇਤਾ ਪਾਉਣ ਲਈ 1-800-541-5555 (TDD 1-800-430-7077) 'ਤੇ ਕਾਲ ਕਰ ਸਕਦੇ ਹੋ। ਪਾਤਰਤਾ ਸੰਬੰਧੀ ਵਿਵਾਦਾਂ ਜਾਂ ਸਵਾਲਾਂ ਦੇ ਲਈ ਆਪਣੇ ਸਥਾਨਕ ਕਾਉਂਟੀ ਦਫਤਰ ਨੂੰ ਕਾਲ ਕਰੋ। (Punjabi)

Внимание: Если Вы говорите по-русски, Вы можете позвонить по номеру 1-800-541-5555 (TDD 1-800-430-7077), чтобы получить бесплатную помощь на Вашем языке. Позвоните в Ваш местный окружной офис по вопросам или проблемам, связанным с соответствием требованиям. (Russian)

Atención: Si usted habla español puede llamar al 1-800-541-5555 (TDD 1-800-430-7077) para obtener ayuda gratuita en su idioma. Llame a la oficina local de su condado si tiene algún problema o alguna pregunta sobre elegibilidad. (Spanish)

Atensiyon: Kung nagsasalita ka ng Tagalog, maaari kang tumawag sa 1-800-541-5555 (TDD 1-800-430-7077) para sa libreng tulong sa wika mo. Tawagan ang lokal mong tanggapan sa county para sa mga isyu sa pagiging nararapat o mga tanong. (Tagalog)

โปรดทราบ: หากท่านพูดภาษาไทย ท่านสามารถโทรศัพท์ไปที่เบอร์ 1-800-541-5555 (TDD 1-800-430-7077) เพื่อรับความช่วยเหลือในภาษาของท่านโดยไม่เสียค่าใช้จ่าย กรุณาโทรศัพท์หาสำนักงานประจำท้องถิ่นของท่านเพื่อสอบถามเกี่ยวกับสิทธิ์ของท่าน (Thai)

Увага: Якщо ви розмовляєте українською, ви можете зателефонувати за номером 1-800-541-5555 (TDD 1-800-430-7077), щоб отримати безкоштовну допомогу Вашою мовою. З питань стосовно права на пільги та іншої інформації, телефонуйте до вашого місцевого окружного офісу. (Ukrainian)

Lưu ý: Nếu quý vị nói tiếng Việt, quý vị có thể gọi 1-800-541-5555 (TDD 1-800-430-7077) để được trợ giúp miễn phí bằng ngôn ngữ của mình. Hãy gọi văn phòng quận địa phương của quý vị nếu có các vấn đề hoặc thắc mắc về tính đủ điều kiện. (Vietnamese)

California Department of
Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

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CHCF Fact Sheet

CalAIM Explained: Overview of New Programs and Key Changes

California Advancing and Innovating Medi-Cal — more commonly known as CalAIM — is a far-reaching, multiyear plan to transform California's Medi-Cal program and enable it to work more seamlessly with other social services. Led by the California Department of Health Care Services (DHCS), the goal of CalAIM is to improve outcomes for the millions of Californians covered by Medi-Cal, including those with the most complex needs. Pending federal approval, CalAIM would add new programs and make important reforms to many existing programs, bringing in significant federal matching dollars in addition to the $782 million allocated from the general fund in the 2021–22 budget and more in future budget years. This explainer provides an overview of all the changes proposed.

Who CalAIM Will Help

CalAIM's broad reach is intended to help all Medi-Cal enrollees through a focus on population health and greater emphasis on prevention and overall wellness. In addition, there are several specific reforms to improve care for people with the most complex needs. In general, this group includes:

- People with significant behavioral health needs, including people with mental illness, serious emotional disturbance, or substance use disorder
- Seniors and people living with disabilities
- People experiencing homelessness who also have complex physical or behavioral health needs
- People transitioning from jail or prison back to the community who also have complex physical or behavioral health needs
- Children with complex medical conditions, such as cancer, epilepsy, or congenital heart disease
- Children and youth in foster care

For examples of how CalAIM will impact the lives of Medi-Cal enrollees, see *CalAIM Explained: A Five-Year Plan to Improve Medi-Cal*.[1]

New Programs

Under CalAIM, DHCS would create several new Medi-Cal programs to improve care for populations with complex health needs. These build on the Whole Person Care Pilots[2] and Health Homes Program,[3] which are ending in 2021.

- **Enhanced Care Management (ECM).** Today, Medi-Cal is highly fragmented, with some enrollees needing to access care paid for by six or more delivery systems, which can make it difficult for people to navigate across providers and services. For example, a person living with agoraphobia who is unable to leave their home but needs dental care, medical care, and mental health care would need to seek authorization for home-based care from three organizations. In response, a new ECM benefit would provide a high-touch care coordinator for Medi-Cal managed care enrollees with multiple complex needs. If successfully implemented, this benefit would ensure that enrollees with complex needs are identified and engaged by someone who understands their goals, develops a plan in partnership with them and their providers, and actively connects them with the clinical and nonclinical services and resources that help them meet those goals. DHCS has designated a dozen specific populations of focus[4] (PDF) for the ECM benefit, and managed care plans can add to that list at their discretion.

- **Community Supports (or "In Lieu of Services").** Medi-Cal's coverage may be comprehensive when it comes to health care services like doctor's visits, hospital or nursing home stays, or medications and equipment. There are, however, situations where traditional health care services on their own are not enough to support well-being. For example, a person experiencing homelessness who is diagnosed with cancer may not be able to tolerate chemotherapy if they don't have a safe place to stay, rest, and recover from treatment. Traditionally, Medi-Cal has not covered that safe place

to recuperate, instead only covering a nursing home or hospital, which is more than what is needed. In response, DHCS is proposing to give managed care plans the option to substitute new clinical and non-clinical services for traditionally covered services like care in a nursing home or hospital. This would give plans the financial flexibility to meet the needs of members in new, more patient-focused ways. These services, selected based on evidence that they can improve outcomes, are also intended to prevent or limit the kinds of health complications that require more expensive interventions.

DHCS has given plans the option of providing the following community supports[5] (PDF):

Housing supports

- Housing transition navigation services (e.g., assistance applying for and finding housing, signing a lease, securing resources for setup, utilities, moving in)
- Housing deposits
- Housing tenancy and sustaining services (e.g., early intervention around behaviors that might jeopardize housing, dispute resolution with landlords and neighbors, recertification support)

Short-term recovery supports

- Short-term, posthospitalization housing
- Recuperative care[6] (medical respite)
- Respite services for caregivers (such as those caring for people with dementia or children with disabilities) who need short-term relief
- Sobering centers[7]

Independent living supports

- Day habilitation programs (e.g., training on independent living skills like cooking, cleaning, and shopping)
- Nursing facility transition/diversion to assisted living facilities, such as residential care facilities for the elderly and adult residential facilities
- Community transition services / nursing facility transition to a home
- Personal care and homemaker services
- Environmental accessibility adaptations (home modifications)
- Medically tailored meals / medically supportive food
- Asthma remediation

- **Prerelease/in-reach care for people who are incarcerated.** People who are incarcerated are much more likely to be living with chronic illness and/or behavioral health conditions — like mental illness and substance use disorder — compared to people who are not incarcerated. Federal law prohibits Medi-Cal coverage for people while they are incarcerated. Instead, the jail or prison health service delivers and finances most care in facilities. However, people transitioning from incarceration face increased risk of adverse health events, including death. Research shows former prisoners are 129 times more likely than the general public to die of a drug-involved overdose in the two weeks after release,[8] and are also at higher risk for suicide after release.[9] As part of CalAIM, DHCS is seeking federal authority to expand coverage for key Medi-Cal services in the 90 days prior to release from jail or prison to ensure adequate planning for a smooth transition. Services while incarcerated include care management / care coordination, physical and behavioral health consultation services, and medication-assisted treatment for addiction. Following release, DHCS proposes to provide a 30-day supply of medication as well as durable medical equipment needed post-release, such as a walker or a glucometer. In addition, DHCS would mandate that counties implement a prerelease application process by January 1, 2023. The hope is that by enrolling people in Medi-Cal nearing their release and providing some targeted services early, CalAIM can help ease transition back to the community and prevent physical health and behavioral health complications, including the risk of post-release homelessness.

- **Providing Access and Transforming Health (PATH).** To successfully implement CalAIM, many providers will need to increase capacity and capabilities up front. For example, many of the providers that serve CalAIM's populations of focus have never contracted

with managed care plans. In fact, many have never interacted with the Medi-Cal program. Some parts of California may not even have enough providers, and those that do may need to train their workforce in delivering care and services in a coordinated way. The data sharing needed to support that coordination will also require investment in technical infrastructure. To address those needs, DHCS is seeking federal support for infrastructure improvements and technical assistance for community-based providers and correctional facilities. This PATH initiative would be able to cover assistance with contracting and payment processes, workforce development, and staff training. It would cover investments in delivery system infrastructure, such as certified electronic health record technology, care management document systems, closed-loop referral, billing systems and services, and onboarding and enhancements to health information exchange capabilities. PATH would also provide resources for county sheriff departments and state prisons to help with the design and launch of prerelease services. These services include IT services and infrastructure to enable jails and prisons to more easily enroll people in Medi-Cal and to begin coverage and care before they are released.

- **Population health management.** While many of CalAIM's reforms are focused on those with the most complex needs, getting to equitable outcomes requires identifying and addressing issues before they become bigger problems. With that in mind, DHCS has proposed requiring managed care plans to develop a comprehensive population health management program. Plans would need to prioritize prevention and wellness in the following ways: assessing member risk consistently and equitably, ensuring effective care coordination to safeguard members during transitions across settings and systems, and ensuring that plans provide services to address social risk factors (e.g., housing, nutrition) and to meet needs outside the managed care delivery system (e.g., behavioral and oral health). DHCS has also recognized that with data housed in many different places, it can be difficult to proactively identify who needs what services. In response, the agency proposes developing a new technology platform to expand access to medical, behavioral, and social service data — both at the individual member level and for aggregate use by plans.

Key Changes to Existing Programs

CalAIM also proposes other key changes to Medi-Cal, including the following:

- **Behavioral health reforms.** The Medi-Cal behavioral health system today is divided three ways, with substance use services and specialty mental health services administered by counties, often across different departments or agencies, and non-specialty mental health services for people with mild to moderate illness administered by managed care plans. These divisions, and the different rules for payment and documentation surrounding them, make it difficult for patients to find the care they need, and for providers to respond in a patient-centered way. While maintaining the fundamental structure of behavioral health services in Medi-Cal, DHCS proposes reforms to ensure that patients can get treatment wherever they seek care — even before they receive a formal diagnosis — and to clarify the division of responsibility for mental health services between managed care plans and county mental health plans. It would also introduce a reimbursement system for behavioral health services based on the type of care provided, rather than the cost of the care, similar to reimbursement in the physical health system. DHCS also proposes streamlining clinical documentation requirements for specialty mental health and substance use disorder treatment services, with the goal of reducing administrative burden and supporting clinicians to focus more on patient care. Finally, CalAIM would help facilitate the integration of specialty mental health and substance use services at the county level into one behavioral health managed care program and proposes a new benefit — known as contingency management — for people with stimulant use disorder.

- **Aligned incentives and integrated care for seniors and people with disabilities.** Fragmentation of care and services is particularly acute for seniors and people with disabilities.[10] Medicare plays a significant role in paying for health care services for these populations. At the same time, they also receive important services, like nursing home care and personal care attendants,

that are paid for by Medi-Cal and are typically carved out of managed care. Under CalAIM, DHCS proposes reforms and incentives to make it easier for managed care plans to help seniors and people with disabilities stay in their homes and communities rather than move to nursing homes. It would also require plans to provide aligned Medicare and Medi-Cal plans for people eligible for both programs,[11] thereby supporting better integration and coordination of services. These reforms would build on lessons learned from the Coordinated Care Initiative.[12]

- **Standardized and enhanced requirements for managed care.** California has many different models of managed care today, each with a unique set of benefits and covered populations. In addition, there is variation in what plans do around population health management, data sharing, and voluntary accreditation. DHCS proposes a new requirement for managed care plans to proactively reach out to their members based on their needs, share data with other organizations and agencies providing care, and become accredited by the National Committee for Quality Assurance.[13] At the same time, DHCS would also introduce an aligned set of benefits and populations for all managed care plans to standardize their offerings and enable regional rate-setting.

- **More flexible payment for public hospitals that care for the uninsured.** Since 2015, public hospitals have been paid differently for care they provide to the uninsured, moving away from a system that focused on acute and emergency care to one focused on preventive care, including primary care and behavioral health. CalAIM would make the Global Payment Program a stronger tool for addressing health inequities by allowing participating public hospitals to be reimbursed for providing additional nontraditional services that address social determinants of health and improve population health outcomes and health equity. If these reforms are successfully implemented, uninsured patients would receive more preventive care, outreach, and care management services and be less likely to have complications that require an emergency room or hospital visit.

- **Enhanced oversight of county eligibility and enrollment processes.** Today, California delegates many functions of Medi-Cal to counties, including the determination of eligibility for Medi-Cal. There is variation in the degree to which counties successfully fulfill state and federal requirements for these functions. Under CalAIM, DHCS would do more to ensure that county eligibility and enrollment processes are compliant with federal and state regulations. The department plans to convene a workgroup to improve the collection of enrollee contact and demographic information in Medi-Cal and other public assistance programs.

- **Enhanced oversight of county California Children's Services programs.** The California Children's Services program is the primary way that Medi-Cal provides case management services and diagnostic and treatment services — as well as physical and occupational therapy services — to children and youth with eligible medical conditions, like cerebral palsy and diabetes. This program is administered by California's 58 counties. Through CalAIM, the state will enhance its oversight of counties to ensure they comply with applicable state and federal requirements.

- **Model of care for foster youth.** CalAIM would also develop a strategy for a fully integrated model of care for foster youth. DHCS has convened a workgroup[14] to determine short- and long-term policy recommendations for coordinating and improving care for this population.

Timeline for Implementation of CalAIM

DHCS maintains a calendar[15] (PDF) with updated time frames for when different reforms will go live. That should be the primary reference for those seeking more information about the timing of specific CalAIM programs.

This is the second in a series of explainers on CalAIM. The first, *CalAIM Explained: A Five-Year Plan to Transform Medi-Cal*, provides a basic overview of the initiative. Additional publications and resources from CHCF can be found in the CalAIM Collection. Additionally, the Department of Health Care Services has information on CalAIM on its website.

About the Foundation

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Endnotes

1. *CalAIM Explained: A Five-Year Plan to Transform Medi-Cal*, CHCF, October 2021.
2. "Whole Person Care Pilots," California Dept. of Health Care Services (DHCS), last modified September 7, 2021.
3. "Health Homes Program," DHCS, last modified June 16, 2021.
4. *CalAIM Enhanced Care Management Policy Guide* (PDF), DHCS, September 2021.
5. *Medi-Cal In Lieu of Services (ILOS) Policy Guide* (PDF), DHCS, September 2021.
6. Jill Donnelly, Jessica Layton, and Lucy Pagel, *Medical Respite: Post-Hospitalization Support for Californians Experiencing Homelessness*, CHCF, July 2021.
7. Shannon Smith-Bernardin and Bonar Menninger, *Sobering Centers Explained: An Innovative Solution for Care of Acute Intoxication*, CHCF, September 2021.
8. Ingrid A. Bingswanger et al., "Release from Prison — A High Risk of Death for Former Inmates," *New England Journal of Medicine* 356 (Jan. 11, 2007): 156–65.
9. Daniel Pratt et al., "Suicide in Recently Released Prisoners: A Population-Based Cohort Study," *Lancet* 368, no. 9530 (July 8, 2006): 119–23.
10. Giselle Torralba et al., *Meeting the Moment: Strengthening Managed Care's Capacity to Serve California's Seniors and Persons with Disabilities*, CHCF, April 2021.
11. Amber Christ and Georgia Burke, *A Primer on Dual-Eligible Californians: How People Enrolled in Both Medicare and Medi-Cal Receive Their Care*, CHCF, September 2020.
12. "Coordinated Care Initiative Overview," DHCS, last modified October 19, 2021.
13. "Health Plan Accreditation," National Committee for Quality Assurance.
14. "Foster Care Model of Care Workgroup," DHCS, last modified September 15, 2021.
15. *DHCS Major Program Initiatives - Go-Live Dates (pending readiness and federal approvals)* (PDF), DHCS, last updated October 13, 2021.

Los Angeles County Commission on HIV (COH)
2025 Meeting Schedule and Topics - Commission Meetings

FOR DISCUSSION /PLANNING PURPOSES ONLY
12.04.24; 12.30.24; 01.06.25; 2.19.25; 03.09.25; 03.24.25; 03.30.25

- **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.

2025 Meeting Schedule and Topics - Commission Meetings	
Month	**Key Discussion Topics/Presentations**
~~1/9/25 @ The California Endowment~~ Cancelled due to Day of Mourning for former President Jimmy Carter	Commission on HIV Restructure ***facilitated by Next Level Consulting and Collaborative Research*** ~~Brown Act Refresher (County Counsel)~~ Replaced with training hosted by EO on Jan. 30.
~~2/13/25 @ The California Endowment~~ ~~*Consumer Resource Fair will be held from 12 noon to 5pm~~	~~Commission on HIV Restructure ***facilitated by Next Level Consulting and Collaborative Research***~~
~~3/13/25 @ The California Endowment~~	• ~~Year 33 Utilization Report for All RWP Services Presentation (DHSP/Sona Oksuzyan, PhD, MD, MPH)~~ • ~~COH Restructuring Report Out~~
4/10/25 @ St. Anne's Conference Center	• Contingency Planning RWP PY 35 Allocations • ~~Year 33 Utilization Report for RW Core Services Presentation (DHSP/Sona Oksuzyan, PhD, MD, MPH)~~ (Move to PP&A 4/15/25 meeting)

5/8/25 @ Location TBD	• ~~Year 33 Utilization Report for RW Support Services Presentation (DHSP/Sona Oksuzyan, PhD, MD, MPH)~~ (Move to PP&A 4/15/25 meeting) • ~~Unmet Needs Presentation (DHSP/Sona Oksuzyan, PhD, MD, MPH)~~ (Move to PP&A 4/15/25 meeting) • COH Restructuring Workgroups Report and Discussion • Housing Task Force Report of Housing and Legal Services Provider Consultations
6/12/25 @ Location TBD	• Medical Monitoring Project (Dr. Ekow Sey, DHSP) • PURPOSE Study (Requested by Suzanne Molino, PharmD, Gilead Sciences, Inc.) *Anchor presentation as part of prevention-focused conversation and planning
7/10/25 @ Vermont Corridor	Consider cancelling; pending Executive Committee discussion (IAS 2025 July 13-17 in Rwanda)
8/14/25 @ Location TBD	
9/11/25 @ Location TBD	
10/9/25 @ Location TBD	Consider cancelling; pending Executive Committee discussion
11/14/24 @ Location TBD	ANNUAL CONFERENCE
12/12/24 @ Location TBD	Consider cancelling; pending Executive Committee discussion

***Consider future or some of the presentation requests as a special stand-alone virtual offerings outside of the monthly COH meetings.**

America's HIV Epidemic Analysis Dashboard (AHEAD) - Host a virtual educational session on 9/11/25

WORKGROUP OUTCOMES

LOS ANGELES COMMISSION ON HIV COMPREHENSIVE EFFECTIVENESS REVIEW AND RESTRUCTURING PROJECT

MARCH 19-21, 2025

COLLABORATIVE RESEARCH

LOS ANGELES COUNTY COMMISSION ON HIV

NL NEXT-LEVEL CONSULTING

Commission on HIV – Workgroup Report: Restructuring

Introduction

The Los Angeles County Commission on HIV (COH) convened community workgroup sessions from March 19th to 21st, 2025, to address the current challenges facing the Commission. In light of the Board of Supervisors' request for all commissions to review operations and the ongoing budget constraints, directives for the COH are to review its operations in relation to sustainability, enhance operational efficiency, and achieve its federal and local obligations. This report outlines the discussions, findings, and recommendations focusing on restructuring the COH's committees and membership to better align with the available budget and improve its overall impact and effectiveness.

Directive and Overview

The core directive presented to the workgroups was clear: the COH's existing structure is no longer sustainable due to current budget constraints and other factors, and significant changes are necessary to continue its mission. Workgroups were tasked with identifying ways to streamline operations, reduce costs, and maintain the commission's capacity to address HIV-related issues in Los Angeles County. The overarching goal is to ensure that the COH remains reflective of the epidemic while staying efficient and impactful despite reduced resources.

Overarching Themes and Considerations

The workgroups identified several key themes and considerations for restructuring:

- **Purposeful Restructuring**: A shift towards a more focused and intentional structure, with clear functional priorities.
- **Functional Focus**: Ensuring that the COH prioritizes essential functions that align with its mission and responsibilities.
- **Reflecting the Epidemic**: The COH must remain attuned to the evolving nature of the HIV epidemic and adapt its structure and information to drive decision making accordingly.
- **Quorum Issues**: Reducing the number of commissioners to address the ongoing challenge of not meeting quorum, which has hindered the commission's ability to effectively conduct its business.
- **Budget Constraints**: Aligning the COH structure to accommodate financial limitations while ensuring that the COH can still fulfill its duties.

Additionally, several considerations were proposed to optimize the functioning of the COH:

- **Reducing Membership Size**: A smaller membership would help alleviate quorum issues and streamline decision-making processes.

- **Reorganizing Committees**: Merging and refocusing committees where possible to maximize efficiency.
- **Meeting Frequency and Duration**: Reducing the frequency and adjusting the length of meetings to minimize costs and time commitment.
- **Education and Communication**: Providing enhanced training for COH members to better understand their roles and educating providers about the COH's mission.

Committee Restructuring Discussion

The restructuring of COH committees was a major focus of discussion. The workgroups explored ways to consolidate, reorganize, and streamline the committee structure to better align with current needs and budget constraints.

- **Public Policy**: One workgroup suggested maintaining the Public Policy Committee (PPC) as is. However, the most frequent recommendation was to elevate the Public Policy workgroup to the Executive Committee, allowing it to have a broader, more strategic role while streamlining the number of committees. Other suggestions included eliminating the PPC entirely, given that the Chief Executive Office under the direction of the Board of Supervisors has a designated office and staff with policy expertise for this function. A final proposal was to have all committees handle policy-related work.
- **Operations**: A popular suggestion was to rename the Operations Committee to "Membership and Community Engagement," consolidating various non-required city members to be members of this committee; and incorporate faith-based leaders, caucuses and task forces into this committee's work for better alignment and coordination. There was extensive discussion about increased youth representation on the COH. This area of concern should be developed by youth for youth to determine an appropriate path forward with greater representation on the Commission. The Assessment of the Efficiency of the Administrative Mechanism (AEAM) and bylaws could be moved out of this committee work, potentially as well to align workloads.
  One workgroup discussed eliminating the Operations Committee, redistributing its responsibilities to the Executive Committee (Bylaws, Recruitment, Community Outreach) and the Planning, Priorities, and Allocations (PP&A) Committee.
- **Standards and Best Practices**: The committee could absorb additional work to better align with standard development and reduce workload on PP&A. The frequency of meetings could also be reduced, and subject matter experts could be consulted on an as-needed basis.
- **Planning, Priorities, and Allocations (PP&A)**: The PP&A Committee could transfer certain duties (e.g., PSRA) to the full Commission and focus solely on planning responsibilities. This could improve the overall engagement of the full COH. The committee could focus on integrated prevention and care planning efforts.
- **Executive Committee**: This committee could absorb additional functions from the Operations and Public Policy Committees, such as policy review, bylaws and AEAM.

Committee Restructuring Recommendations:
The primary goal of the committee restructuring is to reduce costs while maintaining the effectiveness of the COH's operations. Key recommendations include minimizing the number of meetings, consolidating overlapping functions, and reducing the overall size of the COH membership. Taskforces and caucuses, while valuable, may need to be reevaluated as non-federally required functions under current budget constraints.

Membership Restructuring Discussion

The workgroups also reviewed the current membership structure and identified ways to reduce its size while still ensuring diverse representation and compliance with federal requirements. The key findings are outlined below:

Quorum Challenges: A consistent issue raised by workgroups was the difficulty in meeting quorum due to the large membership size, which hampers the COH's ability to conduct business effectively.

Through the workgroup discussion, there were two scenarios recommended as a potential outcome:

- **Option 1 – Status Quo**: One workgroup preferred maintaining the current structure with 51 members, arguing that Los Angeles County's size necessitates a larger membership to represent diverse communities. However, this option does not address quorum issues, nor does it offer a potential reduction in operational costs.
- **Option 2 – Reduced Membership**: A majority of workgroups (four out of five) favored reducing the membership size by removing non-RWA-required positions, except for the five Board of Supervisors' representatives which is a local requirement. This option proposes the creation of a new "Membership and Community Engagement" committee (formerly Operations) to include cities with separate Health Departments and integrate Part F into the Standards and Best Practices or local AIDS Education and Training Center (AETC) work. Academics/Behavioral social scientists could be included as a required position, reducing the overall membership to 28 COH members. The COH members should be reviewed during the application period for epidemic reflectiveness to include youth representation as a priority since it continues to be a challenge.

Membership Recommendation:
Option 2 is strongly recommended, as it would reduce costs, address quorum challenges, and streamline decision-making. This approach ensures that the COH can meet federal obligations while remaining responsive to the needs of the community.

Conclusion

The workgroup sessions held from March 19th to 21st, 2025, have laid a foundation for a more efficient and sustainable COH. By restructuring committees, reducing membership, and aligning operations with budget constraints, the COH can continue to fulfill its vital mission to address HIV in Los Angeles County. The proposed changes will not only ensure the COH's continued effectiveness, but will also allow it to operate within the fiscal realities currently facing the organization.

The consensus of the workgroups was that the COH needed to restructure with a purpose, while reducing membership to improve the ability to accomplish the business of the COH. The discussion resulted in two potential restructuring recommendations: see Exhibit A and Exhibit B.

Membership of the COH should be scaled down to address the quorum issue of the committees and commission meetings and reduce budget costs. The recommendation is to have a 28-member COH with the following positions: fifteen federally mandated positions, five local required positions, one representing Academia, and 7 non-affiliated reflective members.

Moving forward, it will be crucial to continue monitoring the implementation of these changes and adjust as needed to maintain a balance between operational efficiency and the COH's public health objectives.

Exhibit A

Restructure Recommendation 1

Commission of HIV

- Clearing House of all operations duties of the Commission
- Priority Setting and Resource Allocation
- Monitor Prevention and Care Funds

Executive Committee

- Oversee administrative and operational activities
- Serve as the clearing house to review and forward items for discussion, approval and action to the Commission and its various working groups/units
- Act on an emergency basis on behalf of the Commission, as necessary, between regular meetings of the Commission;
- Approve the agendas for the Commission's regular, Annual & special meetings;
- Address matters related to Commission office staffing, personnel and operations, when needed;
- Develop and adopt the Commission's annual operational budget
- Overseeing and monitoring Commission expenditures and fiscal activities; and
- Carry out other duties and responsibilities, as assigned by the BOS or the Commission.
- Provide Public Policy recommendations on areas that impact STD/HIV
- Bylaws and policy reviews and updates

Integrated Planning

- Needs assessments
- Comprehensive HIV Plan
- Monitoring prevention and care funds
- Monitoring service needs and systems improvements
- Service utilization review
- AEAM
- Service Standards
- QM data activities

Membership and Community Outreach

- Membership, recruitment, retention, leadership development and training
- Community Outreach and Engagement
- Community report out
- Caucus reports
- Taskforce Reports

Frequency: 6 times a year with Priority Setting & Resource Allocation in a shorter timeframe closer together for the full Commission. Half-day planning session resulting in two separate days with one day priority ranking and one day allocation setting.

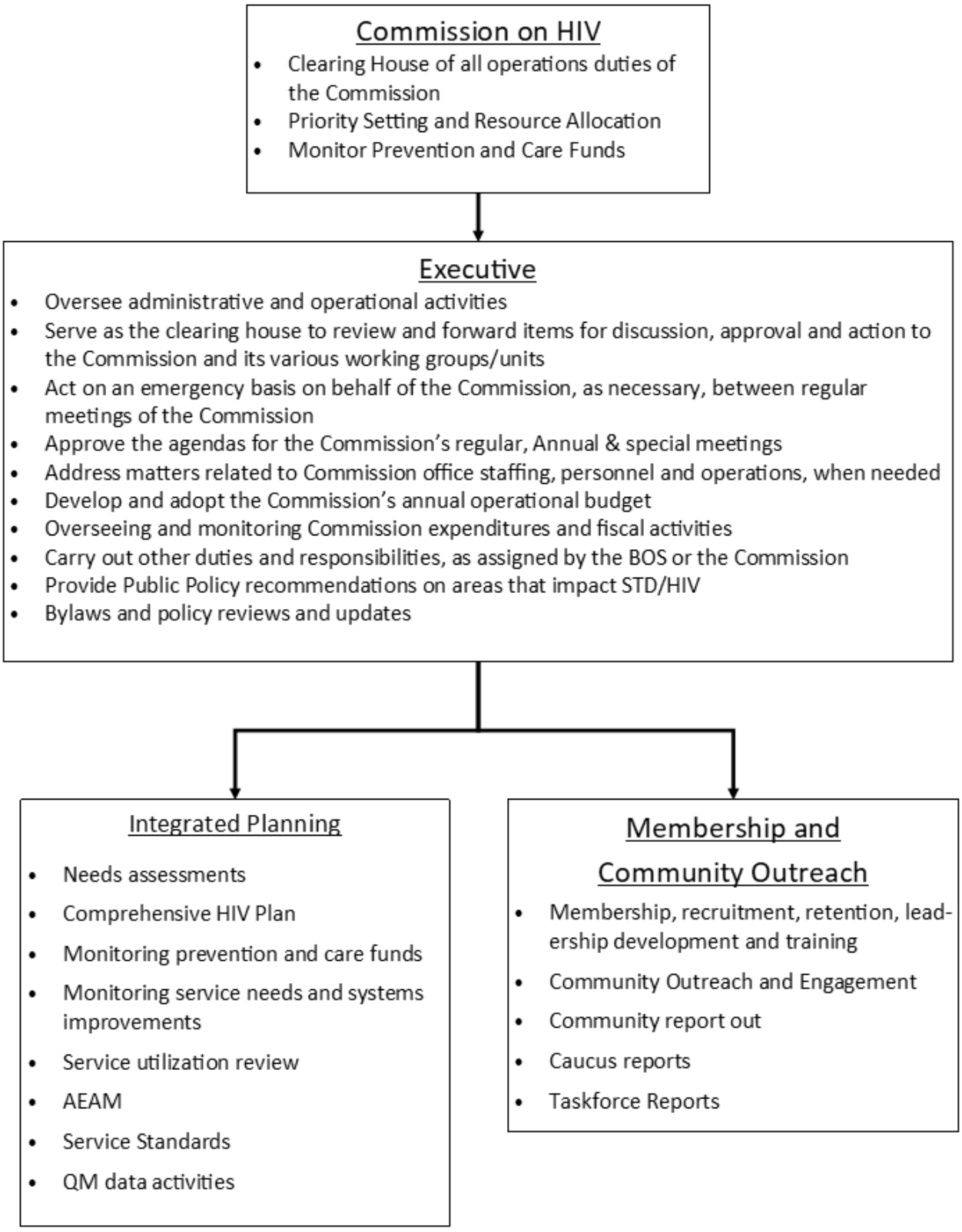

Figure 1 Exhibit A - Frequency is 6 times a year with P&R in a shorter timeframe closer together for the full Commission. Half-day planning session resulting in two separate days with one day priority ranking and one day allocation setting.

Exhibit B

Restructure Recommendation 2

Commission of HIV

- Clearing House of all operations duties of the Commission

Executive Committee

- Oversee administrative and operational activities
- Serve as the clearing house to review and forward items for discussion, approval and action to the Commission and its various working groups/units
- Act on an emergency basis on behalf of the Commission, as necessary, between regular meetings of the Commission;
- Approve the agendas for the Commission's regular, Annual & special meetings;
- Address matters related to Commission office staffing, personnel and operations, when needed;
- Develop and adopt the Commission's annual operational budget
- Overseeing and monitoring Commission expenditures and fiscal activities; and
- Carry out other duties and responsibilities, as assigned by the BOS or the Commission.
- Provide Public Policy recommendations on areas that impact STD/HIV
- Bylaws and policy reviews and updates

Planning, Priorities and Allocations

- Priority Setting and Resource Allocation
- Monitor Prevention and Care Funds
- Needs assessments
- Comprehensive HIV Plan
- Monitoring prevention and care funds
- Monitoring service needs and systems improvements
- Service utilization review

Standards and Best Practices

- Service Standards
- Best practice recommendations
- QM data activities
- AEAM

Membership and Community Outreach

- Membership, recruitment, retention, leadership development and training
- Community Outreach and Engagement
- City reports
- Caucus reports
- Taskforce Reports

Frequency - All committees are to meet 6 times a year. Work PSRA into a multi-day longer session in the summer months, before the application is due, usually before August.

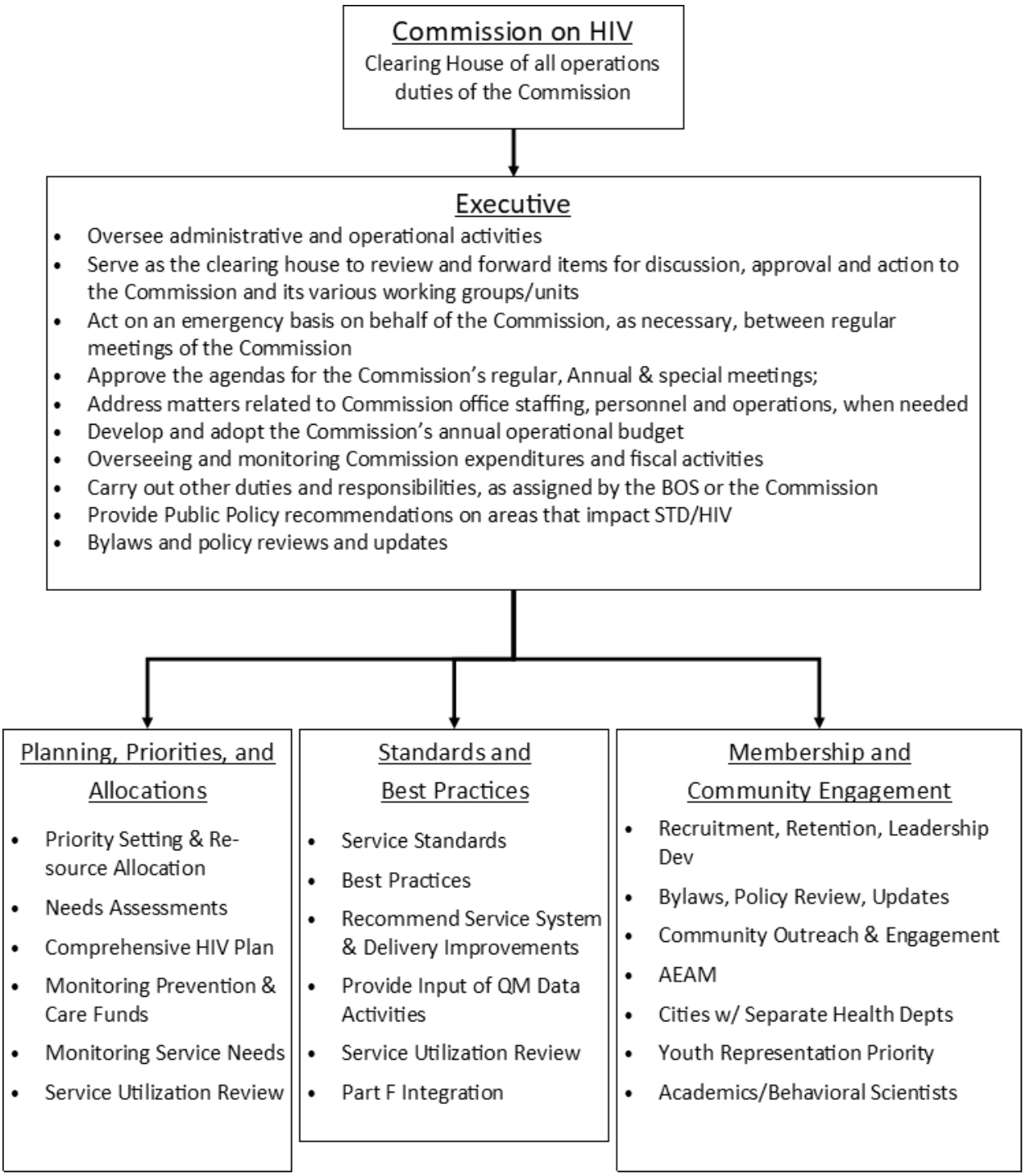

Figure 2 Exhibit B - All committees are to meet 6 times a year. Work PSRA into a multi-day longer session in the summer months, before the application is due, usually before August.

From: HRSA HIV/AIDS Bureau
To: Barrit, Cheryl
Subject: HRSA HIV/AIDS Bureau Special Bulletin - April 7, 2025
Date: Monday, April 7, 2025 2:26:38 PM

HIV/AIDS Bureau Header

HRSA HIV/AIDS Bureau Update: Special Bulletin

The Health Resources and Services Administration's (HRSA) HIV/AIDS Bureau (HAB) shares the following update with our Ryan White HIV/AIDS Program (RWHAP) and HAB Ending the HIV Epidemic in the U.S. (EHE) recipients, subrecipients, stakeholders, national partners, and federal colleagues.

Dear Colleague Letter from HRSA Administrator Thomas J. Engels

HRSA Administrator Thomas J. Engels has issued a Dear Colleague Letter. It will be posted on HRSA's HIV/AIDS Bureau's website.

Dear Ryan White HIV/AIDS Program Awardees and Stakeholders,

Since its inception over three decades ago, the Ryan White HIV/AIDS Program (RWHAP) has been a cornerstone of hope and a lifeline for Americans living with HIV and AIDS. The largest federal initiative of its kind, RWHAP has provided critical care and support to low-income, uninsured, and under-insured Americans with HIV and AIDS. During his first term, President Donald J. Trump championed the ambitious Ending the HIV Epidemic initiative, a transformative plan to reduce new HIV infections by 75 percent by 2025 and 90 percent by 2030. Now in President Trump's second term, the Health Resources and Services Administration's (HRSA) HIV/AIDS Bureau (HAB) stands recommitted and ready to achieve this bold agenda. With your support and collaboration, HAB will leverage the RWHAP to fulfill this Administration's pledge to all Americans, particularly those living with HIV/AIDS—to Make America Healthy Again.

Program integrity and responsible fiscal stewardship are critical elements of the indispensable services RWHAP provides. But under the previous administration, certain interpretations of RWHAP's allowable uses, as outlined in prior communications, co-opted the program's patient-centered mission in favor of radical ideological agendas and policies.[1] Congress envisioned RWHAP as a lifeline for those battling HIV and AIDS, not as a vehicle for broader social or medical experimentation. More to the point, this politicized commandeering risks diverting resources away from HIV/AIDS patients, whose lives depend on RWHAP's core medical services.

Accordingly, HAB reaffirms that RWHAP funds shall be marshaled exclusively toward evidence-based interventions proven to combat HIV, sustain viral suppression, and improve the quality of life for those living with the disease. This includes outpatient medical care, antiretroviral therapies, and essential support services such as case management, housing assistance, and substance use disorder treatment—each a vital thread in the fabric of HIV/AIDS care, each demonstrably aligned with the program's statutory intent.[2]

We clarify and remind RWHAP awardees that funds are not authorized for procedures or interventions beyond the scope of outpatient care, as expressly delineated in Policy Clarification Notice #16-02.[3] The prohibition on surgeries and inpatient care, irrespective of setting or anesthesia, remains absolute, ensuring that resources remain laser-focused on the HIV-specific needs of eligible individuals. Where disparities persist, particularly among underserved populations, our response shall be targeted, evidence-driven enhancements to HIV care delivery, not a broadening of scope that risks undermining this progress.

The Trump Administration, in its renewed commitment to Make America Healthy Again, calls upon RWHAP recipients and subrecipients to join us in this realignment. We will provide training and technical assistance through the AIDS Education and Training Centers to ensure culturally competent, patient-centered care that maximizes antiretroviral adherence and viral suppression—goals that unite us in the fight to end the HIV epidemic. Together, we can honor the congressional vision that birthed RWHAP, delivering on its promise to those it was designed to serve, without deviation or distraction.

Sincerely,

Thomas J. Engels

Administrator

[1] Health Resources and Services Administration, Gender Affirming Care and the Ryan White

HIV/AIDS Program (2021), https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/hiv-care/gender-affirming-care-rwhap.pdf.

[2] *See generally* 42 U.S.C. §§ 300ff-11-140.

[3] Eligible Individuals & Allowable Uses of Funds Clarification Notice. Available at: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf.

Sign up for the RWHAP listserv and share the link with a friend/colleague.

For additional information on the HIV/AIDS Bureau and the Ryan White HIV/AIDS Program, check out our website.

Follow HRSA on X, Facebook, and Instagram.

HRSA HAB Logo

STAY CONNECTED:

Questions for HRSA?
Contact us

STANDING COMMITTEES AND CAUCUSES REPORT | KEY TAKEAWAYS | APRIL 10, 2025

1. Operations

Link to the Operations Committee meeting packet can be found HERE.
Key outcomes/results from the meeting:

- The Operations Committee last met on March 27, 2025.
- Executive Director, Cheryl Barrit, informed the Committee that the Restructuring Work Group sessions received positive feedback, and staff will pursue ways for commissioners who were unable to participate to provide input.
- Operations Co-Chair, Erica Robinson, led the Committee in a discussion regarding exploring alternative meeting options, including reducing the frequency of committee meetings in light of limited resources and preparation for the Commission restructuring outcomes. The Committee agreed that one way to facilitate the best use of time, positive meeting outcomes, and make informed decisions is for commissioners to take personal responsibility to read the meeting materials prior to meetings.
- The Committee reviewed responses to the Assessment of the Efficiency of the Administrative Mechanism (AEAM) survey; a draft report will be reviewed at the April 23rd meeting.
- The Committee discussed interest for participating in upcoming PRIDE events. Staff will poll Commissioners if there is interest in hosting a resource table and participating in the West Hollywood (WeHo) parade.

Action needed from full body:

- The next Operations Committee meeting will be held on Thursday, April 24th, from 10 am – 12 pm.
- Register for and attend the upcoming Priority Setting and Resource Allocations Process training on April 23rd from 12 pm – 1 pm.

2. Executive

Link to the March 27, 2025 meeting packet can be found HERE.
Key outcomes/results from the meeting:

- The Committee approved the following items for full council's approval on April 10th: Housing service standards, Transgender Caucus statement of solidarity, and the 20205 Legislative Docket.
- Discussed gauging interest from Commissioners who may be willing to chair a Latino Caucus if it was established.
- Staff reported that a formal report on the outcomes of the COH restructuring workgroups will be included in the April 10 COH packet.

- Agreed to prioritize contingency planning for April 10 COH meeting. Dr. Green will use the slides DHSP presented at the HIV provider meeting held on March 25 with additional Ryan Whtie service utilization data to help the COH with their deliberations. The remaining Ryan White service utilization data and unmet needs presentations will be delivered instead at the upcoming Planning, Priorities and Allocations (PP&A) Committee meetings.
- Brainstormed on ideas on team building activities for Commissioners. D. Russell agreed to send ideas to the Co-Chairs for feedback.
- Dr. M. Green, representing, DHSP, reported that an HIV service provider meeting on the uncertainty of Ryan White and CDC funding for HIV services was convened on March 25. DHSP leadership is lining up meetings with the Board and DPH leadership to appeal for full funding to fill the gap in HIV resources. DHSP is also meeting with the Substance Abuse Prevention and Control (SAPC) to explore if they have resources that may be shifted to support HIV services. Additionally, DHSP leadership have also met with the County Homeless Initiative (HI) Executive Director (Cheri Todoroff) to explore the possibility of shifting HIV-related housing costs/services to HI. Based on the conversation with HI Executive Director, it was reported that DHSP should be able to reasonably support transitioning RCFCI, TRCF, and SUD transitional housing clients to other beds and facilities administered by the HI program.
- DPH has been severely affected by the current funding landscape and recently lost $43 million that support public health core infrastructure.

Action needed from full body:

- Commissioners are reminded to complete all training requirements and associated quizzes. The training schedules, slides and recordings are posted on the COH website.

3. Planning, Priorities and Allocations (PP&A)

Link to the February Planning, Priorities and Allocations meeting packet can be found HERE.

Key outcomes/results from the meeting:

- During their February meeting, the Planning, Priorities and Allocations Committee welcomed four new members to the committee - G. Green, R. Lester, I. Salamanca and C. Vega-Matos.
- DHSP staff provided a Program Year 34 (PY34) Expenditures report to the Committee. The report focused on minor updates to Part A and Minority AIDS Initiative (MAI) expenditures from the February report as well as current spending to date and end of year (February 28, 2025) projections for Ryan White Part B and Ending the HIV Epidemic (EHE) funds. The report shows that both Ryan White Part B and EHE will fully expend program funds for PY34.

- To date, DHSP has received a HRSA EHE partial notice of award of $3.3 million and a Part A and MAI partial notice of award of approximately $8 million. At this time, DHSP does not know when they will receive a final notice of award for RWP Part A and MAI and cannot expect funding beyond the partial award. DHSP noted that the County had seen increases in funding in recent years and is now shifting into a period of limited resources. Difficult conversations are needed to decide how to best use the limited resources available.
- The Committee began discussions around contingency planning in the event of reduced RWP Part A and MAI funding. The Committee outlined a contingency plan for the worst-case scenario of currently secured available funding at $13 million deciding to preserve Ambulatory Outpatient Medical (AOM) services, Medical Transportation Services, Benefits Specialty Services and Medical Care Coordination (MCC) Services. Finally, the Committee suggested developing additional contingency planning scenarios between 25-70% reductions (of the total award amount based on the PY34 final award of $42 million).
- The next PP&A Committee meeting will be on Tuesday, April 15th from 1pm-3pm at the Vermont Corridor.

Action needed from full body:

- Commissioners should continue review the PP&A meeting minutes and attend PP&A Committee meetings, when possible, to stay informed of current funding challenges, to develop a deeper understanding of the priority setting and allocation process, and to observe how data is used to inform decision-making.

4. Standards and Best Practices (SBP)

Link to the April 1, 2025, meeting packet can be found HERE.

Key outcomes/results from the meeting:

- The Standards and Best Practices (SBP) committee reviewed their service standard revision tracker and decided to review the following service standards: Mental Health, Legal Services, and Patient Support Services.
- The committee continued their review of the Transitional Case Management (TCM) service standards and discussed the service components to include in the document. The revised TCM service standards document will include guidance for the following special populations: youth, justice-involved, and older adults 50+. Lastly, the committee decided to invite subject matter experts to their next meeting to inform their deliberations.
- The next SBP committee meeting will be on Tuesday, May 6, 2025, from 10am-12pm at the Vermont Corridor. Committee members, commissioners, and members of the public planning on attending the meeting must check-in with security personnel on the 9th floor lobby and wait to be escorted to the 14th by a COH staff member.

Action needed from full body:

- Encourage consumer participation in the service standard development process.

5. Public Policy

Link to the April 7, 2025, meeting packet can be found HERE.

Key outcomes/results from the meeting:

- The Public Policy Committee (PPC) did not meet in April. Additionally, the May 5, 2025, PPC meeting is canceled. The next PPC meeting will be on June 2, 2025.

Action needed from full body:

- Review the bills on the 2025-26 Legislative Docket included in the meeting packet.

6. Aging Caucus

The Aging Caucus meets every other month and will not meet during the month of April. The Aging Caucus last met on March 11, 2025.

Link to the March 11, 2025 meeting packet can be found HERE.

Key outcomes/results from the meeting:

- The Aging Caucus met on 3/11/25 , virtually from 1pm to 2pm and finalized their 2025 key priorities and brainstormed on ideas for a cross-caucus collaborative event (slated for September) to address HIV and aging across intersectional identities and age groups.

Action needed from full body:

- Keep informed of resources regarding Medicaid and Medicare, which are critical resources for low income, older adults, and people with disabilities.
  - ☐ How Medicaid Funding Caps Would Harm Older Adults
  - ☐ Lambda Legal Help Desk
  - ☐ Facing the Future Together: FAQs, Guidance, & Resources for Older Adults
- Join the next Aging Caucus virtual meeting on May 13, 2025 from 1pm to 2pm.

7. Black Caucus

The Black Caucus last met on March 20, 2025; link to the meeting packet can be found HERE.

Key outcomes/results from the meeting:

- **Co-Chair Nominations & Election.** A second round of nominations for the 2025 Black Caucus Co-Chair position was opened to fill a vacancy. To ensure fairness and allow

space for additional candidates, a new election was held. Congratulations to Dechelle Richardson, who will now serve as Co-Chair alongside Dr. Leon Maultsby.

- **Organizational Assessment & Recommendations.** Consultant, Equity & Impact Solutions, presented findings from the second phase of the organizational needs assessment focused on Black-led and Black-serving organizations in Los Angeles County. This assessment builds on previous recommendations and sheds light on ongoing barriers to funding, organizational capacity, and sustainability. The Los Angeles County Black-Led Organizations Assessment: Integrated Report can be found HERE. Plans are in motion to host a focus group for organizations not included in the initial assessment.
- **Community Listening Sessions**. Final community listening sessions will be conducted to center the voices of:
    - Non-Traditional HIV Providers
    - Transgender individuals
    - Youth
    - Justice-involved persons
    - Heterosexual men and men who do not identify as MSM
- **Next Virtual Meeting**. The next meeting will be held virtually on April 17, 2025 at 4PM.

Action needed from full body:

- Attend the April 17, 2025, virtual meeting and support outreach efforts to ensure broad community participation.

8. Consumer Caucus

The Consumer Caucus last met on March 13, 2025; the link to the meeting packet can be found HERE.

Key outcomes/results from the meeting:

- **February Resource Fair Recap.** Despite the rain, our February 13th Consumer Resource Fair was a success! Over 200 attendees came out to receive vital resources and support related to HIV care and services.
- **DHSP Clinical Quality Management (CQM) Program.** DHSP consultant Michael Haeger provided an overview of DHSP's Clinical Quality Management (CQM) program, which aims to improve health outcomes through strong infrastructure, outcomes measurement, and quality improvement projects. DHSP will keep the Caucus informed and updated on CQM's efforts.
- **Housing Service Standards Review.** The Caucus reviewed and provided feedback on the Housing Service Standards.
- **2025 Co-Chair Elections.** Congratulations to our newly elected Consumer Caucus Co-Chairs: Alasdair Burton, Ish Herrera, and Vilma Mendoza! Special thanks and

appreciation to 2024 Caucus Co-Chairs, Lilieth Conolly and Damone Thomas, for their service and leadership.

- **Meeting Timing Feedback.** Although it was acknowledged that holding Consumer Caucus meetings after full Commission meetings can make for a long day, many members expressed a strong preference for keeping them on the same day. This structure supports better attendance, as many indicated they would be unable to join if the meetings were scheduled separately.
- **April 10, 2025, Ryan White Dental Services Listening Session**. This session will provide a space for consumers and providers of Ryan White Program Oral Healthcare services to share their experiences, needs, and recommendations. See FLYER for details.

Action needed from full body:

- Share the April 10 Ryan White Dental Services Listening Session flyer to both consumers and providers to encourage broad participation.
- Engage in Commission and Committee meetings by offering consumer perspectives, sharing feedback, and staying informed on key issues impacting HIV services.

9. Transgender Caucus

The Transgender Caucus last met on March 25, 2025; link to the meeting packet can be found HERE.

Key outcomes/results from the meeting:

- **Solidarity Statement Updates:** The Caucus discussed proposed edits to the draft solidarity statement including the use of appropriate terminology. Caucus members recommended to include examples highlighting the accomplishments and resiliency of the Transgender, Gender-Expansive, Intersex, Two-Sprit + (TGI2S+) community in the solidarity statement. The revised draft was shared with the Executive Committee and is included in the meeting packet.
- **Community Listening Sessions Collaboration with Women's Caucus:** The Caucus reviewed the suggested discussion questions developed by the Women's Caucus and provided feedback on the next steps for conducting a community listening session for transgender women. Caucus members volunteered to host/lead a listening session and will meet with COH staff to discuss logistics. Additionally, the Caucus discussed developing a toolkit to share with listening session participants.

Action needed from full body:

- Read the solidarity statement included in the meeting packet and once approved by the full body of the COH, disseminate widely.
- Join the next virtual Transgender Caucus meeting on April 22, 2025, from 10am to 11:30am.

10. Women's Caucus

Link to the January Women's Caucus meeting packet can be found HERE.

Key outcomes/results from the meeting:

- The Women's Caucus last met on March 17 and continued planning for upcoming women's listening sessions. The chairs noted that the plan is to host 3-4 in-person listening sessions in May through June with at least one session devoted to Spanish-speakers and another session targeting transgender women. The Transgender Caucus will take the lead in planning and executing the listening session for transgender women.
- The Caucus reviewed the suggested discussion questions and provided feedback to improve and refine the questions.
- Dr. Spencer offered to host a listening session and Commission staff are working with co-chairs to identify additional locations and solidify listening session dates and times. More details to follow.
- The next virtual Women's Caucus meeting will be on Monday, May 19 from 2pm-3pm via Webex.

Action needed from full body:

- Continue to promote the WC within your networks and identify potential partners and locations to assist with hosting listening sessions.

11. Housing Task Force

Link to the March 28 meeting packet can be found HERE.

Key outcomes/results from the meeting:

- Healthcare Matters Inc., delivered a presentation titled, "Understanding Healthcare Access and Experiences in Skid Row." The presentation discussed healthcare access and experiences in Los Angeles, highlighting the use of street medicine and mobile health services, the need for food and housing assistance, and the importance of peer support models.
    - Majority of respondents in Skid Row had health insurance, primarily Medi-Cal
    - Street medicine and mobile health services were utilized by 80% of respondents, with high likelihood of using them again.
    - Food assistance services and housing assistance are the most requested services by individuals.
    - Street medicine and mobile health services are highly valued and helpful, but there are issues with continuity of care.
    - Peer support and community health worker models have been successful in filling gaps in healthcare access.
    - About four individuals out of the 200 disclosed that they are HIV positive.
    - People who tested positive already knew their status and used the tests to check on their current condition.

  - Majority of the 200 tests were done without compensation, indicating a strong desire for individuals to know their status.
  - Limited new positives found in on-the-street HIV testing, further investigation needed.
  - Need to gather data from other street medicine programs to compare results and prevalence of HIV.
- The HTF reviewed its 2025 workplan and prioritized developing a housing needs assessment among PLWH. Once the data collected is analyzed and finalized, the HTF will convene a housing summit composed of housing services policy and decision-makers in the County and present the findings and discuss pathways to housing services for PLWH. The HTF discussed presenting their findings from the Ryan White housing and legal services provider consultations at the May 8 Commission meeting.
- The HTF will present key themes from consultations held with RW housing and legal services providers at the May full COH meeting.

Action needed from full body:

- Read the March 28 meeting packet for details on the Healthcare Matters, Inc. presentation.
- Send specific questions to include in the housing needs assessment to staff.
- Join the virtual HTF meeting on April 25 from 9am to 10am.

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave. Floor 14, Los Angeles, CA 90020| (213) 738-2816 | hivcomm@lachiv.org

DRAFT FOR COH REVIEW *(As of 04/08/25)*

HOUSING SERVICE STANDARDS: RESIDENTIAL CARE FACILITY FOR THE CHRONICALLY ILL (RCFCI) AND TRANSITIONAL RESIDENTIAL CARE FACILITY (TRCF)

IMPORTANT: The service standards for Residential Care Facility For the Chronically Ill (RCFCI) and Transitional Residential Care Facility (TRCF) 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 Policy Clarification Notice (PCN) # 18-02: The use of Ryan White HIV/AIDS Program Funds for Core Medical Services and Support Services for People Living with HIV Who Are Incarcerated and Justice Involved

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

PURPOSE: Service standards outline the elements and expectations a Ryan White service provider follows when implementing a specific service category. The purpose of the service standards is to ensure that all Ryan White service providers offer the same fundamental components of the given service category across a service area. Service standards establish the minimal level of service or care that a Ryan White funded agency or provider may offer in Los Angeles County.

Description

Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

Housing activities also include housing referrals services, including assessment, search placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

Program Guidance:

HRSA RWHAP recipients and subrecipients that use funds to provide Housing must have mechanisms in place to assess and document the housing status and housing service needs of new clients, and at least annually for existing clients.

HRSA RWHAP recipients and subrecipients, along with local decision-making planning bodies, are strongly encouraged to institute duration limits to housing activities. HRSA HAB recommends recipients and subrecipients align duration limits with those definitions used by other housing programs, such as those administered by the Department of Housing and Urban Development, which currently uses 24 months for transitional housing.

Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments. RWHAP funding may be used to pay for a RWHAP client's security deposit **if** a RWHAP recipient or subrecipient has policies and procedures in place to ensure that the security deposit is returned to the RWHAP recipient or subrecipient and not to the RWHAP client. https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/hrsa-hab-security-deposit-program-letter.pdf

BASIC ELIGIBILITY AND DOCUMENTATION REQUIREMENTS FOR RYAN WHITE SERVICES IN LOS ANGELES COUNTY

- Have an HIV-positive diagnosis; Be a resident of Los Angeles County;
- Have an income at or below 500% of Federal Poverty Level, and;
- Be uninsured or underinsured.
- Given the barriers with attaining documentation for unstably housed PLWH, contractors are expected to follow the Los Angeles County, Department of Public Health, Division of HIV and STD Programs (DHSP) guidance for using self-attestation forms to documentation eligibility for Ryan White services.

RESIDENTIAL CARE FACILITY FOR THE CHRONICALLY ILL (UP TO 24 MONTHS) GENERAL REQUIREMENTS

Residential Care Facilities for the Chronically Ill (RCFCI) are licensed under the California Code of Regulations, Title 22, Division 6, Chapter 8.5 to provide services in a non-institutional, home-like environment in any building or housing arrangement which is maintained and operated to provide 24-hour care and supervision to the following PLWH: Adults 18 years age or older; unable to work.

The goal of the RCFCI program is to improve the health status of PLWH who need to receive care, support, and supervision in a stable living environment to improve their health status. Clients receiving RCFCI services will have a maximum stay of 24 months. Approval will be required for extensions beyond 24 months based on the client's health status. Additional services provided can include case management services, counseling, nutrition services, and consultative services regarding housing, health benefits, financial planning, and referrals to other community or public resources.

Each RCFCI program must adhere to the following general requirements:

RCFCI GENERAL REQUIREMENTS	
STANDARD	**MEASURE**

RCFCIs are licensed to provide 24-hour care and supervision to any of the following: • Adults 18 years of age or older with living HIV/AIDS	Program review and monitoring to confirm.
RCFCIs may accept clients that meet each of the following criteria: • Have an HIV/AIDS diagnosis from a primary care physician. • Be certified by a qualified a qualified health care professional to need regular or ongoing assistance with Activities of Daily Living (ADLs) • Have a Karnofsky score of 70 or less. • Have an unstable living situation. • Be a resident of Los Angeles County. • Have an income at or below 500% Federal Poverty Level • Cannot receive Ryan White services if other payor source is available for the same service	Program review and monitoring to confirm.
RCFCIs may accept clients with chronic and life-threatening diagnoses requiring different levels of care, including: • Clients whose illness is intensifying and causing deterioration in their condition. • Clients whose conditions have deteriorated to a point where death is imminent. • Clients who have other medical conditions or needs, or require the use of medical equipment that the facility can provide	Program review and monitoring to confirm.
RCFCIs will **not** accept or retain clients who: • Require inpatient care. • Require treatment and/or observation for more than eight hours per day. • Have communicable TB or any reportable disease. • Require 24-hour intravenous therapy. • Have dangerous psychiatric conditions.	Program review and monitoring to confirm.

• Have a Stage II or greater decubitus ulcer. • Require renal dialysis in the facility. • Require life support systems. • Do not have chronic life-threatening illness. • Have a primary diagnosis of Alzheimer's disease. • Have a primary diagnosis of Parkinson's disease	
Maximum length of stay is 24 months with extensions based on client's health status.	Program review and monitoring to confirm.
RCFCI will develop criteria and procedures to determine client eligibility to ensure that no other options for residential services are available.	Program review and monitoring to confirm.

INTAKE
As part of the intake process, the client file will include the following information (at minimum):

RCFCI INTAKE	
STANDARD	**DOCUMENTATION**
Eligibility for services is determined	Client files include documentation that basic eligibility requirements for Ryan White services in Los Angeles County are met.
Intake process is begun after completion of eligibility screening.	Intake tool is completed and in client file.
Confidentiality Policy, Consent to Receive Services and Release of Information is discussed and completed. Release of Information (must be updated annually). New forms must be added for those individuals not listed on the existing Release of Information (specification should be made about what type of information can be released)	Release of Information signed and dated by client on file and updated annually.
Client is informed of Rights and Responsibility and Grievance Procedures including the DHSP Customer Support Program.	Signed and dated forms in client file.

ASSESSMENT

Prior to acceptance of a client, the facility will obtain a written medical assessment of the client which enables the facility to determine if they are able to provide the necessary health-related services required by the client's medical condition. Clients must be reassessed on a quarterly basis to monitor and document changes in health status, progress toward treatment goals, and progress towards self-sufficiency with Activities of Daily Living (ADL). Upon reaching and sustaining a Karnofsky score above 70, RCFCI clients will be expected to transition towards independent living or to another type of residential service more suitable to their needs. Assessments will include the following:

RCFCI ASSESSMENT	
STANDARD	**MEASURE**
Written medical assessments completed or supervised by a licensed physician not more than three months old are required within 30 days of acceptance.	Signed, dated medical assessment on file in client chart.
Assessments will include the following: • Need for palliative care. • Age • Health status, including HIV and STI prevention needs. • Record of medications and prescriptions • Ambulatory status • Family composition • Special housing needs • Level of independence • Level of resources available to solve problems. • ADLs • Income • Benefits assistance/Public entitlements • Substance use and need for substance use services, such as treatment, relapse prevention, and support groups. • Mental health • Personal finance skills • History of evictions • Co-morbidity factors	Signed, dated assessment on file in client chart.

• Physical health care, including access to tuberculosis (TB) screening and routine and preventative health and dental care. • Treatment adherence • Educational services, including assessment, GED, and school enrollment. • Linkage to potential housing out-placements should they become appropriate alternatives for current clients (e.g., residential treatment facilities and hospitals) • Representative payee • Legal assistance on a broad range of legal and advocacy	
Clients must be reassessed on a quarterly basis to monitor and document changes in health status, progress toward treatment goals, and progress towards self-sufficiency with ADL.	Record of assessment on file in client chart.
If a RCFCI cannot meet a client's needs a referral must be made to an appropriate health facility.	Documentation of client education on file in client chart.
Upon intake, facility staff must provide or link client with the following: • Information about the facility and its services • Policies and procedures • Confidentiality • Safety issues • House rules and activities • Client rights and responsibilities • Grievance procedures • Licit and illicit drug interactions • Medical complications of substance use hepatitis. • Important health and self-care practices information about referral agencies that are supportive of people living with HIV and AIDS.	Documentation of client education on file in client chart.

INDIVIDUAL SERVICE PLAN (ISP)

The RCFCI will ensure that there is an Individual Service Plan (ISP) for each client. A service plan must be developed for all clients within 7 days of admission to RCFCI program. The plan will serve as the framework for the type and duration of services provided during the client's stay in the facility and should include the plan review and reevaluation schedule. RCFCI program staff will regularly observe each client for changes in physical, mental, emotional, and social functioning. The plan will be updated every three months or more frequently as the client's condition warrants. The plan will also document mechanisms to offer or refer clients to primary medical services and case management services. The ISP should be developed with the client and will include the following:

RCFCI INDIVIDUAL SERVICE PLAN (ISP)	
STANDARD	**MEASURE**
ISP will be completed within 7 days of admission.	Needs and services plan on file in client chart.
The plan will include, but not be limited to: • Current health status • Current mental health status • Current functional limitations and abilities • Current medications • Medical treatment/therapy • Specific services needed. • Intermittent home health care required. • Agencies or persons assigned to carry out services. • "Do not resuscitate" order, if applicable	Needs and services plan on file in client chart.
Plans should be updated every three months or more frequently to document changes in a client's physical, mental, emotional, and social functioning.	Updated needs and services plan on file in client chart.
Clients must be reassessed on a quarterly basis to monitor and document changes in health status, progress toward treatment goals, and progress towards self- sufficiency with ADL.	Record of reassessment on file in client chart.
If a client's needs cannot be met by facility, the facility will assist in relocating the client to appropriate level of care.	Record of relocation activities on file in client chart.

The provider will ensure that the ISP for each client is developed by the ISP team. In addition to the RN case manager, the following persons will constitute the ISP team and will be involved in the development and updating of the client's ISP: The client and/or their authorized representative The client's physician Facility house manager Direct care personnel Facility administrator/designee Social worker/placement worker Pharmacist, if needed Others, as deemed necessary	Record of ISP team on file in client chart.

MONTHLY CASE CONFERENCE

A monthly case conference will include review of the ISP, including the client's health and housing status, the need for and use of medical and other support services, and progress towards discharge, as appropriate. Attendees at the monthly case conference will include the client, the registered nurse, the case manager, and direct care staff representatives. Participants can include housing coordination staff and/or representatives from other community organizations, subject to the client's approval. The client may also invite the participation of an advocate, family member or other representative. The case conference must be documented and include outcomes, participants, and any specific steps necessary to obtain services and support for the client.

RCFCI MONTHLY CASE CONFERENCE	
STANDARD	**MEASURE**
All residents, registered nurse, case manager and direct care staff representatives will participate in monthly case conferences to review health and housing status, need for medical and supportive services and progress towards discharge.	Documentation of case conference on file in client chart including outcomes, participants, and necessary steps.

SERVICE AGREEMENTS

The provider will obtain and maintain written agreements or contracts with the following:

RCFCI MONTHLY SERVICE AGREEMENTS	
STANDARD	**MEASURE**
Programs will obtain and maintain written agreements or contracts with:	Written agreements on file at provider agency.

• A waste disposal company registered by the California Department of Toxic Substance Control and the California Department of Public Health if generating or handling bio-hazardous waste.
• A licensed home health care or hospice agency and individuals or agencies that can provide the following basic services:
  ○ Case management services
  ○ Counseling regarding HIV disease and AIDS, including current information on treatment of the illness and its possible effects on the resident's physical and mental health.
  ○ Counseling on death, dying, and the grieving process; psychosocial support services; substance misuse counseling.
  ○ Nutritionist services
  ○ Consultation on housing, health benefits, financial planning, and availability of other community- based and public resources, if these services are not provided by provider staff or the subcontracted home health agency personnel	

MEDICATION MANAGEMENT

Administration of medication will only be performed by an appropriate skilled professional.

RCFCI MEDICATION MANAGEMENT	
STANDARD	**MEASURE**
Direct staff will assist the resident with self-administration medications if the following	Record of conditions on file at provider agency.

conditions are met: • Have knowledge of medications and possible side effects; and • On-the-job training in the facility's medication practices.	
The following will apply to medications which are centrally stored: • Medications must be kept in a locked place that is not accessible to persons other than employees who are responsible for the supervision of the centrally stored medications. • Keys used for medications must not be accessible to residents. • All medications must be labeled and maintained in compliance with label instructions and state and federal laws.	Record of conditions on file at provider agency.

SUPPORT SERVICES

Support services provided must include, but are not limited to:

RCFCI SUPPORT SERVICES	
STANDARD	**MEASURE**
Programs will provide or coordinate the following (at minimum): • Provision and oversight of personal and supportive services. • Health-related services • Transmission risk assessment and prevention counseling • Social services • Recreational activities • Meals • Housekeeping and laundry • Transportation • Provision and/or coordination of all services identified in the ISP. • Assistance with taking medication. • Central storing and/or distribution of medications • Arrangement of and assistance	Program policy and procedures to confirm. Record of services and referrals on file in client chart.

with medical and dental care • Maintenance of house rules for the protection of clients • Arrangement and managing of client schedules and activities. • Maintenance and/or management of client cash resources or property.	

EMERGENCY MEDICAL TREATMENT

Clients receiving RCFCI services who require emergency medical treatment for physical illness or injury will be transported to an appropriate medical facility or emergency room.

RCFCI EMERGENCY MEDICAL TREATMENT	
STANDARD	**MEASURE**
Clients requiring emergency medical treatment will be transported to medical facility or emergency room.	Program review and monitoring to confirm.

DISCHARGE PLANNING

Discharge planning should start as soon as the client achieves stability and readiness towards alternative forms of housing. As much as possible, early planning (at least 12 months prior to the end date of the client's term in the program) must be conducted to a ensure a smooth transition/discharge process. In all cases, a Discharge/Transfer Summary will be completed for all clients discharged from the agency. The Discharge Summary will be completed by the RN case manager or the social worker.

RCFCI DISCHARGE PLANNING	
STANDARD	**MEASURE**
Discharge planning services include, but are not limited to, RCFCIs providing discharge planning services to clients that include (at minimum): • Linkage to primary medical care, emergency assistance, supportive services, and early intervention services as appropriate • Linkage to supportive services that enhance retention in care (e.g., case management, meals, nutritional support, and transportation) • Ensure linkage to primary care	Discharge plan on file in client chart.

• Housing such as permanent housing, independent housing, supportive housing, long-term assisted living, or other appropriate housing	
A Discharge/Transfer Summary will be completed for all clients discharged from the agency. The summary will include, but not be limited to: • Admission and discharge dates • Services provided. • Diagnosis(es) • Status upon discharge • Notification date of discharge • Reason for discharge • Transfer information, as applicable	Discharge/Transfer Summary on file in client chart.

PROGRAM RECORDS

Programs will maintain a separate, complete, and current record for each client in sufficient detail to permit an evaluation of services. These notations will be dated and include, but not limited to, type of service provided, client's response, if applicable, and signature and title of person providing the service.

RCFCI PROGRAM RECORDS	
STANDARD	**MEASURE**
Client records on file at provider agency that include (at minimum): • Client demographic data • Admission agreement • Names, addresses and telephone numbers of physician, case manager and other medical and mental health providers, if any • Names, addresses and telephone numbers of any person or agency responsible for the care of a client. • Medical assessment • Documentation of HIV/AIDS • Written certification that each family unit member free from active TB • Copy of current childcare contingency plan, if applicable	Programs will maintain sufficient records on each resident

• Current ISP • Record of ISP contacts • Documentation of all services provided. • Record of current medications • Physical and mental health observations and assessments	

LINKAGE TO MEDICAL CARE COORDINATION AND BENEFITS SPECIALTY SERVICES (BSS)
Based on assessment and client needs, eligible individuals should be linked to Ryan White-funded Medical Care Coordination (MCC) service and Benefits Specialty services (BSS). MCC service providers must follow the Division on HIV and STD Programs MCC protocol. For MCC-specific service standards, click HERE. For BSS-specific service standards, click HERE.

TRANSITIONAL RESIDENTIAL CARE FACILITY (UP TO 24 MONTHS) GENERAL REQUIREMENTS
A Transitional Residential Care Facility (TRCF) provides short-term housing with ongoing supervision and assistance with independent living skills for people living with HIV who are homeless or unstably housed. TRCF are 24-hour alcohol-drug-free facilities that are secure and home-like. The goal of the TRCF program is to help clients be safely housed while they find a more permanent, stable housing situation. This service focuses on removing housing-related barriers that negatively impact a client's ability to access and/or maintain HIV care or treatment.

BASIC ELIGIBILITY AND DOCUMENTATION REQUIREMENTS FOR RYAN WHITE SERVICES IN LOS ANGELES COUNTY

- Have an HIV-positive diagnosis;
- Be a resident of Los Angeles County;
- Have an income at or below 500% of Federal Poverty Level, and;
- Be uninsured or underinsured.
- Given the barriers with attaining documentation for unstably housed PLWH, contractors are expected to follow the Los Angeles County, Department of Public Health, Division of HIV and STD Programs (DHSP) guidance for using self-attestation forms to documentation eligibility for Ryan White services.

TRCFs must maintain a current, written, definitive plan of operation that includes (at minimum):

- Admission/discharge policies and procedures
- Admission/discharge agreements, including policies and procedures regarding drug and/or alcohol use on-site and off-site.
- Provide ample opportunity for family participate in activities in the facility.

- Include a safety plan to include precautions enacted to protect clients and staff (for those facilities that admit or specialize in care for clients who have a propensity for behaviors that result in harm to self or others)
- Adhere to basic facility safety requirements under Federal laws and State of California Health and Safety codes.

TRCF GENERAL REQUIREMENTS	
STANDARD	**MEASURE**
TRCF Facilities are short-term housing accommodations providing supervision and supportive services to any of the following: • Adults 18 years of age or older living with HIV/AIDS	Program review and monitoring to confirm.
TRCFs may accept clients that meet each of the following criteria: • Have an HIV/AIDS diagnosis from a primary care physician. • Have a Karnofsky score of 70 or above; able to work, volunteer, and if receiving Supplemental Security Income, able to enroll into ticket to work program • Homeless or have an unstable living situation • Be a client of Los Angeles County • Have an income at or below 500% Federal Poverty Level • Cannot receive Ryan White services if other payor source if available for the same service.	Program review and monitoring to confirm.
TRCF's will not accept or retain clients who: • Require daily assistance with Activities of Daily Living (ADLs) • Are currently engaging in drug or alcohol use • Require direct supervision due to physical or mental health diagnoses	Program review and monitoring to confirm.
Maximum length of stay is 24 months with extensions considered on an as needed basis based on client needs and progress of documented goals.	Program review and monitoring to confirm.

TRCF will develop criteria and procedures to determine client eligibility to ensure that no other options for residential services are available.	Program review and monitoring to confirm.

INTAKE
As part of the intake process, the client file will include the following information (at minimum):

TRCF INTAKE	
STANDARD	**DOCUMENTATION**
Eligibility for services is determined	Client files include documentation that basic eligibility requirements for Ryan White services in Los Angeles County are met.
Intake process is begun after the interview process is completed and acceptance into program has been determined.	Intake tool is completed and in client file.
Confidentiality Policy, Consent to Receive Services and Release of Information is discussed and completed. Release of Information (must be updated annually). New forms must be added for those individuals not listed on the existing Release of Information (specification should be made about what type of information can be released)	Release of Information signed and dated by client on file and updated annually.
Client is informed of Rights and Responsibility and Grievance Procedures, including the DHSP Customer Support Program.	Signed and dated forms in client file.

ASSESSMENT
At minimum, each client will be assessed to identify strengths and gaps in their support system to move toward permanent housing. Clients receiving TRCF services must be reassessed on a quarterly basis to monitor and document changes in health status, progress toward treatment goals, and progress towards self-sufficiency with independent living skills. TRCF clients will be expected to transition towards independent living or another type of residential service more suitable to their needs. Assessments will include the following:

TRCF ASSESSMENT	
STANDARD	**MEASURE**
Assessments will include the following: • Age	Signed, dated assessment on file in client chart.

• Health status • Family involvement • Family composition • Special housing needs • Level of independence • ADLs • Income • Public entitlements • Current engagement in medical care • Substance use history; if applicable, current recovery program status, relapse prevention or additional support needs • Mental health • Personal finance skills • History of evictions • Level of resources available to solve problems • Co-morbidity factors • For clients with substance use disorders, case managers must assess for eligibility and readiness for residential substance use treatment facilities. • Eligibility for Medical Care Coordination • Physical health care, including access to tuberculosis (TB) screening and routine and preventative health and dental care. • Treatment adherence • Educational services, including assessment, GED, and school enrollment • Linkage to potential housing placements, as they become available.	
Clients receiving TRCF services must be reassessed on a quarterly basis to monitor and document changes in health status,	Signed, dated assessment on file in client chart.

progress toward treatment goals, and progress towards self-sufficiency with independent living skills.	
Upon intake, facility staff must provide client with the following: • Admission agreement, including information about the facility and its services • Policies and procedures • Confidentiality • House rules • Client rights and responsibilities • Grievance procedures • Program requirements and expectations	Signed, dated documentation maintained in client chart.

INDIVIDUAL SERVICE PLAN (ISP)

The TRCF will ensure that there is an Individual Service Plan (ISP) created jointly with each client, complete with action steps to ensure linkage and retention in HIV medical care. Based upon the initial assessment, ISP will be completed within 7 days of the client's admission. The ISP will address the short-term and long-term housing needs of the client and identify resources for housing and referrals to appropriate medical and social services. Plans will also include specialized services needed to maintain the client in housing and access and adherence to primary medical care services. Documentation within the needs and services plan will include the identified goals, steps to achieve the goals, expected timeframe in which to complete the goals, and the disposition of each goal.

TRCF INDIVIDUAL SERVICE PLAN (ISP)	
STANDARD	**MEASURE**
ISP will be completed within 7 days of the client's admission.	ISP on file in client chart signed by client and TRCF staff and updated every 3 month or as needed based on client's individual needs.
The ISP will include, but not be limited to: • Current health status and compliance with care. • Current mental health status and compliance with care, if applicable. • Current status of employment OR outlined goal to obtain employment. • Current status of any education or vocational training, if applicable.	ISP on file in client chart signed by client and TRCF staff.

• Budgeting goals and/or status of current budget plan. • Housing goals, including action step to complete said goals. • Current status of any legal issues and steps being taken to resolve them.	
If a client's needs cannot be met by facility, the facility will assist in relocating the client to appropriate level care. This may include possible RCFCI placement or substance use treatment facilities.	Record of relocation activities on file in client chart.
The provider will ensure that the ISP for each client is developed by the ISP team. In addition to facility management and the master's level social worker (MSW), the following persons will constitute the ISP team and will be involved in the development and updating of the client's ISP: • The client and/or authorized representative • Physical health Care Providers, if needed. • Mental Health Care Providers, if needed. • Social Worker/Care Management, if needed. • Others, as deemed necessary.	ISP on file in client chart signed by client, TRCF staff and any additional participant(s) involved in the ISP.

MONTHLY CARE CONFERENCE

A monthly case conference will include review of the ISP, including progress of goals, health and housing status and progress towards discharge. Attendees at the monthly case conference will include the client, facility management and social worker. Participants can include housing coordination staff and/or representatives from other community organizations, subject to the client's approval. The client may also invite the participation of an advocate, family member or other representative. The case conference must be documented and include outcomes, participants, and any specific steps necessary to obtain services and support for the client.

TRCF MONTHLY CASE CONFERENCE	
STANDARD	**MEASURE**
Each client, facility manager and social worker will participate in monthly case conferences to review current ISP, between	Documentation of case conference on file in client chart including outcomes, participants, and necessary steps.

quarterly updates; this includes but it not limited to: • Status of current goals. • Status of physical and/or mental health. • Employment. • Status of education or vocational training. • Progress towards discharge.	

MEDICATION STORAGE

Each client is responsible to obtain their medications, keep them stored in the locked area provided to each client and take their medication as prescribed.

TRCF MEDICATION STORAGE	
STANDARD	**MEASURE**
TRCF will keep an updated list of current medications.	Record of medication list to be kept in client file.

SUPPOT SERVICES

Support services provided must include, but are not limited to:

TRCF SUPPORT SERVICES	
STANDARD	**MEASURE**
Programs will provide or coordinate the following (at minimum): • Health-related services • Mental health related services • Transmission risk assessment and prevention counseling • Social services • Maintenance of house rules for the protection of clients • Budget planning • Discharge planning • Assistance with completion of application process for any housing program.	Program policy and procedures to confirm. Record of services and referrals on file in client chart.

EMERGENCY MEDICAL TREATMENT

Clients receiving TRCF services who require emergency medical treatment for physical illness or injury will be transported to an appropriate medical facility.

TRCF EMERGENCY MEDICAL TREATMENT	
STANDARD	**MEASURE**
Clients requiring emergency medical treatment will be transported to medical facility.	Program review and monitoring to confirm.

DISCHARGE PLANNING

Discharge planning and goals should start within 30 days of admission. In all cases, a Discharge/Transfer Summary will be completed for all clients discharged from the agency. The Discharge Summary will be completed by facility management and the social worker.

TRCF DISCHARGE PLANNING	
STANDARD	**MEASURE**
Discharge planning services include, but are not limited to, (at minimum): • Linkage to primary medical care, emergency assistance, supportive services, and early intervention services, as appropriate. • Linkage to supportive services that enhance retention in care (e.g., case management, meals, nutritional support, and transportation). • Housing such as permanent housing, independent housing, supportive housing, long-term assisted living, or other appropriate housing.	Discharge plan on file in client chart.
A Discharge/Transfer Summary will be completed for all clients discharged from the agency. The summary will include, but not be limited to: • Admission and discharge dates • Services provided • Diagnoses • Status upon discharge • Notification date of discharge • Reason for discharge • Transfer information, as applicable.	Discharge/Transfer Summary on file in client chart.

PROGRAM RECORDS

Programs will maintain a separate, complete, and current record for each client in sufficient detail to permit an evaluation of services. These notations will be dated and include, but not limited to, type of service provided, client's response, if applicable, and signature and title of person providing the service.

TRCF PROGRAM RECORDS	
STANDARD	**MEASURE**
Client record on file at provider agency that include (at minimum): • Client demographic data • Admission agreement • Names, addresses and telephone numbers of physician, case manager and other medical and mental health providers, if any. • Documentation of HIV/AIDS diagnosis • Written certification that client is free from active TB • Current ISP • Record of ISP contacts • Documentation of all services provided • Record of current medications • Physical and mental health observations	Programs will maintain sufficient records on each resident.

LINKAGE TO MEDICAL CARE COORDINATION AND BENEFITS SPECIALTY SERVICES (BSS)
Based on assessment and client needs, eligible individuals should be linked to Ryan White-funded Medical Care Coordination (MCC) service and Benefits Specialty services (BSS. MCC service providers must follow the Division of HIV and STD Programs MCC Protocol. For MCC-specific service standards, click HERE. For BSS-specific service standards, click HERE.

LOS ANGELES COUNTY
COMMISSION ON HIV

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DRAFT FOR COH REVIEW *(As of 04/08/25)*

HOUSING SERVICE STANDARDS: TRANSITIONAL HOUSING (Up to 24 months)

IMPORTANT: The service standards for Transitional Housing Programs 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 Policy Clarification Notice (PCN) # 18-02: The use of Ryan White HIV/AIDS Program Funds for Core Medical Services and Support Services for People Living with HIV Who Are Incarcerated and Justice Involved

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

PURPOSE: Service standards outline the elements and expectations a Ryan White service provider follows when implementing a specific service category. The purpose of the service standards is to ensure that all Ryan White service providers offer the same fundamental components of the given service category across a service area. Service standards establish the minimal level of service or care that a Ryan White funded agency or provider may offer in Los Angeles County.

Description

Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services). Housing activities also include housing referrals services, including assessment, search placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

Program Guidance:

HRSA RWHAP recipients and subrecipients that use funds to provide Housing must have mechanisms in place to assess and document the housing status and housing service needs of new clients, and at least annually for existing clients.

HRSA RWHAP recipients and subrecipients, along with local decision-making planning bodies, are strongly encouraged to institute duration limits to housing activities. HRSA HAB recommends recipients and subrecipients align duration limits with those definitions used by other housing programs, such as those administered by the Department of Housing and Urban Development, which currently uses 24 months for transitional housing.

Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments.

RWHAP funding may be used to pay for a RWHAP client's security deposit if a RWHAP recipient or subrecipient has policies and procedures in place to ensure that the security deposit is returned to the RWHAP recipient or subrecipient and not to the RWHAP client. https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/hrsa-hab-security-deposit-program-letter.pdf

BASIC ELIGIBILITY AND DOCUMENTATION REQUIREMENTS FOR RYAN WHITE SERVICES IN LOS ANGELES COUNTY

- Have an HIV-positive diagnosis;
- Be a resident of Los Angeles County;
- Have an income at or below 500% of Federal Poverty Level, and;
- Be uninsured or underinsured.
- Given the barriers with attaining documentation for unstably housed PLWH, contractors are expected to follow the Los Angeles County, Department of Public Health, Division of HIV and STD Programs (DHSP) guidance for using self-attestation forms to documentation eligibility for Ryan White services.

TRANSITIONAL HOUSING (UP TO 24 MONTHS)

Transitional housing (TH) is designed to provide people living with HIV and their families who are homeless or unstably housed with the interim stability and support to successfully move to and maintain permanent housing. Transitional housing may be used to cover the costs of up to 24 months of housing with accompanying supportive services. Transitional housing pertains to short-term rentals, short-term residential and transitional programs designed to stabilize an individual and to support transition to a long-term sustainable housing situation.

INTAKE

As part of the intake process, the client file will include the following information (at minimum):

TRANSITIONAL HOUSING INTAKE	
STANDARD	**DOCUMENTATION**
Intake process is begun as soon as possible upon acceptance.	Intake tool is completed and in client file.

Eligibility for services is determined	Client files include documentation that basic eligibility requirements for Ryan White services in Los Angeles County are met.
Confidentiality Policy, Consent to Receive Services and Release of Information is discussed and completed. Release of Information (must be updated annually). New forms must be added for those individuals not listed on the existing Release of Information (specification should be made about what type of information can be released)	Release of Information signed and dated by client on file and updated annually.
Client is informed of Rights and Responsibility and Grievance Procedures	Signed and dated forms in client file.

ASSESSMENT

At minimum, each prospective client will be assessed to identify strengths and gaps in their support system to move toward longer term or permanent housing. Assessments will include the following:

TRANSITIONAL HOUSING ASSESSMENT	
STANDARD	**MEASURE**
Clients or representatives will be interviewed to complete eligibility determination, assessment and participant education.	Record of eligibility, assessment and education on file in client chart.
Assessments will include the following: • Age • Health status • Family involvement • Family composition • Special housing needs • Level of independence • Activities of Daily Living (ADL)s • Income • Public entitlements • Current engagement in medical care • Substance use • Mental health • Personal finance skills • History of evictions	Signed, dated assessment on file in client chart.

• Level of resources available to solve problems • Co-morbidity factors • For clients with substance use disorders, case managers must assess for eligibility and readiness for residential substance use treatment facilities. • Eligibility for Medical Care Coordination	

HOUSING CASE MANAGEMENT WITH HOUSING PLAN

TRANSITIONAL HOUSING PLAN	
STANDARD	**DOCUMENTATION**
• Housing plan	• Housing plan that describes specific action and target dates for securing additional services (as needed) and pathway to stable and permanent housing. Additional services may include Ryan White and non-Ryan White funded programs necessary to move the client to longer-term, more permanent housing. • The housing plan is reviewed with the client monthly to ensure that services and timeliness are met to achieve the goal of moving the client to stable and permanent housing. • Evidence of service referrals and completion of medical and supportive services for the client. • Evidence and dates of changes made to the housing plan.

OTHER REQUIRED DOCUMENTATION:
Case managers are responsible for working with the clients with to secure necessary documents such as:

- Client Intake Form - signed by both client and the case manager
- Case Management Housing Plan/Consent to Release Information - signed by client
- Rules and Regulations - reviewed by case manager and signed by both the case manager and the client

- Diagnosis Form
- Other documentation may be required by agencies to comply with funding agency requirements.
- Self-attestation forms or documents already secured under other Ryan White -funded agencies may be used to avoid duplication and ease administrative burden on the client and service providers.

LINKAGE TO MEDICAL CARE COORDINATION AND BENEFITS SPECIALTY SERVICES (BSS)

Based on assessment and client needs, eligible individuals should be linked to Ryan White-funded Medical Care Coordination (MCC) service and Benefits Specialty services (BSS. MCC service providers must follow the Division of HIV and STD Programs MCC Protocol. For MCC-specific service standards, click HERE. For BSS-specific service standards, click HERE.

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DRAFT FOR COH REVIEW *(As of 04/08/25)*

HOUSING SERVICE STANDARDS: EMERGENCY/CRISIS HOUSING ASSISTANCE

IMPORTANT: The service standards for Emergency/Crisis Housing Assistance 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 Policy Clarification Notice (PCN) # 18-02: The use of Ryan White HIV/AIDS Program Funds for Core Medical Services and Support Services for People Living with HIV Who Are Incarcerated and Justice Involved

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

PURPOSE: Service standards outline the elements and expectations a Ryan White service provider follows when implementing a specific service category. The purpose of the service standards is to ensure that all Ryan White service providers offer the same fundamental components of the given service category across a service area. Service standards establish the minimal level of service or care that a Ryan White funded agency or provider may offer in Los Angeles County.

Description

Housing provides transitional, short-term, or emergency/crisis housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

Housing activities also include housing referrals services, including assessment, search placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

Program Guidance:

HRSA RWHAP recipients and subrecipients that use funds to provide Housing must have mechanisms in place to assess and document the housing status and housing service needs of new clients, and at least annually for existing clients.

HRSA RWHAP recipients and subrecipients, along with local decision-making planning bodies, are strongly encouraged to institute duration limits to housing activities. HRSA HAB recommends recipients and subrecipients align duration limits with those definitions used by other housing programs, such as those administered by the Department of Housing and Urban Development, which currently uses 24 months for transitional housing.

Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments. RWHAP funding may be used to pay for a RWHAP client's security deposit if a RWHAP recipient or subrecipient has policies and procedures in place to ensure that the security deposit is returned to the RWHAP recipient or subrecipient and not to the RWHAP client. https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/hrsa-hab-security-deposit-program-letter.pdf

BASIC ELIGIBILITY AND DOCUMENTATION REQUIREMENTS FOR RYAN WHITE SERVICES IN LOS ANGELES COUNTY

- Have an HIV-positive diagnosis; Be a resident of Los Angeles County; Have an income at or below 500% of Federal Poverty Level, and;
- Be uninsured or underinsured. Given the barriers with attaining documentation for unstably housed PLWH, contractors are expected to follow the Los Angeles County, Department of Public Health, Division of HIV and STD Programs (DHSP) guidance for using self-attestation forms to documentation eligibility for Ryan White services.

EMERGENCY/CRISIS HOUSING ASSISTANCE

Emergency/crisis housing assistance may be provided through hotel/motel vouchers and/or placements in emergency shelters. Emergency housing pertains to emergency stays intended to assist clients with immediate housing crises.

Short-term facilities provide temporary shelter to eligible individuals to prevent homelessness and allow an opportunity to develop an Individual Housing and Service Plan to guide beneficiary linkage to permanent housing. Hotel/motel vouchers and emergency shelters are available for a maximum of 60 days per year. Agencies must provide meal vouchers and/or grocery gift cards to ensure that clients have access to food during their stay in motels/hotels or emergency shelters. Eligible clients may receive up to 3 meals per day.

Emergency/crisis housing assistance must adhere to the following requirements:

EMERGENCY HOUSING CASE MANAGEMENT REQUIREMENTS	
STANDARD	**DOCUMENTATION**
To access emergency/crisis housing assistance, a client must be receiving case management services from a Ryan White-funded agency. Case management services will ensure that the client: • Is engaged in care.	Program review and monitoring to confirm.

• Has a definitive housing plan that assesses their housing needs and assists them in obtaining longer term housing within the 60-day limit (residential substance abuse or mental health treatment program, residential care facility for the chronically ill, transitional housing or permanent housing). • Is receiving supporting services that promote stabilization, including needs assessments, case management, mental health counseling and treatment, substance abuse counseling and treatment, benefits counseling, individual case planning, budget counseling, assistance in locating and obtaining affordable housing and follow-up services. • Case managers should attempt to secure other types of housing prior to exhausting a client's emergency voucher limit. • Under extenuating circumstances, a client may receive more than 60 days of hotel/motel, emergency shelter, and meal vouchers under this program (e.g., a client is on a waiting list for a housing program with a designated move-in date that extends past the 60-day period). Such extensions are made on a case-by-case basis and must be carefully verified.	

REQUIRED DOCUMENTATION

Case managers are responsible for working with the clients with to secure necessary documents such as:

REQUIRED DOCUMENTATION	
STANDARD	**MEASURE**
Client Intake Form - signed by both client and the case manager	Signed intake form on file.

Case Management Housing Plan/Consent to Release Information - signed by client	Case management housing plan on file.
Rules and Regulations - reviewed by case manager and signed by both the case manager and the client	Client records.
Diagnosis Form	Client records.
Other documentation required by agencies to comply with funding agency requirements.	Agency records and client files.
Housing plan that describes specific action and target dates for securing additional services (as needed) and pathway to transitional and/or permanent housing.	Housing plan in client files.
Self-attestation forms or documents already secured under other Ryan White -funded agencies may be used to avoid duplication and ease administrative burden on the client and service providers.	Client files.

LINKAGE TO MEDICAL CARE COORDINATION AND BENEFITS SPECIALTY SERVICES (BSS)

Based on assessment and client needs, eligible individuals should be linked to Ryan White-funded Medical Care Coordination (MCC) service and Benefits Specialty services (BSS). MCC service providers must follow the Division on HIV and STD Programs MCC protocol. For MCC-specific service standards, click HERE. For BSS-specific service standards, click HERE.

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DRAFT FOR COH REVIEW *(As of 04/08/25)* HOUSING SERVICE STANDARDS: PERMANENT SUPPORTIVE HOUSING

IMPORTANT: The service standards for Permanent Supportive Housing Programs 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 Policy Clarification Notice (PCN) # 18-02: The use of Ryan White HIV/AIDS Program Funds for Core Medical Services and Support Services for People Living with HIV Who Are Incarcerated and Justice Involved

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

PURPOSE: Service standards outline the elements and expectations a Ryan White service provider follows when implementing a specific service category. The purpose of the service standards are to ensure that all Ryan White service providers offer the same fundamental components of the given service category across a service area. Service standards establish the minimal level of service or care that a Ryan White funded agency or provider may offer in Los Angeles County.

While there are time limitations for using Ryan White Care Act funding for housing services, other resources may be leveraged to identify and secure permanent supportive housing for PLWHA. With several local initiatives aimed at combatting homelessness in Los Angeles County, opportunity exists for complementing Ryan White funded housing services with longer term, permanent supportive housing under programs such as Housing for Health, Measure H and HHH.

PERMANENT SUPPORTIVE HOUSING PROGRAMS (PSHPS)

PSHP services include permanent housing with supportive services that assist people living with HIV and their families to adjust to new living arrangements, maintain independent living and coordinate overall housing and service needs. Supportive services include service coordination, mental health counseling and treatment and substance abuse counseling and treatment. While programs cannot, in most cases, require tenants to use supportive services, they will make every attempt to encourage and engage tenants to do so. Permanent supportive housing can be provided either in a congregate setting or through scattered-site master leasing.

GENERAL REQUIREMENTS

Programs providing permanent housing with supportive services will comply with program requirements of the funding entity. Programs that provide rental subsidies will do so in accordance with guidelines approved by the subsidizing entity.

SERVICE COMPONENTS REQUIREMENTS FOR PERMANENT SUPPORTIVE HOUSING PROGRAMS

Depending on the needs of the clients, service providers are required to provide these Minimum Services to residents, either directly or through referrals to other agencies:

- Jointly with each tenant develop an intensive case management plan or a similar supportive plan linking clients to needed services, complete with action steps to ensure linkage and retention to primary care provider
- Mental health care, such as assessment, crisis counseling, individual and group therapy, and support groups
- Substance use services, such as treatment, relapse prevention, and support groups
- Physical health care, including access to tuberculosis (TB) screening and routine and preventative health and dental care
- Medication management
- HIV treatment and adherence
- Educational services, including assessment, GED, and school enrollment
- Employment services, such as job skills training, job readiness, job placement, and job retention services
- Linkage to potential housing out-placements should they become appropriate alternatives for current residents (e.g., residential treatment facilities and hospitals)
- Life skills training, such as household maintenance, nutrition, cooking, and laundry, personal finance
- Benefits assistance
- Legal assistance on a broad range of legal and advocacy issues
- Peer advocacy
- Transportation assistance
- Social, recreational activities, and community volunteer service
- Linkage to Medical Care Coordination services
- Referrals to food banks and/or linkage to meal delivery
- Referral to agencies that can assist with activity of daily living
- If applicable, childcare, as needed
- Referrals to needed services

ASSESSMENT

An assessment serves as the basis for developing a needs and services plan and to ensure the quality of services provided. Initial assessments must be completed within 30 days of a client's admission to a permanent supportive housing program. Reassessments will be offered to residents at least twice a year. Assessments are developed collaboratively and signed by both the resident and staff member completing the assessment.

Assessment information should include (at minimum):

ASSESSMENT	
STANDARD	**MEASURE**
Assessments will be completed within 30 days of client admission.	Assessment, signed by client and staff on file in client chart that includes: • HIV medical treatment • History of trauma • Substance use and history • ADL needs • Spiritual/religious needs • Social support system • Legal issues • Family issues • Financial/insurance status • Nutritional needs • Harm reduction practices • Mental health treatment history • History of housing experiences • Case management history and needs • Needs and current services
Reassessments will be offered to residents at least twice a year.	Reassessments on file in client chart.

EDUCATION

Tenant education is a continuous process. To ensure the relevance of the information provided, tenants should be given ongoing opportunities to have input into the education planning process. Upon intake, tenants should be offered information about the facility, policies and procedures and services to include (at minimum):

- Confidentiality
- Safety issues
- House rules and activities
- Client rights and responsibilities
- Grievance procedures
- Risk reduction practices
- Harm reduction
- Licit and illicit drug interactions
- Medical complications of substance abuse
- Hepatitis
- Health and self-care practices
- Referral information
- Pet-owner responsibilities
- Neighbor relations
- TB

EDUCATION	
STANDARD	**MEASURE**
Tenants will be educated about building, policies and procedures and services.	Education contacts recorded in client chart.

INTENSIVE CASE MANAGEMENT (ICM) OR SIMILAR SUPPORTIVE SERVICES

Based on the assessment of client needs and strengths, intensive case management services or similar supportive services may be provided to the client. ICM services should follow requirements from Los Angeles County Department of Health Services Supportive Housing Services contractors.

ICMS form the core of the services for people who are homeless, at risk of homelessness, formerly homeless and who have complex health and/or behavioral health conditions; are high utilizers of public services and other vulnerable populations including individuals with criminal justice histories and individuals who are exiting institutions such as hospitals, residential treatment programs, and custody facilities.

ICMS can be provided in a variety of settings including interim housing, rapid rehousing, permanent supportive housing, field-based locations, community-based locations, health and behavioral health facilities, sobering centers, recuperative care centers, criminal justice and custody facilities, and other settings as needed to end homelessness and support the community reintegration of persons leaving institutions.

INTENSIVE CASE MANAGEMENT (ICM)	
STANDARD	**MEASURE**
Documentation of client need for ICM through assessments and patient medical and social needs history.	ICM services documented in client chart.

LINKAGE TO MEDICAL CARE COORDINATION AND BENEFITS SPECIALTY SERVICES (BSS)

Based on assessment and client needs, eligible individuals should be linked to Ryan White-funded Medical Care Coordination (MCC) service and Benefits Specialty services (BSS). MCC service providers must follow the Division on HIV and STD Programs MCC protocol. For MCC-specific service standards, click HERE. For BSS-specific service standards, click HERE.

LOS ANGELES COUNTY
COMMISSION ON HIV

2025-2026 Legislative Docket (*Last updated: 03/27/25)*

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

BILL	TITLE	DESCRIPTION / COMMENTS	POSITION	STATUS
AB 4 (Arambula)	Covered California Expansion	This bill would require the California Health Benefit Exchange to design a program, upon appropriation by the Legislature, to allow individuals to obtain coverage regardless of immigration status. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB4 Given the political climate, what is the state's capacity to expand access to the healthcare exchange?	**SUPPORT**	Referred to Committee on Health. 02-03-25
AB 11 (Lee)	The Social Housing Act	This bill would enact the Social Housing Act and would establish a state housing authority with the goal of developing social housing to tackle California's chronic housing shortage. The housing would be publicly backed, mixed-income, affordable, and financially self-sustaining. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB11 How is this different from the CA department on Housing and Community Development? CA HCD serves as a program administrator that provides grants and loans and creates rental and homeownership opportunities for Californians. HCD does not manage properties or place individuals in affordable housing.	**SUPPORT**	Referred to Committee on Housing & Community Development. 02-03-25
AB 20 (DeMaio)	Homelessness: Housing First	This bill would end the "Housing First" homeless model currently used and replace it with a "People First" model, which will redirect funds to programs that require mental health and substance abuse treatment to address the root causes of homelessness. The bill would prioritize expansion of shelter beds over permanent supportive housing, impose work requirements on individuals receiving assistance, and require the removal of homeless camps near schools and in public areas. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB20 **NOTE:** AB 20 is an Intent Bill which includes a statement of intent by legislators and very little other language. As an intent bill makes its way through the legislative session to be considered for approval, substantive amendments will be added, including agree upon activities, actions, and desired outcomes.	**WATCH**	*Re-referred to Com. on Housing and Community Development. 03-25-25*

APPROVED BY PPC ON 03/03/25. FOR COH REVIEW 04/10/25

BILL	TITLE	DESCRIPTION / COMMENTS	POSITION	STATUS
AB 45 (Bauer-Kahan)	Privacy: Health Care Data	This bill would protect health data privacy by prohibiting geofencing around healthcare providers and shielding research records from out-of-state subpoenas that interfere with abortion rights. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB45	**SUPPORT**	Form printer: May be heard in committee Jan. 2 12-03-24
AB 67 (Bauer-Kahan)	Attorney General: Reproductive Privacy Act: Enforcement	This bill grants the Attorney General authority to enforce penalties against local governments that obstruct reproductive healthcare, ensuring statewide accountability and access. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260AB67	**SUPPORT**	*Referred to Coms. On Judiciary, and Privacy and Consumer Protection. 03/24/25*
AB 73 (Jackson)	Mental Health: Black Mental Health Navigator Certification	*This bill would require the Department of Health Care Access and Information (HCAI) to develop, upon appropriation by the Legislature, as a component of an existing Community Health Worker (CHW) certificate program, criteria for a specialty certificate program and specialized training requirements for a Black Mental Health Navigator Certification, and report related program data.* https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB73	**SUPPORT**	*Re-referred to Com. on APPR. 03-26-25*
AB 96 (Jackson)	Community Health Workers	This bill would expand the definition of community health workers (CHW) to include peer support specialists, who are people with personal experience with a particular health issue and help others going through the same thing. The bill also states that if a peer support specialist is certified, they will be considered to have completed all the education and training needed to be certified as a CHW. *https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260AB96*	**SUPPORT**	Re-referred to Committee on Health. 02-12-25
AB 229 (Davies)	Criminal Procedure: Sexually Transmitted Disease Testing	*This bill would authorize a search warrant for evidence for any sexually transmitted disease where a defendant is accused or charged with a specified sex offense.* https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260AB229&search_keywords=HIV	**WATCH**	Referred to Com. on APPR. 03-04-25
AB 257 (Flora)	Specialty Care Network Telehealth and Other Virtual Services	This bill would require the California Health and Human Services Agency, in collaboration with HCAI and DHCS to establish a demonstration project for a telehealth and other virtual services specialty care network that is designed to serve patients of safety-net providers consisting of quality providers, defined to include, among others, rural health clinics and community health centers. *https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB257*	**SUPPORT**	*Read second time and amended. 03-27-25*

BILL	TITLE	DESCRIPTION / COMMENTS	POSITION	STATUS
AB 260 (Aguiar-Curry)	Sexual and Reproductive Health Care	This bill would state the intent of the Legislature to enact legislation to ensure that patients can continue to access care, including abortion, gender-affirming care, and other sexual and reproductive health care in California, and to allow patients to access care through asynchronous modes. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260AB260&search_keywords=HIV	**SUPPORT**	*Re-referred to Com. on Health. 03-18-25*
AB 290 (Bauer-Kahan)	Emergency services and care	This bill would strengthen protections for patients seeking emergency reproductive healthcare by increasing civil penalties for hospital that fail to provide life-saving care in emergencies. *https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260AB290*	**SUPPORT**	*In Health Com. Hearing postponed by committee. 03-24-25*
AB 281 (Gallagher)	Comprehensive Sexual Health Education and Human Immunodeficiency Virus Prevention Education	This bill would amend Section 51938 of the Education Code to enhance parental rights and transparency in comprehensive sexual health and HIV prevention education. Key changes include allowing parents or guardians to inspect and copy educational materials, providing details on outside consultants or guest speakers, and clarifying notification and opt-out processes. Schools may charge a nominal fee for copies of materials. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260AB281&search_keywords=HIV	**WATCH**	*In ED. Committee: hearing postponed by committee. 03-26-25*
AB 309 (Zbur)	Hypodermic needles and syringes	This bill would ensure that pharmacists maintain the discretion to furnish sterile syringes without a prescription and that adults may legally possess syringes solely for personal use, as part of the state's comprehensive strategy to prevent the spread of HIV and viral hepatitis. *https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB309*	**SUPPORT**	Referred to Committee on Health. 02-10-25
AB 396 (Tangipa)	Needle and syringe exchange services	This bill would require an entity that provides needle and syringe exchange services to ensure that each needle or syringe dispensed by the entity is appropriately discarded and destroyed. The bill would require those entities to ensure that each needle or syringe dispensed by the entity includes a unique serial number. *https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB396*	**OPPOSE**	Referred to Committee on Health. 02-18-25
AB 403 (Carrillo)	Medi-Cal Community Health Worker Services	*This bill requires Department of Health Care Services (DHCS) to report annually on several aspects of the Medi-Cal Community Health Worker (CHW) benefit, including assessing outreach and education efforts by managed care plans, CHW spending and utilization, referrals by provider type, and demographic disaggregation of CHWs and Medi-Cal members receiving CHW services.* *https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260AB403*	**SUPPORT**	*Re-referred to Com. on APPR. 03-26-25*

BILL	TITLE	DESCRIPTION / COMMENTS	POSITION	STATUS
AB 543 (Gonzalez and Elhawary)	Medi-Cal: Street Medicine	This bill would introduce and integrate street medicine into Medi-Cal for persons experiencing homelessness. This bill would allow unhoused Californians to automatically qualify for full-scope Medi-Cal benefits during the eligibility process. *https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB543*	**SUPPORT**	*In Health committee; hearing postponed by committee. 03-24-25*
AB 554 (Gonzalez)	Health Care coverage: antiretroviral drugs, drug devices, and drug products	This bill, the Protecting Rights, Expanding Prevention, and Advancing Reimbursement Equity (PrEPARE) Act of 2025, prevents health care plans and insurance companies from requiring prior authorization or step therapy for all antiretroviral drugs, including injectable medications, used for HIV/AIDS prevention. This bill also requires these drugs be covered without cost sharing or utilization review for individuals with private insurance. *https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260AB554*	**SUPPORT**	Amended and Re-referred to Committee on Health. 03-04-25
AB 590 (Lee)	Social Housing Bond	This bill would enact the Social Housing Bond Act to build publicly developed and owned, mixed-income housing for Californians and place a bond measure on the November 2026 ballot to provider $950 million in funding dedicated to creating social housing in California. *https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260AB590*	**SUPPORT**	Referred to Com. on Housing and Community Development. 03-03-25
AB 688 (Gonzalez)	Telehealth for all Act of 2025	This bill would enact the Telehealth for all Act of 2025 which requires DHCS to publish a report every 2 years, beginning in 2028, that analyzes how telehealth is being used in the Medi-Cal Program. The report will utilize Medi-Cal data to look at how telehealth is helping people get care, the quality of care, and the costs, while also disaggregating the data based on location, race, and social determinants of health categories to identify disparities in accessibility of telehealth services. *https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB688*	**SUPPORT**	*Re-referred to Com. on APPR. 03-26-25*
SB 41 (Wiener)	Pharmacy Benefit Manager (PBM) Regulation	This bill would require all PBMs be licensed and disclose basic information regarding their business practices to the licensing entity. This bill would also prohibit steering patients to affiliate pharmacies and instead allow patients to choose which in-network pharmacy best meets their needs; prohibits spread pricing, where PBMs charge a plan more for a drug than it pays a pharmacy; requires that the PBM pass through all negotiated drug rebates to the payers or patients; outlaws making any untrue, deceptive, or misleading statements; prohibits PBMs from negotiating exclusive arrangements with manufacturers for drugs, devices, or other products; and limits how fees may be charged and requires transparency in fees. *https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260SB41*	**SUPPORT**	*From committee with author's amendments. Read second time and amended. Re-referred to Com. on Health. 03-17-25*

BILL	TITLE	DESCRIPTION / COMMENTS	POSITION	STATUS
SB 278 (Cabaldon)	Health data: HIV test results	This bill would allow the disclosure of the health records of people living with HIV/AIDS to the state's Medi-Cal program to improve the care they are receiving. It would also allow the disclosure of HIV test results for the purpose of administering quality improvement programs under Medi-Cal. *https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260SB278*	**SUPPORT**	*Re-referred to Com. on JUD. 03-26-25*

FEDERAL BILLS

BILL	TITLE	DESCRIPTION/COMMENTS	POSITION	STATUS
TBD	Protecting Sensitive Locations Act	The Protecting Sensitive Locations Act would codify the longstanding guidance into law and ensure that future administrations would not be able to so easily dismiss the protections in place. The guidance on limiting enforcement in and near sensitive locations played a critical role in providing immigrant families with a sense of security in places they accessed every day to thrive and contribute to their communities. It is imperative that Congress codify this policy into law so future administrations cannot disregard those protections that provide immigrant families safety. Endorse the Protecting Sensitive Locations Act	**SUPPORT**	

Endnotes

(1) Under Joint Rule 56, bills introduced in the first year of the regular session that do not become carry-over bills shall be returned to the Chief Clerk of the Assembly or the Secretary of the Senate.

LOS ANGELES COUNTY
COMMISSION ON HIV

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

Solidarity Statement in Support of Transgender, Gender Expansive, Intersex, and Two-Spirit (TGI2S+) Communities

The Transgender Caucus of the Los Angeles County Commission on HIV condemns all forms of hate and violence and remains steadfast in solidarity with our Transgender, Gender Expansive, Intersex, and Two-Spirit (TGI2S+) community. The HIV/AIDS movement knows too well that the proliferation of disinformation created with the aim of restricting access to healthcare has real-life consequences. The harmful rhetoric of the current administration against the TGI2S+ community is rooted in the same forms of racism, discrimination, sexism, and misogyny that continue to hinder our progress in ending HIV/AIDS.

We recognize the contributions and leadership of TGI2S+ people who continue to enrich the LGBTQ+ civil rights and the HIV/AIDS movements. We acknowledge the achievements of TGI2S+ people in the United States and across the world and recognize their bravery and resilience in their hard-fought work for equality, inclusion, and the full recognition of their human rights. We are determined to advocate fiercely, and unapologetically, for the safety, health, and well-being of our TGI2S+ community. This is not just our responsibility; it is our moral imperative. In the face of societal and political challenges that attempt to divide us, we affirm our unwavering stance:

- Every person—regardless of sexual orientation, gender identity, gender expression, background, disabilities, immigration status, race, faith, culture, or housing situation—deserves to be seen, feel safe, and supported.
- We reject any attempt to undermine dignity, create division, or deny the right to gender-affirming care, HIV prevention and care service delivery, and to be safe in the workplace.

We call on our allies to speak out against the demonization of the TGI2S+ community and remain diligent and committed to actively engaging in policy action that promotes health equity, eliminates barriers, and addresses social determinants of health.

We stand in memoriam of our TGI2S+ community members, siblings, and loved ones who have been lost to hateful acts of violence, police brutality, and HIV/AIDS. We celebrate the strength, joy, and courage of our TGI siblings who remind us that visibility is both a powerful act of resistance and ray of hope.

In solidarity,
Transgender Caucus of the Los Angeles County Commission on HIV

If you are interested in joining us in developing a progressive and inclusive agenda to address the disproportionate impact of HIV/STDs within our TGI2S+ communities in Los Angeles County, please contact us at hivcomm@lachiv.org.

the OA Voice
CDPH California Department of Public Health
Issue: April 2025

INSIDE:

This newsletter is organized to align with the six Social Determinants of Health found in the *Ending the Epidemics Integrated Statewide Strategic Plan*, addressing the syndemic of HIV, HCV, and STIs in California. More about the *Strategic Plan* is available on the Office of AIDS (OA) website.

STAFF HIGHLIGHT

We are excited to announce that **Matt Willis** has accepted the position of Chief of the Sexual Health & Program Resilience Section in the Prevention Branch.

Matt has been with OA since 2006 where he started as an Associate Governmental Program Analyst (AGPA) in the Care Branch providing oversight, technical assistance, and contract monitoring related to the Health Care Program's Bridge Project, and Minority AIDS Initiative programs. In 2011, he joined the Prevention Branch as a Contract Monitor in the Prevention Operations Unit. There he analyzed and approved budgets and scopes of work, processed budget revisions and amendments, and provided technical assistance to LHJs in receipt of federal prevention funding. Additionally, he provided program implementation assistance to Expanded Testing grantees, monitored progress through site visits and reporting, and coordinated a monthly webinar series. In 2013, Matt became the Focused HIV Testing Specialist/CBA Liaison and demonstrated progressive responsibility as the subject matter expert for Prevention-funded focused testing programs that provided rapid, point of care HIV and HCV testing, linkage to care, and other prevention services. He has worked directly with 20 LHJs in program planning, provision of technical assistance and quality assurance, and in assisting in identifying priority populations for testing.

In 2019, Matt accepted a Health Program Specialist I position as the HIV/STD Program Coordinator. In this role, he supported the development of HIV/STD prevention programs, lead the development of funding applications, leads RFA processes, and coordinated with leadership to identify priorities for new funding. Matt developed and implemented tools and processes for identifying HIV prevention gaps and barriers at the local level and best practices to address them. He also carried out quality improvement (QI) processes and initiatives aimed at improving prevention outcomes

including participating in planning and evaluation of QI interventions. Matt truly excels at hosting webinars, facilitating meetings, and providing technical assistance and capacity building support and in 2020, as the COVID emergency response redirected 57% of the Prevention Branch management team, he took on the additional responsibility of an approved out of class assignment as the Acting Chief of the High Impact Prevention Unit and eventually took on this role in an official capacity. Matt took on the hiring of new staff to fill vacancies, developed team workplans, coached and mentored new staff to further build an already amazing team. He assisted in the development and facilitation of a monthly COVID-19 Impact webinar series and developed guidance for implementing HIV in-home testing for LHJs. Matt is also a CPG State Co-Chair and Co-Chair of NASTAD's Antiracism in Public Health Committee.

When not working, Matt likes to spend time with family, take his dogs Boogeyman, Mambo, Benny, and Cupid on excursions by the river, and spends time with his boyfriend, Chris. He also absolutely loves to cook and taking day trips to Marin County.

Please join us in congratulating Matt on his promotion!

HIV AWARENESS

April 10 is National Youth HIV/AIDS Awareness Day (NYHAAD). NYHAAD was organized by Advocates for Youth, an association dedicated to improving the health and well-being of young people and prompt discussions about the impact of HIV on young people. NYHAAD is observed to raise awareness about HIV/AIDS among young people, educate youth about prevention efforts, and promote awareness and access to treatment and care.

HIV stigma continues to discourage young people from getting tested, access to prevention methods, and disclosing their HIV status. HIV education is paramount to responsiveness and prevention. The California Department of Public Health (CDPH) OA is committed to ensuring its youth have access to information, prevention, and treatment services. For more information,visit our OA Youth Community Health webpage.

April 18 is National Transgender HIV Testing Day (NTHTD). NTHTD is observed to raise awareness about the importance of HIV testing among transgender and non-binary individuals. This day also promotes access to HIV testing, treatment, and prevention services. Transgender women of color, especially Black/African American and Latinx women experience disproportionately high rates of HIV. NTHTD encourages ongoing efforts to reduce stigma, discrimination, and anti-trans violence this community faces every day. It is imperative that we combat disinformation and discrimination, transgender and non-binary people are increasingly experiencing.

CDPH-OA is committed to ensuring its Transgender and non-binary people have access to information, prevention, and treatment services. For more information, visit our OA Transgender Community Health in California webpage.

GENERAL UPDATES

Mpox

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

Digital assets continue to be available for LHJs

and CBOs on DCDC's Campaign Toolkits website.

HIV Care Connect (HCC)

HCC is going **live on April 7, 2025**. Users of the AIDS Regional Information and Evaluation System (ARIES) will transition to HCC on April 7, 2025. HCC provides a more efficient and user-friendly interface. Data collection is more efficient with access to selected ADAP and lab data to help coordinate care and a simpler process to import lab data. Users will have access to online training modules to learn the system. Providers can generate the Ryan White Services Report (RSR) and Consolidated Annual Performance and Evaluation Report (CAPER) from HCC.

Those HIV Care Program (RWHAP Part B) and HOPWA providers funded by CDPH-OA will be required to manually enter or import their data into HCC. HCP and HOPWA subrecipients will also submit their budgets and invoices to OA through the system.

Agencies not funded by CDPH-OA for the HIV Care Program (RWHAP Part B), or HOPWA must sign and return the Data Use Agreement (DUA). **Agencies will not be able to access HCC until the DUA is signed**. The DUA were e-mailed to the individuals listed on the Agency Info screen in ARIES.

ARIES will be available in read-only mode until June 30, 2025, for users to view data. E-mail communications and trainings are sent out to all active ARIES users.

We look forward to our continued collaboration. If you have any questions or need assistance, please do not hesitate to contact us at CEMS@cdph.ca.gov.

HIV/STI/HCV Integration

We continue to move forward with the necessary steps to integrate our HIV, STI, and HCV programs into a single new Division. We will continue to keep you apprised on our journey as new information comes in.

ENDING THE EPIDEMICS STRATEGIC PLAN OA/STD

The visual at the top of page four is a high-level summary of our *Strategic Plan* that organizes 30 Strategies across six Social Determinants of Health (SDoH).

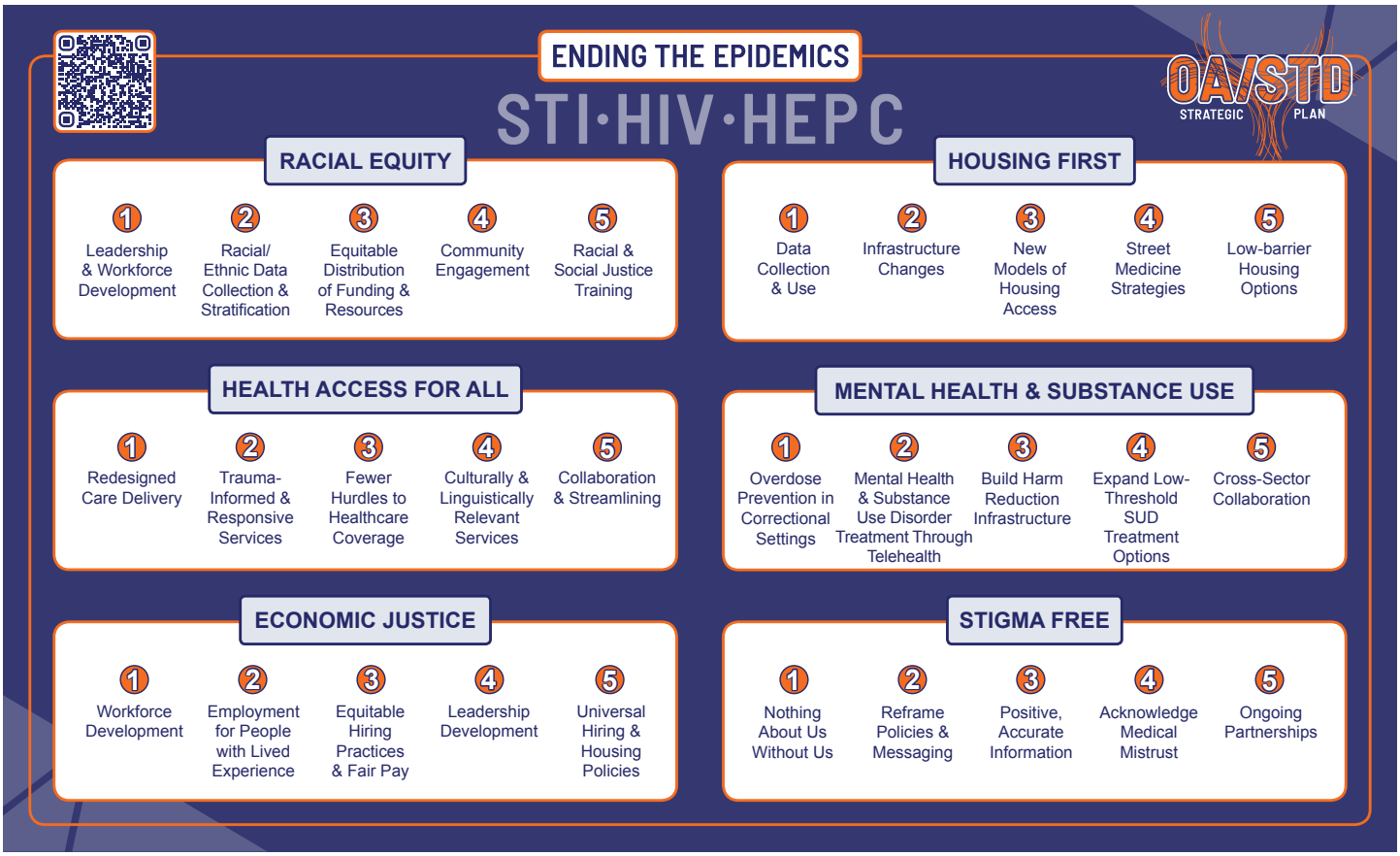
OA and STD Control Branch would like you to continue to use and share the *Strategic Plan* and the *Implementation Blueprint*. These documents address HIV as a syndemic with HCV and other STIs, through a SDoH lens.

For technical assistance in implementing the *Strategic Plan*, California LHJs and CBOs can vist Facente Consulting's webpage.

HEALTH ACCESS FOR ALL

Strategy 1: Redesigned Care Delivery

No-Cost Mpox Vaccination and Optional Rapid HIV/Syphilis/HCV Testing Available: CDPH is offering a free, turnkey service for LHJs and CBOs to provide mpox vaccination for people who are uninsured, underinsured, experiencing homelessness, or facing other barriers to care. This service can also include on-site rapid testing for HIV, syphilis, and hepatitis C, with telehealth services available for select treatments, including syphilis treatment, HIV PrEP, and doxy PEP. To request this resource, complete this survey, and for any questions, please email mpoxadmin@cdph.ca.gov.



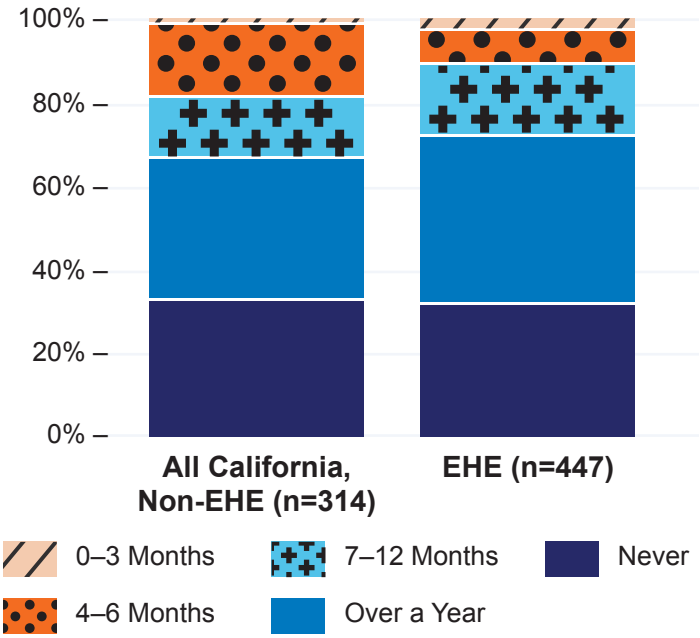
TAKEMEHOME

Strategy 1: Redesigned Care Delivery

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

In February, 314 individuals in 34 counties ordered self-test kits, with 228 (72.6%) individuals ordering 2 tests. Additionally, OA's existing TakeMeHome Program continues in the six California Consortium Phase I Ending the HIV Epidemic in America counties. Between the program's initiation in September 1, 2020, and February 28, 2025, 16,348 tests have been distributed. This month, mail-in lab tests (including dried blood spot tests for HIV, syphilis, and Hepatitis C, as well as 3-site tests for gonorrhea and chlamydia) accounted for 161

HIV Test History Among Individuals Who Ordered TakeMeHome Kits, Feb. 2025



(36.0%) of the 447 total tests distributed in EHE counties. Of those ordering rapid tests, 204 (71.3%) ordered 2 tests.

Additional Key Characteristics	EHE	All California, Non-EHE
Of those sharing their gender, were cisgender men	52.3%	57.3%
Of those sharing their race or ethnicity, identify as Hispanic or Latinx	41.0%	44.5%
Were 17-29 years old	42.3%	36.0%
Of those sharing their number of sex partners, reported 3 or more in the past year	46.2%	44.3%

Since September 2020, 1,832 test kit recipients have completed the anonymous follow up survey from EHE counties; there have been 769 responses from the California expansion since January 2023.

Survey Highlights	EHE	All California, Non-EHE
Would recommend TakeMeHome to a friend	94.6%	94.2%
Identify as a man who has sex with other men	48.9%	52.0%
Reported having been diagnosed with an STI in the past year	8.6%	9.9%

Strategy 1: Redesigned Care Delivery

The Fiscal Year (FY) 2022–2023 and FY 2021–2022 **ADAP Annual Reports** are now available on the ADAP Reports webpage.

Produced by the **ADAP Evaluation & Monitoring (AEM) team**, these reports provide a detailed review of the program through tables and figures using data from the ADAP Enrollment System (AES). The team has been addressing a backlog of reports caused by staffing shortages during the COVID-19 pandemic and is working to publish reports from previous fiscal years going back to FY 2019-2020, starting with the most recent years.

Strategy 3: Fewer Hurdles to Healthcare Coverage

As of March 31, 2025, there are 279 PrEP-AP enrollment sites and 229 clinical provider sites that currently make up the PrEP-AP Provider network.

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

As of March 31, 2025, the number of ADAP clients enrolled in each respective ADAP Insurance Assistance Program are shown at the top of page seven of this newsletter.

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

Active PrEP-AP Clients by Age and Insurance Coverage:

Current Age	PrEP-AP Only		PrEP-AP With Medi-Cal		PrEP-AP With Medicare		PrEP-AP With Private Insurance		TOTAL	
	N	%	N	%	N	%	N	%	N	%
18 - 24	304	10%	---	---	---	---	13	0%	317	10%
25 - 34	1,062	33%	---	---	---	---	143	4%	1,205	38%
35 - 44	781	25%	---	---	2	0%	132	4%	915	29%
45 - 64	449	14%	---	---	8	0%	88	3%	545	17%
65+	36	1%	---	---	157	5%	5	0%	198	6%
TOTAL	**2,632**	**83%**	**0**	**0%**	**167**	**5%**	**381**	**12%**	**3,180**	**100%**

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

Current Age	Latinx		American Indian or Alaskan Native		Asian		Black or African American		Native Hawaiian/ Pacific Islander		White		More Than One Race Reported		Decline to Provide		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
18 - 24	173	5%	2	0%	41	1%	15	0%	1	0%	45	1%	3	0%	37	1%	317	10%
25 - 34	651	20%	3	0%	116	4%	99	3%	7	0%	238	7%	8	0%	83	3%	1,205	38%
35 - 44	510	16%	4	0%	77	2%	56	2%	4	0%	197	6%	7	0%	60	2%	915	29%
45 - 64	302	9%	---	---	43	1%	13	0%	1	0%	136	4%	1	0%	49	2%	545	17%
65+	17	1%	---	---	5	0%	5	0%	---	---	159	5%	---	---	12	0%	198	6%
TOTAL	**1,653**	**52%**	**9**	**0%**	**282**	**9%**	**188**	**6%**	**13**	**0%**	**775**	**24%**	**19**	**1%**	**241**	**8%**	**3,180**	**100%**

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

Gender	Latinx		American Indian or Alaskan Native		Asian		Black or African American		Native Hawaiian/ Pacific Islander		White		More Than One Race Reported		Decline to Provide		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Female	48	2%	---	---	4	0%	10	0%	1	0%	8	0%	---	---	10	0%	81	3%
Male	1,505	47%	8	0%	256	8%	174	5%	11	0%	740	23%	18	1%	207	7%	2,919	92%
Trans	82	3%	---	---	16	1%	3	0%	1	0%	12	0%	1	0%	6	0%	121	4%
Unknown	18	1%	1	0%	6	0%	1	0%	---	---	15	0%	---	---	18	1%	59	2%
TOTAL	**1,653**	**52%**	**9**	**0%**	**282**	**9%**	**188**	**6%**	**13**	**0%**	**775**	**24%**	**19**	**1%**	**241**	**8%**	**3,180**	**100%**

All PrEP-AP charts prepared by: ADAP Fiscal Forecasting Evaluation and Monitoring (AFFEM) Section, ADAP and Care Evaluation and Informatics Branch, Office of AIDS. Client was eligible for PrEP-AP as of run date: 03/31/2025 at 12:01:19 AM Data source: ADAP Enrollment System. Site assignments are based on the site that submitted the most recent application.

ADAP Insurance Assistance Program	Number of Clients Enrolled	Percentage Change from February
Employer Based Health Insurance Premium Payment (EB-HIPP) Program	586	1.37%
Office of AIDS Health Insurance Premium Payment (OA-HIPP) Program	5,905	-0.02%
Medicare Premium Payment Program (MPPP)	2,273	1.72%
Total	**8,764**	**0.52%**

Source: ADAP Enrollment System

CORRECTION to the March 2025 issue of *The OA Voice*. The "Percentage Change from January" column should have had the following percentages:

ADAP Insurance Assistance Program	Number of Clients Enrolled	Percentage Change from January
Employer Based Health Insurance Premium Payment (EB-HIPP) Program	578	3.81%
Office of AIDS Health Insurance Premium Payment (OA-HIPP) Program	5,906	2.51%
Medicare Premium Payment Program (MPPP)	2,234	4.66%
Total	**8,718**	**3.14%**

Source: ADAP Enrollment System

CDPH
California Department of Public Health

We're Listening

share your concerns with us.

HIV + STD Services Customer Support Line

(800) 260-8787

Why should I call?

The Customer Support Line can assist you with accessing HIV or STD services and addressing concerns about the quality of services you have received.

Will I be denied services for reporting a problem?

No. You will not be denied services. Your name and personal information can be kept confidential.

Can I call anonymously?

Yes.

Can I contact you through other ways?

Yes.

By Email:
dhspsupport@ph.lacounty.gov

On the web:
http://publichealth.lacounty.gov/dhsp/QuestionServices.htm

County of Los Angeles Public Health
Division of HIV and STD Programs

Estamos Escuchando

Comparta sus inquietudes con nosotros.

Servicios de VIH + ETS
Línea de Atención al Cliente

(800) 260-8787

¿Por qué debería llamar?

La Línea de Atención al Cliente puede ayudarlo a acceder a los servicios de VIH o ETS y abordar las inquietudes sobre la calidad de los servicios que ha recibido.

¿Se me negarán los servicios por informar de un problema?

No. No se le negarán los servicios. Su nombre e información personal pueden mantenerse confidenciales.

¿Puedo llamar de forma anónima?

Si.

¿Puedo ponerme en contacto con usted a través de otras formas?

Si.

Por correo electronico:
dhspsupport@ph.lacounty.gov

En el sitio web:
http://publichealth.lacounty.gov/dhsp/QuestionServices.htm

County of Los Angeles
Public Health
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