LOS ANGELES COUNTY
COMMISSION ON HIV

Visit us online: http://hiv.lacounty.gov
Get in touch: hivcomm@lachiv.org
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EXECUTIVE COMMITTEE MEETING

Thursday, October 23, 2025
1:00PM – 4:00PM (PST) **EXTENDED**

510 S. Vermont Avenue, 9th Floor, LA 90020
Validated Parking @ 523 Shatto Place, LA 90020

**As a building security protocol, attendees entering the building must notify parking attendant and/or security personnel that they are attending a Commission on HIV meeting.*

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

Register Here to Join Virtually

https://lacountyboardofsupervisors.webex.com/weblink/register/r450d366eed99fef7a4d490c89a4fdad3
To Join by Telephone: 1-213-306-3065
Password: EXECUTIVE Access Code: 2532 586 3335

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

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

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

EXECUTIVE COMMITTEE

Thursday, October 23, 2025 | 1:00PM-4:00PM *Extended

510 S. Vermont Ave, Terrace Level Conference, Los Angeles, CA 90020
Validated Parking: 523 Shatto Place, Los Angeles 90020
**As a building security protocol, attendees entering the building must notify the parking attendant and security personnel that they are attending a Commission on HIV meeting in order to access the Terrace Conference Room (9th flr) where our meetings are held.*

MEMBERS OF THE PUBLIC:
To Register + Join by Computer:
https://lacountyboardofsupervisors.webex.com/weblink/register/r450d366eed99fef7a4d490c89a4fdad3
To Join by Telephone: 1-213-306-3065
Password: EXECUTIVE Access Code: 2532 586 3335

EXECUTIVE COMMITTEE MEMBERS			
Danielle Campbell, PhD, MPH, Co-Chair	*Joseph Green, Co-Chair*	Miguel Alvarez (Executive At-Large)	Alasdair Burton (Executive At-Large)
Erika Davies (SBP Committee)	Kevin Donnelly (PP&A Committee)	Arlene Frames (SBP Committee)	Arburtha Franklin (Public Policy Committee)
Katja Nelson, MPP (Public Policy Committee)	Mario J. Pérez, MPH (DHSP)	Dechelle Richardson (Executive At-Large)	Daryl Russel (PP&A Committee)
QUORUM: 7			

AGENDA POSTED: October 17, 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 th'e Commission's consideration of the item, that is within the subject matter jurisdiction of the Commission. To submit Public Comment, you may submit in person, email 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.

I. ADMINISTRATIVE MATTERS

1.	Call to Order & Meeting Guidelines/Reminders		1:00 PM – 1:03 PM
2.	Introductions, Roll Call, & Conflict of Interest Statements		1:03 PM – 1:05 PM
3.	Approval of Agenda	**MOTION #1**	1:05 PM – 1:07 PM
4.	Approval of Meeting Minutes	**MOTION #2**	1:07 PM – 1:10 PM

II. PUBLIC COMMENT 1:10 PM – 1:13 PM

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

III. COMMITTEE NEW BUSINESS ITEMS 1:13 PM – 1:15 PM

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

IV. REPORTS

7. COH Staff Report 1:15 PM – 1:30 PM

A. Commission (COH)/County Operational Updates

(1) 2025 COH Workplan & Meeting Schedule Updates

a. November and December Committee Meeting Schedule

8. Co-Chair Report 1:30 PM – 1:45 PM

A. 2025 Annual Conference Planning – Updates
B. December 11, 2025, COH Meeting Agenda Development
   (1) Meeting Venue: Chase Burton Park **13650 Mindanao Way, Marina del Rey, California 90292**
   (2) Annual Conference Follow Up/Debrief
   (3) Patient Support Services (PSS) Service Standards Approval
   (4) COH Effectiveness Review & Restructuring Project
      a. Proposed Changes to Bylaws for Approval
C. Conferences, Meetings & Trainings (*An opportunity for members to share information and resources material to the COH's core functions, with the goal of advancing the Commission's mission*)

9. Division of HIV and STD Programs (DHSP) Report 1:45 PM – 2:00 PM

A. Fiscal, Programmatic and Procurement Updates
   (1) Ryan White Program Funding & Services Update
   (2) CDC HIV Prevention Funding & Services Update
   (3) EHE Program and Funding Update
   (4) Other Updates

10. Standing Committee Report 2:00 PM – 2:30 PM

A. Planning, Priorities and Allocations (PP&A) Committee
   (1) PY 34 Utilization Report – Support Services
   (2) 2027-2031 Integrated HIV Plan Preparation Updates
   (3) Proposed PY 36 PP&A Meeting/Activity Schedule
B. Operations Committee
   (1) Membership Updates
   (3) Membership Materials Review Workgroup Updates
   (4) Outreach & Recruitment Workgroup Updates
C. Standards and Best Practices (SBP) Committee
   (1) Patient Support Services Service Standards **MOTION #3**
   (2) Mental Health Service Standards
   (3) Service Standards Schedule
D. Public Policy Committee (PPC)
   (1) County, State and Federal Policy & Budget Updates
      a. 2025-2026 Legislative Docket Updates

11. Caucus, Task Force, and Work Group Reports: 2:30 PM – 2:45 PM

A. Aging Caucus
B. Black/AA Caucus
C. Consumer Caucus
D. Transgender Caucus
E. Women's Caucus
F. Housing Task Force

IV. DISCUSSION

12. COH Effectiveness Review & Restructuring Project 2:45 PM – 3:50 PM

A. Prevention Planning as an Integrated Planning Body Updates

B. Proposed Changes to Bylaws

(1) Public Comments Review – Continuation

C. Outreach & Engagement Strategies in Preparation for December 11th COH Vote

(1) Restructure & Bylaws Revision Process — FAQ

(2) Completion of Required Bylaws Training Review & Acknowledgment

(3) Agendized Committee/Caucus Refresher

D. Next Steps

V. NEXT STEPS 3:50 PM – 3:55 PM

13. Task/Assignments Recap

14. Agenda development for the next meeting

VI. ANNOUNCEMENTS 3:55 AM – 3:55 PM

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

VII. ADJOURNMENT 4:00 PM

16. Adjournment of the extended regular Executive Committee meeting on October 23, 2025.

PROPOSED MOTIONS	
MOTION #1	Approve the Agenda Order as presented or revised.
MOTION #2	Approve the meeting minutes, as presented or revised.
MOTION #3	Approve the Patient Support Services (PSS) service standards, as presented or revised, and forward to the full body at its December 11, 2025, meeting for final approval.

LOS ANGELES COUNTY
COMMISSION ON HIV

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

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.

Updated 9.12.25

Meeting Schedule

- All Commission and Committee meetings are held monthly, open to the public and conducted in-person at 510 S. Vermont Avenue, Terrace Conference Room, Los Angeles, CA 90020 (unless otherwise specified). Validated parking is conveniently located at 523 Shatto Place, Los Angeles, CA 90020.
- A virtual attendance option via WebEx is available for members of the public. To learn how to use WebEx, please click here for a brief tutorial.
- Subscribe to the Commission's email listserv for meeting notifications and updates by clicking here. **Meeting dates/times are subject to change.*

January - December 2025

2nd Thursday (9AM-1PM)	**Commission (full body)**	Vermont Corridor *subject to change
4th Thursday (1PM-3PM)	**Executive Committee**	Vermont Corridor *subject to change
4th Thursday (10AM-12PM)	**Operations Committee**	Vermont Corridor *subject to change
3rd Tuesday (1PM-3PM)	**Planning, Priorities & Allocations (PP&A) Committee**	Vermont Corridor *subject to change
1st Monday (1PM-3PM)	**Public Policy Committee (PPC)**	Vermont Corridor *subject to change
1st Tuesday (10AM-12PM)	**Standards & Best Practices (SBP) Committee**	Vermont Corridor *subject to change

The Commission on HIV (COH) convenes several caucuses and other subgroups to harness broader community input in shaping the work of the Commission around priority setting, resource allocations, service standards, improving access to services, and strengthening PLWH voices in HIV community planning. Currently, the Commission convenes the Aging Caucus, Black Caucus, Consumer Caucus, Transgender Caucus and the Women's Caucus. Caucuses meet virtually unless otherwise announced. For meeting dates and times, contact COH staff directly or email hivcomm@lachiv.org.

LOS ANGELES COUNTY COMMISSION ON HIV

2025 MEMBERSHIP ROSTER| UPDATED 10.20.25

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		Leroy Blea	California Department of Public Health, Office of AIDS	July 1, 2024	June 30, 2026	
8	Part C representative			***Vacant***		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	1	OPS	Leon Maultsby, DBH, MHA ***(pending)***	In The Meantime Men's Group, Inc	July 1, 2023	June 30, 2025	
12	Provider representative #2			***Vacant***		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			***Vacant***		July 1, 2024	June 30, 2026	
17	Provider representative #7	1		David Hardy ,MD	University of Southern California	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	
20	Unaffiliated representative, SPA 2			***Vacant***		July 1, 2024	June 30, 2026	
21	Unaffiliated representative, SPA 3	1	OPS	Ish Herrera ***(LOA)***	*Unaffiliated representative*	July 1, 2023	June 30, 2025	Joaquin Gutierrez (OPS)
22	Unaffiliated representative, SPA 4	1	PP	Jeremy Mitchell (aka Jet Finley)	*Unaffiliated representative*	July 1, 2024	June 30, 2026	Lambert Talley (PP&A)
23	Unaffiliated representative, SPA 5			***Vacant***	*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	EXC|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			***Vacant***	*Unaffiliated representative*	July 1, 2024	June 30, 2026	
29	Unaffiliated representative, Supervisorial District 3	1	SBP	Arlene Frames	*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	
32	Unaffiliated representative, at-large #1			***Vacant***	*Unaffiliated representative*	July 1, 2024	June 30, 2026	Reverend Gerald Green (PP&A)
33	Unaffiliated representative, at-large #2	1	PPC	Terrance Jones	*Unaffiliated representative*	July 1, 2023	June 30, 2025	
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			***Vacant***		July 1, 2023	June 30, 2025	
40	Representative, Board Office 5	1		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	*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	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			***Vacant***		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	1	EXC|OPS	Dechelle Richardson	No affiliation	July 1, 2023	June 30, 2025	
50	HIV stakeholder representative #7	1	PP&A	William D. King, MD, JD, AAHIVS ***(LOA)***	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:	**37**						

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

LOA: Leave of Absence

Overall total: 42

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 10/20/25

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.	Benefits Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Mental Health
			Oral Health
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HTS - Syphilis, DX Link TX - CSV
			Biomedical HIV Prevention
			Data to Care Services
			Medical Transportation Services
BLEA	**Leroy**	California Department of Public Health, Office of AIDS	Part B Grantee
BURTON	**Alasdair**	No Affiliation	No Ryan White or prevention contracts
CAMPBELL	**Danielle**	T.H.E. Clinic, Inc.	Core HIV Medical Services - AOM; MCC & PSS
			Medical Transportation Services
CIELO	**Mikhaela**	Los Angeles General Hospital	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	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
DAVIES	**Erika**	City of Pasadena	No Ryan White or prevention contracts
DAVIS (PPC Member)	**OM**	Aviva Pharmacy	No Ryan White or prevention contracts
DOLAN (SBP Member)	**Caitlyn**	Men's Health Foundation	Core HIV Medical Services - AOM; MCC & PSS
			Biomedical HIV Prevention Services
			Vulnerable Poplulations (YMSM)
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			Medical Transportation Services
DONNELLY	**Kevin**	Unaffiliated representative	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)
GERSH (SBP Member)	**Lauren**	APLA Health & Wellness	Benefits Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Intensive Case Managemenet Services
			Nutrition Support (Food Bank/Pantry Service)
			Oral Health
			STD-Ex.C
			HERR
			Biomedical HIV Prevention Services
			Medical Transportation Services
			Data to Care Services
			Residential Facility For the Chronically Ill (RCFCI)
GONZALEZ	**Felipe**	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**	Unaffiliated representative	No Ryan White or prevention contracts
HARDY	**David**	University of Southern California	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	Core HIV Medical Services - AOM; MCC & PSS
			Biomedical HIV Prevention Services
			Vulnerable Poplulations (YMSM)
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			Medical Transportation Services
MARTINEZ (PP&A Member)	**Miguel**	Children's Hospital Los Angeles	Core HIV Medical Services - AOM; MCC & PSS
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			Biomedical HIV Prevention Services
			Medical Transportation Services
MARTINEZ-REAL	**Leonardo**	Unaffiliated representative	No Ryan White or prevention contracts
MAULTSBY	**Leon**	In the Meantime Men's Group	Promoting Healthcare Engagement Among Vulnerable Populations
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
NASH	**Paul**	University of Southern California	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
NELSON	**Katja**	APLA Health & Wellness	Benefits Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Intensive Case Managemenet Services
			Nutrition Support (Food Bank/Pantry Service)
			Oral Health
			STD-Ex.C
			HERR
			Biomedical HIV Prevention Services
			Medical Transportation Services
			Data to Care Services
			Residential Facility For the Chronically Ill (RCFCI)
PATEL	**Byron**	Los Angeles LGBT Center	Core HIV Medical Services - AOM; MCC & PSS
			Vulnerable Populations (YMSM)
			Vulnerable Populations (Trans)
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HTS - Social and Sexual Networks
			Biomedical HIV Prevention Services
			Medical Transportation Services
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
RICHARDSON	**Dechelle**	No Affiliation	No Ryan White or prevention contracts
RUSSEL	**Daryl**	Unaffiliated representative	No Ryan White or prevention contracts
SALAMANCA	**Ismael**	City of Long Beach	Benefits Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Biomedical HIV Prevention Services
			HTS - Social and Sexual Networks
			Medical Transportation Services

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
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
SAN AGUSTIN	**Harold**	JWCH, INC.	Benefits Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Mental Health
			Oral Health
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HTS - Syphilis, DX Link TX - CSV
			Biomedical HIV Prevention Services
			Data to Care Services
			Medical Transportation Services
SAUNDERS	**Dee**	City of West Hollywood	No Ryan White or prevention contracts
SPENCER	**LaShonda**	Oasis Clinic (Charles R. Drew University/Drew CARES)	Core HIV Medical Services - PSS
			HTS - Storefront
			HTS - Social and Sexual Networks
TALLEY	**Lambert**	Grace Center for Health & Healing	No Ryan White or prevention contracts
VEGA-MATOS	**Carlos**	Men's Health Foundation	Core HIV Medical Services - AOM; MCC & PSS
			Biomedical HIV Prevention Services
			Vulnerable Poplulations (YMSM)
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			Medical Transportation Services
WEEDMAN	**Jonathan**	ViaCare Community Health	Biomedical HIV Prevention
			Core HIV Medical Services - AOM & MCC

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: October 20, 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= 13 | 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**
Miguel Alvarez	Co-Chair, OPS	Commissioner
Alasdair Burton	At-Large	Commissioner
Erika Davies	Co-Chair, SBP	Commissioner
Kevin Donnelly	Co-Chair, PP&A	Commissioner
Arlene Frames	Co-Chair, SBP	Commissioner
Arburtha Franklin	Co-Chair, Public Policy	Commissioner
Vilma Mendoza	Co-Chair, OPS	Commissioner
Katja Nelson, MPP	Co-Chair, Public Policy	Commissioner
Dèchelle Richardson	At-Large	Commissioner
Darryl Russell	Co-Chair, PP&A	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= 7 | Number of Quorum= 5**		
COMMITTEE MEMBER	**MEMBER CATEGORY**	**AFFILIATION**
Miguel Alvarez	**Committee Co-Chair***	**Commissioner**
Vilma Mendoza	**Committee Co-Chair***	**Commissioner**
Jayda Arrington	*	Commissioner
Alasdair Burton	At-Large	Commissioner
Joaquin Gutierrez *(alternate to Ish Herrera)*	*	Alternate
Ismael Herrera *(LOA)*	*	Commissioner
Leon Maultsby, DBH, MHA	*	Commissioner
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= 12| Number of Quorum= 7**		
COMMITTEE MEMBER	**MEMBER CATEGORY**	**AFFILIATION**
Kevin Donnelly	**Committee Co-Chair***	Commissioner
Daryl Russell, M.Ed	**Committee Co-Chair***	Commissioner
Al Ballesteros, MBA	*	Commissioner
Felipe Gonzalez	*	Commissioner
Reverend Gerald Green	*	Alternate
William D. King, MD, JD, AAHIVS *(LOA)*	*	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
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= 8 | 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 *(LOA)*	*	Committee Member
Terrance Jones	*	Commissioner
Lee Kochems	*	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 = 10 | Number of Quorum = 6**		
COMMITTEE MEMBER	**MEMBER CATEGORY**	**AFFILIATION**
Arlene Frames	**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
Lauren Gersh	*	Committee Member
Sabel Samone-Loreca *(alternate to Arlene Frames)*	*	Alternate
Mark Mintline, DDS	*	Committee Member
Byron Patel, RN, ACRN	*	Commissioner
Martin Sattah, MD	*	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 & 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: Chi Chi Navarro & Diamond Paulk** ***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 (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; 4.19.25; 4.28.25; 7.23.25; 9.25.25; 10.09.25
June, August and September Cancellations approved by the Executive Committee on 4/24/25

- **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 @ St. Anne's Conference Center~~	• ~~Year 33 Utilization Report for RW Support Services Presentation (DHSP/Sona Oksuzyan, PhD, MD, MPH)~~ ~~(Move to PP&A 5/1/25 meeting)~~ • ~~Unmet Needs Presentation (DHSP/Sona Oksuzyan, PhD, MD, MPH)~~ ~~(Move to PP&A meeting, date TBD)~~ • ~~Approve 20% RWP funding scenario allocations~~ • ~~COH Restructuring Workgroups Report and Discussion~~ • ~~Housing Task Force Report of Housing and Legal Services Provider Consultations~~
~~**6/12/25**~~	• ~~**CANCELLED**~~
~~7/10/25 @ Vermont Corridor~~	• ~~COH Restructuring/Bylaws Updates~~ • ~~Medical Monitoring Project (Dr. Ekow Sey, DHSP) CONFIRMED~~ • ~~PURPOSE Study (Requested by Suzanne Molino, PharmD, Gilead Sciences, Inc.); CONFIRMED~~
~~8/14/25~~	~~**CANCELLED**~~
~~9/11/25~~	~~**CANCELLED**~~
~~10/9/25 @ Jesse Owens~~	~~**Vote on Revised COH Bylaws *Update: Vote on Proposed Bylaws Rescheduled Tentatively to December 11 COH Meeting.***~~
11/13/25 @ St. Anne's	**ANNUAL CONFERENCE** Theme: Resilience in Uncertain Times: Advancing Science, Policy, and Community Together
12/11/25 @ Chace Burton (MDR)	Proposed: Vote on Revised COH Bylaws

***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 – *Postponed until further notice.*

2025 COMMISSION ON HIV ANNUAL CONFERENCE

RESILIENCE IN UNCERTAIN TIMES: SCIENCE, POLICY, AND COMMUNITY IN ACTION

SAVE THE DATE

NOVEMBER 13 2025

St. Anne's Conference and Event Center
155 N. Occidental Blvd.
Los Angeles, CA 90026
9AM - 4PM

LOS ANGELES COUNTY
COMMISSION ON HIV

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Planning, Priorities and Allocations Committee
Key Annual Activities & Committee Calendar
** FOR DISCUSSION**

- **Co-chair nominations and elections** - Each year the committee facilitates an open process to nominate and elect co-chairs who will provide leadership, ensure fair representation of stakeholders, and guide the committee's agenda and decision-making throughout the year.
- **Workplan development and review** - The committee develops an annual workplan aligned with the overall Commission's workplan and strategic goals. The workplan outlines timelines, milestones, and deliverables, and is reviewed periodically to monitor progress and make adjustments.
- **Annual directives updates*** - Directives provide guidance to the recipient on service delivery expectations and how best to meet the needs of consumers. Annual progress/updates to ensure alignment with community needs, emerging public health trends, and funding requirements.
- **Quarterly Expenditure Reports*** - Quarterly expenditure reports to monitor how allocated funds are being spent. This oversight ensures fiscal accountability, helps identify under- or over-spending, and informs potential reallocations.
- **Utilization Reports*** - Service utilization reports are examined to evaluate service usage across funded programs These reports highlight increases or decreases in service utilization by service type, cost per service, gaps in service use, potential barriers to care, and opportunities for improving service delivery.
- **HIV/STD Surveillance Data*** - Surveillance data is reviewed to track trends in HIV and STD incidence, prevalence, and disparities. This information informs priority-setting, prevention strategies, and resource allocation.
- **Unmet Needs Reports*** - Help the committee identify services that clients require but are not currently receiving. Use findings to help inform needs assessments and funding priorities.
- **Resource Inventory*** - Review of funding and services offered via Part B funds, EHE, Prevention, and other resources. This allows the committee to determine what care/support services to fund (and at what allocation amounts) that will compliment these services.
- **2027-2031 Integrated Plan Updates and Review*** - Provide updates to the committee on the progress of the Integrated Plan progress/development and provide the committee an opportunity to provide feedback on the plan.

- **Needs Assessment Planning** - Planning for needs assessments is a critical responsibility. The committee determines target populations, defines the scope, methodology, and timeline to ensure that assessments capture the experiences and priorities of people living with and affected by HIV. May lean on specific caucuses or workgroups to assist with needs assessment planning and execution including data collection tools, outreach strategies, and final analysis.
- **Needs Assessment Data Review** – Review finds from needs assessment data to identify service gaps, barriers to access, and emerging trends. This data directly informs decision-making around funding priorities and allocations.
- **Review PSRA Framework -** Review the Priority Setting and Resource Allocation (PSRA) process for effectiveness and equity. Update criteria and scoring systems as needed. Ensures knowledge of and understanding that decision-making processes before priority setting and resource allocation.
- **Review Priorities –** Revisit annual service priorities (from 3 yr projections) to determine whether adjustments are necessary based on updated data, funding changes, or shifts in the epidemic.
- **Annual Allocations*** - Revisit annual service allocations (from 3 yr projections) to determine funding levels for each service category for the upcoming fiscal year. Compare against multi-year projections and adjust based on current data. Ensure allocations align with priorities and available resources.
    - **Contingency Planning* (as needed)** - Contingency scenarios are developed to address potential funding increases or decreases. Identify critical services that require protection during budget cuts. These plans ensure that DHSP can respond quickly while minimizing disruption to critical services.
- **Reallocations* -** Review needs assessment date, expenditures, and utilization data to identify areas for reallocation. Shift funds between service categories to optimize impact. Document and communicate reallocation decisions to DHSP and federal partners.
- **Prevention Planning –** Review prevention HIV/STI data and collaborate with prevention stakeholders to align care and prevention strategies, ensuring an integrated response that addresses both treatment and prevention priorities across the HIV continuum.

LOS ANGELES COUNTY
COMMISSION ON HIV

Option 1 – Monthly Meeting Calendar (March 2026 – February 2027)

Month	Key Activities
March 2026	• Co-chair nominations and elections • Review and adopt annual workplan and meeting calendar • HIV/STD Surveillance Data report*
April 2026	• Needs Assessment Planning • Resource Inventory Review • Prevention and Testing Data Report*
May 2026	• Expenditure Report* • Needs Assessment Data Review (prior year findings) • Integrated Plan Update*
June 2026	• Unmet Needs Report* • Review PSRA Framework
July 2026	• Utilization Reports*
August 2026	• Expenditure Report* • Review All Data – summaries with key info • Final Reallocations for PY36*
September 2026	• Review PY37 Priority Rankings and Allocations, revise as needed • Contingency Planning, as needed
October 2026	
November 2026	• Contingency Planning, as needed • Prevention Planning • Expenditure Report*
December 2026	
January 2027	• Directive Development (not this year but in future years)
February 2027	• Expenditure Report* • Directives Updates*

Unmet Needs Report, HIV/STI Surveillance Report – Have been presented at full COH meetings

LOS ANGELES COUNTY
COMMISSION ON HIV

Option 2 – Bi-Monthly Meeting Calendar (March 2026 – February 2027)

Month	Key Activities
March 2026	• Co-chair nominations and elections • Review and adopt annual workplan and meeting calendar • HIV/STD Surveillance Data report
May 2026	• Needs Assessment Planning • Review PSRA Framework • Integrated Plan Update* • Expenditure Report*
June 2026 (meet 2-3x)	• Resource Inventory Review • Prevention and Testing Data Report* • Unmet Needs Report*
July 2026 (meet 2-3x)	• Utilization Reports* • Needs Assessment Data Review (prior year findings) • Expenditure Report* • Review All Data – summaries with key info • Final Reallocations for PY36*
August 2026	• Review PY37 Priority Rankings and Allocations, revise as needed • Contingency Planning, as needed
November 2026	• Expenditure Report* • Prevention Planning
January 2027	• Directive Development (not this year but in future years) • Expenditure Report* • Directives Updates*

LOS ANGELES COUNTY
COMMISSION ON HIV

Option 3 – Bi-Monthly Meeting Calendar with Data Summit (March 2026 – February 2027)

Month	Key Activities
March 2026	• Co-chair nominations and elections • Review and adopt annual workplan and meeting calendar • Needs Assessment Planning
May 2026	• Needs Assessment Planning • Review PSRA Framework • Integrated Plan Update (Status of Submittal)
Virtual Data Summit (tentative for the month of June over the course of 2-4 days)	• Prevention and Testing Data Report* • HIV/STD Surveillance Data Report* • Unmet Needs Report* • Utilization Reports* • Needs Assessment Data Review (prior year findings)
July 2026	• Resource Inventory Review • Expenditure Report* • Review All Data – summaries with key info • Final Reallocations for PY36*
September 2026	• Review PY37 Priority Rankings and Allocations, revise as needed • Contingency Planning, as needed
November 2026	• Expenditure Report* • Prevention Planning • Directive Development (not this year but in future years)
January 2027	• Directive Development (not this year but in future years) • Expenditure Report* • Directives Updates*

Ryan White Program Utilization Summary Year 34: Support Services (March 1, 2024-February 28, 2025)

Sona Oksuzyan, Supervising Epidemiologist

Amanda Wahnich, Supervising Epidemiologist

Monitoring and Evaluation Unit

Division of HIV and STD Programs

October 21, 2025

Agenda

- Support Services Overview
- Support Services Deep Dive Framework
- Support Services Expenditures
- Key Takeaways

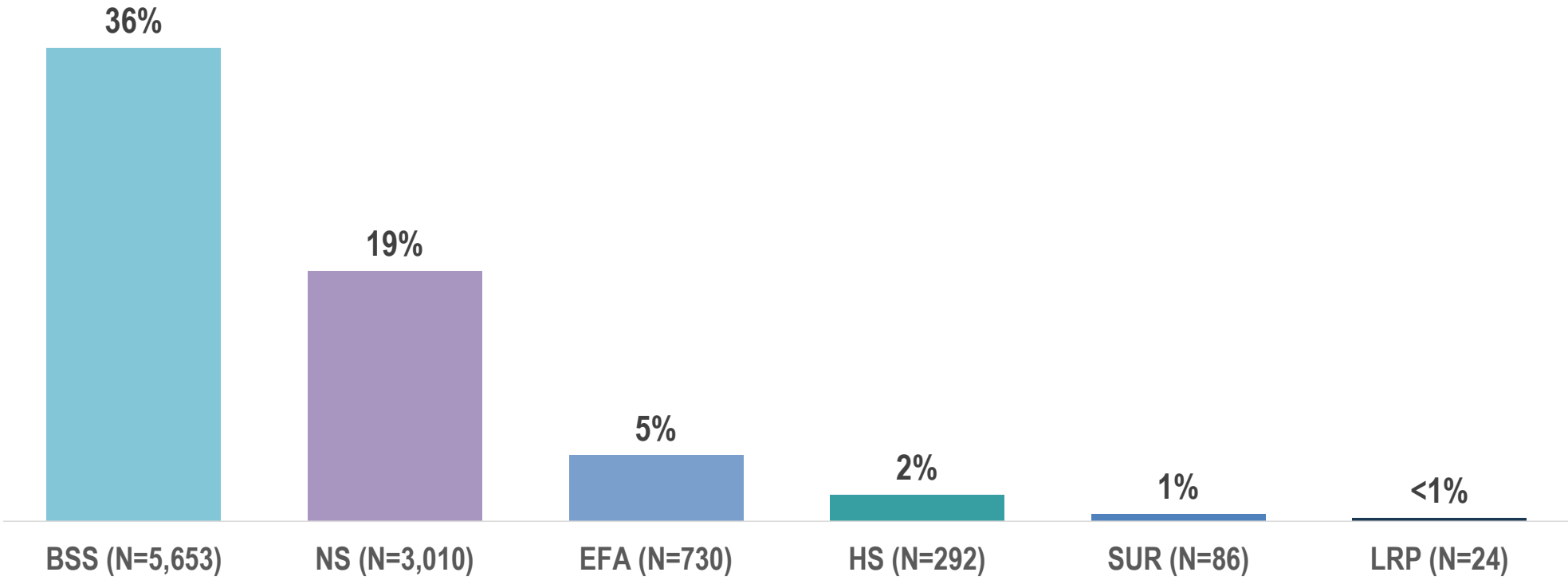
County of Los Angeles Public Health

Overview of Support Services

Emergency Financial Assistance (EFA) 2 contracted agencies (DHS, APLA)	Provides **limited one-time or short-term payments to assist RWP clients with an urgent need for rent**. Annual cap was $5,000.
Housing Service (HS) 4 contracted sites (APLA, DHS, Project New Hope, Salvation Army Alegria)	Provides **temporary or permanent housing with supportive services** for RWP clients
Benefit Specialty Services (BSS) 12 contracted sites	Provide **coordination, guidance and assistance in accessing multiple services** (medical, social, community, legal, financial, employment, vocational, and/or other needed services) and additional public and private programs (if eligible)
Nutrition Support (NS) 3 contracted sites (APLA, Bienestar, and Project Angel Food)	Provides **food to RWP clients**, improving and sustaining nutrition, food security and quality of life
Substance Use Residential (SUR) 1 contracted site (Tarzana Treatment Center)	Provides **outpatient treatment services for substance use disorders**
Linkage and Re-engagement Program (LRP) DHSP: DCS Health Navigators	Assists **people newly diagnosed or living with HIV who are lost or returning to treatment to re-engage in care** (medical and psychosocial services).

In Year 34, Benefits Specialty Services (BSS) and Nutrition Services (NS) were the most highly utilized support services.

Utilization of RWP Support Services, Year 34
(Total RWP clients N=15,843)



Support Service Category Deep Dive Framework

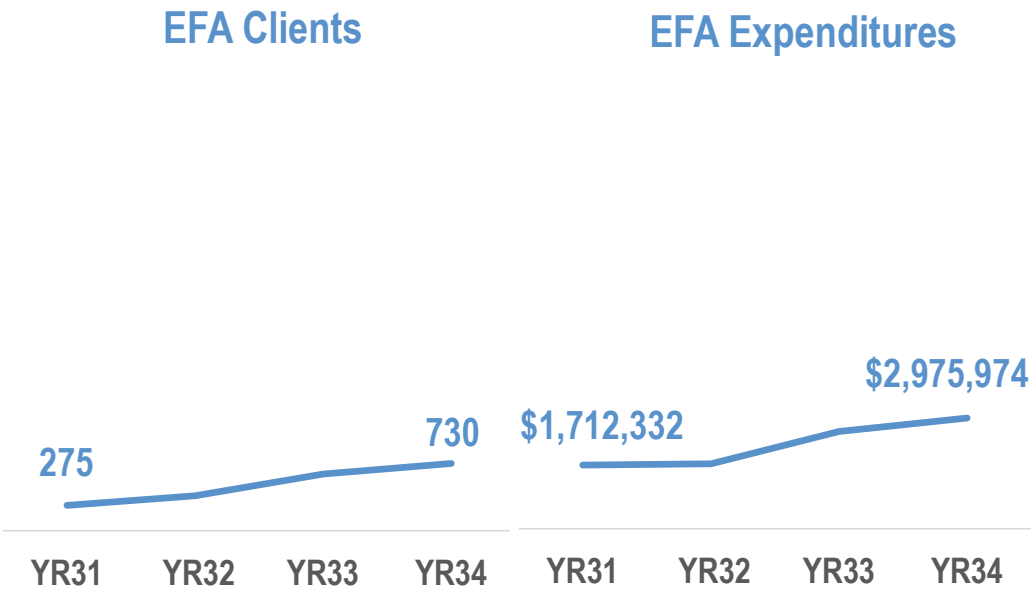
Overall Service Utilization and Expenditure Summary	• Client Served • Service Units (Total and Per Client) • Expenditures (Total and Per Client)
Client Demographics	• Gender • Race • Age
Priority Population Engagement	• Latinx MSM • Black/AA MSM • Age ≥ 50 years • Women of color • Transgender Clients • Age 13-29 clients • People who inject drugs (PWID) • Unhoused < 12 months
Health Determinants	• Primary language • Income • Primary insurance • Housing Status • Incarceration history
HIV Care Continuum Outcomes	• Engaged in Care • Retained in Care • Suppressed Viral Load

Emergency Financial Assistance (EFA)

- **18% increase in service utilization in Year 34 compared to Year 33**
- **14% increase in expenditures in Year 34 compared to Year 33**

County of Los Angeles Public Health

- A total of **730 unique clients** received EFA services, representing **4% of RWP clients**
- There was an **overall increase in EFA utilization and expenditures** over the last four years



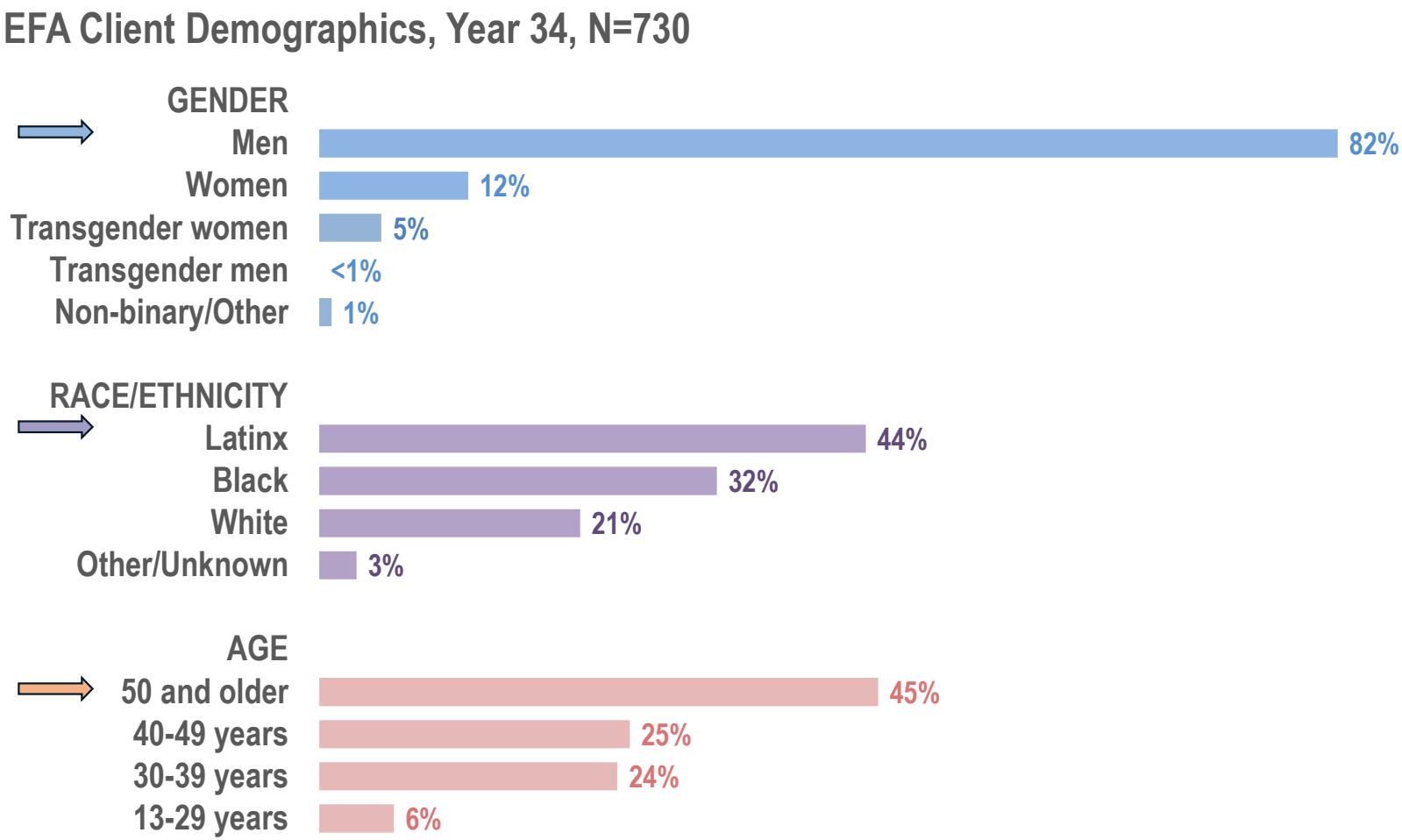
EFA Service Utilization & Expenditures Summary, Year 34

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units per client	Expenditures	Expenditures per client
EFA	730	Dollars	2,873,110	3,936	*$2,975,974*	*$4,077*

Funding Source:

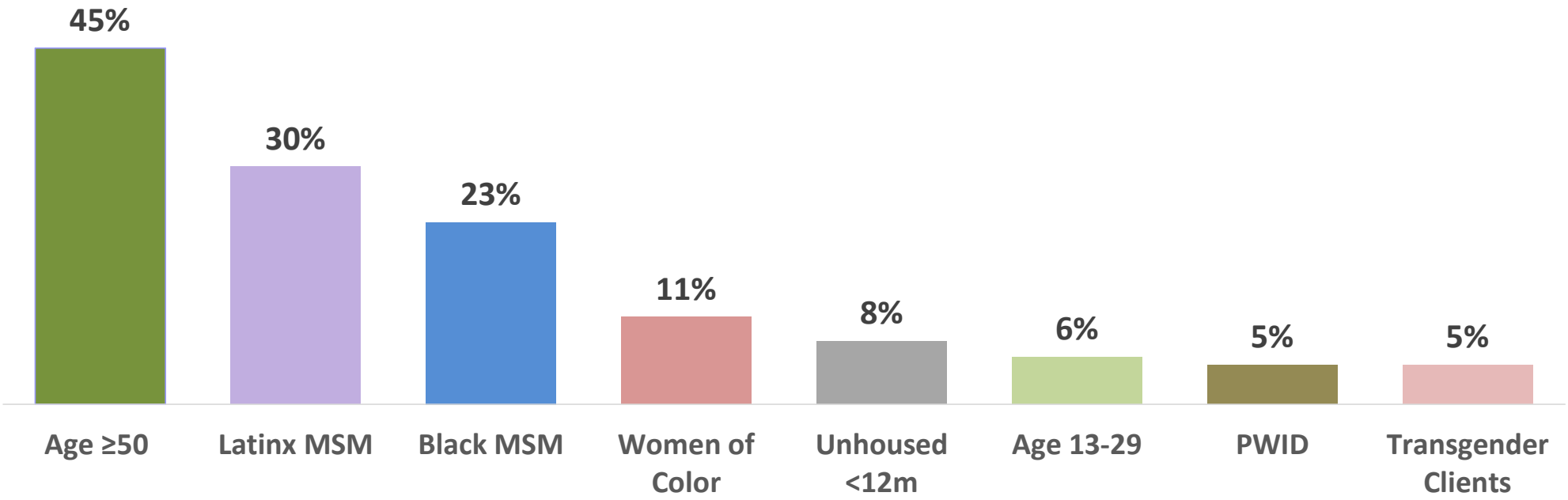
- *Part A - $1,539,288*
- *HRSA EHE - $765,693*
- *HIV NCC - $670,993*

EFA clients were predominantly men, Latinx, and RWP clients aged 50 and older



LAC Priority Populations* Accessing EFA, Year 34

- Over half of EFA clients were **aged 50 and older,** representing the largest group
- **Latinx MSM** represented almost a third of EFA clients
- **Black MSM** represented about a quarter of EFA clients

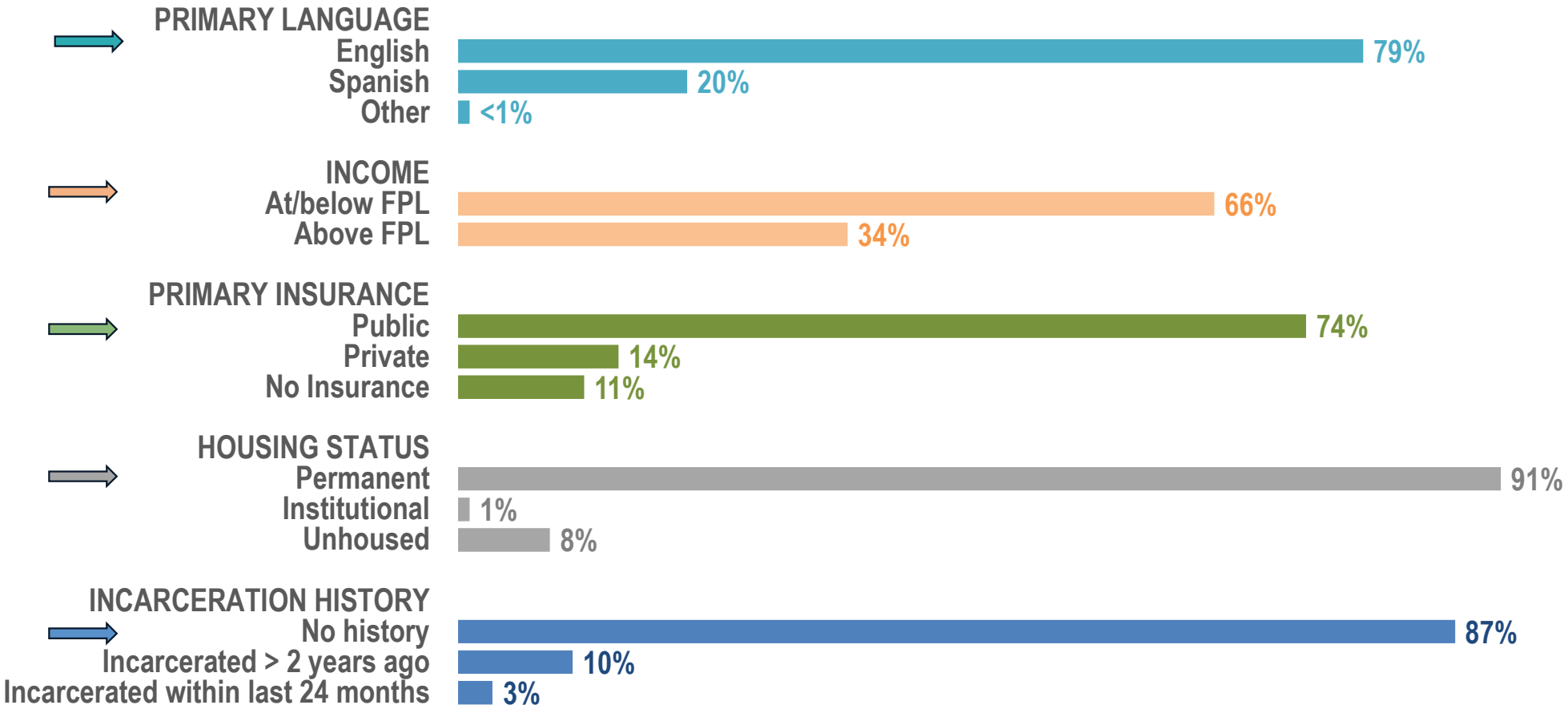


*Priority population groups are not mutually exclusive, they may overlap

Most EFA clients were English speakers, living ≤ FPL, had private insurance, were permanently housed, and had no incarceration history

County of Los Angeles Public Health

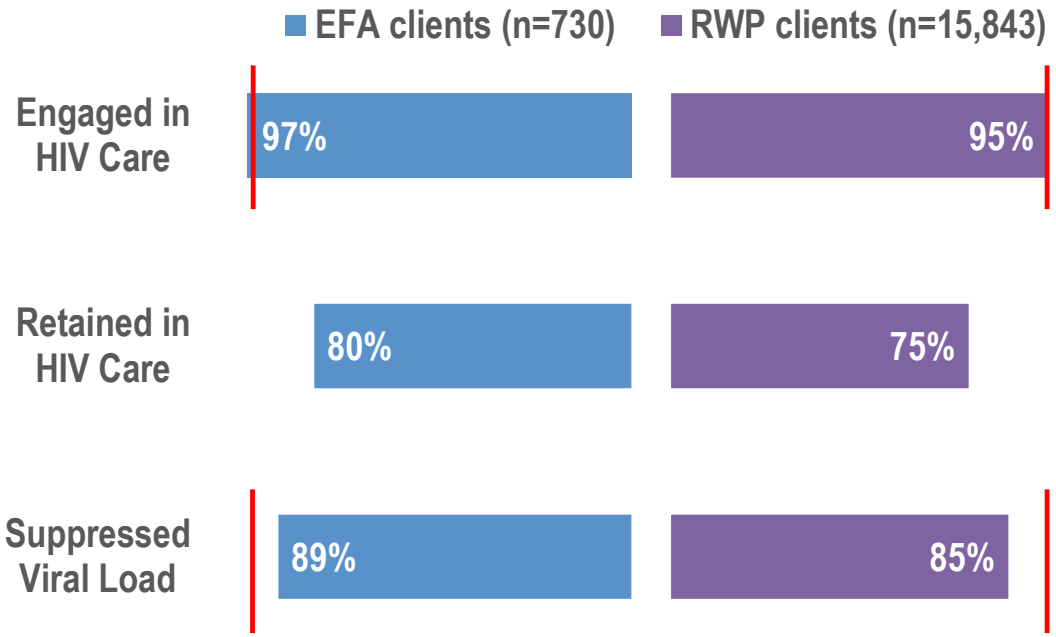
EFA Client Health Determinants, Year 34, N=730



HIV Care Continuum in EFA clients, Year 34

- Engagement[a], retention in care[b], and viral load suppression[c] percentages were higher for EFA clients compared to RWP clients overall, Year 34

- EFA clients did not meet the EHE target of 95% for viral suppression However, they met the local target of 95% for engagement in care



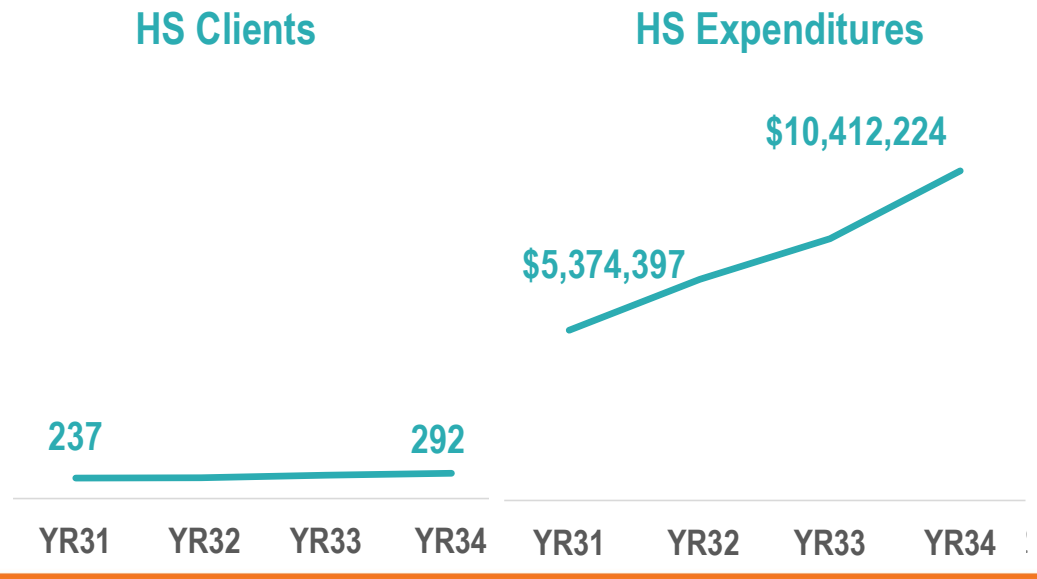
Data source: HIV Casewatch as of 5/1/2025

[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 5/5/2025
[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 5/5/2025
[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 5/5/2025

Housing Services (HS)

- **18% increase in service utilization in Year 34 compared to Year 33**
- **26% increase in expenditures in Year 34 compared to Year 33**

- A total of **292 unique clients** received **HS**, representing **2% of RWP clients** in Year 34
  - *Permanent Supportive Housing (H4H): **193** clients*
  - *Residential Care Facilities for the Chronically Ill: **68** clients*
  - *Transitional Residential Care Facilities: **39** clients*
- **HS utilization and expenditures increased** in the last 4 years.



County of Los Angeles Public Health

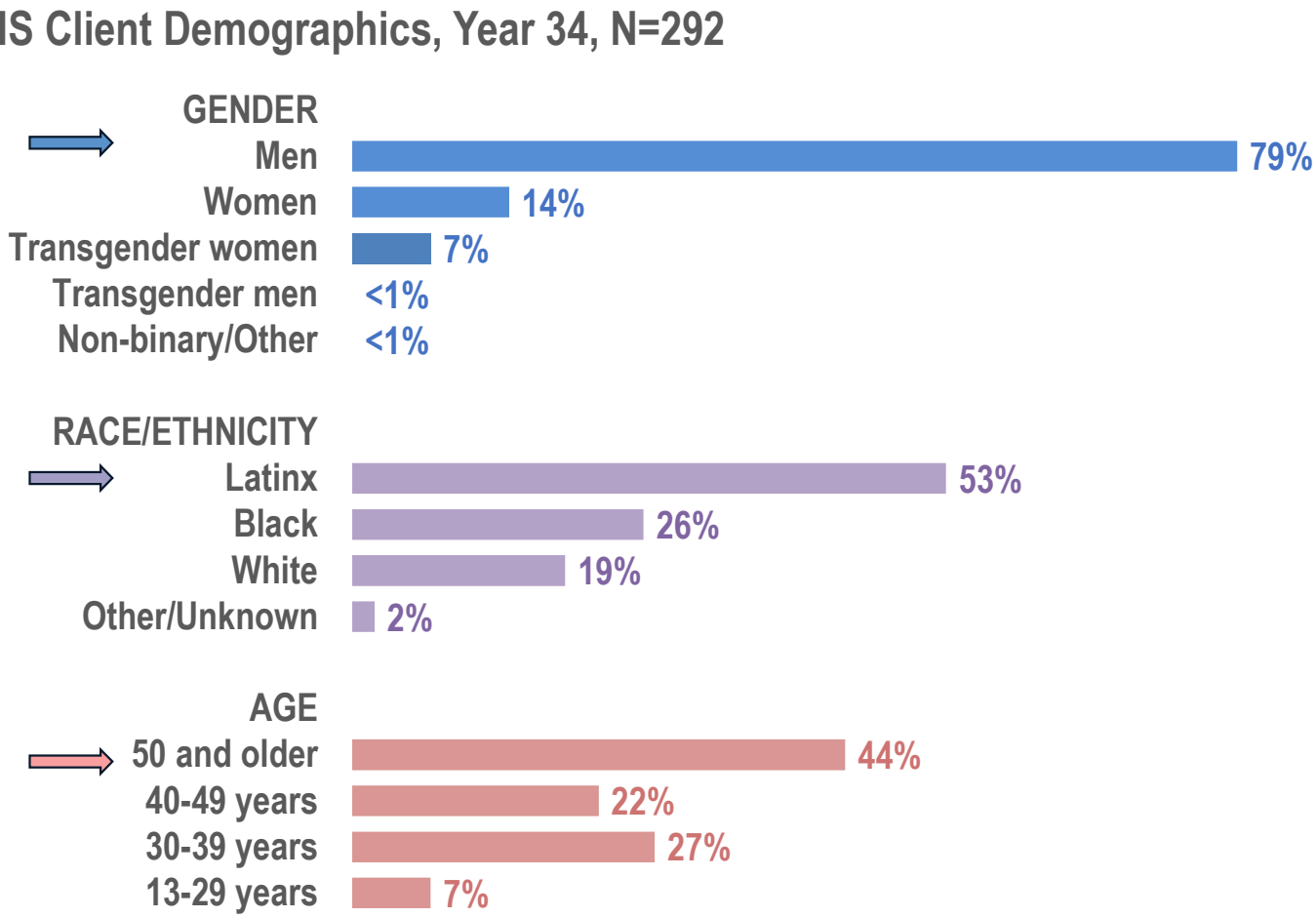
HS Service Utilization & Expenditures Summary, Year 34

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units per client	Expenditures	Expenditures per client
HS	**292**	**Days**	**61,766**	**280**	**$10,412,224**	***$35,658***
Permanent Supportive Housing (H4H)	193	Days	61,525	319	$5,530,755	*$28,657*
Residential Care Facilities for the Chronically Ill	68	Days	14,049	207	$4,033,827	*$59,321*
Transitional Residential Care Facilities	39	Days	6,192	159	$847,642	*$21,734*

Funding Source:

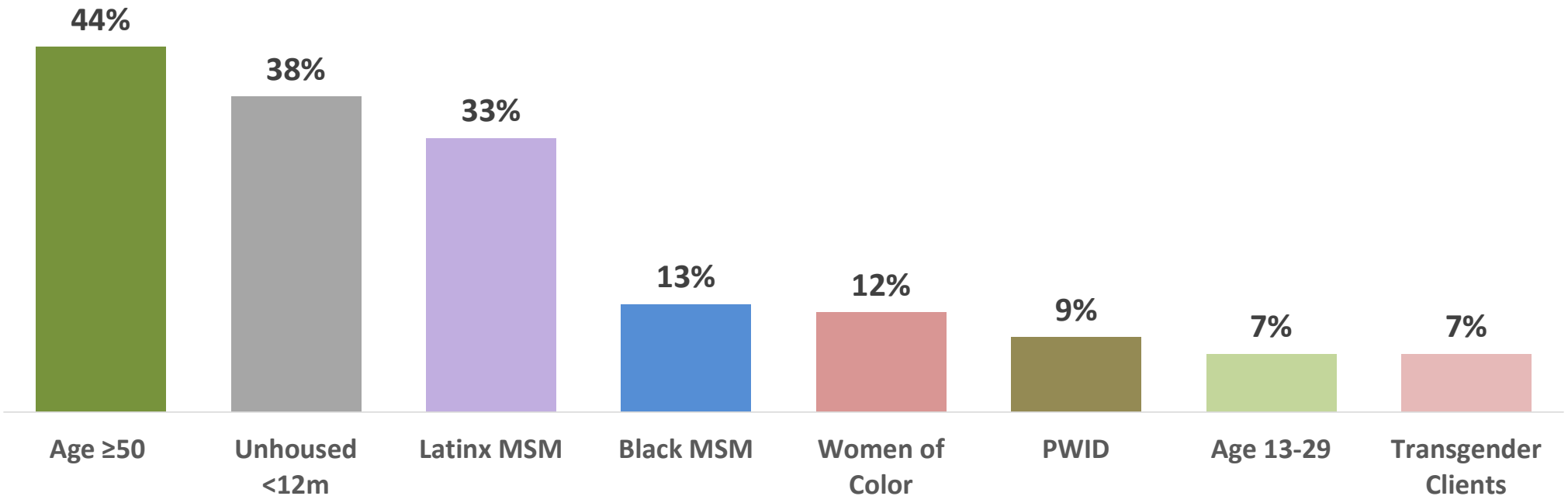
- *Part A - $484,771*
- *MAI - $3,305,635*
- *Part B – $4,396,698*
- *HIV NCC - $2,225,120*

HS clients were predominantly men, Latinx, and were aged 50 and older



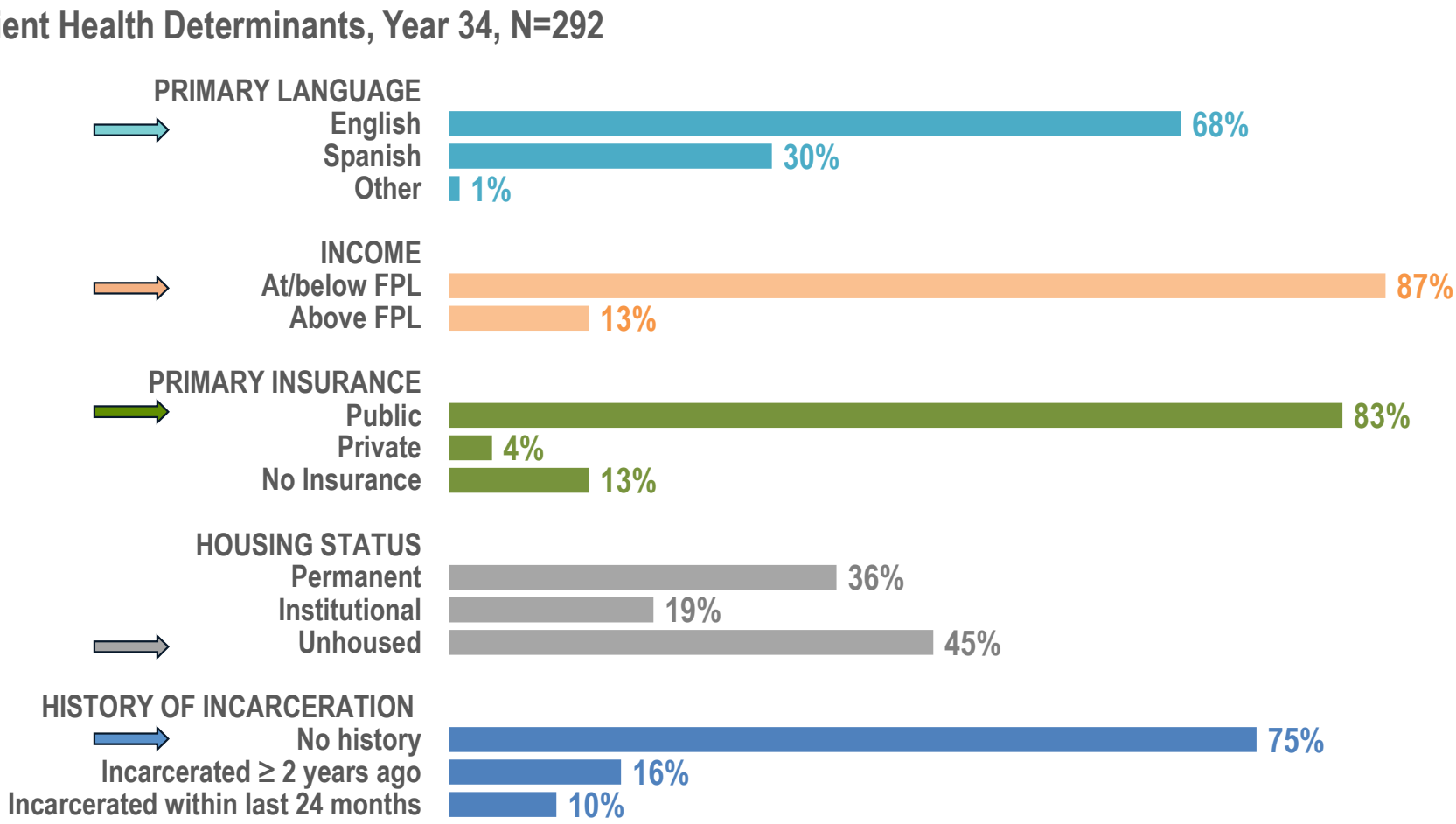
LAC Priority Populations* Accessing HS, Year 34

- RWP clients **aged 50 and older** represented 44% of HS clients, the largest priority populations
- **Unhoused** at some point during Year 34 people represented about 38% of HS clients
- **Latinx MSM** represented a third of HS clients



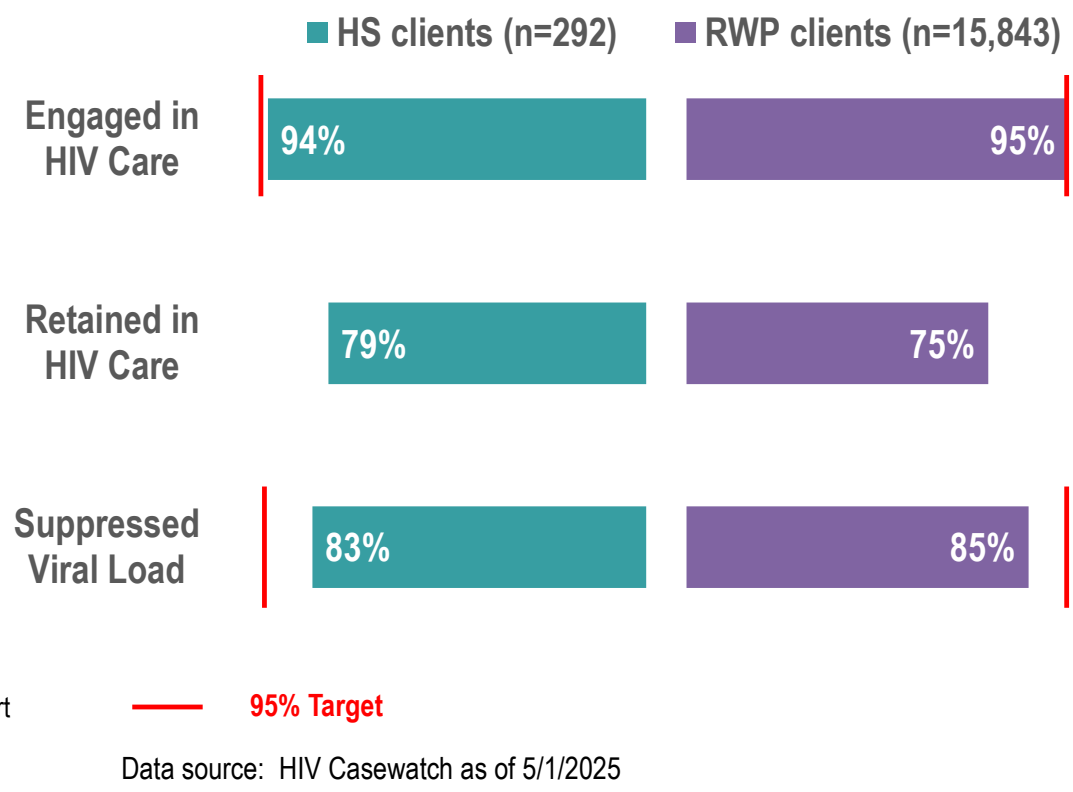
*Priority population groups are not mutually exclusive, they may overlap

Most HS clients were English-speakers, living ≤ FPL, had public insurance, were unhoused, and had no history of incarceration



HIV Care Continuum in HS Clients, Year 34

- Engagement[a] and viral load suppression[c] percentages were lower for HS clients compared to RWP clients overall, Year 34 Retention in care[b] was higher among housing clients than RWP clients overall
- HS clients did not meet the EHE targets



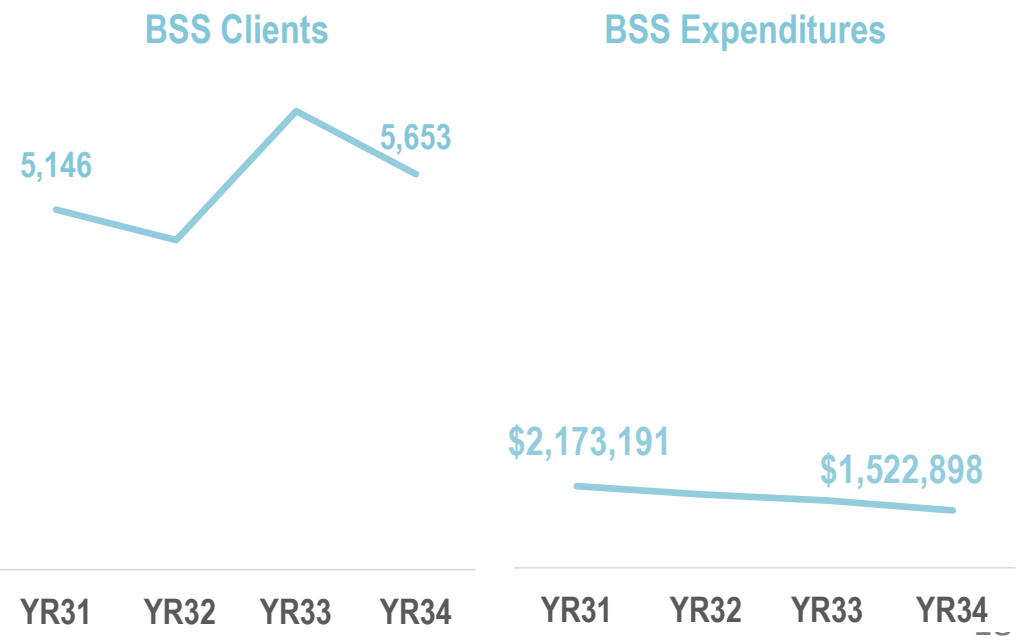
Data source: HIV Casewatch as of 5/1/2025

[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 5/5/2025
[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 5/5/2025
[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 5/5/2025

Benefit Specialty Services (BSS)

- 14% decrease in service utilization in Year 34 compared to Year 33
- 15% decrease in expenditures in Year 34 compared to Year 33

- A total of **5,653 unique clients** received **BSS**, representing **36% of RWP clients**
- While **BSS utilization** varied in the past 4 years, expenditures have **decreased**.



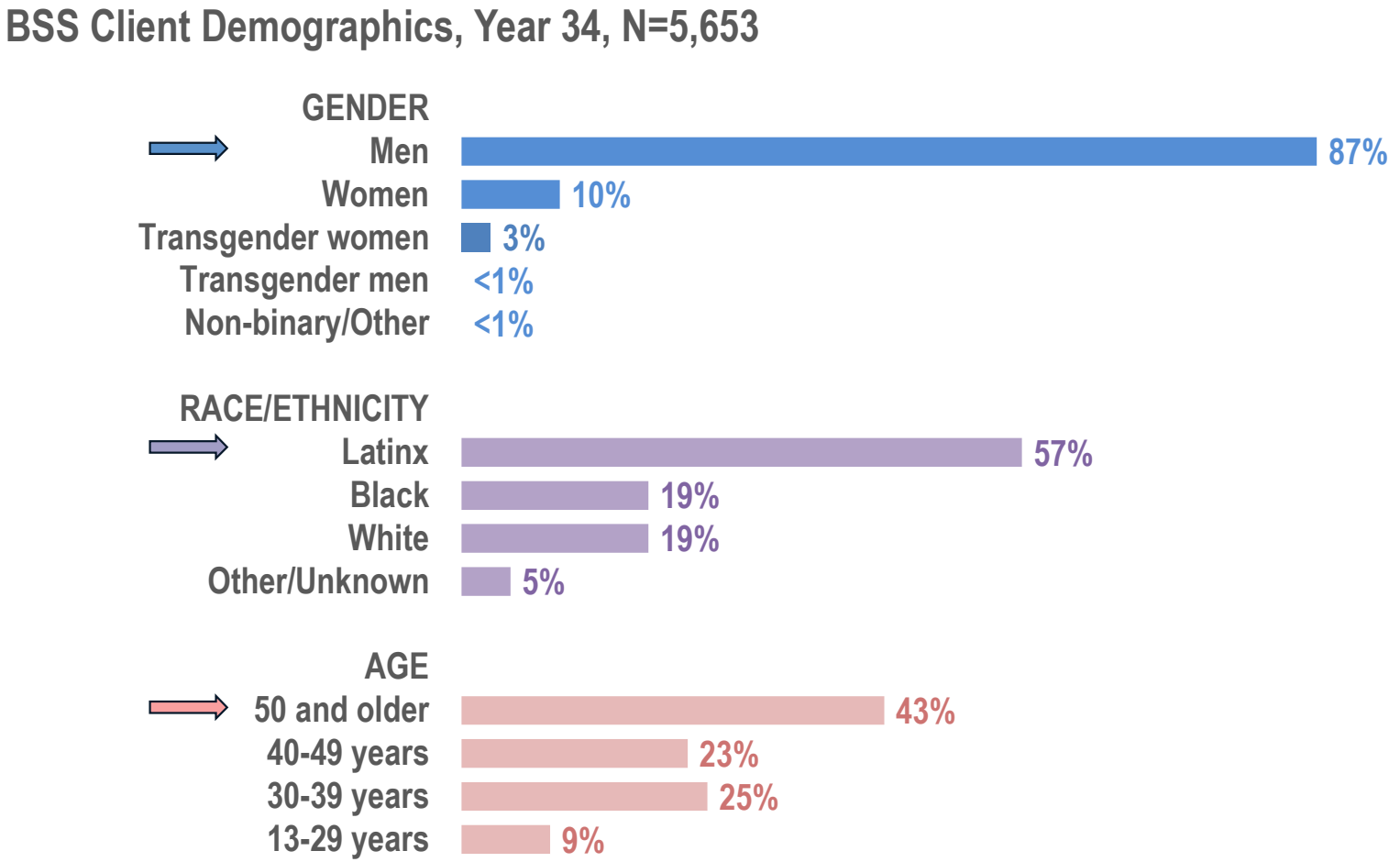
BSS Service Utilization & Expenditures Summary, Year 34

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units per client	Expenditures	Expenditures per client
BSS	5,653	23,541	Hours	4	*$1,522,898*	*$269*

Funding Source:

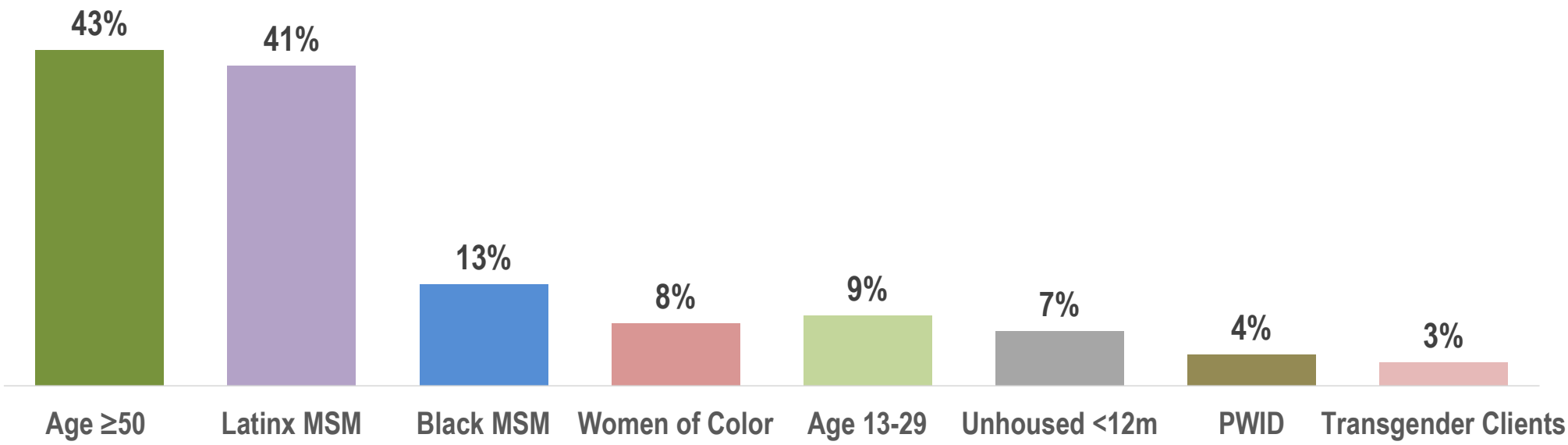
- *Part A - $1,522,898*

Most BSS clients were men, Latinx, and were aged 50 and older



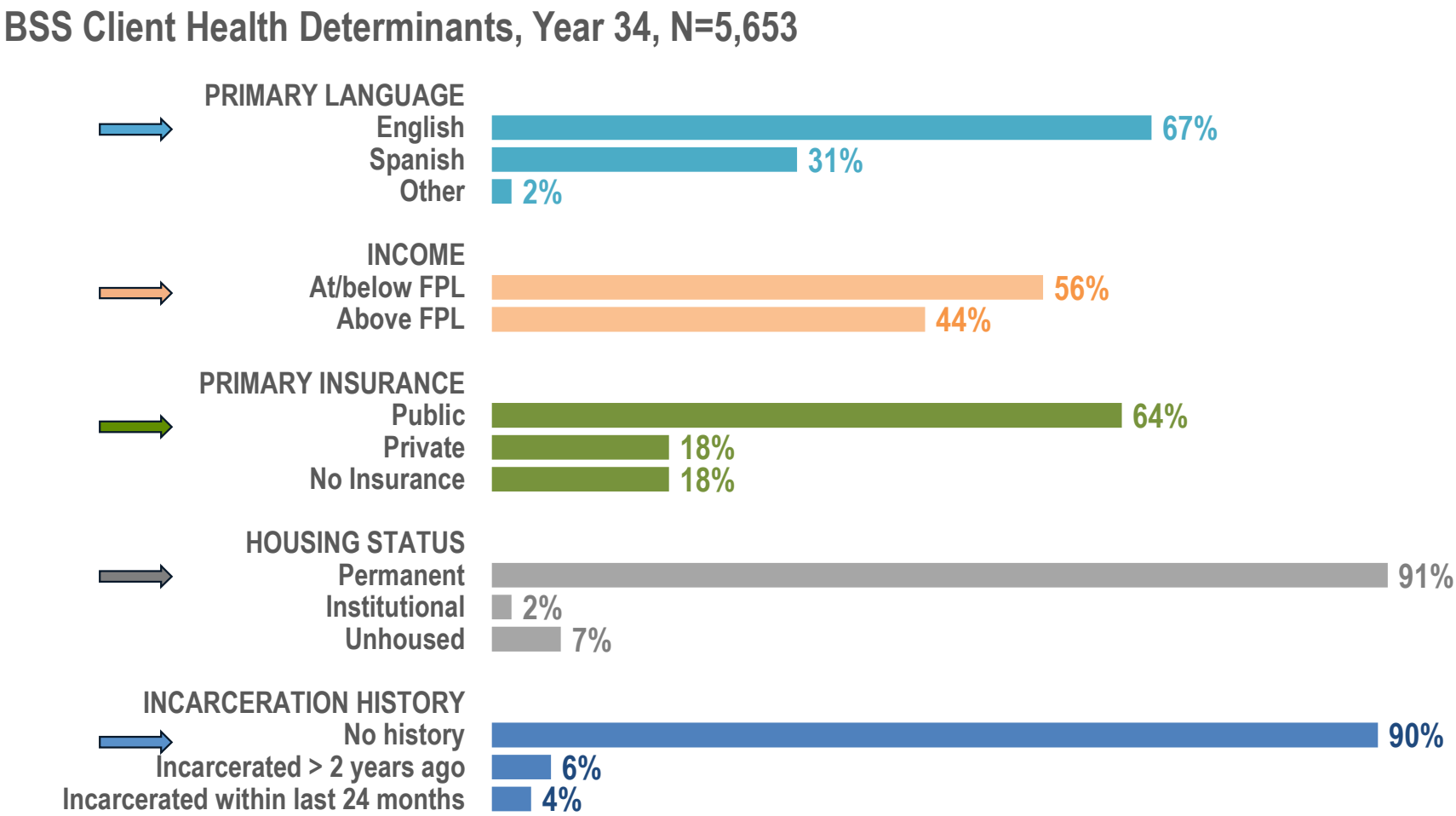
LAC Priority Populations* Accessing BSS, Year 34

- **Clients age ≥ 50** represented the **largest percentage of BSS clients**
- **Latinx MSM** clients were the second highest priority population served by BSS



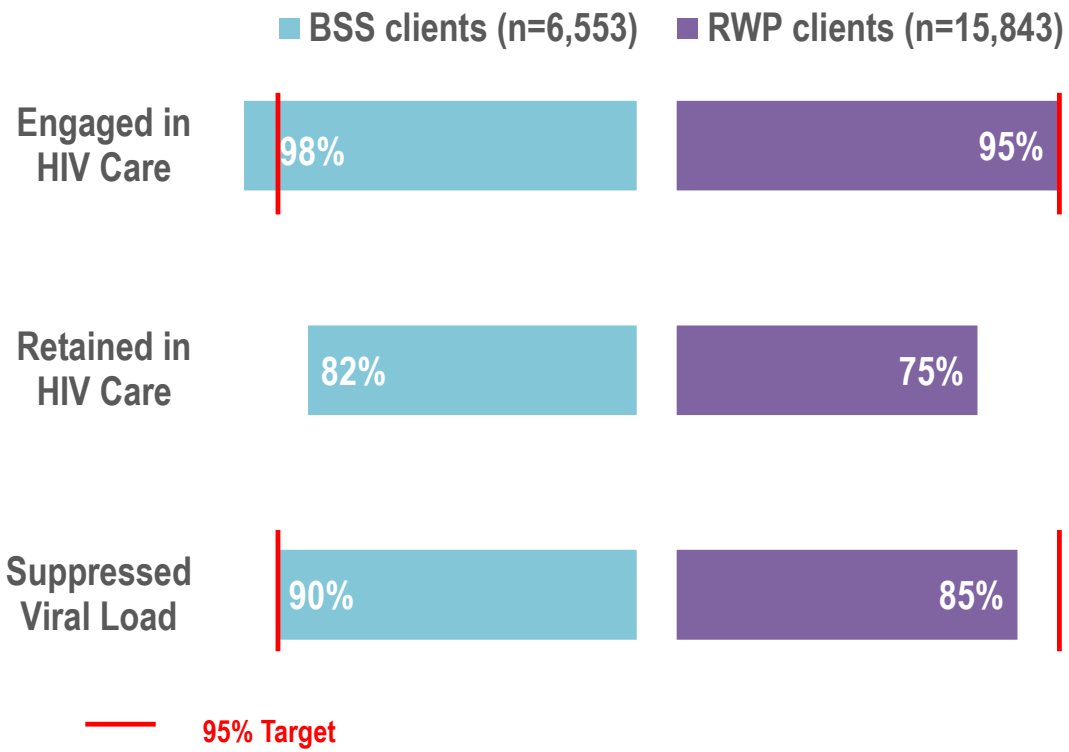
*Priority population groups are not mutually exclusive, they may overlap

Most BSS clients were English-speakers, were living ≤ FPL, had public insurance, were permanently housed, and had no history of incarceration



HIV Care Continuum in BSS clients, Year 34

- Engagement[a], retention[b], and viral load suppression[c] percentages were higher for BSS clients compared to RWP clients overall, Year 34
- BSS clients did not meet the EHE target of 95% for viral suppression However, they met the local target of 95% for engagement in care



Data source: HIV Casewatch as of 5/1/2025

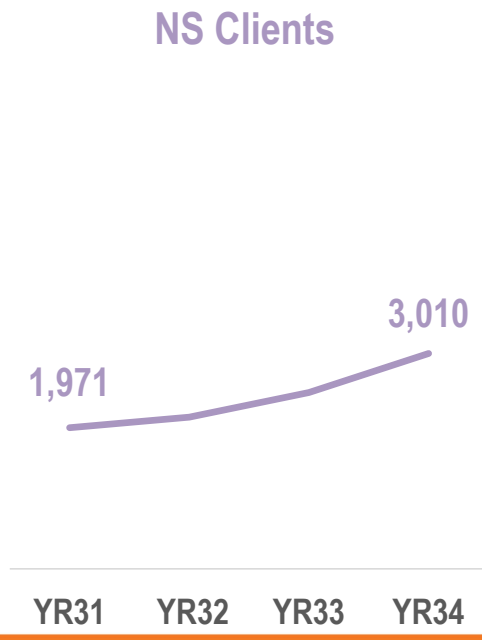
[a]**Engagement in Care** defined as 1 ≥ viral load, CD4 or genotype test reported in the 12-month period based on HIV laboratory data as of 5/5/2025
[b]**Retention in care** defined as 2 ≥ viral load, CD4 or genotype test reported >30 days apart in the 12-month period based on HIV laboratory data as of 5/5/2025
[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 5/5/2025

Nutrition Support Services (NS)

- **22**% increase in service utilization in Year 34 compared to Year 33
- 1% increase in expenditures in Year 34 compared to Year 33

County of Los Angeles Public Health

- A total of **3,010 unique clients** received **NS**, representing **19% of RWP clients**
  - *Delivered Meals* – **457** clients
  - *Food Bank* – **2,700** clients
- **NS utilization and expenditures increased** in the last four years



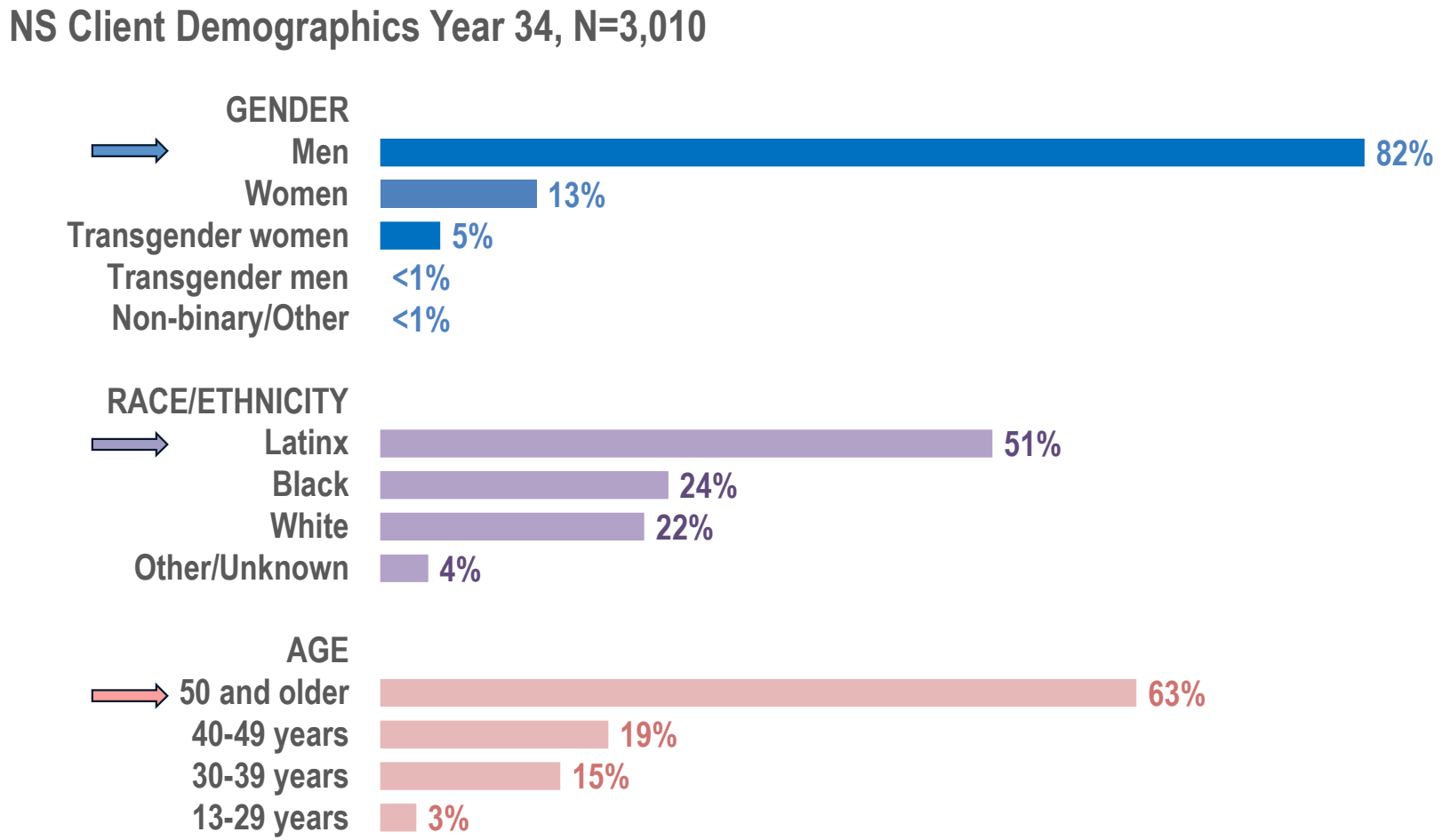
NS Service Utilization & Expenditures Summary, Year 34

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units per client	Expenditures	Expenditures per client
NS	**3,010**	**Various**	**507,949**	**169**	**$3,928,501**	***$1,305***
Delivered Meals	457	*Meals*	270,390	592	$2,597,212	*$5,683*
Food Bank	2,700	*Bags of groceries*	237,559	88	$1,331,289	*$493*

Funding Source:

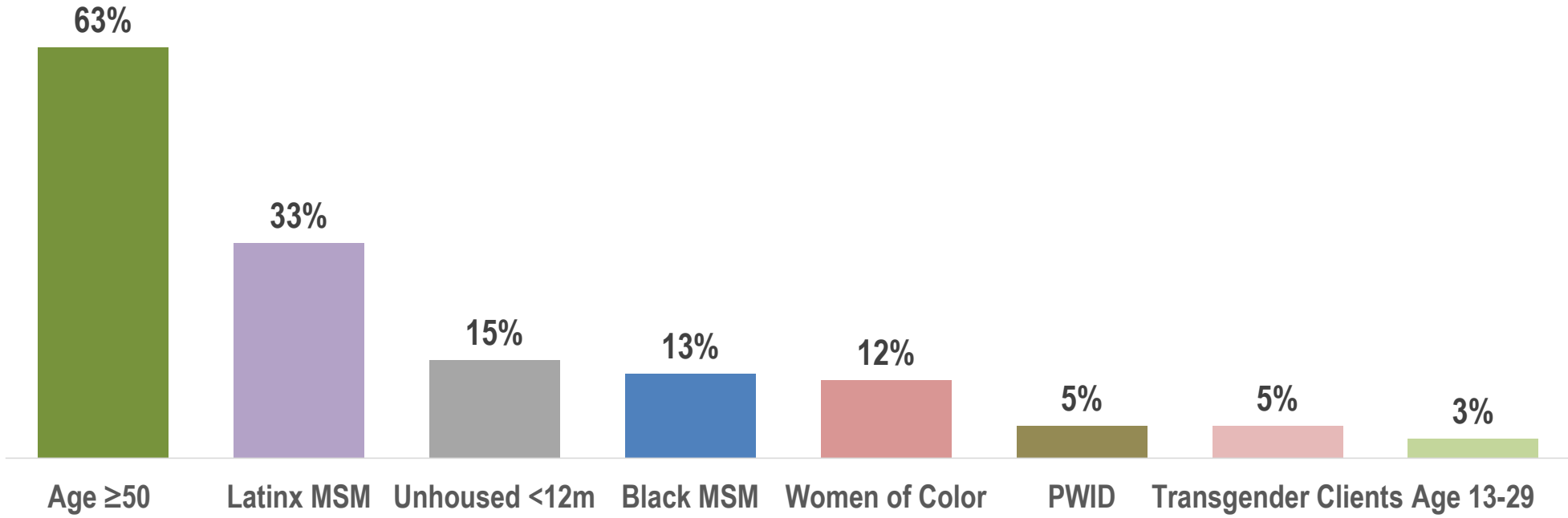
- *Part A - $2,597,212*
- *HRSA EHE - $1,000,000*
- *HIV NCC - $331,289*

Most NS clients were men, Latinx and were aged 50 and older



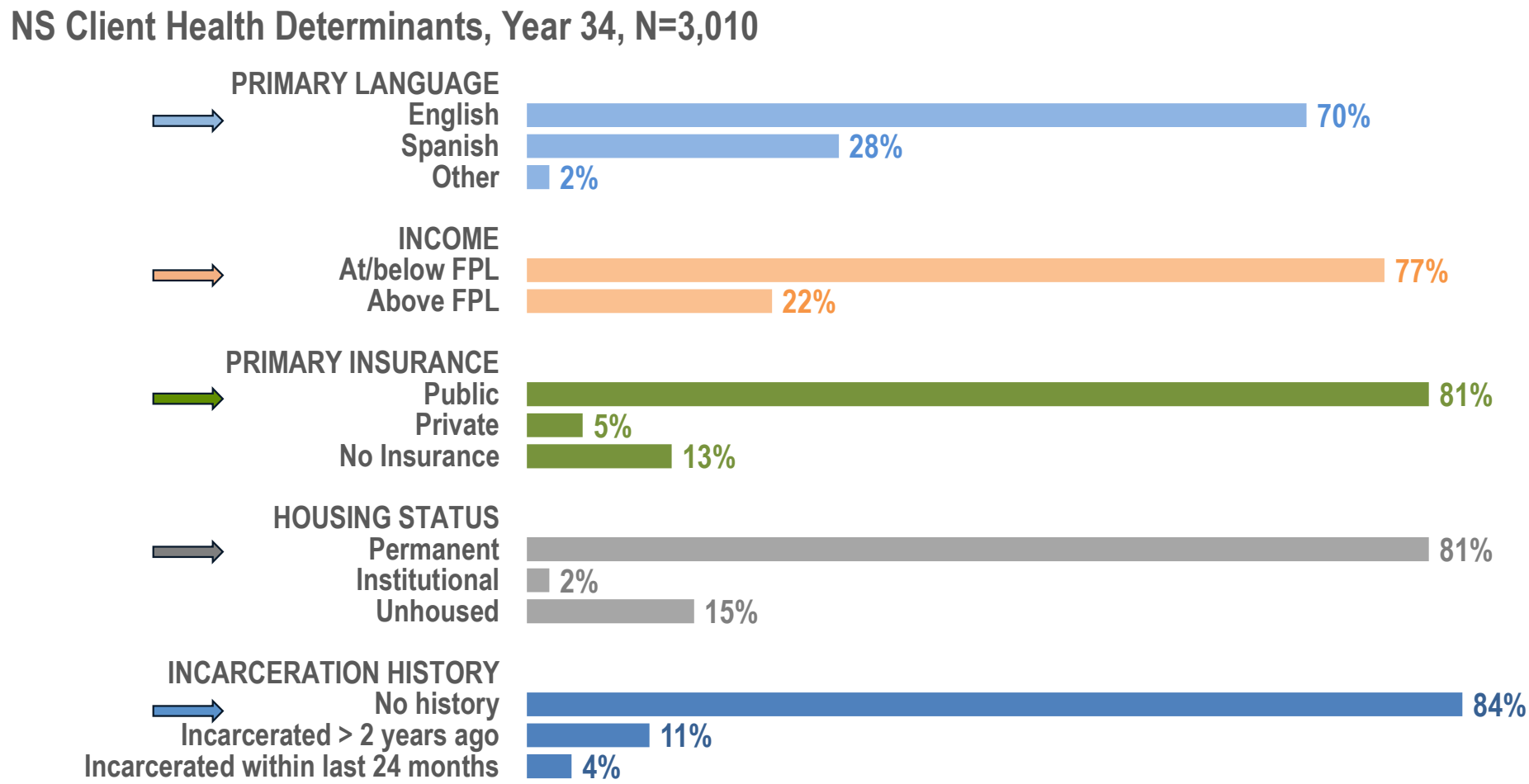
LAC Priority Populations* Accessing NS, Year 34

- **Clients age ≥ 50** represented **most** NS utilization clients (including subservices)
- **Latinx MSM** clients were the **second highest** NS utilization clients (including subservices)



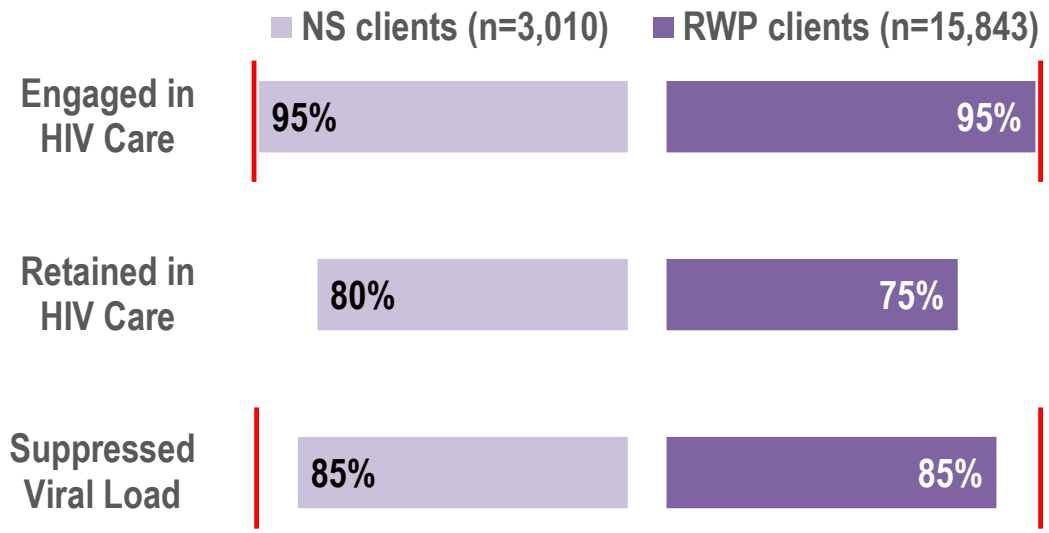
*Priority population groups are not mutually exclusive, they may overlap

Most of NS clients were English-speakers, lived ≤ FPL, had public insurance, were permanently housed, and had no history of incarceration



HIV Care Continuum in NS Clients, Year 34

- Engagement[a] and viral load suppression[c] percentages were similar for NS service clients compared to RWP clients in Year 34. Retention in care[b] was higher among NS clients than RWP clients overall
- NS service clients did not meet EHE or local targets



[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 5/5/2025
[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 5/5/2025
[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 5/5/2025

Data source: HIV Casewatch as of 5/1/2025

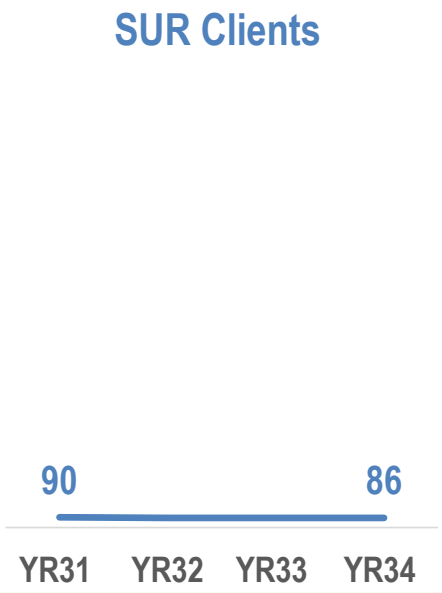
Substance Use Residential (SUR) Services

➡ No significant changes in the number of clients served.

⬆ 34% increase in expenditures in Year 34 compared to Year 33

County of Los Angeles Public Health

- A total of **86 unique clients** received **SUR** services, represented **<1% of RWP clients.**
- While **utilization of SUR services** had no significant changes over four years, **expenditures increased** considerably.



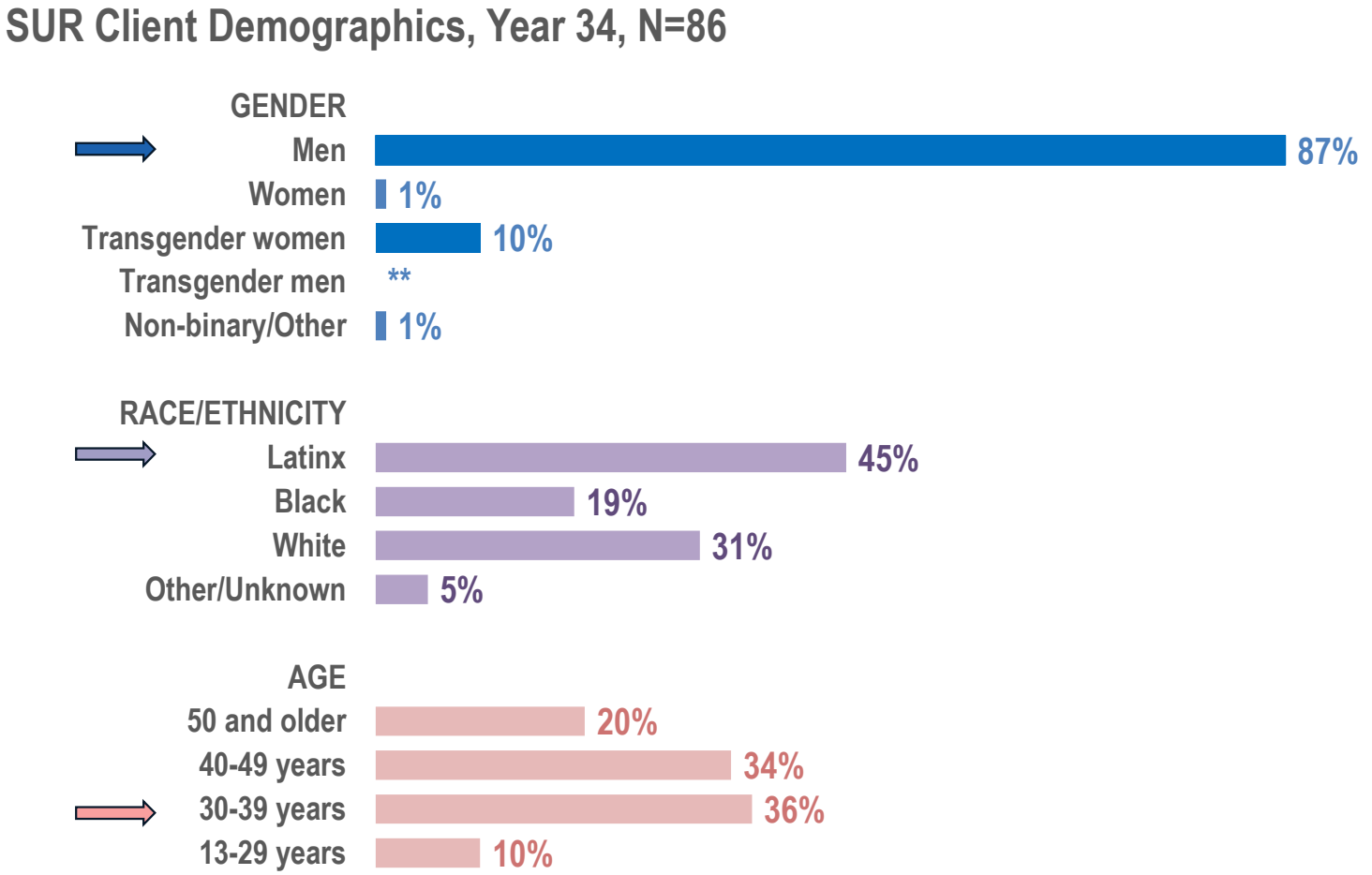
SUR Service Utilization & Expenditures Summary, Year 34

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units per client	Expenditures	Expenditures per client
SUR	86	Days	12,975	151	*$973,125*	*$11,315*

Funding Source:

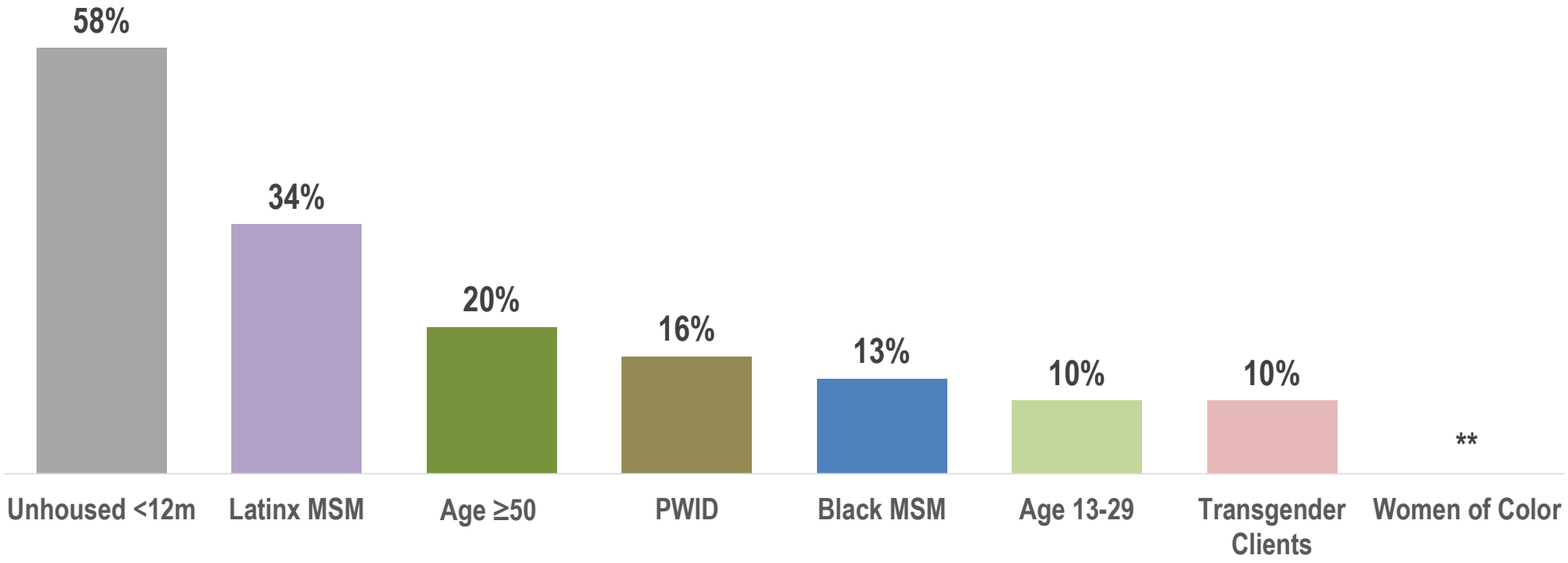
- *Part B - $891,175*
- *SAPC Non-DMC - $55,000*
- *HIV NCC - $ 6,950*

SUR clients were predominantly men, Latinx, and aged 30-39 years old



LAC Priority Populations* Accessing SUR, Year 34

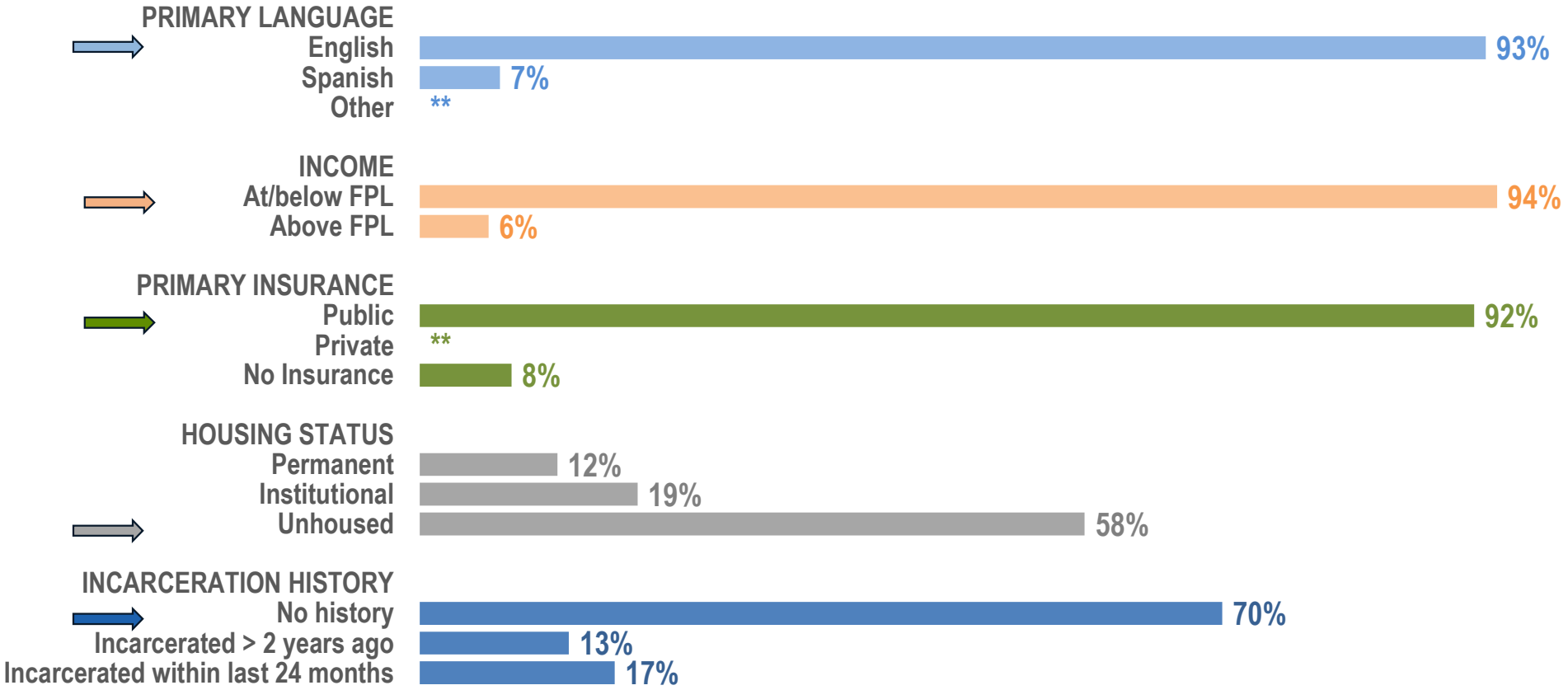
- **Unhoused** at some point during Year 34 clients represented the majority of SUR clients
- **Latinx MSM** were the next highest served by SUR followed by people aged 50 and older



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

SUR clients were predominantly English-speakers, living ≤ FPL, had public insurance, were unhoused, and had no incarceration history.

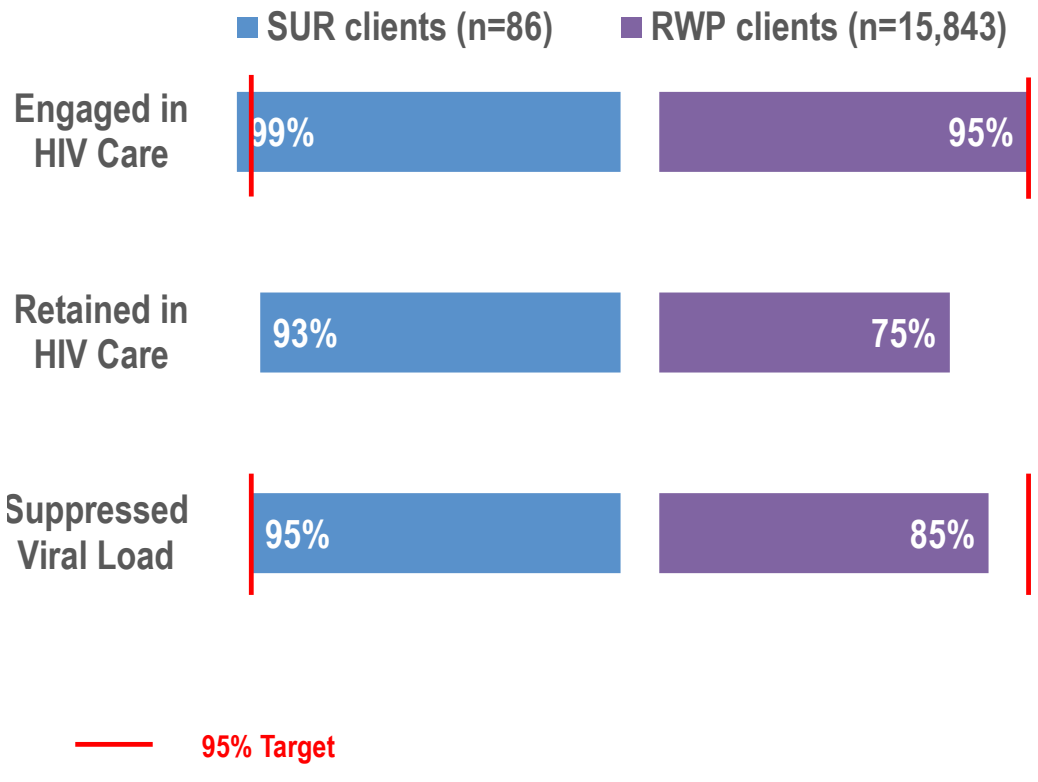
SUR Client Health Determinants, Year 34, N=86



HIV Care Continuum in SUR Clients, Year 34

- Engagement[a], retention[b], and viral load suppression[c] percentages were higher for SUR clients compared to RWP clients overall, Year 34

- SUR clients met the EHE target of 95% for viral suppression and the local target of 95% for engagement in care



Data source: HIV Casewatch as of 5/1/2025

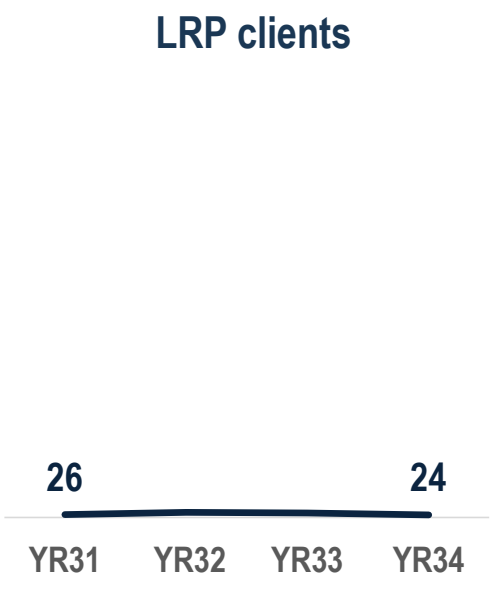
[a]**Engagement in Care** defined as 1 ≥ viral load, CD4 or genotype test reported in the 12-month period based on HIV laboratory data as of 5/5/2025
[b]**Retention in care** defined as 2 ≥ viral load, CD4 or genotype test reported >30 days apart in the 12-month period based on HIV laboratory data as of 5/5/2025
[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 5/5/2025

Linkage and Re-engagement Program (LRP)

- **40% decrease in service utilization in Year 34 compared to Year 33**
- **No significant decrease in expenditures in Year 34 compared to Year 33**

County of Los Angeles Public Health

- A total of **24 unique clients** received **LRP** services, representing **<1% of RWP clients**
- While **utilization of LRP service decreased** in the past 4 years, **expenditures increased**



LRP Service Utilization & Expenditures Summary, Year 34

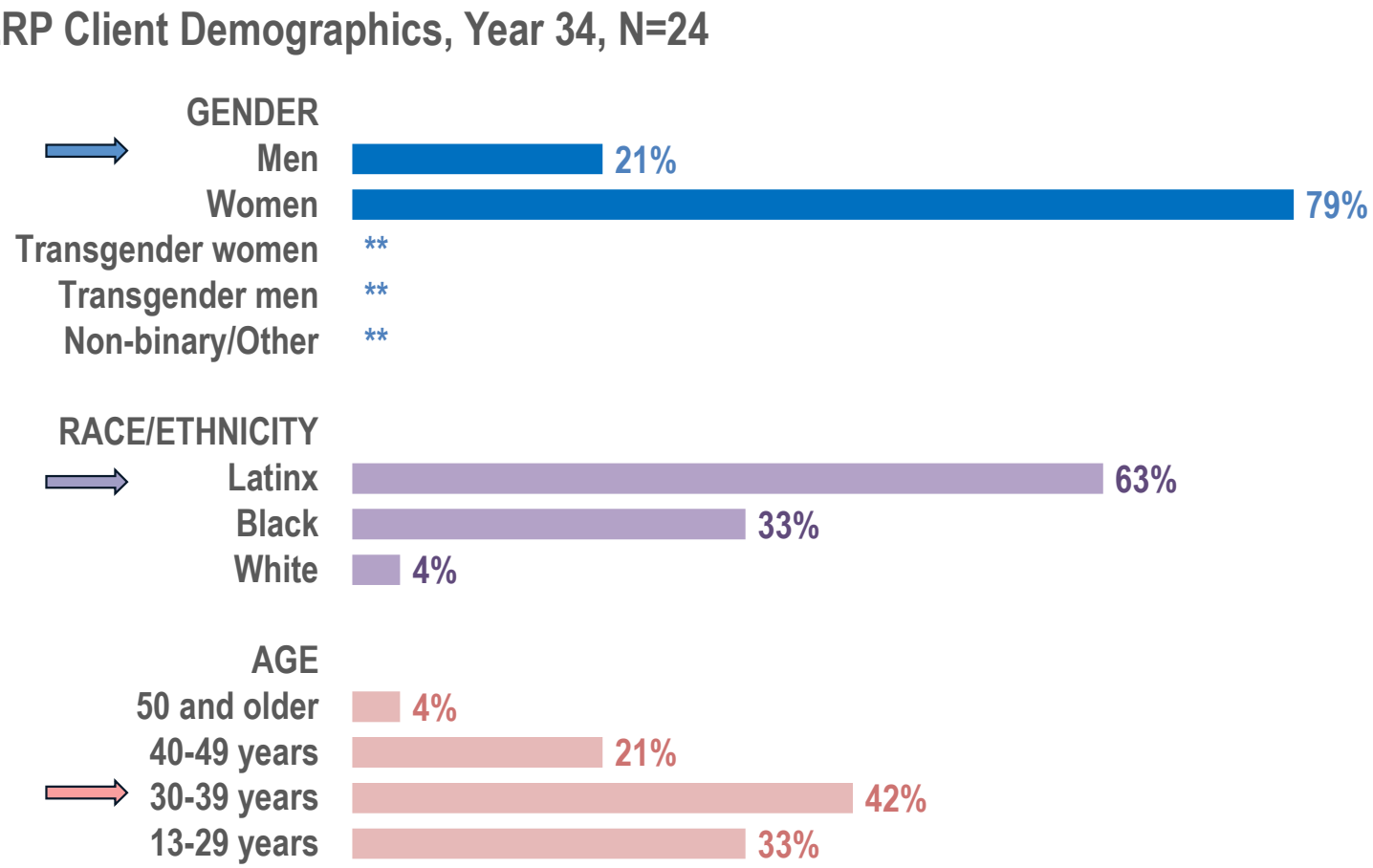
Service Category	Unique Clients Served*	Service Unit(s)	Total Service Units	Units per client	Expenditures	Expenditures per client
LRP	24	Hours	479	20	*$917,429*	*$38,226*

Funding Source:

- *HRSA EHE- $697,379*
- *HIV NCC- $220,050*

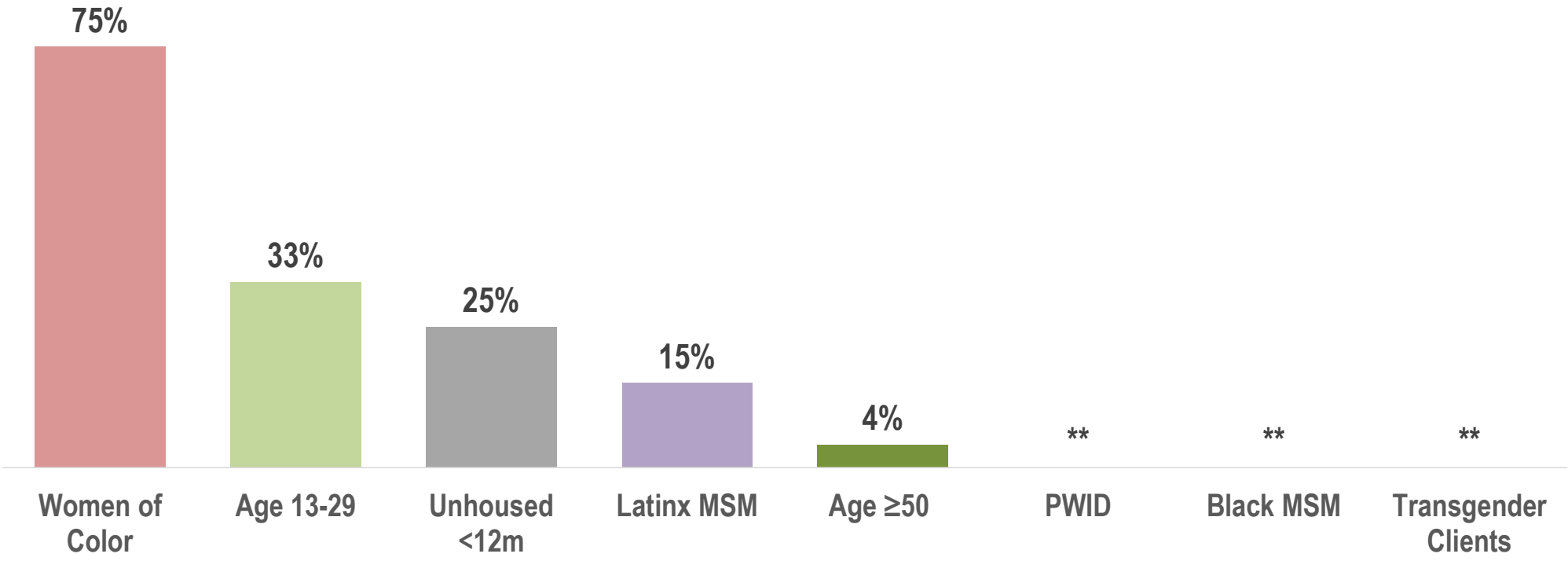
**244 referrals for LRP, 196 accepted referrals; 24 served by LRP entered in CaseWatch*

Most LRP clients were women, Latinx, and aged 39 years and below



LAC Priority Populations* Accessing LRP, Year 34

- **Women of color** represented the majority of LRP clients
- LRP clients **aged 13-29** and recently **unhoused** were the second highest priority population



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

Most of LRP clients were English-speakers, living ≤ FPL, insured, permanently housed, and had incarceration history

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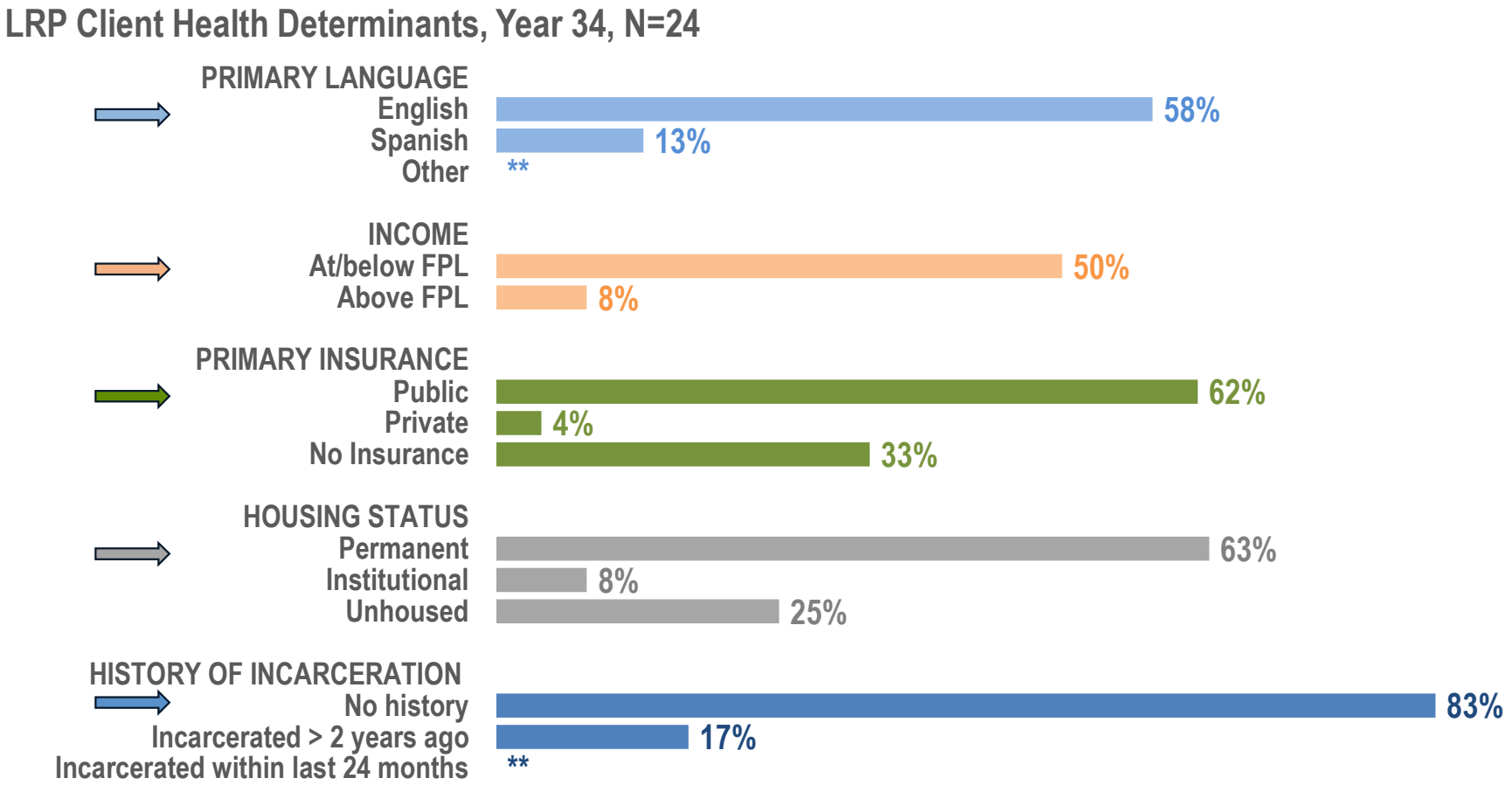

Totals may not sum to 100% due to incomplete reporting

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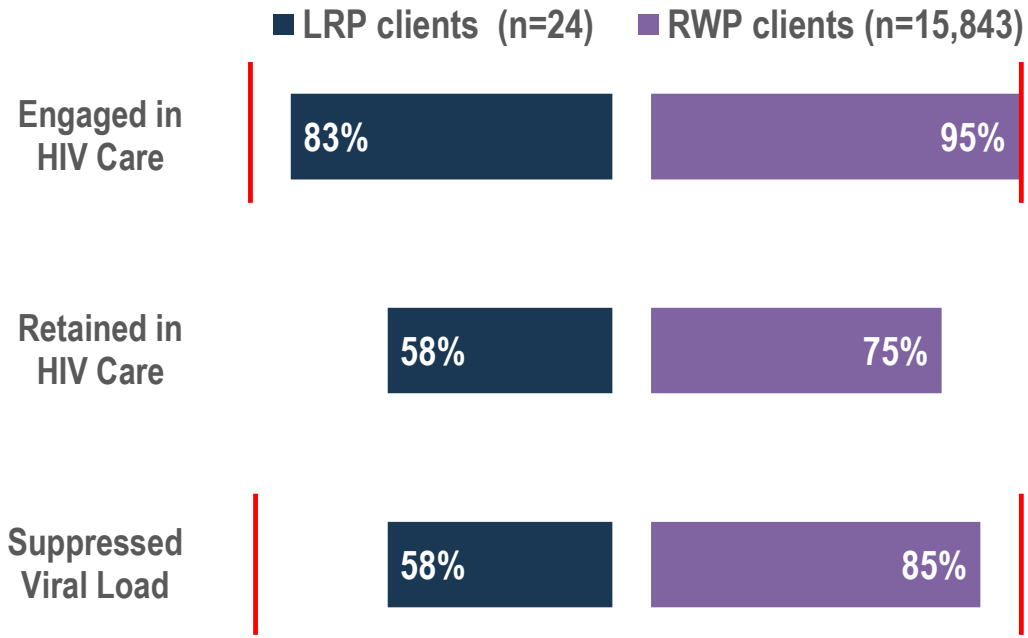
HIV Care Continuum in LRP clients, Year 34

- Engagement[a], retention in care[b], and viral suppression[c] was lower for LRP clients compared to RWP clients overall, Year 34
- LRP clients did not meet the EHE target of 95% for viral suppression; neither they met the local target of 95% for engagement in care



Data source: HIV Casewatch as of 5/1/2025

[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 5/5/2025
[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 5/5/2025
[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 5/5/2025

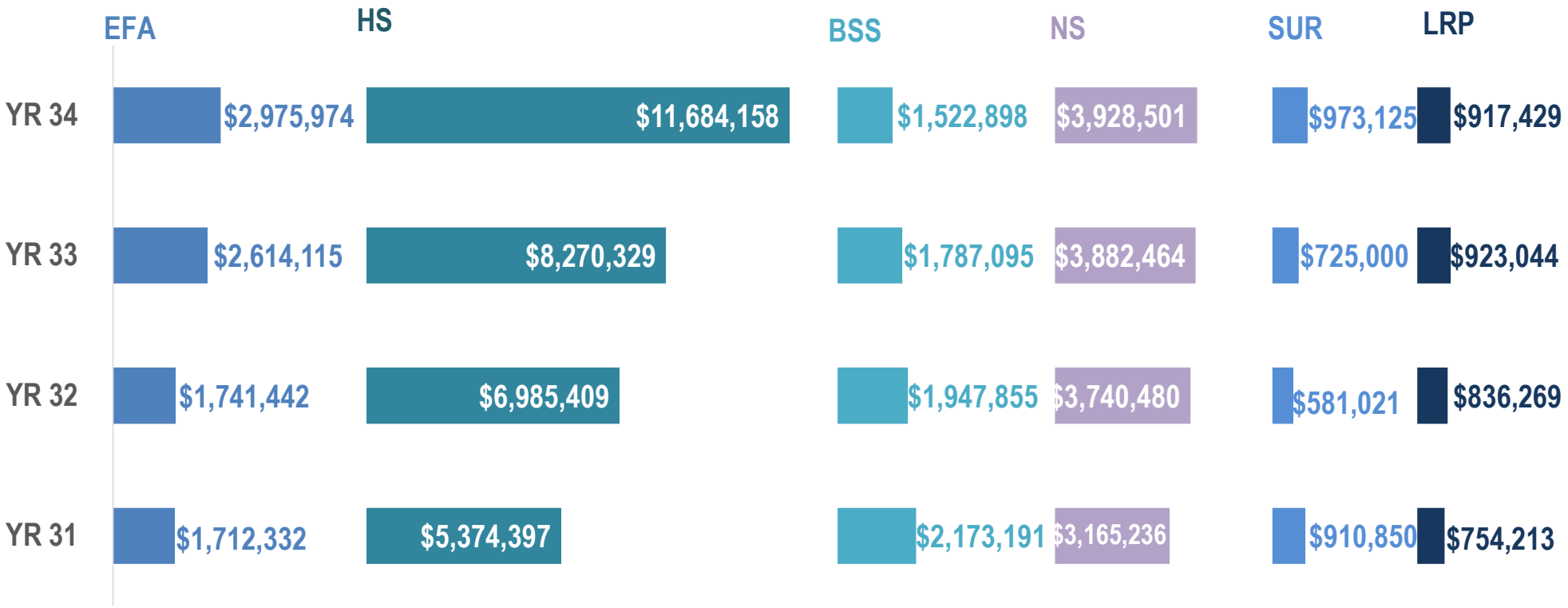
Expenditures for Support RWP Services, Year 34

EFA	*$2,975,974*
HS	*$10,412,224*
BSS	*$1,522,898*
NS	*$3,928,501*
SUR	*$973,125*
LRP	*$917,429*

County of Los Angeles Public Health

Expenditures by Support Service Category, Years 31-34

EFA, HS, NS, SUR services expenditures increased since Year 31 or 32 with the highest in Year 34.
LRP expenditures also increased compared to Years 31-32.
Expenditures for **BSS** decreased over four years.



Expenditures per Client for Support RWP Services, Year 34

- **The highest expenditures per client** were spent **for HS**, followed by **LRP** services.
- **The lowest expenditures per client** were spent for **BSS**, followed by **NS** Support services.

Service Category	Number of clients	% of RWP clients	Expenditures	% of expenditures	Expenditures per client
LRP	24	<1%	*$917,429*	2%	***$38,226***
HS	292	2%	*$10,412,224*	18%	*$35,658*
SUR	86	<1%	*$973,125*	2%	*$11,315*
EFA	730	4%	*$2,975,974*	6%	*$4,077*
NS	3,010	19%	*$3,928,501*	8%	*$1,305*
BSS	5,653	36%	*$1,522,898*	4%	*$269*

Early Intervention Services*	*$2,143,916*
Legal*	*$1,073,964*
Transportation*	*$738,442*

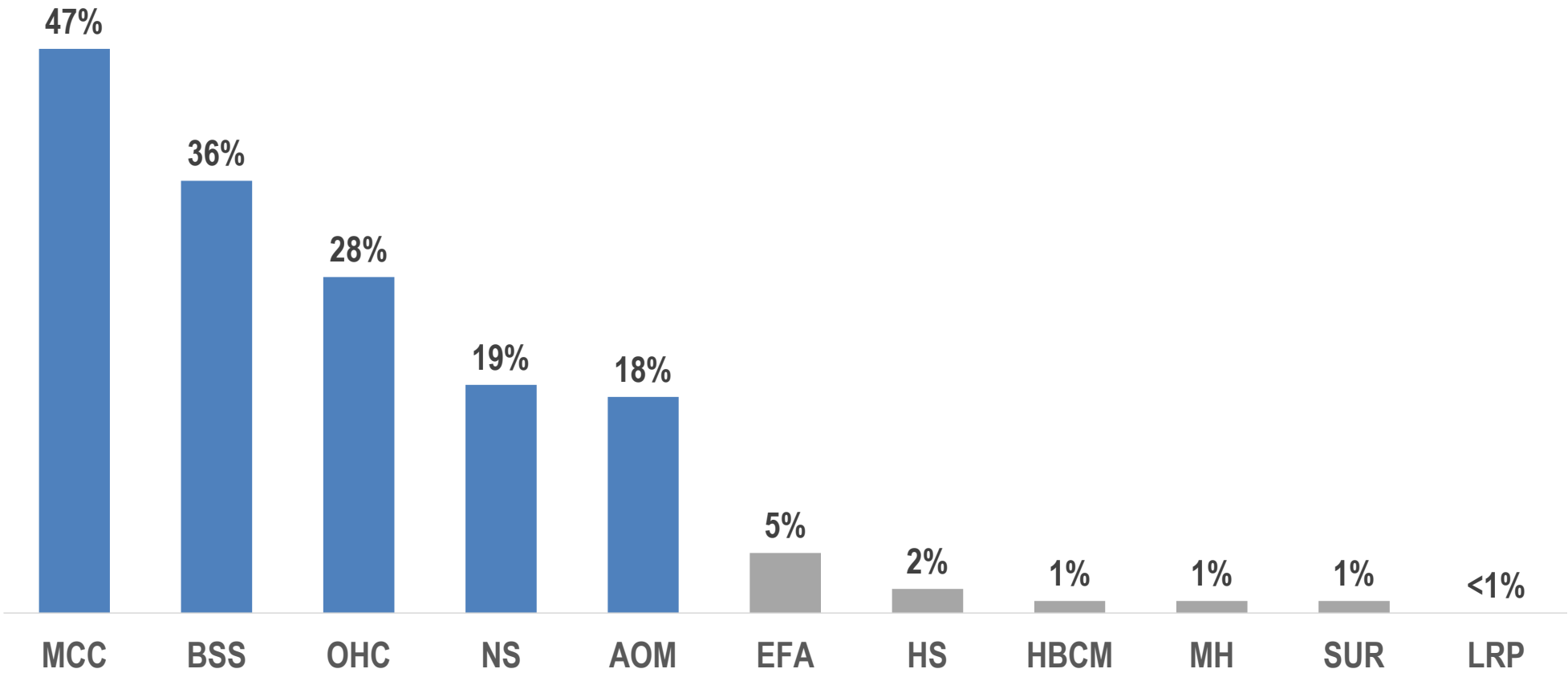
*No information on these services in CaseWatch

Top 5 RWP Services Utilized

Year 34

The top five services utilized by RWP clients in Year 34 were MCC, BSS, Oral Health, Nutrition Support and AOM

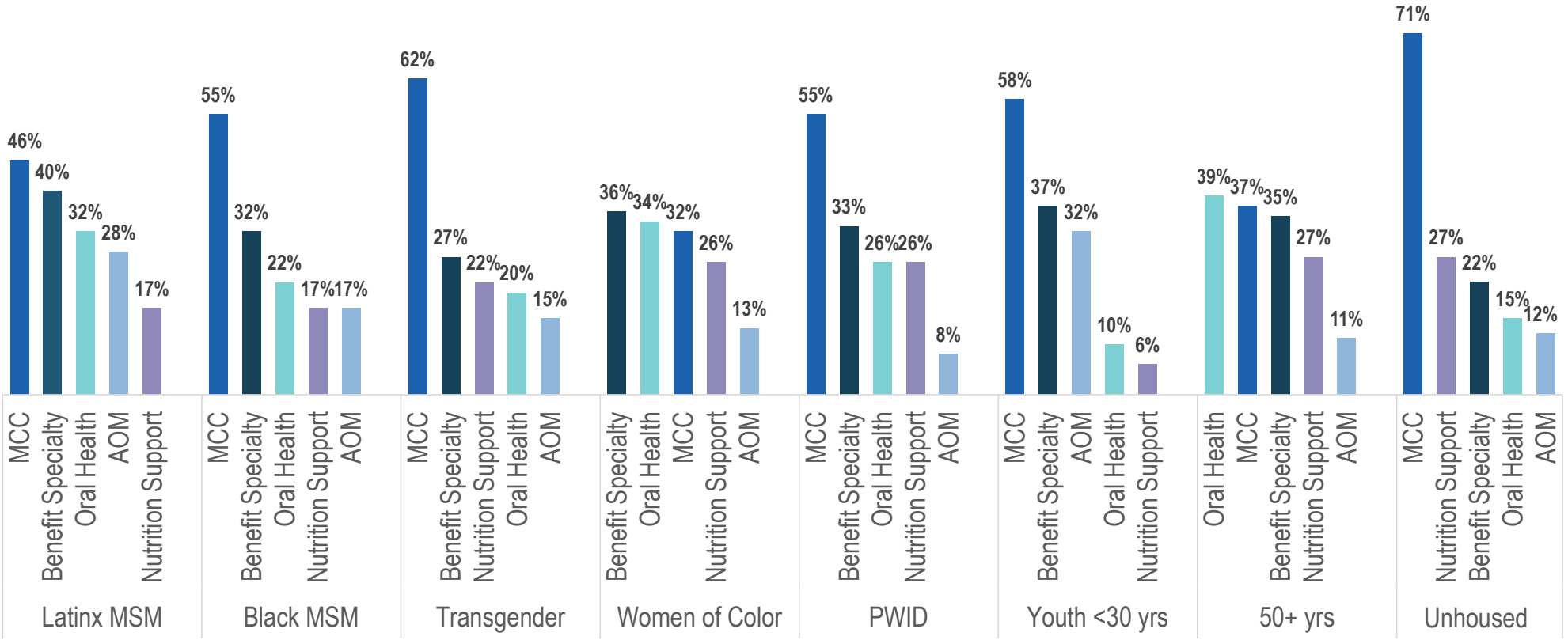
Utilization of RWP services in Year 34



The most utilized RWP service by most priority populations was MCC and the second most used service was Benefit Specialty.

County of Los Angeles Public Health

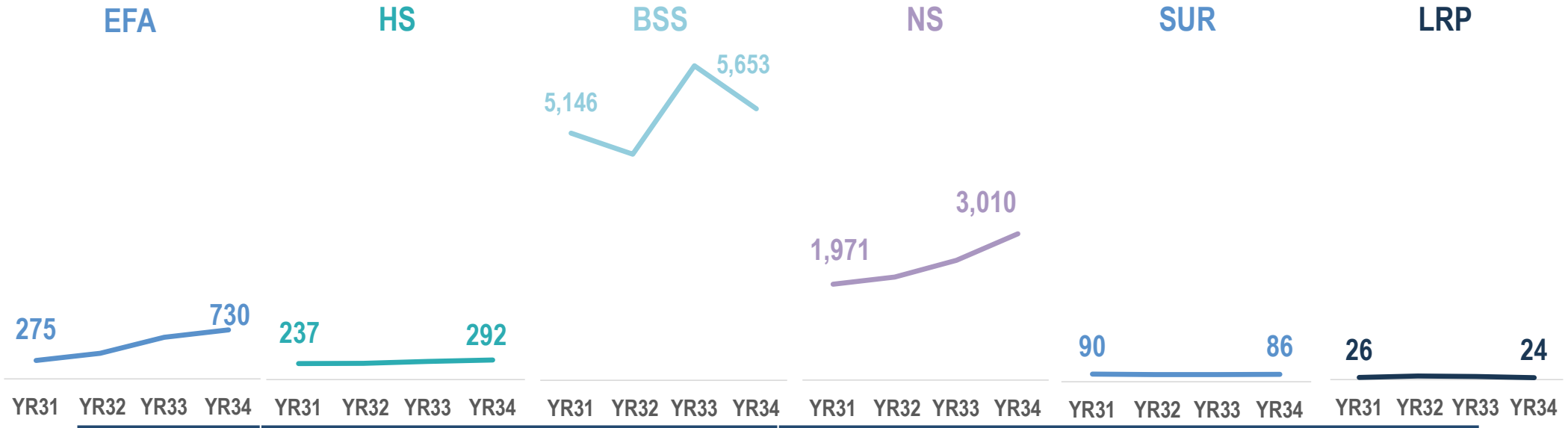
Top 5 RWP Services Used by Priority Populations, Year 34



Key Takeaways

- Support Services Utilization
- Client Demographics
- HIV Care Continuum Outcomes
- Expenditures

Support Service Utilization, Years 31-34



Service	Year 34 Service Utilization Impact	Reasons for Year 34 Impact
EFA	Increased utilization	High demand
HS	Increased utilization	High demand
BSS	Decreased utilization	
NS	Increased utilization	High demand
SUR	No major changes in utilization	
LRP	Decreased utilization	Very small pool of clients

Key Takeaways: Client Demographics

	RWP n=15,843	EFA n=730	HS n=292	BSS n=5,653	NS n=3,010	SUR n=86	LRP n=24
GENDER							
Men	86%	92%	79%	87%	82%	87%	21%
Women	10%	12%	14%	10%	13%	10%	79%
Transgender Women	4%	5%	7%	3%	5%	1%	**
Trangender Men	0%	<1%	<1%	<1%	<1%	**	**
Non-binary/Other	0%	1%	<1%	<1%	<1%	1%	**
RACE/ETHNICITY							
Latinx	53%	44%	53%	57%	51%	45%	63%
Black	23%	32%	26%	19%	24%	31%	33%
White	21%	21%	19%	19%	22%	19%	4%
Other/Unknown	5%	3%	2%	5%	4%	5%	
AGE							
50 and older	44%	45%	44%	43%	63%	20%	4%
40-49 years	22%	25%	22%	23%	19%	34%	21%
30-39 years	25%	24%	27%	25%	15%	36%	42%
13-29 years	9%	6%	7%	9%	3%	10%	33%

- Mostly **men** across all services, except LRP
- **Latinx** race/ethnicity was most represented across all services
- Services EFA, HS, BSS were mostly used by those age 50+
- SUR used mostly by those age 30-49 years
- LRP used mostly by those age 13-30 years

Key Takeaways: Client Demographics

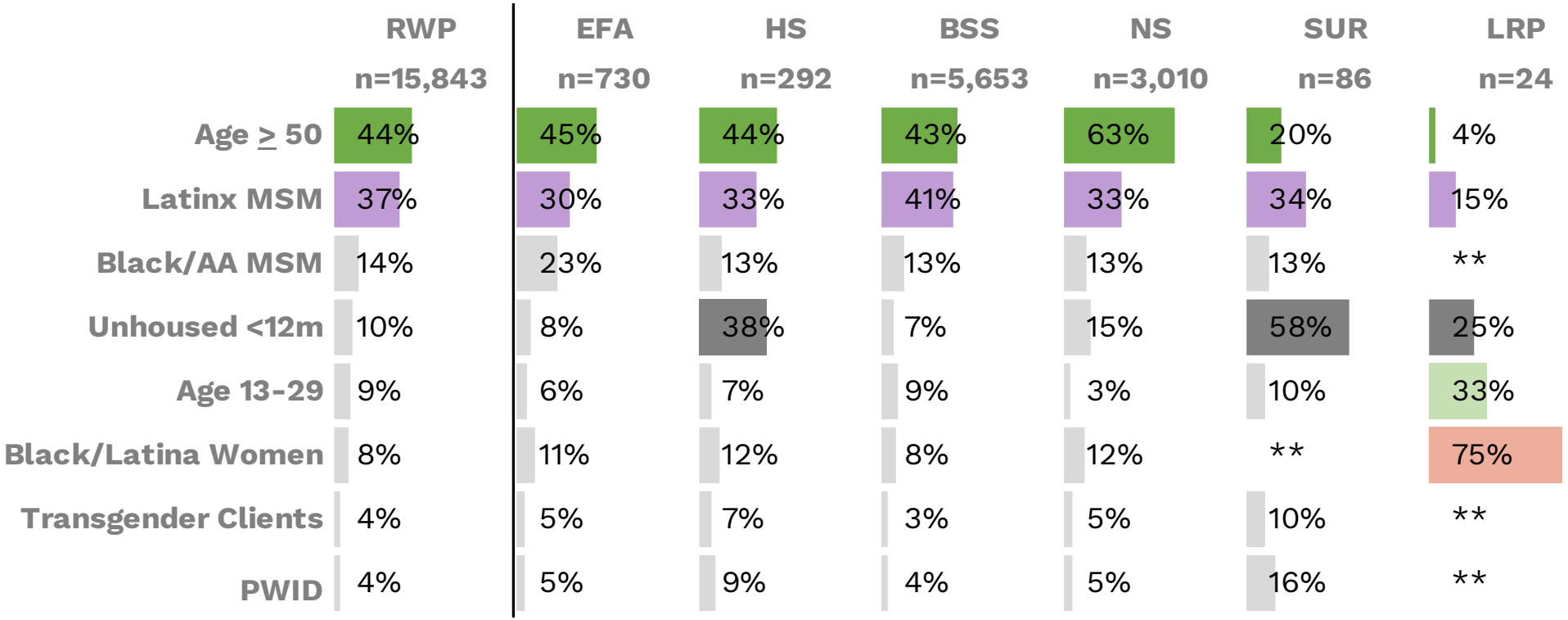
- Across services, most were **English-speakers**, lived **at/below FPL**, had **public insurance**, and **no incarceration history**
- Notable exceptions
  - More individuals who were **unhoused** accessed **SUR and LRP services**
  - **SUR service** had the lowest percent of **Spanish-speaking** clients
  - Higher percent of **incarceration history** among **HS, SUR, LRP** clients

	RWP n=15,843	EFA n=730	HS n=292	BSS n=5,653	NS n=3,010	SUR n=86	LRP n=24
PRIMARY LANGUAGE							
English	72%	79%	68%	67%	70%	93%	58%
Spanish	26%	20%	30%	31%	28%	7%	13%
Other	2%	1%	1%	2%	2%	**	**
INCOME							
At/below FPL	61%	66%	87%	56%	77%	94%	50%
Above FPL	38%	34%	13%	44%	22%	6%	8%
PRIMARY INSURANCE							
Public	63%	74%	83%	64%	81%	92%	62%
Private	14%	14%	4%	18%	5%	**	4%
No insurance	22%	11%	13%	18%	13%	8%	33%
HOUSING STATUS							
Permanent	87%	91%	45%	91%	81%	12%	63%
Institutional	2%	1%	19%	2%	2%	19%	8%
Unhoused	10%	8%	36%	7%	15%	58%	25%
HISTORY OF INCARCERATION							
No history	87%	87%	75%	90%	84%	70%	83%
Incarcerated > 2yrs ago	5%	10%	16%	6%	11%	17%	17%
Incarcerated within last 24 months	7%	3%	10%	4%	4%	13%	**

Totals may not sum to 100% due to incomplete reporting

Key Takeaways: Highest Service Utilization by Priority Population

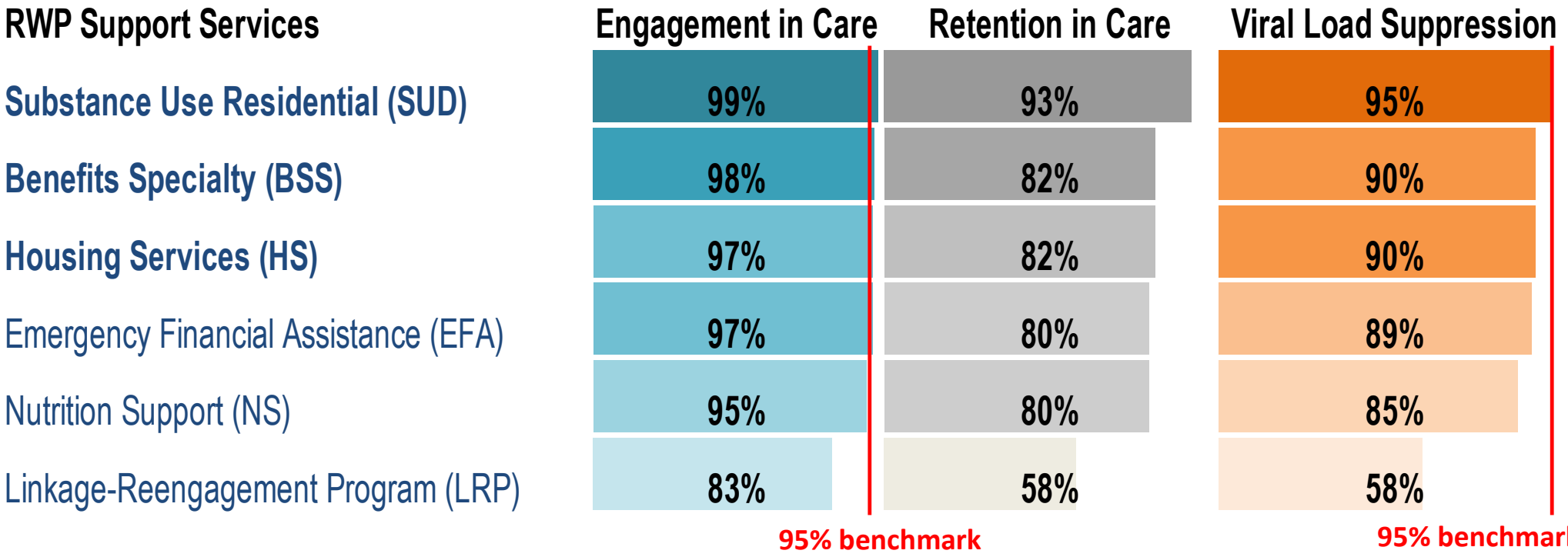
- **People over 50 and Latinx MSM** highest utilizers of EFA, HS, BSS, NS
- SUR most accessed by **unhoused < 12m** and **Latinx MSM**
- LRP most accessed by **women of color** and youth **age <30 year**



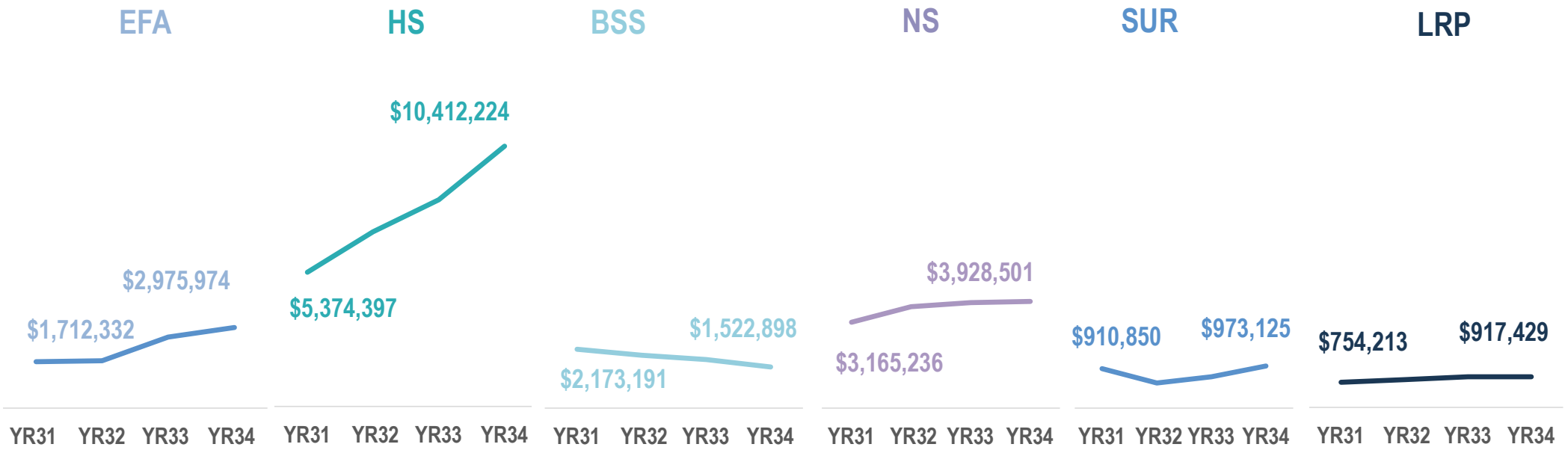
*Priority population groups are not mutually exclusive, clients may overlap

HIV Care Continuum Outcomes for Support Services, Year 34

Best outcomes were observed among RWP clients using Substance Use Residential **(SUR),** Benefit Specialty Service **(BSS)**, and Housing Service **(HS)**



Key Takeaways – Expenditures



Service	Expenditures per Service	Expenditures per Client	Reasons for Year 34 Changes
EFA	Increased expenditures	Third lowest expenditures per client	Increase in both expenditures and the number of clients
HS	Increased expenditures	Second highest expenditures per client	Considerable increase in both expenditures and the number of clients
BSS	Decreased expenditures	Lowest expenditures per client	Decrease in both expenditures and the number of clients (vacancies?)
NS	No major changes in expenditures	Second lowest expenditures per client	Slight increase in both expenditures and the number of clients
SUR	Increased expenditures	Third highest expenditures per client	Stable number of clients, but increased expenditures (higher cost per day)
LRP	No major changes in expenditures	Highest expenditures per clients	Number of clients considerably decreased, but expenditures did not change

Next Steps

- Examine detailed utilization of RWP services within each LAC priority populations
- Examine RWP services by priority population over time

Questions/Discussion

Acknowledgements

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- RWP agencies and providers
- RWP clients

THANK YOU!

Service Standard Development

LOS ANGELES COUNTY COMMISSION ON HIV

KEYWORDS AND ACRONYMS

BOS: Board of Supervisors
COH: Commission on HIV
SBP: Standards and Best Practices
DHSP: Division of HIV & STD Programs
RFP: Request for Proposal
HRSA: Health Resources and Services Administration
HAB: HIV/AIDS Bureau
RWHAP: Ryan White HIV/AIDS Program
PSRA: Priority Setting and Resource Allocations
PCN: Policy Clarification Notice

WHAT ARE SERVICE STANDARDS?

Service Standards establish the minimal level of service of care for consumers in Los Angeles County. Service standards outline the elements and expectations a RWHAP service provider must follow when implementing a specific Service Category **to ensure that all RWHAP service providers offer the same basic service components**.

WHAT ARE SERVICE CATEGORIES?

Service categories are the services funded by the RWHAP as part of a comprehensive service delivery system for people with HIV to improve retention in medical care and viral suppression.

Services fall under two categories: **Core Medical Services** and **Support Services**. **The COH develops service standards for 13 Core Medical Services, and 17 Support services.** As an integrated planning body for HIV prevention and care services, the COH also develops service standards for 11 Prevention Services.

A key resource the SBP Committee utilizes when developing services standards is the **HRSA/HAB PCN 16-02** which **defines and providers program guidance for each of the Core Medical and Support Services** and defines individuals who are eligible to receive these RWHAP services.

HRSA/HAB GUIDANCE FOR SERVICE STANDARDS

- Must be consistent with Health and Human Services guidelines on HIV care and treatment and the HRSA/HAB standards and performance measures and the National Monitoring Standards.
- Should NOT include HRSA/HAB performance measures or health outcomes.
- Should be developed at the local level.
- Are required for every funded service category.
- Should include input from providers, consumers, and subject matter experts.
- Be publicly accessible and consumer friendly.

COH SERVICE STANDARDS

Universal Service Standards	• General agency policies and procedures
	  ○ Intake and Eligibility
	  ○ Staff Requirements and Qualifications
	  ○ Cultural and Linguistic Competence
	  ○ Referrals and Case Closures
	• Client Bill of Rights and Responsibilities

Category-Specific Service Standards	• Include link to Universal Service Standards • Core Medical Services • Support Services
Service Standards General Structure	• Introduction • Service Overview • Service Components • Table of Standards & Documentation requirements

REMINDER

Service standards are meant to be flexible, not prescriptive, or too specific. Flexible service standards allow service providers to adjust service delivery to meet the needs of individual clients and reduce the need for frequent revisions/updates.

DEVELOPING SERVICE STANDARDS

Service standard development is a joint responsibility shared by DHSP and the COH. There is no required format or specific process defined by HRSA HAB. **The SBP Committee leads the service standard development process for the COH.**

SERVICE STANDARD DEVELOPMENT PROCESS

SBP REVIEW	• Develop review schedule based on service rankings, DHSP RFP schedule, a consumer/provider/service concern, or in response to changes in the HIV continuum of care. • Conduct review/revision of service standards which includes seeking input from consumers, subject matter experts, and service providers. • Post revised service standards document for public comment period on COH website.
COH REVIEW	• After SBP has agreed on all revisions, SBP holds a vote to approve. • Once approved, the document is elevated to Executive Committee and COH for approval. • COH reviews the revised/updates service standards and holds vote to approve. Once approved, the document is sent to DHSP.
DISSEMINATION	• Service standards are posted on **COH website** for public viewing and to encourage use by non-RWP providers. • DHSP uses service standards when developing RFPs, contracts, and for monitoring/quality assurance activities.
CYCLE REPEATS	• Service standards undergo revisions at least every 3 years or as needed. • DHSP provides summary information to COH on the extent to which service standards are being met to assist with identifying possible need for revisions to service standards.

together.

WE CAN END HIV IN OUR COMMUNITY ONCE AND FOR ALL

For additional information about the COH, please visit our website at: http://hiv.lacounty.gov

Subscribe to the COH email list: https://tinyurl.com/y83ynuzt

LOS ANGELES COUNTY
COMMISSION ON HIV

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DRAFT NON-MEDICAL CASE MANAGEMENT: PATIENT SUPPORT SERVICES (PSS)

Table of Contents

Introduction....2
General Eligibility Requirements for Ryan White Services....2
Non-Medical Case Management Service Description....2
Non-Medical Case Management Service Standards....4
Appendix A: HRSA Guidance for Non-Medical Case Management....9
Appendix B: Patient Support Services (PSS) Support Specialist Descriptions....10

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

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

HRSA HAB Policy Clarification Notice (PCN) # 16-02: 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

Introduction

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. The development of the service standards includes guidance from service providers, consumers, and members of the Los Angeles County Commission (COH) on HIV, Standards and Best Practices (SBP) Committee.

General Eligibility Requirements for Ryan White Services

- Be diagnosed with HIV or AIDS with verifiable documentation.
- Be a resident of Los Angeles County
- Have an income at or below 500% of Federal Poverty Level.
- Provide documentation to verify eligibility, including HIV diagnosis, income level, and residency.

Given the barriers with attaining documentation, 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 for documentation eligibility for Ryan White services.

Non-Medical Case Management Service Description

Non-Medical Case Management (NMCM) consists of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and other needed services. NMCM may also include assisting clients to obtain access to other public and private programs for which they may be eligible.

NMCM services include all types of case management models such as intensive case management, strengths-based case management, and referral case management. ~~An agency may offer a specific type of case management model depending on its capacity and/or the contract from the Division on HIV and STD Programs (DHSP). Depending on the type of case management offered, NMCM may also involve assisting the client's support network, key family members, and other individuals that play a direct role in the client's health and well-being.~~

Service components include:

- Initial assessment of service needs
- Development of a comprehensive, Individual Service Plan (ISP)

- Timely and coordinated access to needed core medical and support services to ensure continuity of care
- Client specific advocacy and service utilization review
- ~~Continuous~~ Ongoing client monitoring to assess progress on ISP and adjust as needed
- ~~Revisiting the Individual Service Plan and adjusting as necessary~~
- ~~Ongoing assessment of client needs and, if appropriate based on the case management offered, other key individuals in the client's support network~~

~~In the past, the DHSP has contracted Transitional Case Management for Youth and Justice-Involved populations under NMCM services.~~

In the past, DHSP has contracted Transitional Case Management services for Youth and Justice-Involved populations under NMCM services. In 2025, DHSP contracted Patient Support Services (PSS) under NMCM to support agencies in providing support services that address the unique needs of its clinic in support of clients' complex medical issues and social challenges. Clients do not need to be enrolled in MCC, AOM, of other clinic-based programs to receive PSS, however they must be Ryan White Program eligible. See the **General Eligibility Requirements for Ryan White Services** for more information.

Patient Support Services (PSS) are conducted by a multi-disciplinary team comprised of specialists who conduct client-centered interventions that target behavioral, emotional, social, or environmental factors that negatively affect health outcomes for Ryan White Program eligible clients with the aim of improving an individual's overall well-being and achieve or maintain viral suppression. PSS will deliver interventions directly to RWP eligible clients, link and actively enroll them with support services, and provide care coordination, when needed. Agencies contracted to provide PSS services must determine the type and number of support specialists from the list in **Appendix B** to makeup up PSS teams.

~~NMCM coordinates services for people living with HIV to improve health outcomes and facilitate client self-sufficiency. Case managers at provider agencies are responsible for educating clients on available HIV non-medical support services as well as serving as liaisons in improving access to services. Case managers are responsible for understanding HIV care systems and wrap-around services, advocating for clients, and accessing and monitoring client progress on an ongoing basis. Case managers identify client service needs in all non-medical areas and facilitate client access to appropriate resources such as health care, financial assistance, HIV education, mental health, substance use prevention, harm reduction and treatment, and other supportive services. Non-Medical Case Management services should be client-focused, increase client~~

~~empowerment, self-advocacy and medical self-management, as well as enhance their overall health status.~~

Non-Medical Case Management Service Standards

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

Client Assessment and Reassessment

NMCM providers must complete an initial assessment within 30 days of intake through a collaborative, interactive, process between the case manager and client with the client as the primary source of information. With client consent, assessments may also include additional information from other sources such as service providers, caregivers, and family members to support client well-being and progress. Case management staff must comply with established agency confidentiality policies when soliciting information from external sources. ~~If a client's income, housing status, or insurance status has changed since assessment or the most recent reassessment, agencies must ensure that the data on the Client Information Form is updated accordingly.~~ Case managers will identify medical and non-medical service providers and make appointments as early as possible during the initial intake process for clients that are not ~~connected to primary medical care~~ linked to an MCC or AOM program~~. It is the responsibility of case management staff at the provider agency to~~ Case managers will conduct reassessments with the client as needed and based on contract guidelines from the DHSP.

The client assessment identifies and evaluates the medical, non-medical, physical, environmental, and financial strengths, needs, and resources. The assessments determines:

- Client needs for ~~treatment~~ core medical and support services
- Client capacity to meet those needs
- Ability of the client social support network to help meet client needs
- Extent to which other agencies are involved in client care
- Areas in which the client requires assistance in securing services

Assessment and reassessment topics may include~~, at minimum:~~

- Client strengths and resources
- Medical Care
- Mental health counseling/therapy
- Substance use, harm reduction, and treatment
- Nutrition/food
- Housing or housing related expenses
- Family and dependent care
- Transportation
- Linguistic services

- Social support system
- Community or family violence
- Financial resources
- Employment and education
- Legal needs
- Knowledge and beliefs about HIV
- Agencies that service client and household

~~Services provided to the client and actions taken on behalf of the client must be documented in progress notes and in the Individual Services Plan, which is developed based on the information gathered in the assessment and reassessments.~~

CLIENT ASSESSMENT AND REASSESSMENT	
STANDARD	**DOCUMENTATION**
Assessments will be completed within 30 days of initiation of services and at minimum should assess whether the client is in care. Accommodations may be made for clients who are unable to attend an appointment within the 30-day timeframe due to health reasons.	Completed assessment in client chart signed and dated by case manager.
Staff will conduct reassessments with the client as needed and in accordance with DHSP contract guidelines.	Completed reassessment in client chart signed and dated by case manager.

Individual Service Plan

An Individual Service Plan (ISP) is a tool that enables the case manager to assist the client in addressing barriers to medical care by developing an action plan to improve access and engagement in medical and ~~other~~ support services. ISPs are developed in conjunction with the client and case manager within two weeks of the conclusion of the comprehensive assessment or reassessment. ISPs include short-term and long-term client goals determined by utilizing information gathered during assessment and subsequent reassessments. ~~It is the responsibility of case managers to review and revise~~ Case managers will review, and revise ISPs as needed. ~~and based on client need.~~

The ISP should include: ~~a description of client specific service needs, referrals to be made, clear timeframes, and a plan to follow-up. ISPs will, at minimum, include the following:~~

- ~~Client and case manager names~~
- ~~Client and case manager signatures and date on the initial ISP and on subsequent, revised ISPs~~
- Description of client goals and desired outcomes

- Timeline for client goals and a plan to monitor client progress
- Action steps to be taken by client and/or case manager to accomplish goals
- Status of each goal as client progresses

As part of the ISP, case managers must ensure the coordination of the various services the client is receiving. Coordination of services requires identifying other staff or service provides with whom the client may be working. As appropriate and with client consent, case management staff act as liaisons among clients, caregivers, and other service providers to obtain and share information that supports optimal care and service provision. If a program is unable to provide a specific service, it must be able to make immediate and effective referrals. Case management staff is responsible for facilitating the scheduling of appointments, transportation, and the transfer of related information.

INDIVIDUAL SERVICE PLAN (ISP)	
STANDARD	**DOCUMENTATION**
ISPs will be developed collaboratively between the client and case manager within two weeks of completing the assessment or reassessment ~~and, at minimum,~~ should include: • Description of client goals and desired outcomes • Timeline for client goals and a plan to monitor client progress • Action steps to be taken by client and/or case manager to accomplish goals • Status of each goal as client progresses • ~~Timeline for when goals are expected to be met~~ • ~~Action steps to be taken and individuals responsible for the activity~~ • ~~Anticipated time for each action step and goal~~ • ~~Status of each goal as it is met, changed or determined to be unattainable~~	Completed ISP in client chart, dated and signed by client and case manager.
Staff will ~~update~~ revise the ISP yearly or as needed based on client progress or DHSP contract requirements.	~~Updated~~ Revised ISP in client chart, dated and signed by client and case manager.

~~Client Monitoring~~ ISP Implementation, Monitoring, and Follow-up

Case managers will implement, monitor, and follow-up on a client's ISP to ensure clients are accessing needed services and resolve any barriers clients may have in achieving their ISP goals. Case managers will maintain ongoing contact with client as appropriate, or based on DHSP contract requirements, to evaluate whether services provided are consistent with a client's ISP and to determine if a client requires a reassessment and/or revisions to their ISP.

~~Implementation, monitoring, and follow-up involve ongoing contact and interventions with, or on behalf of, the client to achieve the goals on the ISP. Case managers management staff are responsible for evaluating whether services provided to the client are consistent with the ISP, and whether there are any changes in the client's status that require a reassessment or updating revising the ISP. Client monitoring ensures that referrals are completed and needed services are obtained.~~

~~CLIENT MONITORING~~ ISP IMPLEMENTATION, MONITORING, AND FOLLOW-UP	
STANDARD	**DOCUMENTATION**
Case managers will implement, monitor, and follow-up on a client's ISP to ensure clients are accessing needed services and resolve any barriers clients may have in achieving their ISP goals. Implementation, monitoring, and follow-up activities include: ~~ensure clients are accessing needed services and will identify and resolve any barriers clients may have in following through with the ISP. Responsibilities include, at minimum:~~ • Monitor changes in the client's condition • Update/revise the ISP based on progress • Provide interventions and follow-up to confirm completion of referrals • Ensure coordination of care among client, caregiver(s), and service providers • Advocate on behalf of clients with other service providers • Empower clients to use independent living strategies	Signed, dated progress notes on file that detail~~, at minimum:~~ • Changes in the client's condition or circumstances • Progress made toward ISP goals • Barriers to ISP goals and actions taken to resolve them • Status of linked referrals and interventions ~~and status/results of same~~ • Barriers to referrals and interventions and actions taken to resolve them • Time spent with client • Case manager's signature and title

• Help clients resolve barriers to completing referrals, accessing or adhering to services • Follow-up on ISP goals • Maintain client contact as appropriate or based on DHSP contract requirements • Follow-up missed appointments by the end of the next business day	

Staff Requirements and Qualifications

~~Case management staff will have the knowledge, skills, and ability to fulfill their role including striving to maintain and improve professional knowledge related to their responsibilities, basing all services on assessment, evaluation, or diagnosis of clients, and providing clients with a clear description of services, timelines, and possible outcomes at the initiation of services. Staff are responsible for educating clients on the importance of adhering and staying engaged in care.~~

Case managers will have the knowledge, skills, and ability to fulfill their role while providing clients with a clear description of services, timelines, and possible outcomes at the initiation of services. Staff are responsible for educating clients on the importance of adhering and starting engaged in care.

Refer to Appendix B for additional staff requirements and qualifications for agencies with Patient Support Services contracts.

Case managers should have experience in or participate in trainings on:

- HIV/AIDS and related issues
- Effective interviewing and assessment skills
- Appropriately interacting and collaborating with others
- Effective written and verbal communication skills
- Working independently
- Effective problem-solving skills
- Responding appropriately in crisis situations

STAFF REQUIREMENTS AND QUALIFICATIONS	
STANDARD	**DOCUMENTATION**

Case managers will possess ~~with~~ experience in clinical and/or case management in an area of social services. Bachelor's degree in social work, counseling, psychology or a related field preferred and/or experienced consumers preferred. Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.	Staff resumes on file.
Case management supervisors will possess ~~with~~ experience in clinical and/or case management in area of mental health, social work, counseling, nursing with specialized mental health training, or psychology. Master's degree in social work, Counseling, Psychology, or related field from an accredited social work program. On a case-by-case basis and with consultation and approval from DHSP, agencies may consider candidates with bachelor's degree in social work, counseling, psychology, or related field and 2 years of related work experience. Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.	Staff resumes on file.

Appendix A: HRSA Guidance for Non-Medical Case Management

Description:
Non-Medical Case Management Services (NMCM) provide guidance and assistance in accessing

medical, social, community, legal, financial, and other needed services. NMCM services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicare, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication including face-to-face, phone contact, and any other forms of communication deemed appropriate by the RWHAP Part recipient. Key activities include:

- Initial Assessment of service needs
- Development of a comprehensive, individualized care plan
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family member's needs and personal support systems

Program Guidance:
Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services whereas Medical Case Management services have as their objective improving health care outcomes.

Appendix B: Patient Support Services (PSS) Support Specialist Descriptions

Agencies contracted to provide PSS services must determine the type and number of support specialists form the list below to make up PSS teams that address the unique needs of its clinic in support of clients' complex medical issues and social challenges.

Retention Outreach Specialist (ROS)

- Ensures that PLWH remain engaged in their care and have access to necessary resources and support.
- Integrates with other HIV clinic team members to effectively identify, locate, and re-engage clients who have lapsed in their HIV care.
- Provides a targeted assessment of barriers of care, outreach, linkage, and re-engagement services, focusing on clients who are considered "out of care," facilitating their return to consistent and effective HIV treatment and support services.
- Conducts field outreach operations to efficiently locate and assist clients who have disengaged from HIV care.
- Acts as the liaison between HIV counseling and testing sites and the medical clinic to ensure that new clients are enrolled in medical care seamlessly and in a timely fashion.
- Provides crisis interventions, offering immediate support in challenging situations.

- Provides services to clients not yet enrolled in PSS, MCC Services, or clinic-based programs and can outreach clients who have not yet enrolled into any services with provider agency.
- Collaborates with the HIV clinic team members, documents client interactions, and contributes to program evaluation.
- Demonstrates cultural and linguistic competency to effectively communicate with and support a diverse range of clients.
- Participates in case conferences as needed.

Must meet the following minimum qualifications:

- Must have a High School Diploma or successful completion of GED.
- Ability and interest in doing field-based work when necessary to locate or assist clients.
- Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.

PSS Social Worker (SW)

- Determines client resources and needs regarding mental health services, substance use counseling and treatment, as well as housing and transportation issues to make appropriate referrals and linkages.
- Holds counselling and psychotherapy sessions for individuals, couples, and families.
- Provides support services utilizing housing-first, harm reduction, and trauma-informed care principles.
- Utilizes a sex positive framework including provision of patient education about U=U.
- Collaborates with the HIV clinic team, documents interactions, and contributes to program evaluation.
- Maintains knowledge of local, State, and federal services available.
- Addresses clients' socioeconomic needs, and as part of the PSS team, assists with client monitoring, referrals, and linkages to services, as well as following up with clients and tracking outcomes.
- Acts as the liaison between HIV counseling and testing sites and the medical clinic to ensure that new clients are enrolled in medical care seamlessly and in a timely fashion.
- Performs home visits and other field outreach on a case by-case basis.
- Provides urgent services to clients not yet enrolled in PSS.
- Participates in case conferences as needed.

- Conducts a comprehensive assessment of the SDH using a cooperative and interactive interview process. The assessment must be initiated within five working days of client contact and be appropriate for age, gender, cultural, and linguistic factors.
    - The assessment will provide information about each client's social, emotional, behavioral, mental, spiritual, and environmental status, family and support systems, client's coping strategies, strengths and weaknesses, and adjustment to illness.
    - SW will document the following details of the assessment in each client's chart:
        - Date of assessment;
        - Title of staff persons completing the assessment; and
        - Completed assessment form.
- Develops a PSS Intervention Plan SW will, in consultation with each client, develop a comprehensive multi-disciplinary intervention plan (IP). PSS IPs should include information obtained from the SDH assessment. The behavioral, psychological, developmental, and physiological strengths and limitations of the client must be considered by the SW when developing the IP. IPs must be completed within five days and must include, but not be limited to the following elements:
- Identified Problems/Needs: One or more brief statements describing the primary concern(s) and purpose for the client's enrollment into PSS as identified in the SDH assessment.
- Services and Interventions: A brief description of PSS interventions the client is receiving, or will receive, to address primary concern(s), describe desired outcomes and identify all respective PSS Specialist(s) assisting the client.
- Disposition: A brief statement indicating the disposition of the client's concerns as they are met, changed, or determined to be unattainable.
- IPs will be signed and dated by the client and respective SW assisting the client.
- IPs must be revised and updated, at a minimum, every six months.

Meets the following minimum qualifications:

- Master's degree in social work, Counseling, Psychology, or related field from an accredited social work program. On a case-by-case basis and with consultation and approval from DHSP, agencies may consider candidates with bachelor's degree in social work, counseling, psychology, or related field and 2 years of related work experience.
- Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a

multicultural environment.

Benefits Specialist

- Conducts client-centered activities and assessments that facilitate access to public benefits and programs. Focuses on assisting each client's entry into and movement through care service systems.
- Stays up to date on new and modified benefits, entitlements, and incentive programs available for PLWH.
- Ensures clients are receiving all benefits and entitlements for which they are eligible.
- Educates clients about available benefits and provides assistance with the benefits application process.
- Helps prepare for and facilitates relevant benefit appeals.
- Collaborates with the HIV clinic team, documents interactions, and contributes to program evaluation.
- Develops and maintains expert knowledge of local, State, and federal services and resources including specialized programs available to PLWH.
- Participates in case conferences as needed.

Meets the following minimum qualifications:

- High school diploma (or GED equivalent).
- Has at least one year of paid or volunteer experience making eligibility determinations and assisting clients in accessing public benefits or public assistance programs.
- Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.

Housing Specialist

- Develops and maintains expert knowledge of, and contacts at, local housing programs and resources including specialized programs available to PLWH.
- Conducts housing assessments and creates individualized housing plans.
- Assists clients with applications to housing support services such as emergency financial assistance, referral and linkage to legal services (for issues such as tenant's rights and evictions), and navigation to housing opportunities for persons with AIDS programs.
- Conducts home or field visits as needed.
- Develops a housing procurement, financial, and self-sufficiency case management plan with clients as part of client housing plans.
- Offers crisis intervention and facilitates urgent referrals to housing services.

- Collaborates with the HIV clinic team, documents interactions, and contributes to program evaluation.
- Attends meetings and trainings to improve skills and knowledge of best practices in permanent supportive housing and related issues.
    - Participates in case conferences as needed.

Meets the following minimum qualifications:

- Bachelor's degree or a minimum of two years' experience in social services, case management, or other related work.
- Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.

Substance Use Disorder (SUD) Specialist

- Conducts SUD assessments and devises personalized SUD plan with clients as part of the client's individualized care plan.
- Provides one-on-one counseling to prevent and/or support clients through recurrence by assisting and recognizing causal factors of substance use and developing coping behaviors.
- Connects clients to harm reduction resources, medications for addiction treatment, cognitive behavioral therapy, and other SUD treatment services available to reduce substance use, or to prevent or cope with recurrence.
- Collaborates with other HIV clinic team members to align substance use treatment goals with overall care, documents interactions, and contributes to program evaluation.
- Conducts individual and group counseling sessions using evidence-based interventions to address personalized goals and develop needed skill sets to minimize relapse and maintain sobriety.
- Oversees or leads day-to-day operations of contingency management programs or other evidence-based interventions.
- Provides education on harm reduction strategies and additional key resources to clients.
- Participates in case conferences as needed.

Meets the following minimum qualifications:

- Certified as a Substance Use Counselor.
- Has at least one year of experience in an SUD program with experience providing counseling to individuals, families, and groups.

- Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.

Clinical Nursing Support Specialist

- Provides enhanced clinical nursing support, performed by a registered nurse to facilitate:
  - Administration and supervision of client injectable medications and vaccinations;
  - Tracking of clients receiving long-acting injectable, multi-dose injectable treatments, or multi-dose vaccine series; monitors clients for side effects; makes appointments for subsequent nursing visits to ensure timely receipt of injections; and
  - Coordinates care activities among care providers for patients receiving long-acting injectable medications, vaccinations, and other injectable medications to ensure appropriate delivery of HIV healthcare services.
- Participates in case conferences as needed.
- Collaborates with the HIV clinic team, conducts health assessments as needed, documents interactions, and contributes to program evaluation.

Meets the following minimum qualifications:

- Must be a Registered Nurse.
- Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.

Peer Navigator

- Provides client-centered group or individual psycho-social support services to assist PLWH by providing a safe space where lived experiences and challenges can be discussed without judgement. Topics to be discussed include but are not limited to:
  - Living with HIV;
  - Healthy lifestyles (including substance use) and relationships;
  - Adherence to treatment;
  - Access and barriers to care;
  - Prevention (PrEP, PEP, DoxyPEP, treatment as prevention);
  - Disclosing status; and
  - Stigma.
- Supports individuals who may be newly diagnosed, newly identified as living with HIV, or who may require additional support to engage in and maintain HIV medical care and

support services to ensure that clients are linked to care and continuously supported to remain in care.

- Conducts individual and group interventions to address personalized goals and develop needed skill sets for healthy living, ensure medication adherence and support a positive outlook for individuals living with HIV.
- Collaborates with other HIV clinic team members to align treatment goals with overall care, documents interactions, and contributes to program evaluation.
- Oversees incentives, contingency management programs, and/or other evidence-based interventions.
- Provides education on HIV clinic services available and additional key resources to clients.
- Participates in case conferences as needed.

Meets the following minimum qualifications:

- Is reflective of the population and community being served.
- Has lived experience.
- Must NOT be a current client of Contractor's clinic.
- Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.

Special Executive Committee Meeting "Recap"

Thursday, September 18, 2025 | 1:00 – 3:00 PM

CLICK HERE FOR MEETING PACKET

Purpose of the Meeting

Led by Danielle Campbell, MPH, PhD, Commission Co-Chair and AJ King, MPH, Consultant, Next Level Consulting, the Executive Committee convened a special session to level set on the Commission's role in HIV prevention within its function as an integrated prevention and care planning body. The session was designed to:

- Clarify expectations between the Commission and the Division of HIV and STD Programs (DHSP)
- Capture strategies to elevate prevention in the Commission's ongoing restructuring, including membership composition, bylaws revisions, and workplan development.
- Engage a broad range of prevention stakeholders and invited guests—including former Prevention Planning Committee members, Prevention Planning Workgroup members, consumers, and community partners—to inform and support the discussion.

Refer to Discussion Guide in meeting packet.

Key Discussion Points

Defining "Prevention"

The meeting opened with the guiding question: *What is prevention*?

Attendees described prevention broadly, emphasizing a status-neutral, syndemic approach that integrates multiple strategies:

- U=U and treatment as prevention (viral suppression prevents transmission).
- Biomedical interventions: PrEP, PEP, TasP, HIV/STI testing.
- Social determinants of health (SDOH): housing, mental health, substance use, poverty.
- Integration of STIs and behavioral health as part of prevention.
- Harm reduction strategies and person-centered approaches.

Participants emphasized that the Commission does not need to "do it all," but can play a central role as a connector, convener, and advocate, leveraging the work of community partners and providers.

Historical Role of the Prevention Planning Committee (PPC)

- Conducted needs assessments of populations at risk (distinct from newly diagnosed).
- Reviewed data and developed syndemic and "fair-share" models in partnership with academic experts.
- Created a resource inventory of prevention services and funding.
- Identified research trends and leveraged evidence to shape planning.

Prevention Planning Workgroup (PPW)

- Created a training schedule of knowledge gaps identified by the analysis of the knowledge, attitudes, and beliefs (KAB) survey to build Commissioner capacity.
- Developed a status neutral framework
- Reviewed Prevention Services Standards
- Provided prevention recommendations to PP&A

DHSP's Expectations and Opportunities

Identified gaps where the Commission can add value:

- Explore innovative prevention programs.
- Developing a resource inventory to track programs and funding across the county.
- Carrying out needs assessments focused on prevention populations. **Clarification: The Commission's listening sessions focus on sexual health, with prevention intentionally integrated into the discussions*.

How DHSP can strengthen partnership with the Commission:

- Improve the data request and sharing process—create a clear, standardized pathway for Commission access to DHSP data.
- Provide ongoing updates to support Commission deliberations on prevention priorities. *Note: Participants expressed appreciation for the recent transparency in prevention portfolio updates and requested that this level of sharing be maintained moving forward*.

Elevating Prevention in the New Commission Structure

- **Membership**: Prevention expertise must be explicitly represented in membership composition—by designated seats (providers, researchers, and those with lived prevention experience), not just by scope.
- **Consumers:** Increase participation of prevention consumers (e.g., individuals on PrEP/PEP, frequent HIV/STI testers, participants in prevention CABs, recipients of non-biomedical prevention services).
- **Standing agenda item**: Add a dedicated prevention item at every full Commission meeting to keep prevention visible and ensure accountability.

- **Education**: Provide ongoing prevention education to members, such as reviving the CHIPTS Colloquia and reestablishing a bi-directional relationship with the research community.
- **Metrics**: Clarify and define prevention outcomes, such as "retained in care on PrEP," and define the PrEP continuum for greater precision and usefulness in planning.

Additional Themes Raised

- **Harm reduction lessons**: Language matters, "people first"; provide information and respect consumer autonomy.
- **Mental health as prevention**: Behavioral health support is a core prevention strategy.
- **Ending the HIV Epidemic (EHE)**: Incorporate Ending the HIV Epidemic (EHE) activities and reference materials into the Commission's prevention planning to ensure alignment with local strategies and best practices.
- **Historical context**: The former Prevention Planning Committee could present lessons learned to inform the Commission's next steps.

CDPH, Office of AIDS (OA) Overview on the Integrated HIV Plan & Prevention

Presentation by LeRoy Blea, CDPH OA – refer to PPT slides in meeting packet:

- OA will create jurisdiction-specific surveillance profiles for LA County to guide planning.
- Two integrated plans will be developed:
  - ✓ A federally compliant version (sanitized to meet federal data and language requirements).
  - ✓ An internal/legacy version retaining full demographic and gender data for meaningful local planning.
- The integrated plan will:
  - ✓ Incorporate a syndemic approach, grounded in social determinants of health.
  - ✓ Integrate LA County's needs assessment and other data, with clear, measurable objectives.
  - ✓ Build upon existing processes and strengths already in place.
- OA encouraged LA County to request technical assistance on refining the PrEP continuum.
- OA and DHSP will continue to meet regularly with Commission staff to ensure alignment on integrated planning activities.

Recommendations & Actionable Next Steps

1. **Standing Prevention Agenda Item**
   - ✓ Add a recurring prevention-focused item to all full Commission meeting agendas.
   - ✓ Use this space to highlight prevention data, emerging issues, and program updates to ensure prevention remains a standing priority.
2. **Bylaws & Restructuring – Prevention Integration**
   - ✓ Ensure prevention expertise and consumer representation are explicitly incorporated into membership composition and committee structures.
   - ✓ Map designated seats for providers, researchers, and individuals with lived prevention experience.
3. **Quarterly Prevention Data Briefs**
   - ✓ Develop a quarterly data briefing process with DHSP, beginning with the PrEP continuum and disparities.
   - ✓ Include plain-language summaries for consumers and technical detail for providers and policymakers.
4. **Prevention Resource Inventory**
   - ✓ Establish and maintain a living, shared inventory of prevention programs, funding streams, and points of access.
   - ✓ Update quarterly and align with DHSP's portfolio to reduce duplication and identify gaps.
5. **Technical Assistance on Prevention/PrEP Continuum**
   - ✓ Submit a formal TA request through OA to refine the prevention continuum for LA County.
   - ✓ Use this to define metrics such as "retained in care on PrEP," initiation, persistence, and re-engagement.
6. **Standardized Data Request & Sharing Process**
   - ✓ Collaborate with DHSP to design a standardized process for prevention data requests, including clear templates, timelines, and points of contact.
   - ✓ Build on recent positive steps in prevention portfolio transparency, ensuring this level of sharing is sustained.
7. **Ongoing Member Education & Engagement**
   - ✓ Re-establish prevention-focused education opportunities (e.g., CHIPTS Colloquia) to bring research and practice back to the Commission.
   - ✓ Strengthen a bi-directional relationship with the research community to inform policy and program design.
8. **Community Engagement & Needs Assessment**
   - ✓ Integrate prevention more explicitly into the Commission's listening sessions on sexual health.
   - ✓ Use findings to shape a prevention-specific needs assessment that complements care-focused assessments.

9. **Alignment with EHE & Best Practices**
   - ✓ Request from DHSP and Incorporate Ending the HIV Epidemic (EHE) activities and materials into the Commission's prevention planning.
   - ✓ Ensure objectives and strategies align with both local best practices and federal/state priorities.
10. **Historical Context & Lessons Learned**
   - ✓ Engage former Prevention Planning Committee members to provide a historical briefing on past prevention planning efforts.
   - ✓ Use lessons learned to guide future prevention planning and avoid duplication.

Commission on HIV Restructure & Bylaws Revision Process — FAQ

FAQ OVERVIEW

We're restructuring to strengthen how the Commission operates, improve efficiency, and stay aligned with federal and local requirements. Change brings questions, so here's what/why/how in one place.

BYLAWS AND ORDINANCE IN THE RESTRUCTURE

Q: What is an ordinance?

An ordinance is a law passed by the Los Angeles County Board of Supervisors. It establishes the Commission, defines its authority, and sets its overall structure. Ordinances are the legal foundation for how the Commission operates. Our current Ordinance 3.029 can be found **HERE**

Q: What are bylaws?

Bylaws are the Commission's internal rules. They guide our day-to-day operations—such as membership categories, meeting procedures, and committee responsibilities. Our current Bylaws can be found **HERE**

Q: How do ordinances and bylaws connect to the restructure?

The Board of Supervisors must update the ordinance to legally change the Commission's size and structure. Simultaneously, the Commission is updating its bylaws to match the ordinance and provide the details for how the new structure will function in practice.

In short: Ordinances set the framework, bylaws fill in the details, and both need to be updated as part of the restructure.

COMMISSION ON HIV RESTRUCTURE & BYLAWS REVISION PROCESS — FAQ

WHY IS THE COMMISSION RESTRUCTURING?

- County direction (Measure G). All commissions were asked to review operations for efficiency and sustainability. To learn more about Measure G, CLICK HERE.
- Sustainability: Budget constraints and quorum challenges made the 51-member model unsustainable.
- HRSA findings: HRSA called for clearer conflict-of-interest processes, term limits, expanded community engagement, and stronger structural alignment.
- Community workgroups: In March 2025, commissioner and community workgroups recommended a streamlined model.

WHAT ARE THE MAIN CHANGES BEING PROPOSED? *SUBJECT TO UPDATES

- Membership reduced from 51 to 33 seats.
- Commission meetings reduced from 10 to six annually.
- Term limits: Maximum 3 consecutive 2-year terms + 1-year break (effective Mar 2026).
- Committees: Public Policy → Executive; Operations → Membership & Community Engagement
- Expanded committee-only membership requirement to individuals with lived experience.
- Consumer stipends proposed *up to* $500/month **contingent upon available funding*
- Conflict-of-interest rules strengthened. Members must declare conflicts related to RWP-funded agencies/services and recuse from related discussion/votes.
- Updated Code of Conduct to cover public/vendors and inclusion of the Commission's Inter-Personal Grievance Policy.
- DHSP Director will serve as a non-voting member and will not be counted toward quorum.

HOW WAS COMMUNITY INPUT INCLUDED?

The restructure process began with meetings between DHSP and the Commission in late 2024 and early 2025, followed by community workgroups in March 2025. Their input was compiled into a formal report reviewed and approved by the Executive Committee in May. A public comment period in June–July 2025 drew 51 responses on stipends, conflicts of interest, caucuses, membership size, quorum, Brown Act compliance, and meeting frequency, with additional input from County Counsel, DHSP, and HRSA.

WHAT HAPPENS TO CAUCUSES AND CONSUMER VOICE?

Caucuses remain vital spaces to lift community perspectives. They won't be on a fixed standing schedule; instead, they'll use the PURGE decision tool to meet. Unaffiliated consumer members must make up 33% of the membership. Consumer voice is lifted through 11+ unaffiliated consumer seats, expanded committee-only membership, the Membership & Community Engagement Committee, and additional community engagement activities.

WHAT ABOUT STIPENDS?

As part of the proposed changes to the bylaws, there is a proposal to raise the Unaffiliated Consumer Stipend Program limit to $500/month (from $150/month à la carte), contingent upon funding and approvals*. Stipends must follow HRSA guidelines and County protocols.

Quick definition: A stipend is a fixed amount of financial support provided to help *offset* costs like transportation, meals, or participation expenses. It is not a salary or wage, and it is not considered compensation for employment and cannot include automatic cost-of-living increases.

*This proposal must still be approved by the full Commission as part of the bylaw changes. Any increase will only be implemented if funding is available.

WHAT IS THE TIMELINE – WHEN DOES THE NEW RESTRUCTURE TAKE EFFECT? *SUBJECT TO CHANGE (UPDATED 10.21.25)

- June 27-July 27, 2025 – Public Comment period for Proposed Changes to Bylaws
- August - November 2025 – Executive Committee continues review of Public Comments
- December 11, 2025 – Commission votes on final bylaws and submits ordinance to BOS for review and approval. **The proposed bylaw updates are contingent upon the Board of Supervisors' approval of the ordinance, which mirrors the changes outlined in the bylaws.*
- December 2025 – January 2026 – Outreach and membership application campaign launch. ** All members must reapply.*
- January – February 2026 – Applications reviewed and BOS appointments.
- Mar 12, 2026 – First meeting of the restructured Commission.

HOW WILL CURRENT MEMBERS BE AFFECTED?

Current members who wish to continue serving must reapply for membership. Committee assignments will change to match new structure. Takes effect once the new membership is seated in March 2026 (term limits not retroactive).

HOW WILL CONFLICTS OF INTEREST BE MANAGED?

All members must complete annual conflict-of-interest forms. Members with conflicts must recuse themselves from related votes and discussions. This addresses HRSA findings and ensures transparency.

WHERE CAN I LEARN MORE OR GET INVOLVED? (UPDATED 10.21.25)

- CLICK HERE: Restructure materials & proposed bylaws
- CLICK HERE: April 2025 Bylaws Training **Current members will be required to view the training recording ahead of December 11th vote.*
- QUESTIONS: hivcomm@lachiv.org

Commission Restructure Transition & Timeline (Updated 10.23.25 – Subject to Change)

Note: The Executive Committee (EC) will continue decision-making in keeping with this timeline if a COH meeting is cancelled.

Phase 1: Restructure Report & Recommendations

Task/Activity	Responsible Party	Timeline / Status
Present restructuring report and recommendations.	Consultants	May 8, 2025 – COH Meeting • Timeline walk-through provided • Full presentation at 5/22/25 EC meeting ✅ Completed
Present restructuring report and recommendations.	Consultants	May 22, 2025 – Executive Committee Meeting • Straw poll result: Exhibit B and reduced membership seats ✅ Completed

Phase 2: Drafting & Review of Updated Bylaws

Task/Activity	Responsible Party	Timeline / Status
Present updated proposed bylaws (based on restructuring report, recommendations, and feedback). Begin 30-day public comment period. Send bylaws and ordinance to County Counsel (CoCo) for review.	Commission Staff, Consultants, COH Co-Chairs	June 26, 2025 – Executive Committee Meeting ✅ Completed
Present updated proposed bylaws; coordinate final layers of review (CoCo, EO) and prepare for BOS approval of ordinance. Cover letter to BOS to include timeline and March 1, 2026 start date (aligned with RW Program Year).	Commission Staff	July 10, 2025 – COH Meeting Public comment: June 27 – July 27, 2025 ✅ Completed in Part; *Cover Letter to BOS Pending Due to Changes in Timeline*

Phase 3: Executive Committee & Final COH Actions

Task/Activity	Responsible Party	Timeline / Status
Executive Committee review of proposed bylaws changes (in lieu of cancelled COH meetings) to prepare for final COH vote.	Executive Committee	July – November 2025 ⚠ Ongoing
COH approve bylaws and submit ordinance to BOS for approval.	Commission Staff, Commissioners	December 11, 2025

Phase 4: Membership Transition & Recruitment

Task/Activity	Responsible Party	Timeline / Status
Highlight proposed restructure COH at Annual Conference.	COH Co-Chairs	November 13, 2025
Disseminate transitional membership application and open nominations process to all stakeholder constituencies (including current Commissioners).	Commission Staff	December 12, 2025 – January 9, 2026
Organize and verify applications for completeness and accuracy.	Commission Staff	Application deadline: January 9, 2026

Phase 5: Membership Interview & Selection Process

Task/Activity	Responsible Party	Timeline / Status
Conduct membership interviews. *Proposed Interview Panel includes academic partners, EO Commission Services representative, former Co-chairs/members not reapplying, 1–2 members from other neighboring planning councils, 1–2 consumers not reapplying, Collaborative Research / Next Level Consulting, COH staff.*	Interview Panel (5–6 members)	January 10–18, 2026 (includes weekend interviews due to short turnaround)

Select initial cohort of candidates to recommend for nomination.	Interview Panel	January 19, 2026
Executive Committee approves initial cohort.	Executive Committee	January 23, 2026
COH approves initial cohort.	Commissioners	February 12, 2026
Forward nominations to EO/BOS for appointment.	Commission Staff	February 12, 2026

Phase 6: BOS Appointments & Launch

Task/Activity	Responsible Party	Timeline / Status
BOS appointment of first cohort of new members to restructured COH.	Board of Supervisors	February – Early March 2026
First meeting of newly restructured Commission on HIV.	—	March 12, 2026

LOS ANGELES COUNTY COMMISSION ON HIV | PUBLIC COMMENTS RECEIVED ON PROPOSED CHANGES TO THE BYLAWS |

Public comment period: June 27, 2025 – July 27, 2025
(Updated 10.21.25)

#	Date Received	Name	Comments	Notes	Executive Committee Decision
1	6/29/25	Daryl Russell	Can the stipend portions always suggest a cost of living increase every two years to the stipend at least 10 percent?	Stipends for unaffiliated consumers is addressed in the ordinance. Stipends are not salaries and not subject to COLAs. For reference, Social Security COLA is 2.5% for 2024. RWHAP Part A funds cannot be used to provide cash payments such as stipends or honoraria. (HRSA HAB RWAP Part A Manual, pg. 30) Where direct provision of the service is not possible or effective, store gift cards,2 vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used. (PCN 16-02)	**8/28: Decline**
2	6/29/25	Daryl Russell	Where it speaks to stipends can it also say to increase unaffiliated consumers stipend to 500.00?	Stipends for unaffiliated consumers is addressed in the ordinance. Ordinance language, pending BOS approval: "*The Commission shall establish, and the Executive Director shall implement, procedures governing*	**8/28: No Change** *Note: Currently reflected in proposed changes.*

#	Date Received	Name	Comments	Notes	Executive Committee Decision
				eligibility and utilization of reimbursements, member services, and/or stipends. Stipend amounts shall be up to, but not exceed, $500 per month, and are subject to the availability of funding as determined by the Executive Director, in accordance with Commission policy and as reported to the Board."	
3	7/7/25	Daryl Russell	I would like to suggest that the bylaws also state that the PP&A committee under the new structure have no more than 20% of those who have Ryan White and HIV prevention contracts from DHSP as committee members. Reason: This is a conflict of interest for those who receive funding from DHSP and will allow certain ones to be more reflected of the suggestion of DHSP and not the charge of the commission which is to have and reflect the interest of those living with HIV	Current COH practice is "no more than 2 people from same agency" may serve on the COH or a Committee. PSRA policy approved 7/11/24, states: "*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*	**8/28: Decline** *Note: Inclusion of all stakeholders, including providers with service delivery expertise, is necessary to ensure a robust and effective planning council. Existing conflict-of-interest provisions address potential power imbalances.*

#	Date Received	Name	Comments	Notes	Executive Committee Decision
				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."	
4	7/8/25	Daryl Russell	In the bylaws, it should state that the need for Caucuses as part of the Commission is a driven force that is needed because they offer ongoing insight as to what is need in the community from those who are living with HIV. Reason: it helps the commission have ongoing need assessments and stay informed about the HIV population as whole and keep population within the HIV community. Those who receive DHSP and Prevention contracts on the PP& A committee shall not have any voting rights, only those who do not receive contracts from DHSP and Prevention shall have voting rights.	Covered in the bylaws with additional information covered under Policy 08.1102 Subordinate Commission Working Units: "*Caucus(es): The Commission establishes caucuses, as needed, to provide a forum for Commission members of designated "special populations" to discuss their Commission- related experiences and to strengthen that population's voice in Commission deliberations."* See Conflicts of Interest policy in #4.	**8/25: Decline**

#	Date Received	Name	Comments	Notes	Executive Committee Decision
			Reason: It is a conflict of interest to vote on your funding source or any issues around your funding source suggestions.		
5	7/8/25	Daryl Russell	All members that receive DHSP and Prevention contracts or subcontracts having no vote rights in any COH voting items	See Conflicts of Interest policy in #4.	**8/28: Decline**
6	7/10/25	Daryl Russell	I submitted a comment asking that 500-dollar stipend be stated in the bylaws all I also would like to also ask that the requires be a three-meeting attendance and no sliding scale be implemented.	• Eligibility requirements for stipends are currently being deliberated at the Consumer Caucus meetings – this recommendation will be shared with the CC. • Refer to HRSA guidance. • Currently, an ala carte model is applied to the $150 monthly stipend.	**8/28: No Decision.** *Note: Defer to Consumer Caucus & COH Leadership*
7	7/14/25	Emily Issa (County Counsel)	Make the membership number 33 (odd number) to avoid ties with votes.	Proposed bylaws show total voting membership at 32. Recommend changing to 33/odd number.	**8/28: Accept**
8	7/25/25	DHSP	Given the uncertainty of HRSA Part F, I recommend removing them from the membership list. Maybe they can be a non-voting member or Priorities and Allocation committee member.	Part F is not a HRSA seat requirement	**8/28: Accept w/ caveat to open opportunity to all committees**

9		DHSP	One recommendation is to have the HRSA Part A legislatively required seats (15 currently), 2 PC co-chairs, and required 33% unaffiliated consumers comprise the voting membership. Additional seats such as academic, dental service representative, etc. can be included as non-voting participants		**8/28: Decline**
10		DSHP	One jurisdiction wrote into their bylaws that a maximum of 1/3 of the voting members can be a subrecipient employee or board member.		**8/28: Decline**
11		DSHP	Given the fiscal situation, I recommend to change the meeting frequency language to at least four times a year. You can have more meetings if necessary.	Current proposed language reduces the current 10 COH meetings to 6 meetings per year.	**8/28: Decline**
12		DSHP	Recommend including language that indicates meetings will be held virtually or in different locations across the County based on epicenters of disease, and will be held in the late afternoon or evenings to foster inclusiveness/representativeness and increase access and participation	• The COH must comply with the Brown Act and cannot have exclusively virtual meetings for the full COH and standing committees. Aside from trainings and social events, all COH and Committee meetings must be conducted in person. • Consider additional costs for renting venues in late afternoons or evenings.	**9/25: Not for applicable for inclusion in bylaws however the COH will explore alternative meeting schedules and locations. COH and Committee meetings must be held in-person per Brown Act.**
13	7/25/25	DHSP	Only 13 HRSA Required Seats. Recommend to further reduce number of voting members	Per HRSA Part A Manual 2025 version, the State Medicaid and Part B representatives are *"[considered two separate categories.]*	**9/25: Decline; HRSA requires 15 seats.**

14	7/25/25	DHSP	Would be helpful to know what will happen to the workgroups and taskforce and caucuses	Article IX, Section 6. Other Working Units. The Commission and its committees may create other working units such as subcommittees, ad-hoc committees, caucuses, task forces, or work groups, as they deem necessary and appropriate. Meeting with current Caucuses and task force co-chairs will be held on 8/14/25 to Walk through some of the legal considerations around standing meetings and determine a more intentional and streamlined meeting schedule moving forward.	**9:25: Subordinate working units will remain as-is, however will not be able to exercise a standing meeting schedule due to the Brown Act. These groups must meet on an as-needed basis according to the PURGE tool.**
15	7/25/25	DHSP	Under Conflict of Interest: Employees and board members of subrecipient agencies can provide information and participate in the discussion. They cannot make a recommendation for allocation or vote on the service category of conflict.	HRSA 2023 Site Visit Finding Excerpt: "*Based on the review of the meeting minutes for the commission and its Planning, Priority and Allocations Committee, it is evident that several of these commissioners* ***participated in allocations/reallocation discussions and voted on allocations including for the service categories for which their agencies are funded,*** *most recently in June 2022 on a revised FY 2023 RWHAP Part A funding allocation. Citation: Section 2602(b)(5)(C) of the PHS Act".*	**9/25: Decline per HRSA finding.**

				As a result of HRSA's finding, stronger language has been included:	
16	7/25/25	DHSP	Under "Background", first bullet: Also reference the August 2023 HRSA letter	Reference: "Health Resources and Services Administration (HRSA) Guidance: "The planning council/planning body (PC/PB) (and its support staff) carry out complex tasks to ensure smooth and fair operations and processes. The development of bylaws, policies and procedures, memoranda of understanding, grievance procedures, and trainings are crucial for the success of the PC/PB. The work also involves establishing and maintaining a productive working relationship with the recipient, developing and managing a budget, and ensuring necessary staff support to accomplish the work. Establishing and operationalizing these policies, procedures, and systems facilitates the ability of the PC/PB to effectively meet its legislative duties and programmatic expectations." [Ryan White HIV/AIDS Program Part A Manual, March 2023, III Chapter 5 (Planning Council and Planning Body Operations)."	**9/25: Accept**
17	7/25/25	DHSP	Under Article I, Section 4: Item D and I are similar. I would keep I and delete item D. Refers to the comprehensive HIV plan.	Reference: d. Develop a comprehensive plan for the organization and delivery of health and support services; i. Develop a local comprehensive HIV plan that is based on assessment of service needs and gaps and that includes a defined continuum of HIV services, monitor the implementation of that plan, assess its effectiveness, and collaborate with the RWHAP recipient - the County of	**9/25: Accept**

				Los Angeles Department of Public Health (DPH) Division of HIV and STD Programs ("DHSP") to update the plan on a regular basis. Per Section 2602(b)(4)(D) of the PHS Act, the comprehensive plan must contain the following . . .	
18	7/25/25	DHSP	Under Article I, Section 4, k; delete "B and CDC prevention." Establish priorities and allocations of RWHAP Part A ~~and B and CDC prevention~~ funding in percentage and/or dollar amounts to various services;,,,,"	Reference: k. Establish priorities and allocations of RWHAP Part A and B and CDC prevention funding in percentage and/or dollar amounts to various services; review DHSP'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 DHSP on how to best meet the need and other factors that further instruct service delivery planning and implementation; and provide assurances to the BOS and HRSA verifying that service category allocations and expenditures are consistent with the Commission's established priorities, allocations and comprehensive HIV plan;	
19	7/25/25	DHSP	Under Article I, Section 4, m: Not a HRSA RWP Part A PC requirement. Refers to "Plan and develop HIV and public health services responses to address the frequency of HIV infection concurrent with STDs and other co-morbidities; plan the deployment of those best practices and innovative models in the County's STD clinics and related health centers; and strategize mechanisms for adapting those models to non-HIV-specific platforms for an expanded STD and co-morbidity response."	COH is a federally mandated integrated planning body under HRSA Part A, responsible for prevention, care, and treatment planning. HRSA (via the Integrated HIV Prevention and Care Plan Guidance) and CDC require collaboration between Ryan White planning councils and local health departments to produce a single integrated plan.	

20	7/25/25	DHSP	Under Article I, Section 4, q, r: Delete q and r. q. Act as the planning body for all HIV programs in DPH or funded by the County; and r. Make recommendations to the BOS, DHSP, and other departments concerning the allocation and expenditure of funding other than RWHAP Part A, B and CDC prevention funds expended by DHP and the County	COH is a federally mandated integrated planning body under HRSA Part A, responsible for prevention, care, and treatment planning. HRSA (via the Integrated HIV Prevention and Care Plan Guidance) and CDC require collaboration between Ryan White planning councils and local health departments to produce a single integrated plan.	
21	7/25/25	DHSP	Under Article I, Section 5: delete "RWHAP". Section 5. Federal and Local Compliance: These Bylaws ensure that the Commission meets all ~~RWHAP~~, HRSA, and CDC requirements and adheres to Chapter 29 of the Los Angeles County Code.		
22	7/25/25	DHSP	Under Article II, Section 2 Composition: 32 members. Recommend to further reduce the number of voting members. There are 15 HRSA RWP Part A required seats, 2 co-chairs, and 33% UA.	The BOS has required that representatives be included as part of the membership.	
23	7/25/25	DHSP	Under Article II, Section 2b: (at least 11 unaffiliated consumers). Reduced number of PC members will decrease this number.		
24	7/25/25	DHSP	Under Article II, Section 2, C: Change to non-voting member. C. One representative from a local academic institution with subject matter expertise in HIV research and data translation.		

25	7/25/25	DHSP	Under Article II, Section 11, DHSP Role and Responsibility. Deletions and additions. DHSP, despite being a non-voting representative, plays a pivotal role in the Commission's work. As the RWHAP Recipient and Part A representative for the Los Angeles County EMA, DHSP provides essential epidemiological data (including surveillance) and ~~surveillance data~~ fiscal information to guide the Commission's ~~decision-making~~ priority setting and resource allocation process.		
26	7/25/25	DHSP	Under Article II, Section 2, Conflict of Interest. Can we add...all members must sign a conflict of interest statement annually and the document will be retained by COH support staff...or something that refers to the HRSA legislative requirement?	Current practice now is that all COH members complete a COI form specific to HRSA annually and 1 required by the County (IRS Form 700). HRSA-specific COI form is retained in each members' electronic folder.	
27	7/25/25	DHSP	Under Article III, Member Requirements, Section 3, Conflict of Interest, C. Deletions and additions. C. Further, in accordance with HRSA Part A Manual 2023, Conflict of Interest, Page 38, dictates that all members must declare conflicts of interest required to recuse themselves from ~~discussion~~ recommending an allocation amount and/or voting concerning that area of conflict. ~~Or funding for those services and/or to those agencies~~.	HRSA 2023 Site Visit Finding Excerpt: "Based on the review of the meeting minutes for the commission and its Planning, Priority and Allocations Committee, it is evident that several of these commissioners participated in allocations/reallocation discussions and voted on allocations including for the service categories for which their agencies are funded, most recently in June 2022 on a revised FY 2023 RWHAP Part A	

				funding allocation. Citation: Section 2602(b)(5)(C) of the PHS Act". As a result of HRSA's finding, stronger language has been included: Members must declare conflicts related to RWP-funded agencies/services and recuse from related discussion/votes.	
28	7/25/25	DHSP	Article V, Meetings, Section 1, B "The Commission and committee meetings are subject to the Brown Act." Given the political environment, there needs to be a "safe space" for some discussions that are not recorded.	The Brown Act and the Roberts Rules of Order require that minutes or an official record of actions taken must be maintained. Official meeting records are the meeting minutes/summaries. Meetings are recorded to assist staff write the minutes. The Brown Act grants the public the right to record meetings, provided it doesn't cause a persistent disruption. The Act ensures transparency by requiring open meetings, public participation, and the ability for individuals to record proceedings.	
29	7/25/25	DHSP	Article V, Meetings, Section 5. Regular Meetings. Can we list fewer number of meetings as the minimum? Maybe 2? 3? 4? Add language to indicate virtual or different meeting locations based on geographic disease burden and alternate meeting times	• The COH must comply with the Brown Act and cannot have exclusively virtual meetings for the full COH and standing committees. • Consider additional costs for renting venues in late afternoons or evenings.	

			(i.e. late afternoon or evenings) to increase representativeness and inclusion.		
30	7/25/25	DHSP	Article VI, Resources, Section 2. Operational Budgeting and Support. Deletions and additions. "Operational support for the Commission is principally derived from the Executive Office of the Board and RWHAP Part A ~~and CDC prevention funds~~ and other funds managed by DHSP. ~~And Net County Costs ("NCC") managed by DHSP.~~ A. The total amount of each year's operational budget is negotiated annually with DHSP and the Executive Office of the Board, in accordance with County budgeting guidelines, and approved by the DHSP Director and the Commission's Executive Committee. B. Projected Commission operational expenditures are allocated from FWHAP Part A administrative funding, ~~CDC prevention, and NCC funding~~, in compliance with relevant guidance and allowable expenses ~~for each funding stream~~ per HRSA.		
31	7/25/25	DHSP	Article VI, Resources, Section 3 Other Support. Additions. Section 3. Other Support. Activities beyond the scope of RWHAP Part A planning councils and CDC HPS, as defined by HRSA		

			and CDC guidance, are supported by other sources, including NCC and the Executive Office of the Board, as appropriate.		
32	7/25/25	DHSP	Article VII. Policies and Procedures, Section 1 Policy/Procedure Manual. Section 1. Policy/Procedure Manual. The Commission develops and adopts policies and procedures consistent with ~~RWHAP,~~ HRSA RWHAP, and the CDC requirements……"		
33	7/25/25	DHSP	Article VII. Policies and Procedures, Section 3 Grievance Procedures. Section 3. Grievance Procedures. The Commission's Grievance Process is incorporated by reference into these Bylaws. The Commission's grievance procedures must comply with ~~RWHAP,~~ HRSA RWHAP and, CDC, and Los Angeles County…..		
34	7/25/25	DHSP	Article VII. Policies and Procedures, Section 5 Conflict of Interest Procedures. Section 5. Conflict of Interest Procedures. The Commission's conflict of interest procedures must comply with the HRSA RWHAP legislation, ~~HRSA guidance,~~ CDC, State of California, and Los Angeles County requirements…..		
35	7/25/25	DHSP	Article XI. Membership and Community Engagement Committee, Section 1. Voting Membership. Maybe most of these can be non-voting participants; refers to Cities of Los Angeles,		

			Pasadena, Long Beach, and West Hollywood, representatives from the youth community; academics/behavioral scientists; members assigned by the Commission Co-Chairs; and the Commission Co-Chairs when attending.		
36	7/25/25	J. Arrington	On Page 20 of 24 - XI. MEMBERSHIP AND COMMUNITY ENGAGEMENT COMMITTEE: Section 2. Responsibilities. Letter L - Identifying, accessing, and expanding other financial resources to support the Commission's special initiatives (what does this intel/mean?) and ongoing operational needs.		
37	7/25/25	J. Arrington	Page 17 of 24 - IX. COMMISSION WORK STRUCTURES: Section 5. Meetings. All committee meetings are open to the public, and the public is welcome to attend and participate. While members of the public do not have voting privileges, they play a critical role in informing discussions. If this fits this or any category on the bylaws, can we add vendors/contractors sign/or agree to COH Code of Conduct while attending meetings?	Also strongly recommended by CoCo.	
38	7/25/25	J. Arrington	This newly drafted version of the COH Bylaws is better. I am glad to see a section from the current version be removed as follows: Section 4. Unaffiliated Consumer Membership. 1. At least one (1) unaffiliated consumer member must be co-infected with Hepatitis B or C; and 2. At least one (1) unaffiliated consumer member must be a person who was incarcerated in a Federal, state or local facility within the past	See proposed changes to the bylaws. These are required by the legislation. See proposed changes to the bylaws to focus on the 15 seats required by the legislation. These seats are reflected on the membership composition.	

			three (3) years and who has a HIV diagnosis as of the date of release, or is a representative of the recently incarcerated described as such. In the current version of the Bylaws was it too much information to keep the members who are recommended descriptions? Such as: On Section 2. Composition. 1. An HIV specialty physician from an HIV medical provider, 2. A Community Health Center/Federally Qualified Health Center ("CHC"/ "FQHC") representative, 3. A mental health provider, 4. A substance abuse treatment provider, 5. A housing provider, etc……Will it be listed elsewhere?		
39	7/10/25	R. Archuleta	Being the Consumers and those living with HIV are the main reasons why the Ryan White Program and Planning Councils were formed, why is the Consumer Caucus only a Caucus and not a Standing Committee?		
40	7/28/25	E. Ahiati (HRSA Project Officer)	**Standards and best practices. Section 2 A.** "Working with DHSP and other bodies to develop and implement a quality management plan and its subsequent operationalization" .	PO Comment: The development of a quality management plan is the subrecipient's responsibility. The PC contributes but is not responsible.	
41	7/28/25	E. Ahiati (HRSA Project Officer)	**Policies and procedures- section 2**- "The Division of Metropolitan HIV/AIDS Program/HIV/AIDS Bureau (DMHAP/HAB) at HRSA requires RWHAP Part A planning councils to submit their grievance and conflict of interest policies and Bylaws for review by the RWHAP Part A project officer". .	PO Comment: HRSA does not require councils to submit their grievance and conflict of interest policies and bylaws for review by the project officer. However, the recipient can share these policies with the PO for additional input and guidance. It's also helpful to the PO	

				to become familiar with the PC's bylaws	
42	7/28/25	E. Ahiati (HRSA Project Officer)	**Section 5. Commission member compensation**: "subsets of Commission members, may be compensated for their service on the Commission contingent upon available funding as determined by the Executive Director and in compliance"	PO Comment: Are the subsets of members referring to unaligned consumers?	
43	8/28/25	Joe Green	One of the comments suggests we remove Prevention from our roles and responsibilities. On paper, we are an integrated planning body, and I am absolutely opposed to separating Prevention and Care. I do believe we could do more. Over the years, we plucked the low hanging prevention fruit that includes: • Development of Prevention Service Standards • PSRA processes have that include EIS, linkage, and retention • Prevention stakeholder engagement through prevention members • Needs assessments identifying prevention service needs and gaps (focus groups, listening sessions, surveys) • Review of data (incidence, prevalence, testing rates, late diagnoses, viral suppression outcomes) The question then becomes: What else can an integrated planning body do to support Prevention? I would welcome the opportunity to work with DHSP to strengthen	Defer to 9/18 Special Executive Committee Meeting Focused Discussion on the Commission's Role in Prevention Planning as an Integrated HIV Planning Body – See Discussion Recap. And additional meeting is being scheduled with DHSP and selected Commissioners w/ prevention expertise to explore prevention planning models that meet the needs of the current prevention landscape.	

			our partnership NOT, in my opinion put Care and Prevention in separate silos. The question of a Prevention Committee was raised during the listening sessions but didn't go anywhere (I am in support of a Prevention Committee). To further our prevention efforts, in our restructuring, we are proposing the creation of a Membership and Community Engagement Committee where Prevention and Care can be **equally addressed**. This can only happen if our partner, DHSP truly supports the Commission's prevention efforts. Under the CDC NOFO (page 28 Items 6b and 6c), it clearly states that an HIV Planning Group needs to exist (item 6b) and under Item 6c; we must conduct and facilitate and HIV planning process and the development of an Integrated HIV Prevention and Care Plan. I believe that if prevention planning was further incorporated into the HIV Commission we would go further towards reducing transmission of HIV. In addition, we should keep all references to CDC prevention in our bylaws.		
44	8/28/25	Joe Green	As to comment 26 regarding the budget, I disagree. believe the proposed language in the bylaws is more than adequate and allows for true negotiations with DHSP. Therefore, I would recommend we retain any and all		

			references to CDC and NCC as funding sources (potentially from the Executive Offices).		
45	8/28/25	Joe Green	As for who should be eligible to vote in the new body, I don't think there is a need to preclude voting by prevention and care providers. I believe that it is sufficient for a commissioner to state their conflicts at the beginning of meetings.		
46	8/28/25	Joe Green	As to the composition of the Commission, I understand why we need to reduce the size of the Commission but would offer that we rethink precluding the 4 cities from being full commissioners and voting members. I believe that their commitment to the commission deserves a vote.		
47	8/28/25	Joe Green	As for the time, location and number of meetings, I concur with DHSP that we should have evening meetings and take the meetings to where the disease burden and prevention efforts are most prevalent. I also believe we should consider having meetings on Saturdays if the body agrees. I do not agree that we should have less meetings but keep the proposed bylaws at a minimum of 6 meetings with the following caveats: 2 meetings should focus on prevention; 2 focus on care (with one meeting for Directives); 1 annual meeting and 1 annual retreat (to occur at the beginning of the fiscal year).		
48	8/28/25	Joe Green	I concur with County Counsel that we should have an odd number of commissioners to		

			avoid ties with votes.		
49	8/28/25	Joe Green	As to comment 43, based on our track record for reviewing and updating bylaws, I believe we should incorporate the 4 – yet to be elected Supervisors	A proposed update to the bylaws includes an annual review of the bylaws. The BOS will not expand from five to nine supervisors until 2032	
OTHER QUESTIONS/ITEMS TO CONSIDER					
50			Do we need to specify number of meetings per year for the Commission and Committees in the bylaws?		
51			Add California Planning Group (CPG) requirement for Planning Council representation. **NOMINATED CPG MEMBERS** Nominated CPG members are appointed by the local planning body that they are representing. Their appointment to the CPG is confirmed by the "Letter of Nomination" that the CPG receives from each planning body. Nominated members serve as liaisons and share the work that is being done in their local community with the CPG membership, occasionally this may include additional meetings with other nominated members, and after, take the information learned from the CPG meetings and go back to their local planning body to provide detailed updates of the information shared during CPG meetings. The CPG will appoint only one nominated member per planning body to serve a full		

			term. If a local planning body has two Co-Chairs, they must choose one to appoint to CPG. A nominated CPG membership is not a rotating position. Should the appointed member fall ill or resign, the second Co-chair can assume the position.		
QUESTIONS FROM BYLAWS REVIEW TRAINING (JULY 23, 2025)					
52			Can termed out members apply to be members of the standing committees?	Consider challenges with meeting quorum with large numbers of committee members. Having termed out Commissioners serve as voting members on a standing committee is not in alignment with the spirit and intent of member rotations. Excerpt from HRSA PC Expectations Letter: "*To ensure the PC/PB are reflective of the demographics of the population of individuals with HIV in the jurisdiction, HRSA HAB expects the PC/PB to establish term limits and membership rotations.*"	
53			Can we add the additional 4 Board members as part of Board expansion under Measure G.	This change in the BOS is not set to be implemented until 2032. Adding additional members that do not yet exist is not recommended.	
54			Can we reduce the number of pages for the bylaws to make it easier for the consumers to read?	Proposed document eliminated 4 pages and staff will use links, where appropriate, to reduce the pages.	

55			How will the staggered terms be handled?	When the updated ordinance becomes effective, the new members appointed by the Board of Supervisors will be seated. The Commission shall classify its members by lot so that 16 members' terms will expire after one (1) year and 17 will expire after two (2) years. Thereafter, each membership term shall be two (2) years.	
56			Where did the City representatives go?	See voting members of the Membership and Community Engagement Committee.	
57			Will new members for the newly restructured COH still have to go through the BOS approval?	Yes. All Commissioners serve at the pleasure of the Board and are appointed by the Board.	
58			If current members who reapply are accepted, will we automatically be assigned on the same committee?	Not necessarily. Co-Chairs will review the members' committee interest selection and reflectiveness across committees.	
59			For unaffiliated consumers applicants, will there be difference between current members who wish to reapply versus new applicants? Will new applicants get an advantage? It takes a while to learn about the COH, especially for some unaffiliated consumers. Consumers deserve the opportunity learn even if they do not have	The Operations Committee is currently revising the membership application form and interview questions to better ascertain best candidates to serve on the COH.	

			previous experience.		
60			Consider keeping city representatives from Los Angeles, West Hollywood, Long Beach, and Pasadena as non-voting members of the full body.		
61			Consider creating an inclusive, all populations Consumer Committee instead of a Caucus.		
ADDITIONAL RECOMMENDATIONS (10/20/25)					
62			Designate the Part B and Medi-Cal representative seats as non-voting and not counted toward quorum to allow greater flexibility for participation given current capacity constraints.		

LOS ANGELES COUNTY COMMISSION ON HIV

POLICY/PROCEDURE #06.1000	Bylaws of the Los Angeles County Commission on HIV	Page 1 of 24

SUBJECT: **The Bylaws of the Los Angeles County Commission on HIV.**

PURPOSE: **To define the governance, structural, operational, and functional responsibilities and requirements of the Los Angeles County Commission on HIV.**

BACKGROUND:

- **Health Resources and Services Administration (HRSA) Guidance**: "The planning council/planning body (PC/PB) (and its support staff) carry out complex tasks to ensure smooth and fair operations and processes. The development of bylaws, policies and procedures, memoranda of understanding, grievance procedures, and trainings are crucial for the success of the PC/PB. The work also involves establishing and maintaining a productive working relationship with the recipient, developing and managing a budget, and ensuring necessary staff support to accomplish the work. Establishing and operationalizing these policies, procedures, and systems facilitates the ability of the PC/PB to effectively meet its legislative duties and programmatic expectations." [Ryan White HIV/AIDS Program Part A Manual, March 2023, III Chapter 5 (Planning Council and Planning Body Operations).

- **Centers for Disease Control and Prevention (CDC) Guidance: "**The HIV Planning Group (HPG) is the official HIV planning body that follows the *HIV Planning Guidance* to inform the development or update of the health department's Jurisdictional HIV Prevention Plan, which depicts how HIV infection will be reduced in the jurisdiction."

- **Los Angeles County Code, Title 3—Chapter 3.29.070 (Procedures)**: "The Commission shall adopt bylaws which may include provisions relating to the time and place of holding meetings, election and terms of its co-chairs and other officers, and such other rules and procedures necessary for its operation."

POLICY:

1) **Consistency with the Los Angeles County Code:** The Commission's Bylaws are developed in accordance with the Los Angeles County Code, Title 3—Chapter 29 ("Ordinance"), the authority which establishes and governs the administration and operations of the Los Angeles County Commission on HIV. These Bylaws serve as the Commission's administrative, operational, and functional rules and requirements.

2) **Commission Bylaws Review and Approval**: The Commission conducts an annual administrative review of these Bylaws to ensure ongoing compliance, relevance, and adaptability to changes in both the external environment and internal structure.
   - **A.** The Commission will request the Ryan White HIV/AIDS Program (RWHAP) Part A project officer to review substantial changes to the Bylaws to ensure compliance and alignment with HRSA requirements.
   - **B.** Amendments to the Bylaws will be promptly considered, with any necessary adjustments made in alignment with amendments to the Ordinance.
   - **C.** Approval of amendments or revisions requires a two-thirds vote from Commission members present at the meeting. To facilitate a thorough and informed decision-making process, proposed changes must be formally noticed for consideration and review at least ten days prior to the scheduled meeting (refer to Article XVI).

ARTICLES:

I. NAME AND LEGAL AUTHORITY:

Section 1. Name. The name of this Commission is the Los Angeles County Commission on HIV.

Section 2. Created. This Commission was created by an act of the Los Angeles County Board of Supervisors ("BOS"), codified in Chapter 29 of the Los Angeles County Code.

Section 3. Organizational Structure. The Commission on HIV is housed as an independent commission within the Executive Office of the BOS in the organizational structure of the County of Los Angeles.

Section 4. Duties and Responsibilities. As defined in Los Angeles County Code section 3.29.090 (*Duties*), and consistent with Section 2602(b)(4) (42 U.S.C § 300ff-12) of the RWHAP legislation, HRSA guidance, and requirements of the CDC HIV Planning Guidance, the Commission is charged with and authorized to:

a. Determine the size and demographics of the population of individuals with HIV/AIDS in Los Angeles County;
b. Determine the needs of such population, with particular attention to individuals who know their status but are not in care, disparities in

access to services, and individuals with HIV/AIDS who do not know their HIV status;

c. Establish priorities for the allocation of funds within the eligible metropolitan area (EMA), how to best meet each such priority, as well as additional factors to consider when allocating RWHAP Part A grant funds;
d. Develop a comprehensive plan for the organization and delivery of health and support services;
e. Assess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible metropolitan area (EMA) and assess the effectiveness of the services offered in meeting the identified needs, if/as needed;
f. Participate in the development of the Statewide Coordinated Statement of Need initiated by the state public health agency;
g. Establish methods for obtaining community input regarding needs and priorities; and
h. Coordinate with other federal grantees that provide HIV-related service in the EMA;
i. Develop a local comprehensive HIV plan that is based on assessment of service needs and gaps and that includes a defined continuum of HIV services, monitor the implementation of that plan, assess its effectiveness, and collaborate with the RWHAP recipient - the County of Los Angeles Department of Public Health (DPH) Division of HIV and STD Programs ("DHSP") to update the plan on a regular basis. Per Section 2602(b)(4)(D) of the PHS Act, the comprehensive plan must contain the following:
    i. a strategy for identifying individuals who know their HIV status and are not receiving such services and for informing the individuals of and enabling the individuals to utilize the services, giving particular attention to eliminating disparities in access and services among affected subpopulations and historically underserved communities, and including discrete goals, a timetable, and an appropriate allocation of funds;
    ii. a strategy to coordinate the provision of such services with programs for HIV prevention (including outreach and early intervention) and for the prevention and treatment of substance abuse (including programs that provide comprehensive treatment services for such abuse);
    iii. compatibility with any State or local plan for the provision of

services to individuals with HIV/AIDS; and

iv. a strategy, coordinated as appropriate with other community strategies and efforts, including discrete goals, a timetable, and appropriate funding, for identifying individuals with HIV/AIDS who do not know their HIV status, making such individuals aware of such status, and enabling such individuals to use the health and support services described in section 2604, with particular attention to reducing barriers to routine testing and disparities in access and services among affected subpopulations and historically underserved communities.

j. Develop service standards for the organization and delivery of HIV care, treatment, and prevention services;

k. Establish priorities and allocations of RWHAP Part A and B and CDC prevention funding in percentage and/or dollar amounts to various services; review DHSP'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 DHSP on how to best meet the need and other factors that further instruct service delivery planning and implementation; and provide assurances to the BOS and HRSA verifying that service category allocations and expenditures are consistent with the Commission's established priorities, allocations and comprehensive HIV plan;

l. Evaluate service effectiveness and assess the efficiency of the administrative mechanism, with particular attention to outcome evaluation, cost effectiveness, rapid disbursement of funds, compliance with Commission priorities and allocations, and other factors relevant to the effective and efficient operation of the local EMA delivery of HIV services;

m. Plan and develop HIV and public health service responses to address the frequency of HIV infection concurrent with STDs and other co-morbidities; plan the deployment of those best practices and innovative models in the County's STD clinics and related health centers; and strategize mechanisms for adapting those models to non-HIV-specific platforms for an expanded STD and co-morbidity response;

n. Study, advise, and recommend policies and other actions/decisions to the BOS, DHSP, and other departments on matters related to HIV;

o. Inform, educate, and disseminate information to consumers, specified target populations, providers, the public, and HIV and health service policy makers to build knowledge and capacity for HIV prevention, care, and treatment, and actively engage individuals and entities concerned about HIV;

p. Provide an annual report to the BOS describing Los Angeles County's progress in ending HIV as a threat to the health and welfare of Los Angeles County residents with indicators to be determined by the Commission in collaboration with DHSP; make other reports as necessary to the BOS, DHSP, and other departments on HIV-related matters referred for review by the BOS, DHSP, or other departments;

q. Act as the planning body for all HIV programs in DPH or funded by the County; and

r. Make recommendations to the BOS, DHSP, and other departments concerning the allocation and expenditure of funding other than RWHAP Part A and B and CDC prevention funds expended by DHSP and the County for the provision of HIV-related services.

Section 5. Federal and Local Compliance. These Bylaws ensure that the Commission meets all RWHAP, HRSA, and CDC requirements and adheres to Chapter 29 of the Los Angeles County Code.

Section 6. Service Area. In accordance with Los Angeles County Code and funding designations from HRSA and the CDC, the Commission executes its duties and responsibilities for Los Angeles County.

II. MEMBERS:

Section 1. Definition. A member of this Commission is any person who has been duly appointed by the BOS as a Commissioner or Alternate.

A. Commissioners are appointed by the BOS as full voting members to execute the duties and responsibilities of the Commission.

B. Alternates are appointed by the BOS to serve in place of a full seated unaffiliated consumer (UC) member when the UC member cannot fulfill their Commission duties and responsibilities.

C. Committee-only members are appointed by the Commission to serve as voting members on the Commission's standing committees, according to the committees' processes for selecting Committee-only members.

Section 2. Composition. As defined by Los Angeles County Code 3.29.030 (*Membership*),

all members of the Commission shall serve at the pleasure of the BOS. The membership shall consist of 32 voting members and one non-voting member from DHSP. Members are nominated by the Commission and appointed by the BOS.

Consistent with the Open Nominations Process, the following recommending entities may forward candidates to the Commission for membership consideration.

A. Specific Membership Required by the Ryan White CARE Act. Section 2602(b)(2) of the PHS Act lists 13 specific membership categories that must be represented on the Commission. These 15 membership categories include:

1. health care providers, including federally qualified health centers;
2. community-based organizations serving affected populations and AIDS service organizations;
3. social service providers, including providers of housing and homeless services;
4. mental health providers;
5. substance use providers
6. local public health agencies;
7. hospital planning agencies or health care planning agencies;
8. affected communities, including people with HIV/AIDS, members of a federally recognized Indian tribe as represented in the population, individuals co-infected with hepatitis B or C, and historically underserved groups and subpopulations;
9. non-elected community leaders;
10. State government (including the State Medicaid agency;
11. the agency administering the program under Part B)
12. recipients under subpart II of Part C;
13. recipients under section 2671 Part D, or if none are operating in the area, representatives of organizations with a history of serving children, youth, women, and families living with HIV and operating in the area;
14. recipients of other federal HIV programs, including but not limited to providers of HIV prevention services; and
15. representatives of individuals who formerly were federal, State, or local prisoners released from the custody of the penal system during the preceding three years, and had HIV as of the date on which the individuals were so released.

B. Unaffiliated Consumer Membership. In accordance with RWHAP Part A legislative requirements outlined in Section 2602(b)(5)(C): REPRESENTATION, the Commission shall ensure that at least 33% (at least 11) of its members are consumers of RWHAP Part A services who are not aligned or affiliated with RWHAP Part A-funded providers as employees, consultants, or Board members.

Unaffiliated consumers should reflect the local HIV burden and geographic diversity of Los Angeles County.

C. One representative from a local academic institution with subject matter expertise in HIV research and data translation.

D. One non-voting member representative from DHSP - the RWHAP Recipient/Part A Recipient. Non-voting members do not count towards quorum.

E. Five representatives, one recommended by each of the five Supervisorial offices.

F. Additional Government Members. Representatives of government agencies and other sectors across Los Angeles County may be invited to participate in Commission or Committee meetings on an ad hoc basis as needed, without requiring appointment as Commission members.

Section 3. Term of Office. Consistent with Los Angeles County Code section 3.29.050 (*Term of Service*):

A. Commissioners may serve a maximum of three consecutive two-year staggered terms as reflected on the Membership Roster.

B. Alternate members may serve a maximum of three consecutive two-year staggered terms as reflected on the Membership Roster.

C. Committee-Only members serve two-year terms, beginning on the date of appointment. Committee-only members may reapply once their two-year term ends.

D. Members (Full, Alternate, and Committee-only) may serve a maximum of three consecutive two-year terms (6 years total) and can reapply after a one-year break. Term limits are calculated from the approval date of these Bylaws.

E. The Executive Committee may make an exception the term limits in order to meet representation requirements, including unaffiliated consumers, or the need for specific expertise.

Section 4. Reflectiveness. In accordance with RWHAP Part A legislative requirements [Section 2602(b)(1)], the Commission shall ensure that its full membership and the subset of unaffiliated consumer members proportionately reflect the demographical characteristics of HIV prevalence in the EMA.

Section 5. Representation. In accordance with RWHAP Part A legislative requirements [Section 2602(b)(2)], the Commission shall ensure that all appropriate specific membership categories designated in the legislation are represented among the membership of Commission. Commission membership shall include individuals

from areas with high HIV and STD incidence and prevalence.

Section 6. Parity, Inclusion, and Representation (PIR). In accordance with CDC's *HIV Planning Guidance,* the planning process must ensure the parity and inclusion of the members.

A. "'Parity' is the ability of HIV planning group members to equally participate and carry out planning tasks or duties in the planning process. To achieve parity, representatives should be provided with opportunities for orientation and skills-building to participate in the planning process and have an equal voice in voting and other decision-making activities."

B. "'Inclusion' is the meaningful involvement of members in the process with an active role in making decisions. An inclusive process assures that the views, perspectives, and needs of affected communities, care providers, and key partners are actively included."

C. "Representation" means that "members should be representative of varying races and ethnicities, genders, sexual orientations, ages, and other characteristics such as varying educational backgrounds, professions, and expertise."

Section 7. HIV and Target Population Inclusion. In all categories when not specifically required, recommending entities and the Commission are strongly encouraged to nominate candidates living with HIV and individuals who are members of populations at disproportionate risk for HIV.

Section 8. Accountability. Members are expected to convey two-way information and communication between their represented organization/constituency and the Commission. Members are expected to provide the perspective of their organization/constituency and the Commission to other, relevant organizations regardless of the member's personal viewpoint. Members may, at times, represent multiple constituencies.

Section 9. Alternates. In accordance with Los Angeles County Code section 3.29.040 (*Alternate members*), any Commission member who has disclosed that they are living with HIV is entitled to an Alternate who shall serve in the place of the Commissioner when necessary.

Alternate members undergo the identical Open Nomination and Evaluation process as Commissioner candidates, submitting the same application and undergoing the same evaluation and scoring procedures.

Section 10. Committee-Only Membership. The Commission's standing committees may elect to nominate Committee-only members for appointment by the Commission to serve as voting members on the respective committees to

provide professional and/or lived experience expertise, as a means of further engaging community participation in the planning process.

Section 11. DHSP Role & Responsibility. DHSP, despite being a non-voting representative, plays a pivotal role in the Commission's work. As the RWHAP Recipient and Part A representative for the Los Angeles County EMA, DHSP provides essential epidemiological and surveillance data to guide the Commission's decision-making. DHSP plays a central role in carrying out needs assessments, conducting comprehensive planning, overseeing contracting and procurement of providers, evaluating service effectiveness, and performing quality management. Collaborating closely with DHSP, the Commission ensures effective coordination and implementation of its integrated comprehensive HIV plan. The Commission heavily relies on this partnership to ensure the optimal use of RWHAP funds and adherence to legislative and regulatory requirements, ensuring the highest standard of HIV services in Los Angeles County. DHSP, the Commission Executive Director, and Co-Chairs, shall establish and maintain a Memorandum of Understanding (MOU) to a collaborative relationship for the common goal of ensuring compliance with Ryan White legislative requirements and supporting a well-functioning community planning process.

III. MEMBER REQUIREMENTS:

Section 1. Attendance. Commissioners and/or their Alternates are expected to attend all regularly scheduled Commission meetings, primary committee meetings, priority- and allocation-setting meetings, orientation, and training meetings, and the Annual Conference.

A. In accordance with Los Angeles County Code 3.29.060 (*Meetings and committees*), the BOS shall be notified of member attendance on a semi-annual basis.

Section 2. Committee Assignments. Commissioners are required to be a member of at least one standing committee, known as the member's "primary committee assignment," and adhere to attendance requirements of that committee. A Commissioner may request a secondary committee assignment, provided that they commit to the attendance requirements.

A. Commissioners who live and work outside of Los Angeles County as necessary to meet expectations of their specific seats on the Commission are exempted from the requirement of a primary committee assignment, i.e., State Office of AIDS/Part B Representative and State Medi-Cal Representative.

B. Commissioners and Alternates are allowed to voluntarily request or accept

"secondary committee assignments" upon agreement of the Co-Chairs.

Section 3. Conflict of Interest. Consistent with the Los Angeles County Code 3.29.046 (*Conflict of Interest*), Commission members are required to abide by the Conflict of Interest and Disclosure requirements of the Commission, the County of Los Angeles, the State of California (including Government Code Sections 87100, 87103, and 1090, et seq.), the RWHAP, as outlined in HRSA and relevant CDC guidance.

A. As specified in Section 2602(b)(5)(A) of the RWHAP legislation, the Commission shall not be involved directly or in an advisory capacity in the administration of RWHAP funds and shall not designate or otherwise be involved in the selection of entities as recipients of those grant funds. While not addressed in the Ryan White legislation, the Commission shall adhere to the same rules for CDC and other funding.

B. Section 2602(b)(5)(B) continues that a planning council member who has a financial interest in, is employed by, or is a member of a public or private entity seeking local RWHAP funds as a provider of specific services is precluded from participating in—directly or in an advisory capacity—the process of selecting contracted providers for those services.

C. Further, in accordance with HRSA Part A Manual, March 2023, Conflict of Interest, Page 38, dictates that all members must declare conflicts of interest involving RWHAP-funded agencies and their services, and the member is required to recuse themselves from discussion and/or voting concerning that area of conflict, or funding for those services and/or to those agencies.

Section 4. Code of Conduct. All Commission members and members of the public are expected to adhere to the Commission's approved Code of Conduct at Commission and sponsored meetings and events. Those in violation of the Code of Conduct will be subject to the Commission's Policy #08.3302 Intra-Commission Grievance and Sanctions Procedures.

Section 5. Comprehensive Training. Commissioners and Alternates are required to fulfill all mandatory County and Commission training requirements.

Section 6. Removal/Replacement. A Commissioner or Alternate may be removed or replaced by the BOS for failing to meet attendance requirements, and/or other reasons determined by the BOS.

A. The Commission, via its Membership and Community Engagement and Executive Committees, may recommend vacating a member's seat if egregious or unresolved violations of the Code of Conduct occur, after three months of consecutive absences, if the member's term is expired, or during

the term if a member has moved out of the jurisdiction and/or no longer meets the qualifications for the seat.

IV. NOMINATION PROCESS:

Section 1. Open Nominations Process. Application, evaluation, nomination and appointment of Commission members shall follow "...an open process (in which) candidates shall be selected based on locally delineated and publicized criteria," as described in Section 2602(b)(1) of the RWHAP legislation and "develop and apply criteria for selecting HPG members, placing special emphasis on identifying representatives of at-risk, persons living with HIV/AIDS, and socio-economically marginalized populations," as required by the CDC *HIV Planning Guidance.*

A. The Commission's Open Nominations Process is defined in Policy/ Procedure #09.4205 (*Commission Membership Evaluation and Nominations Process*) and related policies and procedures.

B. Nomination of candidates that are forwarded to the BOS for appointment shall be made according to the policy and criteria adopted by the Commission.

Section 2. Application. Application for Commission membership shall be made on forms as approved by the Commission.

A. All candidates for first-time Commission membership shall be interviewed by the Membership and Community Engagement (MCE) Committee. Renewing members must complete an application and may be subject to an interview as determined by the MCE Committee.

B. Any candidate may apply individually or through recommendation of other stakeholders or entities.

C. Candidates cannot be recommended to the Commission or nominated by the BOS without completing the appropriate Commission-approved application, BOS Statement of Qualifications, and being evaluated and scored by the MCE Committee.

Section 3. Appointments. Commissioners and Alternates must be appointed by the BOS.

V. MEETINGS:

Section 1. Public Meetings. The Commission adheres to federal open meeting regulations outlined in Section 2602(b)(7)(B) of the RWHAP legislation, accompanying HRSA guidance, and California's Ralph M. Brown Act (Brown Act).

A. According to the RWHAP legislation, Council meetings must be open to the public with adequate notice. HRSA guidance extends these rules to Commission and committee meetings.

B. The Commission and committee meetings are subject to the Brown Act.
C. Specific public meeting requirements for Commission working units are detailed in Commission Policy #08.1102: Subordinate Commission Working Units.

Section 2. Public Noticing. Advance public notice of meetings shall comply with HRSA's open meeting requirements, Brown Act public noticing requirements, and all other applicable laws and regulations.

Section 3. Meeting Minutes/Summaries. Meeting summaries and minutes are produced in accordance with HRSA's open meeting requirements, the Brown Act, Commission policies and procedures, and all other applicable laws and regulations. Meeting minutes are posted to the Commission's website at https://hiv.lacounty.gov/ following their approval by the respective body.

Section 4. Public Comment. In accordance with Brown Act requirements, public comment on agendized and non-agendized items is allowed at all Commission meetings open to the public. The Commission is allowed to limit the time of public comment consistent with Los Angeles County rules and regulations and must adhere to all other County and Brown Act rules and requirements regarding public comment.

Section 5. Regular meetings. In accordance with Los Angeles County Code section 3.29.060 (*Meetings and committees*), the Commission shall meet *at least* 6 times per year. Commission and committee meetings are held every other month, unless cancelled, at a time and place to be designated by the Co-Chairs or the Executive Committee or committee Co-Chairs. The Executive Committee or Co-Chairs and committee Co-Chairs may convene additional meetings, as needed, to meet operational and programmatic needs.

The Commission's Annual Conference will replace one of the regularly scheduled monthly meetings.

Section 6. Special Meetings. In accordance with the Brown Act, special meetings may be called as necessary by the Co-Chairs, the Executive Committee, or a majority of the members of the Commission.

Section 7. Executive Sessions. In accordance with the Brown Act, the Commission or its committees may convene executive sessions closed to the public to address pending litigation or personnel issues. An executive session will be posted as such.

Section 8. Robert's Rules of Order. All meetings of the Commission shall be conducted according to the current edition of "*Robert's Rules of Order, Newly Revised*,"

except where superseded by the Commission's Bylaws, policies/procedures, and/or applicable laws.

Section 9. Quorum. In accordance with Los Angeles County Code section 3.29.070 (*Procedures*), the quorum for any regular, special, or committee meeting shall be a majority of voting, seated Commission or committee members.

VI. RESOURCES:

Section 1. Fiscal Year. The Commission's Fiscal Year (FY) and programmatic year coincide with the County's fiscal year, from July 1 through June 30 of any given year.

Section 2. Operational Budgeting and Support. Operational support for the Commission is principally derived from RWHAP Part A and CDC prevention funds, and Net County Costs ("NCC") managed by DHSP. Additional support may be obtained from alternate sources, as needed and available, for specific Commission activities.

A. The total amount of each year's operational budget is negotiated annually with DHSP, in accordance with County budgeting guidelines, and approved by the DHSP Director and the Commission's Executive Committee.

B. Projected Commission operational expenditures are allocated from RWHAP Part A administrative, CDC prevention, and NCC funding in compliance with relevant guidance and allowable expenses for each funding stream. As the administrative agent of those funds, DHSP is charged with oversight of the funds to ensure that their use for Commission operational activities is compliant with relevant funder program regulations and the terms and conditions of the award/funding.

C. Costs and expenditures are enabled through a Departmental Service Order between DHSP/DPH and the Executive Office of the BOS, the Commission's fiscal and administrative agent.

D. Expenditures for staffing or other costs covered by various funding sources will be prorated in the Commission's annual budget according to their respective budget cycles.

Section 3. Other Support. Activities beyond the scope of RWHAP Part A planning councils and CDC HPGs, as defined by HRSA and CDC guidance, are supported by other sources, including NCC, as appropriate.

Section 4. Additional Revenues. The Commission may receive other grants and/or revenues for projects/activities within the scope of its duties and responsibilities,

as defined in these Bylaws Article I, Section 4. The Commission will follow County-approved procedures for allocating project-/activity-related costs and resources in the execution of those grants and/or fulfillment of revenue requirements.

Section 5. Commission Member Compensation. In accordance with Los Angeles County Code section 3.29.080 (*Compensation*), RWHAP Part A planning council requirements, CDC guidance, and/or other relevant grant restrictions, Commission members, or designated subsets of Commission members, may be compensated for their service on the Commission contingent upon available funding as determined by the Executive Director and in compliance with established policies and procedures governing Commission member compensation practices.

Section 6. Staffing. The Executive Director serves as the Commission's lead staff person and manages all personnel, budgetary, and operational activities of the Commission.

A. The Co-Chairs and the Executive Committee are responsible for overseeing the Executive Director's performance and management of Commission operations and activities consistent with Commission decisions, actions, and directives.

B. Within Los Angeles County's organizational structure, the County's Executive Officer and/or their delegated representative serves as the supervising authority of the Executive Director.

VII. POLICIES AND PROCEDURES:

Section 1. Policy/Procedure Manual. The Commission develops and adopts policies and procedures consistent with RWHAP, HRSA, and CDC requirements, Chapter 29 of the Los Angeles County Code, these Bylaws, and other relevant governing rules and requirements to operationalize Commission functions, work, and activities. The policy/procedure index and accompanying adopted policies/procedures are incorporated by reference into these Bylaws.

Section 2. HRSA Approval(s). The Division of Metropolitan HIV/AIDS Program/HIV/AIDS Bureau (DMHAP/HAB) at HRSA requires RWHAP Part A planning councils to submit their grievance and conflict of interest policies and Bylaws for review by the RWHAP Part A project officer.

Section 3. Grievance Procedures. The Commission's *Grievance Process* is incorporated by reference into these Bylaws. The Commission's grievance procedures must comply with RWHAP, HRSA, CDC, and Los Angeles County requirements, and will

be amended from time to time, as needed.

Section 4. Complaints Procedures. Complaints related to internal Commission matters such as alleged violations of the Code of Conduct or other disputes among members are addressed and resolved in adherence to Commission's Policy #08.3302: Intra-Commission Grievance and Sanctions Procedure.

Section 5. Conflict of Interest Procedures. The Commission's conflict of interest procedures must comply with the RWHAP legislation, HRSA guidance, CDC, State of California, and Los Angeles County requirements, and will be amended from time to time, as needed. These policies/procedures are incorporated by reference into these Bylaws.

VIII. LEADERSHIP:

Section 1. Commission Co-Chairs. The officers of the Commission shall be two Commission Co-Chairs ("Co-Chairs").

A. One of the Co-Chairs must be a person living with HIV/AIDS. Best efforts shall be made to have the Co-Chairs reflect the diversity of the HIV epidemic in Los Angeles County.

B. The Co-Chairs' terms of office are two years, which shall be staggered. In the event of a vacancy, a new Co-Chair shall be elected to complete the term. The nominations and elections to fill the vacancy and complete the term will occur within 60 days of the resignation of the chair.

C. The Co-Chairs are elected by a majority vote of Commissioners or Alternates present at a regularly scheduled Commission meeting at least four months prior to the start date of their term. The term of office begins at the start of the calendar year. When a new Co-Chair is elected, this individual shall be identified as the Co-Chair-Elect and will have four months of mentoring and preparation for the Co-Chair role.

D. As reflected in the Commission Co-Chair Duty Statement, one or both Co-Chairs shall preside at all regular or special meetings of the Commission and at the Executive Committee. In addition, the Co-Chairs shall:

1. Assign the members of the Commission to committees.
2. Represent the Commission at functions, events, and other public activities, as necessary.
3. Call special meetings, as necessary, to ensure that the Commission fulfills its duties.
4. Consult with and advise the Executive Director regularly, and the RWHAP Part A and CDC project officers, as needed.
5. Conduct the performance evaluation of the Executive Director, in

consultation with the Executive Committee and the Executive Office of the BOS.

6. Chair or co-chair committee meetings in the absence of both committee co-chairs.
7. Serve as voting members on all committees when attending those meetings.
8. Act on behalf of the Commission or Executive Committee on emergency matters.
9. Attend to such other duties and responsibilities as assigned by the BOS or the Commission.

Section 2. Committee Co-Chairs: Each committee shall have two co-chairs.

A. Committee co-chairs' terms of office are for one year and may be re-elected by the committee membership. In the event of a vacancy, a new co-chair shall be elected by the respective committee to complete the term.

B. Committee co-chairs are elected by a majority vote of the members of the respective committees present at regularly scheduled meetings at the beginning of the calendar year, following the open nomination period at the prior regularly scheduled meetings of the committees. As detailed in the Commission Co-Chair Duty Statement, one or both co-chairs shall preside at all regular or special meetings of their respective committee. Committee co-chairs shall have the following additional duties:

1. Serve as members of the Executive Committee.
2. Develop annual work plans for their respective committees in consultation with the Executive Director, subject to approval of the Executive Committee and/or Commission.
3. Manage the work of their committees, including ensuring that work plan tasks are completed; and
4. Present the work of their committee and any recommendations for action to the Executive Committee and the Commission.

IX. COMMISSION WORK STRUCTURES:

Section 1. Committees and Working Units. The Commission completes much of its work through a strong committee and working unit structure outlined in Commission Policy #08.1102: Subordinate Commission Working Units.

Section 2. Commission Decision-Making. Committee work and decisions are forwarded to the full Commission for further consideration and approval through the Executive Committee, unless that work or decision has been specifically delegated to a committee. All final decisions and work presented to the Commission must be approved by at least a majority of the quorum of the

Commission.

Section 3. Standing Committees. The Commission has established four standing committees: Executive; Membership and Community Engagement (MCE); Planning, Priorities and Allocations (PP&A); and Standards and Best Practices (SBP).

Section 4. Committee Membership. Only Commissioners or Alternates assigned to the committees by the Commission Co-Chairs, the Commission Co-Chairs themselves, and Committee-Only members nominated by the committee and approved by the Commission shall serve as voting members of the committees.

Section 5. **Meetings.** All committee meetings are open to the public, and the public is welcome to attend and participate. While members of the public do not have voting privileges, they play a critical role in informing discussions.

Section 6. Other Working Units. The Commission and its committees may create other working units such as subcommittees, ad-hoc committees, caucuses, task forces, or work groups, as they deem necessary and appropriate.

A. The Commission is empowered to create caucuses of subsets of Commission members who are members of "key or priority populations" or "populations of interest" as identified in the comprehensive HIV plan, such as consumers. Caucuses are ongoing for as long as they are needed.
B. Task forces are established to address a specific issue or need and may be ongoing or time limited.

X. EXECUTIVE COMMITTEE:

Section 1. Membership. The voting membership of the Executive Committee shall be comprised of the Commission Co-Chairs, the Committee Co-Chairs, three Executive Committee At-Large members who are elected by the Commission, subject matter expert(s) appointed by the Executive Committee necessary to fulfill the duties of the Commission, a person with public policy expertise, DHSP, as a non-voting member, and one of the Co-Chairs from the Caucuses. Caucus representatives on the Executive Committee must be Commissioners or Alternates

Section 2. Co-Chairs. The Commission Co-Chairs shall serve as the co-chairs of the Executive Committee, and one or both shall preside over its meetings.

Section 3. Responsibilities. The Executive Committee is charged with the following responsibilities:

A. Overseeing all Commission operational and administrative activities.
B. Serving as the clearinghouse to review and forward items for discussion, approval and action to the Commission and its various working groups and units.
C. Acting on an emergency basis on behalf of the Commission, as necessary, between regular meetings of the Commission.
D. Approving the agendas for the Commission's regular, annual, and special meetings.
E. Determining the annual Commission work plan and functional calendar of activities, in consultation with the committees and subordinate working units.
F. Conducting strategic planning activities for the Commission.
G. Adopting a Memorandum of Understanding ("MOU") with DHSP, if needed, and monitoring ongoing compliance with the MOU.
H. Resolving potential grievances or internal complaints informally when possible and standing as a hearing committee for grievances and internal complaints.
I. Making amendments, as needed, to the Ordinance, which governs Commission operations.
J. Making amendments or revisions to the Bylaws consistent with the Ordinance and/or to reflect current and future goals, requirements and/or objectives.
K. Recommending, developing, and implementing Commission policies and procedures and maintenance of the Commission's Policy/Procedure Manual.
L. Advocating public policy issues at every level of government that impact Commission efforts to implement a continuum of HIV services or a service delivery system for Los Angeles County, consistent with the comprehensive HIV plan.
M. Initiating policy initiatives that advance HIV care, treatment and prevention services and related interests.
N. Providing education and access to public policy arenas for the Commission members, consumers, providers, and the public.
O. Facilitating communication between government and legislative officials and the Commission.
P. Recommending policy positions on governmental, administrative, and legislative action to the Commission, the BOS, other County departments, and other stakeholder constituencies, as appropriate.
Q. Advocating specific public policy matters to the BOS, County departments, interests and bodies, and other stakeholder constituencies, as appropriate.
R. Researching and implementing public policy activities in accordance with the

County's adopted legislative agendas.

S. Advancing specific Commission initiatives related to its work into the public policy arena; and

T. Carrying out other duties and responsibilities, as assigned by the Commission or the BOS.U. Addressing matters related to Commission office staffing, personnel, and operations, when needed.

V. Developing and adopting the Commission's annual operational budget.

W. Overseeing and monitoring Commission expenditures and fiscal activities.

X. Carrying out other duties and responsibilities, as assigned by the BOS or the Commission.

Section 4. At-Large Member Duties. As reflected in *Executive Committee At-Large Members Duty Statement*, the At-Large members shall serve as members of both the Executive and Membership and Community Engagement Committees.

XI. MEMBERSHIP AND COMMUNITY ENGAGEMENT COMMITTEE:

Section 1. Voting Membership. The voting membership of the Membership and Community Engagement Committee shall be comprised of the Executive Committee At-Large members; representatives from the Cities of Los Angeles, Pasadena, Long Beach, and West Hollywood; representative from the youth community; academics/behavioral scientists; members assigned by the Commission Co-Chairs; and the Commission Co-Chairs when attending.

Section 2. Responsibilities. The Membership and Community Engagement Committee is charged with the following responsibilities:

A. Ensuring that the Commission membership adheres to RWHAP reflective-ness and representation and CDC PIR requirements (*detailed in Article II, Sections 5, 6 and 7*), and all other membership composition requirements.

B. Recruiting, screening, scoring, and evaluating applications for Commission membership and recommending nominations to the Commission in Accordance with the Commission's established Open Nominations Process.

C. Developing, conducting, and overseeing ongoing, comprehensive training for the members of the Commission and public to educate them on matters and topics related to the Commission, HIV service delivery, skills building, leadership development, and providing opportunities for personal/professional growth.

D. Conducting regular orientation meetings for new Commission members and interested members of the public to acquaint them with the Commission's role, processes, and functions.

E. Developing and revising, as necessary, Commission member duty statements

(job descriptions).

F. Recommending and nominating, as appropriate, candidates for committee, task force, and other work group membership to the Commission.

G. Coordinating ongoing community outreach, public awareness and information referral activities in cross-collaboration with other committees and subordinate working units to educate and engage the public about the Commission and promote the availability of HIV services.

H. Working with local stakeholders to ensure their representation and involvement in the Commission and in its activities.

I. Identifying, accessing, and expanding other financial resources to support the Commission's special initiatives and ongoing operational needs.

J. Carrying out other duties and responsibilities, as assigned by the Commission or the BOS.

XII. PLANNING, PRIORITIES AND ALLOCATIONS (PP&A) COMMITTEE:

Section 1. Voting Membership. The voting membership of the PP&A Committee shall be comprised of members assigned by the Commission Co-Chairs, Committee-Only members nominated by the committee, and the Commission Co-Chairs when attending.

Section 2. Responsibilities. The PP&A Committee is charged with the following responsibilities:

A. Conducting continuous, ongoing needs assessment activities and related collection and review as the basis for decision-making, including gathering expressed need data from consumers on a regular basis, and reporting regularly to the Commission on consumer and service needs, gaps, and priorities.

B. Overseeing development and updating of the comprehensive HIV plan and monitoring implementation of the plan.

C. Recommending to the Commission annual priority rankings among service categories and types of activities and determining resource allocations for Part A, Part B, prevention, and other HIV-related funding.

D. Ensuring that the priorities and implementation efforts are consistent with needs, the continuum of HIV services, and the service delivery system.

E. Monitoring the use of funds to ensure they are consistent with the Commission's allocations.

F. Recommending revised allocations for Commission approval, as necessary.

G. Coordinating planning, funding, and service delivery to ensure funds are used to fill gaps and do not duplicate services provided by other funding sources and/or health care delivery systems.

H. Developing strategies to identify, document, and address "unmet need" and to identify people living with HIV who are unaware of their status, make HIV testing available, and bring them into care.

I. Collaborating with DHSP to ensure the effective integration and implementation of the continuum of HIV services.

J. Reviewing monthly fiscal reporting data for HIV and STD expenditures by funding source, service category, service utilization and/or type of activity.

K. Monitoring, reporting, and making recommendations about unspent funds.

L. Identifying, accessing, and expanding other financial resources to meet Los Angeles County's HIV service needs.

M. Carrying out other duties and responsibilities, as assigned by the Commission or the BOS.

XII. STANDARDS AND BEST PRACTICES (SBP) COMMITTEE:

Section 1. Voting Membership. The voting membership of the SBP Committee shall be comprised of members assigned by the Commission Co-Chairs; Committee-Only members as nominated by the committee; a representative from local Part F organization; and the Commission Co-Chairs when attending.

Section 2. Responsibilities. The SBP Committee is charged with the following responsibilities:

A. Working with DHSP and other bodies to develop and implement a quality management plan and its subsequent operationalization.

B. Identifying, reviewing, developing, disseminating, and evaluating service standards for HIV and STD services.

C. Reducing the transmission of HIV and other STDs, improving health outcomes, and optimizing quality of life and self-sufficiency for all people infected by HIV and their caregivers and families through the adoption and implementation of "best practices".

D. Recommending service system and delivery improvements to DHSP to ensure that the needs of people at risk for or living with HIV and/or other STDs are adequately met.

E. Developing and defining directives for implementation of services and service models.

F. Evaluating and designing systems to ensure that other service systems are sufficiently accessed.

G. Identifying and recommending solutions for service gaps.

H. Ensuring that the basic level of care and prevention services throughout Los

Angeles County is consistent in both comprehensiveness and quality through the development, implementation, and use of outcome measures.

I. Reviewing aggregate service utilization, delivery, and/or quality management information from DHSP, as appropriate.

J. Evaluating and assessing service effectiveness of HIV and STD service delivery in Los Angeles County, with particular attention to, among other factors, outcome evaluation, cost effectiveness, capacity, and best practices.

K. Conducting an annual assessment of the administrative mechanism, and overseeing implementation of the resulting, adopted recommendations

L. Verifying system compliance with standards by reviewing contract and Request For Proposal (RFP) templates.

M. Carrying out other duties and responsibilities, as assigned by the Commission or the BOS.

XV. OFFICIAL COMMUNICATIONS AND REPRESENTATIONS:

Section 1. Representation/Misrepresentation. No officer or member of the Commission shall commit any act or make any statement or communication under circumstances that might reasonably give rise to an inference that they are representing the Commission, including, but not limited to communications upon Commission stationery; public acts; statements; or communications in which they are identified as a member of the Commission, except only in the following:

A. Actions or communications that are clearly within the policies of the Commission and have been authorized in advance by the Commission.

B. Actions or communications by the officers that are necessary for and/or incidental to the discharge of duties imposed upon them by these Bylaws, policies/procedures and/or resolutions/decisions of the Commission.

C. Communications addressed to other members of the Commission or to its staff, within Brown Act rules and requirements.

XVI. AMENDMENTS: The Commission shall have the power to amend or revise these Bylaws at any meeting at which a quorum is present, provided that written notice of the proposed change(s) is given at least 10 days prior to such meeting. In no event shall these Bylaws be changed in such a manner as to conflict with Chapter 29 of the Los Angeles County Code establishing the Commission and governing its activities and operations, or with CDC, RWHAP, and HRSA requirements.

NOTED AND APPROVED: _____ **EFFECTIVE DATE:** July 11, 2013

Originally Adopted: 3/15/1995 *Revision(s): 1/27/1998, 10/14/1999, 8/28/2002, 9/8/2005, 9/14/2006, 7/1/2007, 4/9/2009, 2/9/2012, 5/2/2013, 7/11/2013; 2/8/24;8/25/24; 6/26/25*

REVISION HISTORY	
COH Approval Date	**Justification/Reason for Updates**
3.15.1995	Original Adoption
1.27.1998	Standard Review
10.14.1999	Standard Review
8.28.2002	Standard Review
9.8.2005	Standard Review
9.14.2006	Standard Review
7.1.2009	Standard Review
2.9.2012	Standard Review
5.2.2013	Integration of Prevention Planning Committee & COH
7.11.2013	Integration of Prevention Planning Committee & COH
12.12.23	First review by OPS/EXEC Committees. Proposed updates include HRSA findings compliance as determined by the Bylaws Review Taskforce (BRT).
2.8.24	Review by COH.
2.12.24	Open Public Comment Period: 2/12/24-3/14/24
6.26.25	Open Public Comment Period: 6/27/25-7/27/25

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
Division of HIV and STD Programs