LOS ANGELES COUNTY
COMMISSION ON HIV

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

****CHANGE IN MEETING TIME & LOCATION****

COMMISSION ON HIV MEETING

Thursday, December 11, 2025
10:00am-1:00pm (PST)

BURTON W. CHACE PARK COMMUNITY ROOM
13650 MINDANAO WAY, MARINA DEL REY, CA 90292
MAP/DIRECTIONS – CLICK HERE

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

Register Here to Join Virtually

https://lacountyboardofsupervisors.webex.com/weblink/register/r4ef9a413aadd608e88bc4c762f70a093

Notice of Teleconferencing Sites

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

Public Comments

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

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

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

Accommodations

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

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

together.

WE CAN END HIV IN OUR COMMUNITIES ONCE & FOR ALL

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

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

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

THURSDAY, DECEMBER 11 | 10:00 AM – 1:00 PM *CHANGE IN TIME

CHANGE IN MEETING LOCATION

BURTON W. CHACE PARK COMMUNITY MEETING ROOM
13650 MINDANAO WAY, MARINA DEL REY, CALIFORNIA 90292
MAP/DIRECTIONS – CLICK HERE

****MEMBERS OF THE PUBLIC MAY PARK IN THE FREE 90+ MINUTE LOT FOR THE ENTIRE DURATION OF THE MEETING – CLICK HERE FOR PARKING MAP – REFER TO LOT WITH RED CIRCLE****

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

MEMBERS OF THE PUBLIC: TO JOIN VIRTUALLY, REGISTER HERE:
https://lacountyboardofsupervisors.webex.com/weblink/register/r4ef9a413aadd608e88bc4c762f70a093
JOIN BY PHONE: +1-213-306-3065 Access code: 2539 360 0193

AGENDA POSTED: December 8, 2025
SUPPORTING DOCUMENTATION: Supporting documentation can be obtained via the Commission on HIV Website at: http://hiv.lacounty.gov or in person. The Commission Offices are located at 510 S. Vermont Ave., 14th Floor Los Angeles, 90020. Validated parking is available at 523 Shatto Place, Los Angeles 90020. **Hard copies of materials will not be made available during meetings unless otherwise determined by staff in alignment with the County's green initiative to recycle and reduce waste.*

PUBLIC COMMENT: Public Comment is an opportunity for members of the public to comment on an agenda item, or any item of interest to the public, before or during the Commission's consideration of the item, that is within the subject matter jurisdiction of the Commission. To submit Public Comment, email your Public Comment to hivcomm@lachiv.org or submit electronically HERE. All Public Comments will be made part of the official record.
ACCOMMODATIONS: Interpretation services for the hearing impaired and translation services for languages other than English are available free of charge with at least 72 hours' notice before the meeting date. To arrange for these services, please contact the Commission Office at (213) 738-2816 or via email at HIVComm@lachiv.org.

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

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

1. ADMINISTRATIVE MATTERS

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

2. HOLDING SPACE FOR OUR COMMUNITIES – REFLECTIVE SILENCE 10:12 AM – 10:15 AM

3. PUBLIC & COMMISSIONER COMMENTS

A. Public Comment *(Opportunity for members of the public to address the Commission on items of interest that are within the jurisdiction of the Commission. For those who wish to provide public comment may do so in person, electronically HERE, or by emailing hivcomm@lachiv.org. If providing oral public comments, comments may not exceed 2 minutes per person.)* 10:15 AM – 10:20 AM

B. Commissioner Comment *(Opportunity for Commission members to address the Commission on items of interest that are within the jurisdiction of the Commission. Comments may not exceed 2 minutes per member.)* 10:20 AM – 10:25 AM

4. COMPREHENSIVE EFFECTIVENESS REVIEW & RESTRUCTURING PROJECT 10:15 AM – 11:00 AM

A. Overview Refresher
B. Proposed Revised Bylaws of the Los Angeles County Commission on HIV | **MOTION #4**
C. Proposed Revisions to Ordinance 3.29 | **MOTION #5**
D. Next Steps

5. ADMINISTRATIVE REPORTS – I 11:00 AM – 11:30 AM

A. COH Staff Report 11:30 AM – 11:35 AM
(1) 2025 BOS Annual Report Preparation
(2) Sunset Review Request for FY 2022/3-2025/6
(3) Funding Cuts Impact on DHS Positive Care Program for PWH Clients

B. COH Co-Chair Report 11:35 AM – 11:45 AM
(1) Code of Conduct Reminder
(2) November 13, 2025, Annual Conference Feedback
(3) Subordinate Working Group Leadership Call Follow Up
(4) December 18, 2025 Executive Committee Meeting
(5) 2026 Meeting Schedule

(6) Conferences, Meetings & Trainings (*Opportunity for members to share information and resources material to the COH's core functions, with the goal of advancing the Commission's mission*)

C. Division of HIV/STD Programs (DHSP) (RWP Grantee/Part A Rep) Report 11:45 AM – 12:00 PM

(1) Ryan White Program Funding & Services Update
(2) CDC HIV Prevention Funding & Services Update
(3) EHE Program and Funding Update
(4) Other Updates

6. <u>COMMUNITY PARTNER/REPRESENTATIVE REPORTS – I</u> 12:00 PM – 12:30 PM

D. California Office of AIDS (OA) Report (Part B Representative) 12:30 PM – 12:10 PM

(1) California Planning Group (CPG) Updates
(2) California Integrated HIV Plan Updates

E. Housing Opportunities for People Living with AIDS (HOPWA) Report 12:10 PM – 12:15 PM

F. Ryan White Program (RWP) Parts C, D, and F Report 12:15 PM – 12:20 PM

G. Cities, Health Districts, Service Planning Area (SPA) Report 12:20 PM – 12:25 AM

7. <u>STANDING COMMITTEE REPORTS – I</u> 12:25 PM – 12:45 PM

(Updates from committees, caucuses, and task forces are summarized in the Key Takeaways document included in the meeting packet. Attendees are encouraged to review the document for the latest highlights, action items, and key developments across the Commission's working bodies.)

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

(1) Program Year 36 (PY36) Ryan White Program (RWP) Reallocation – Contingency Planning
(2) PY35 - PY37 Directives Review

B. Operations Committee

(1) Membership Materials Review & Updates
(2) Attendance Review Updates

C. Standards and Best Practices (SBP) Committee

(1) Patient Support Services (PSS) Service Standards | **MOTION #6**
(2) Mental Health Service Standards | Public Comments Due January 6, 2026
(2) Service Standards Schedule

D. Public Policy Committee (PPC)

(1) County, State and Federal Policy & Budget Updates
(2) 2025 Policy Priorities Updates
(3) 2025 Legislative Docket Updates
(4) Transition Activities in Anticipation of Restructure

E. Caucus, Task Force, and Work Group Reports

(1) Aging Caucus
(2) Black Caucus
(3) Consumer Caucus
(4) Transgender Caucus
(5) Women's Caucus
(6) Housing Taskforce

8. MISCELLANEOUS

A. Public Comment 12:45 PM – 12:50 PM

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

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

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

C. Announcements 12:55 PM – 1:00 PM

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

D. Adjournment and Roll Call 1:00 PM

Adjournment of the regular December 11, 2025, Commission meeting.

PROPOSED MOTION(S)/ACTION(S)	
MOTION #1	Approve meeting agenda, as presented or revised.
MOTION #2	Approve meeting minutes, as presented or revised.
MOTION #3	Approve Consent Calendar, as presented or revised.
CONSENT CALENDAR	
MOTION #4	Approve the proposed revisions to the Bylaws of the Los Angeles County Commission on HIV, as presented or revised.
MOTION #5	Approve the proposed revisions to Ordinance 3.29, as presented or revised, and elevate to the Board of Supervisors for review and approval.
MOTION #6	Approve the Patient Support Services standard as presented or revised and forward to DHSP for implementation.

LOS ANGELES COUNTY COMMISSION ON HIV

COMMISSION ON HIV MEMBERS			
Danielle Campbell, PhD, MPH, Co-Chair	*Joseph Green, Co-Chair*	Dahlia Alé-Ferlito	Miguel Alvarez
Jayda Arrington	Al Ballesteros, MBA	LeRoy Blea	Alasdair Burton
Mikhaela Cielo, MD	Sandra Cuevas	Mary Cummings (LOA)	Erika Davies
Kevin Donnelly	Arlene Frames	Arburtha Franklin	Rev. Gerald Green (**Alternate) (LOA)
Felipe Gonzalez	Joaquin Gutierrez (**Alternate)	David Hardy, MD	Ismael Herrera
Terrance Jones	William King, MD, JD, AAHIVS	Lee Kochems, MA	Leonardo Martinez-Real
Leon Maultsby, MHA, DBH	Vilma Mendoza	Jeremy Mitchell aka Jet Findley (LOA)	Paul Nash, CPsychol, AFBPsS FHEA
Katja Nelson, MPP	Byron Patel, RN	Mario J. Pérez, MPH	Dechelle Richardson (LOA)
Daryl Russell	Ismael Salamanca	Sabel Samone-Loreca (**Alternate)	Harold Glenn San Agustin, MD
Martin Sattah, MD	DeeAna Saunders	LaShonda Spencer, MD	Lambert Talley (*Alternate)
Carlos Vega-Matos (**Alternate)	Jonathan Weedman		
		MEMBERS:	**35**
		QUORUM:	**18**

LEGEND:

LoA = Leave of Absence; not counted towards quorum

Alternate*= Occupies Alternate seat adjacent a vacancy; counted toward quorum

Alternate**= Occupies Alternate seat adjacent a filled primary seat; counted towards quorum in the absence of the primary seat member

LOS ANGELES COUNTY
COMMISSION ON HIV

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

VISION

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

MISSION

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

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Approved by COH 6/8/23

CODE OF CONDUCT

APPROVED BY OPERATIONS COMMITTEE ON 05/25/23; COH 06/08/23
Approved (11/12/1998); Revised (2/10/2005; 9/6/2005); **Revised (4/11/19; 3/3/22, 3/23/23; 5/30/23)**

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.)

OVERVIEW OF THE COUNTYWIDE LAND ACKNOWLEDGMENT

AS ADOPTED BY THE BOARD OF SUPERVISORS ON NOVEMBER 1, 2022 AND UPDATED NOVEMBER 4, 2025

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

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

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

WHAT IS A LAND ACKNOWLEDGMENT?

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

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

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

HOW WAS THE COUNTYWIDE LAND ACKNOWLEDGMENT DEVELOPED?

JUNE 23, 2020

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

JULY 13, 2021

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

OCTOBER 5, 2021

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

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

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

NOVEMBER 2021 – MARCH 2022

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

MARCH 30 – SEPTEMBER 30, 2022

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

OCTOBER 18, 2022

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

NOVEMBER 1, 2022

The Board adopts the Countywide Land Acknowledgment.

DECEMBER 1, 2022

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

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

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

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.

LOS ANGELES COUNTY COMMISSION ON HIV

PARLIAMETARY PROCEDURES – QUICK GUIDE

BASED ON ROBERTS RULES OF ORDER (2025)

1. QUORUM

A quorum is the minimum number of members who must be present to conduct official business. No motions or votes can occur without a quorum. The Commission's quorum is 20 members (as stated on the agenda and subject to change). If quorum is lost during the meeting, only informational updates or discussion may continue—no actions or votes can be taken until quorum is reestablished.

2. MAKING A MOTION

Members propose action by saying, "I move that…". Requires a second before discussion. Only one motion on the floor at a time.

3. SPEAKING & DISCUSSION

Raise your hand and wait to be recognized. Stay on topic; avoid side conversations. Speak once before speaking again.

4. VOTING (ROLL CALL)

The Co-Chair will call for a roll call vote for all motions requiring Commission action. Each member responds "Yes," "No," or "Abstain" when their name is called. Results are recorded in the official minutes, and abstentions are noted when stated aloud.

5. AMENDING

Say, "I move to amend the motion by…". Requires a second, then vote on the amendment first.

6. POINT OF ORDER

Used to address a procedural error or breach in decorum. Co-Chair pauses to rule or clarify.

7. POINT OF CLARIFICATION (PROPERLY: POINT OF INFORMATION)

Ask factual questions during discussion. Say, "Point of Information," and wait to be recognized.

8. TABLING / POSTPONING

To delay an item: "I move to table…" or "…postpone until [date]."

9. DECORUM & RESPECT

Speak through the Co-Chair. Be concise and kind. Uphold the Code of Conduct—respect, integrity, and collaboration.

10. QUICK TIP

When in doubt—ask! Co-Chairs and staff are here to help keep meetings inclusive and on track.

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 12.8.25

SEAT NO.	MEMBERSHIP SEAT	Commissioners Seated	Committee Assignment	COMMISSIONER	AFFILIATION (IF ANY)	TERM BEGIN	TERM ENDS	ALTERNATE
1	Medi-Cal representative			***Vacant***		July 1, 2023	June 30, 2025	
2	City of Pasadena representative	1	EXC|SBP	Erika Davies	City of Pasadena Department of Public Health	July 1, 2024	June 30, 2026	
3	City of Long Beach representative	1	PP&A	Ismael Salamanca	Long Beach Health & Human Services	July 1, 2023	June 30, 2025	
4	City of Los Angeles representative	1	SBP	Dahlia Ale-Ferlito	AIDS Coordinator's Office, City of Los Angeles	July 1, 2024	June 30, 2026	
5	City of West Hollywood representative	1	PP&A	Dee Saunders	City of West Hollywood	July 1, 2023	June 30, 2025	
6	Director, DHSP **Non Voting*	1	EXC	Mario Pérez, MPH	DHSP, LA County Department of Public Health	July 1, 2024	June 30, 2026	
7	Part B representative	1		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	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	SBP	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	*Unaffiliated representative*	July 1, 2023	June 30, 2025	Joaquin Gutierrez (OPS)
22	Unaffiliated representative, SPA 4	1	PP	Jeremy Mitchell (aka Jet Finley) ***(LOA)***	*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	everend Gerald Green (PP&A) ***(LOA)***
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	PP&A	Jonathan Weedman	ViaCare Community Health	July 1, 2024	June 30, 2026	
41	Representative, HOPWA			***Vacant***		July 1, 2023	June 30, 2025	
42	Behavioral/social scientist	1	EXC|PP	Lee Kochems, MA	*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 (LOA)	Bartz-Altadonna Community Health Center	July 1, 2024	June 30, 2026	
49	HIV stakeholder representative #6	1	EXC|OPS	Dechelle Richardson ***(LOA)***	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

Division of HIV and STDs Contracted Community Services

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

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

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

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

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 9/2/25

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
FERGUSON	**Kerry**	No Affiliation	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
YBARRA	**Russell**	Capitol Drugs	No Ryan White or prevention contracts

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: December 8, 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= 7**		
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 *(LOA)*	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= 4**		
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	*	Commissioner
Leon Maultsby, DBH, MHA	*	Commissioner
Dèchelle Richardson *(LOA)*	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= 14| 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
Jonathan Weedman	*	Commissioner
Michael Green, PhD	DHSP staff	DHSP

PUBLIC POLICY (PP) COMMITTEE		
Regular meeting day: 1st Monday of the Month **Regular meeting time: 1:00-3:00 PM** **Number of Voting Members= 8 | Number of Quorum= 4**		
COMMITTEE MEMBER	**MEMBER CATEGORY**	**AFFILIATION**
Arburtha Franklin	**Committee Co-Chair***	Commissioner
Katja Nelson, MPP	**Committee Co-Chair***	Commissioner
Mary Cummings *(LOA)*	*	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 = 11 | 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
David Hardy, MD	*	Commissioner
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

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

COMMISSION ON HIV (COH)

November 13, 2025 MEETING
MINUTES

ST. ANNE'S CONFERENCE & EVENT CENTER
FOUNDATION ROOM
155 N. Occidental Blvd, Los Angeles, CA 90026
CLICK HERE FOR MEETING PACKET

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

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

1. ADMINISTRATIVE MATTERS

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

- The meeting was called to order at 9:20 AM with greetings from the LA County Commission on HIV (COH) Co-chairs.
- Commission Co-chairs Danielle Campbell and Joe Green expressed gratitude to staff, partners, and community members whose contributions make the Commission's work possible.
- The 2025 Annual Conference theme: Resilience in Uncertain Times: Advancing HIV Science, Policy, and Community Together.

ROLL CALL (PRESENT): D. Ale-Ferlito, M. Alvarez, J. Arrington (online), L. Blea, A. Burton, M. Cielo, S, Cuevas, K. Donnelly, A. Franklin, F. Gonzalez, J. Gutierrez, I. Herrera, T. Jones, W. King, L. Kochems, L. Martinez-Real, L. Maultsby, V. Mendoza, K. Nelson, B. Patel, M. Perez, D. Russell, I. Salamanca, H. San Agustin, M. Sattah, L. Spencer, L. Talley, J. Weedman (online), D. Campbell, and J. Green.

B. APPROVAL OF AGENDA

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

C. COUNTY LAND ACKNOWLEDGEMENT

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

2. OPENING REMARKS – DR. MARISA RAMOS, STATE OFFICE OF AIDS, CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

Dr. Ramos thanked attendees for participating in the Commission on HIV's 2025 Annual Conference and acknowledged the extensive work being done by thousands of people to address HIV and STIs. Dr. Ramos emphasized the need for integrated efforts, continued progress, and attention to equity, especially for Black communities and other people of color. Dr. Ramos underlined the importance of coming together at meetings like this to address ongoing challenges. Key sessions focusing on reimagining the Commission's work, improving community engagement, advancing science and implementation, and protecting policy gains were outlined. The conference was described as an opportunity to share experiences, strategies, and resources to move forward collectively. Dr. Ramos closed with appreciation for everyone's continued commitment and work.

3. REIMAGINING THE COMMISSION: A NEW ERA OF IMPACT

AJ King from Next Level Consulting was introduced to lead the upcoming presentation on these efforts.

Background

- Over the past year, the Commission has been engaged in a major reimagining and restructuring process (not mandated by the Board of Supervisors but initiated internally).
- Goals: strengthen Commission structure, elevate community voices, and improve effectiveness as an integrated HIV prevention and care planning body.

Rationale for Restructuring

- The Commission's long-standing work is acknowledged, but several issues prompted change:
  - 51-member size makes quorum and decision-making difficult.
  - Too many meetings with limited outcomes; lack of nimbleness.
  - Concerns about member capacity, expertise, and ability to address the broader HIV syndemic (HIV, STIs, HCV, and social determinants).
  - Shifts in the HIV landscape and political environment.
- Conclusion: The current composition is unsustainable and must evolve.

Restructure Objectives

- Identify a structure with maximum impact and efficiency.

- Create a composition best suited to current and emerging needs of the HIV epidemic.

Proposed Structural Changes

- Reduce commissioners from 51 to 33.
- Shift from monthly meetings to every other month, with extra meetings added only as needed (approximately 50% reduction).

Committee Structure

- Four standing committees:
  1. Executive
  2. Membership & Community Engagement (new focus, absorbs Public Policy)
  3. Planning, Priorities & Allocations
  4. Standards & Best Practices
- Public Policy Committee will be dissolved, with functions moved under Membership & Community Engagement.
- Emphasis on strengthening prevention efforts and aligning with the California Planning Group.

Timeline for Implementation

- Next month: Commission votes on new bylaws/structure.
- Following day**:** Applications open for all seats (current commissioners must reapply).
  - Application window: Dec 12 – Jan 9
- January–February:
  - Interview panel reviews applicants, nominates cohorts.
  - Recommendations proceed to Executive Committee, full Commission, then Board of Supervisors.
- New Commission expected to be seated March 12, 2026.

Additional Notes & Q&A Highlights

- Caucus and workgroup reporting will shift to the Membership & Community Engagement Committee; details still being finalized.
- Physical and online applications will be offered; outreach strategy is still in development.
- Commissioners noted the importance of messaging around efficiency and ensuring the right representation at the table.
- Staff acknowledged the need to streamline numerous meetings and workgroups.
- Appreciation expressed for commissioners and community members who participated in difficult but necessary restructuring discussions.
- Recognition that change is challenging but essential to meeting the goals of the Commission.
- Thanks were extended to staff and the Executive Committee for supporting the process.

5. STATE OF HIV AND STIs IN LOS ANGELES COUNTY

Presenter: Mario J. Perez, Director, Division of HIV & STD Programs (DHSP)

Summary of Key Updates and Discussion

1. Opening Remarks

Mr. Perez thanked the Commission for the invitation and emphasized the importance of partnership, compassion, and collaboration across agencies and community stakeholders. He acknowledged statewide and local partners present at the meeting.

2. Federal Funding Updates

Mr. Perez provided an overview of forthcoming federal funding cycles and emphasized the impact of national budget negotiations on local HIV/STI programming:

- Ryan White Part A – New grant year begins March 1; funding level dependent on federal appropriations.
- Ryan White Part B – State allocations expected in April.
- CDC HIV Prevention & Surveillance Cooperative Agreement: New grant begins June 1; federal budget decisions may significantly affect funding levels.
- DHSP is preparing operational budgets based on an estimated $32 million funding scenario (previously ~$50 million).

3. HIV Trends

- New HIV diagnoses have remained flat, despite an estimated 5,000–6,000 undiagnosed individuals in the county.
- The Commission was reminded that diagnoses may temporarily rise with improved case-finding among the undiagnosed population.
- Racial and gender disparities persist, including rising HIV infections among African American women, requiring targeted program enhancements.
- Declines noted among young gay/bisexual men of color, reflecting successful targeted interventions.
- Continued focus on high-burden geographic areas.

4. STI Trends

Improvements

- Chlamydia: Approximately 16% reduction.
- Gonorrhea: Continued multi-year decline.
- Primary & Secondary Syphilis: Local declines outpacing national trends.

- Congenital Syphilis: Cases decreased from 150+ to approximately 120, though still significantly elevated compared to prior years.

Drivers of Progress

- Expansion of emergency department screening for pregnant individuals.
- Strengthened diagnosis, treatment access, and penicillin distribution.
- Enhanced provider education and contact tracing.
- Uptake of Doxy-PEP, though its direct impact on overall morbidity remains under evaluation.

5. Mpox Update

- Vaccination uptake remains low, including among people living with HIV.
- The expected 2024 summer surge did not occur, likely due to increased prevention efforts.
- The county continues to monitor Clade II, the dominant strain in circulation.
- Recent identification of three local Clade I cases; all recovered. Ongoing contact tracing continues, with no new recent cases reported.

6. Federal Legislative Risks

Mr. Perez outlined substantial proposed cuts in the U.S. House budget bill affecting HIV/STI programs, including potential eliminations or reductions to:

- CDC High Impact HIV Prevention
- STD Prevention funding
- National HIV Behavioral Surveillance
- Minority AIDS Initiative
- Ryan White Part C (local clinics, approximately $5.7 million)
- Ryan White Part D (USC/UCLA/AltaMed, approximately $1.6 million)
- Oral health and family planning (Title X) programs

M. Perez emphasized that these cuts would significantly weaken the county's HIV/STI response infrastructure.

7. ADAP Rebate Fund

- Approximately $900 million has been previously borrowed from the ADAP rebate fund.
- DHSP is advocating for greater state flexibility in the use of rebate funds to stabilize services during federal delays or budget shortfalls.
- Proposed shift toward multi-year planning (3-year cycles) to better navigate fiscal uncertainty.

8. Workforce Adjustments and Operational Planning

- DHSP is implementing workforce reductions and cost-containment strategies to align with anticipated funding levels.
- Ongoing engagement with funded sectors—prevention, housing, oral health, nutrition.
- The county's housing department reported a projected $303 million deficit for FY 2026, which could affect housing services for people living with HIV.

9. Priority-Setting Framework

Mr. Perez referenced guidance from Dr. Matt Golden (Seattle/King County) to inform decisions under resource constraints. Critical priorities include:

1. Maintaining viral suppression for people living with HIV.
2. Preventing congenital syphilis.
3. Preserving surveillance capacity.
4. Strengthening linkage to care.
5. Supporting drug user health initiatives.
6. Treating symptomatic STIs.
7. Increasing the healthcare system's role in HIV/STI control.
8. High-yield syphilis case finding.
9. Maintaining cost-effective HIV testing, focusing on settings with highest yield.

10. HIV Testing Efficiency

- Nationally, approximately 22% of new HIV diagnoses are identified through federally funded testing programs.
- Cost-per-diagnosis varies widely by setting; community-based organizations often demonstrate higher cost efficiency than primary care systems.
- DHSP will share local cost-effectiveness analyses with providers ahead of future planning sessions.

6. PANEL DISCUSSION #1 | SCIENCE IN ACTION, RESEARCH FOR CHANGE: ADVANCING GLOBAL AND LOCAL EFFORTS TO END HIV

Moderator: Danielle M. Campbell, PhD, MPH, COH Co-Chair
Judith S. Currier, MD, Professor of Medicine, Executive Vice Chair for Research, Department of Medicine
Sue and Michael Steinberg Chair in Global AIDS Research, Chair, AIDS Clinical Trials Group
Rhodri Dierst-Davies, PhD, MPH, Director, CA HIV/AIDS Research Program (CHRP)
William D. King, JD, MD, AAHIVS, W. King Health Care Group
Leon Maultsby, DBH, MHA, Executive Director, In the Meantime Men's Group Executive

1. Emerging Scientific Innovations

Long-acting therapies were consistently highlighted as the most promising breakthrough:

- Injectable PrEP and treatment options (e.g., annualized injectable prevention, long-acting ART) have the potential to reduce new infections and improve adherence.
- Advances in immunotherapy and cure research continue to progress.
- Panelists stressed that despite major scientific promise, progress is threatened by instability in federal funding and growing policy hostility toward HIV research and marginalized populations.

2. Implementation and Access Challenges

Panelists reiterated that innovation is only effective if it reaches communities who need it:

- Insurance barriers remain a central obstacle; long-acting medications are frequently denied due to cost.
- Primary care providers, not only HIV specialists, must be trained and supported to prescribe PrEP, manage long-acting regimens and discuss sexual health confidently.
- Many communities, particularly Black, Latino, Transgender, and rural populations, remain underserved.
- Clinics face operational barriers such as storage, staffing, and billing capacity.

3. The Importance of Trust, Representation, and Community Engagement

Panelists emphasized:

- Consistent presence of providers and researchers in community spaces builds trust.
- Representation matters: more Black and Latino clinicians and culturally competent providers are needed.
- Providers must create safe, nonjudgmental environments where patients can disclose sexual health needs.
- Research must include meaningful community voice, not just surveys but ongoing dialogue and shared leadership.

4. Ethical and Equity-Focused Research Practice

Dr. Currier underscored:

- Community participation is essential in shaping ethical, equitable research.
- Data collection on marginalized groups (e.g., transgender individuals) must continue despite political pushback.
- Integration of public health, primary care, and research systems is necessary for impact.

5. CHRP's Role and State-Level Leadership

Dr. Dierst-Davies outlined how CHRP, the only state-funded HIV research program in the U.S., is:

- Shielded from current federal cuts.
- Expanding investments in equity-focused research, including:
    - studies on racism's impact on HIV outcomes,
    - transgender health and HIV prevention,
    - mental health interventions such as ketamine-assisted therapy,
    - community-academic research partnerships (with equal funding to CBOs).
- Advocating for increased state investment and more responsive, innovative research infrastructures (e.g., Senate Bill 607).

6. Calls to Action

Across the discussion, panelists urged:

- Strengthening primary care capacity and integrating HIV innovation into routine health systems.
- Improving insurance policies and educating medical directors.
- Continued activism against political attacks on gender-affirming care, HIV services, and DEI initiatives.
- Supporting community-based research sites with sustainable funding and infrastructure.
- Ensuring Black, Latino, and LGBTQ+ communities are centered in research design and dissemination.

7. Audience Remarks

Audience members emphasized:

- The need for stronger inclusion of Latino communities in science, research, and policy leadership.
- The importance of building safe, culturally grounded pathways into research for communities historically excluded.
- Interest in emerging genetic-engineering approaches (e.g., CRISPR-based HIV cure strategies).

7. <u>ART EXHIBITION & GIVEAWAY</u>

Presenter: Dr. Sonja Wright, Commission on HIV Staff

Dr. Sonja Wright welcomed attendees and introduced a special conference activity connected to the Art Legacy Exhibition. Dr. Wright explained that the exhibition honors artwork created by artists living with HIV, originally commissioned and gifted to the Commission more than 20 years ago. These pieces have historically been displayed in Commission offices as reminders of community resilience, creativity, and lived experience. As part of the Commission's ongoing transition and reimagining process, selected pieces will be gifted to new homes throughout Los Angeles County.

Activity Components

The art giveaway consisted of three interactive components scheduled throughout the day:

1. **Hidden Surprise Stickers:**
   - Attendees were asked to check under their chairs for colorful Post-it notes.
   - Individuals who found them were invited to the front and introduced themselves before selecting an artwork.
2. **Commission Trivia Game:**
   - Dr. Wright announced a 10-question trivia challenge focused on Commission history, structure, and mission.
   - Participants wrote answers at their tables; the first three with correct responses received an art piece.
   - Only one artwork could be awarded per participant.
3. **Raffle Drawings:**
   - Additional art pieces were to be distributed via raffle later in the conference.

Purpose of the Activity

Dr. Wright explained that the activity was designed to:

- Celebrate the Commission's history and artistic legacy.
- Encourage learning about the Commission's work.
- Promote engagement, fun, and community connection.

- Honor the contributions of artists and advocates living with HIV.

Trivia Questions Covered

Topics included:

- Year of Commission integration with the CDC HIV Prevention Planning Committee
- Current number of commissioners
- Federal programs supported by the Commission
- Commission mission
- Departmental partnerships
- Committee structure
- Administrative mechanism assessment
- 2025 annual conference theme
- Appointment process for commissioners

Outcome

Three winners were selected based on correct trivia responses, and staff continued distributing prizes. Individuals with hidden surprise stickers were directed to staff, Jose Rangel-Garibay, for artwork selection. The session concluded smoothly, and the next agenda item proceeded.

8.PANEL DISCUSSION #2: POLICY & LEGISLATION: SAFEGUARDING HIV PROGRAMS AMID CENSORSHIP AND FUNDING THREATS

Moderator: Commissioner Arburtha Franklin, Public Policy Committee Co-Chair
Bee Curiel, MSW, Manager of Policy & Training Innovations, TransLatin@ Coalition
Darryn Harris, Chief Government Affairs & Community Relations Officer, St. John's Community Health Center
Katja Nelson, MPP, Local Affairs Specialist, Government Affairs Division, APLA Health

Key Action Items & Recommendations

1. Strengthen Advocacy at All Government Levels

- Increase outreach to federal, state, and local elected officials to protect HIV prevention and care funding.
- Mobilize constituents to make regular contacts with legislators; encourage calls, emails, and district-level engagement.
- Support multi-state coalition efforts to influence federal districts with high decision-making impact.

2. Prepare for and Mitigate Funding Cuts

- Develop contingency plans for service continuity in the event of federal or state budget reductions.
- Explore alternative funding streams, including:
  - Local revenue measures or ballot initiatives,
  - Philanthropic funding,
  - Flexible use of state ADAP rebate funds (pending state approval).
- Document service impacts and share data with policymakers to demonstrate need.

3. Maintain Equity Work Despite DEI Restrictions

- Continue core DEI work using alternative approved language (e.g., "priority populations," "cultural responsiveness").
- Ensure internal communication with patients remains clear, culturally competent, and consistent.

- Encourage larger institutions to publicly support equity efforts when smaller organizations face heightened scrutiny.

4. Enhance Community Communication and Engagement

- Leverage trusted messengers, including promotorx, peer navigators, and community partners, to ensure accurate information reaches vulnerable populations.
- Strengthen partnerships with grassroots organizations, particularly those serving transgender, immigrant, and Black communities.
- Provide transparent updates to patients and stakeholders during shifting policy conditions.

5. Protect Access to Gender-Affirming Care

- Integrate gender-affirming care into HIV prevention and treatment messaging.
- Advocate for the preservation of state and local funding streams that support gender-affirming services.
- Continue legal and administrative challenges when restrictions target LGBTQ+ or transgender care.

6. Improve Cross-Sector Collaboration

- Maintain and expand rapid-response coalitions to address emerging threats to funding or services.
- Foster increased collaboration between clinics, CBOs, health departments, and advocacy organizations.
- Share data, talking points, and mobilization strategies across the network to align messaging.

7. Strengthen Organizational Capacity for Policy Action

- Support development of C4 or similar advocacy-focused arms within organizations to legally engage in political work.
- Provide training for staff on policy literacy, communication strategies, and community mobilization.
- Build internal systems to identify and respond quickly to harmful legislation or administrative actions.

8. Center Community Voices and Lived Experience

- Prioritize storytelling in advocacy campaigns, as personal narratives are more influential than fiscal arguments in the current climate.
- Create structured opportunities for community members to testify, submit letters, and participate in advocacy days.
- Ensure planning processes include voices of transgender, immigrant, youth, and Black communities most affected by disruptions.

9.) MINI-LUNCH PRESENTATION: CULTURAL HUMILITY| PRESENTED BY MICHAEL BARAJAS, SENIOR COMMUNITY LIAISON, GILEAD SCIENCES

Overview

Michael Barajas provided a presentation on cultural humility, its relevance to HIV care, and its broader applicability across all healthcare settings. He emphasized the ongoing need to address structural inequities, social determinants of health, and medical mistrust to improve outcomes, particularly for marginalized communities.

Key Points

1. Importance of Cultural Humility

- Cultural humility is essential to achieving the National HIV/AIDS Strategy's health equity goals (2022–2025).
- It requires lifelong learning, self-reflection, and adaptation to changing language and evolving identities.
- Participants were encouraged to "lean into discomfort" during discussions of trauma and inequities.

2. Gaps in HIV Care

Participants identified barriers including:

- Stigma
- Medical mistrust
- Racism and discrimination
- Transphobia
- Financial instability and insurance barriers
- Substance use
- Cultural norms/conventionalism
- Lack of local services and transportation barriers

These factors interact with broader social determinants of health, impacting an individual's ability to access and remain in care.

3. Status-Neutral HIV Care Framework

- Care systems must respond with equal urgency regardless of HIV status.
- People testing negative should be offered PrEP; people testing positive should be linked immediately to HIV treatment.

4. Disparities Affecting Transgender Communities

National data presented included:

- 67% of transgender individuals live at or below the poverty line.
- 42% have experienced housing instability.
- Approximately 42% have been diagnosed with HIV, with disproportionate impact on Black transgender women.
- Transgender individuals experience significantly higher rates of violence.
- Mistreatment can occur even within LGBTQ-friendly settings, underscoring the need for whole-staff training (security, janitorial, front desk, not just clinicians).

5. Medical Mistrust – Historical Context

M. Barajas reviewed four major examples of unethical research contributing to mistrust:

- Tuskegee Syphilis Study (1932–1972)
- Guatemala Syphilis Experiments (1946–1948)
- Havasupai Tribe Diabetes Study
- Eugenics-era sterilization abuse of marginalized women (1930–1980)

These events highlight why mistrust persists and why culturally responsive care is essential.

6. Core Concepts Defined

- Cultural Awareness: Recognizing that individuals have distinct experiences, values, and backgrounds.
- Cultural Humility: Acknowledging one's limitations in understanding others; maintaining openness and willingness to learn.
- Cultural Responsiveness: Acting on cultural understanding—for example, adapting communication, using interpreters, or adjusting care approaches to patient needs.

7. Intersectionality

M. Barajas encouraged participants to consider individuals' overlapping identities (race, gender, family values, religion, sexuality, income, ability, etc.) to better understand patient experiences and barriers.

8. Grant Opportunities

- Gilead currently has open grant funding for PrEP engagement, available through the Gilead North America Corporate Grants portal.
- Applications are accepted on a rolling basis through December 31st.

10. KEYNOTE ADDRESS: RESILIENCE THROUGH POLICY: ADVANCING EQUITY AND ACCESS THROUGH THE PrEP AND PEP ARE PREVENTION ACT (H.R.5127)

Robert Gamboa, MPP, Associate Director of Public Policy, Los Angeles LGBT Center

- **Context & Acknowledgment:** Robert opens by honoring Congresswoman Maxine Waters' statement and the dedication of HIV/AIDS service providers in LA County. He highlights the contradiction of advances in science alongside shrinking resources and systemic challenges.
- **Community Focus:** Emphasized that HIV prevention and care are not abstract, they impact real lives, particularly marginalized groups like transgender people, undocumented migrants, Black and Brown LGBTQ communities, sex workers, and people experiencing homelessness.
- **Challenges:** Funding cuts, resource constraints, and policy hostility threaten access to essential services. Efficiency without equity can harm the most vulnerable.
- **Science & Policy:** Encouraging developments include long-acting injectables, mRNA vaccine trials, and broadly neutralizing antibodies. But these innovations require strong policies like HR 5126 & HR 5127 to ensure equitable prevention access (PrEP/PEP).
- **Personal Testimony:** Robert shares his lived experience of homelessness, trauma, addiction, HIV positivity, and systemic neglect, crediting community support and the Commission with his survival and recovery.
- **Call to Action:**
  1. Uphold the oath to serve all community members.
  2. Fight for every program, funding, and policy that sustains communities.
  3. Be creative, firm, and inclusive in decision-making.
  4. Keep both prevention and treatment central.
  5. Hold county officials accountable to equity, justice, and community needs.
  6. Ensure restructuring does not silence vulnerable voices.
  7. Champion and center marginalized groups in all policies.

Closing Message: Stand resilient, collaborative, and courageous against systemic challenges. Emphasized that the Commission's foundation is resilience and must now lead with courage to protect and advance community well-being.

11. PANEL DISCUSSION #3: COMMUNITY ENGAGEMENT & ADVOCACY: STRATEGIES FOR COLLECTIVE ACTION

Moderator: Commissioner Miguel Alvarez, Operations Committee Co-Chair
Gerald Garth, MBA, Executive Director, AMAAD Institute
Kevin Pizarro, Outreach Coordinator, UCLA Health CARE Center

Shellye Jones, MSW, LCSW, Clinical Supervisor, Drew CARES
Thelma Garcia, Director of HIV Services, East Los Angeles Women's Center

The panel emphasized the critical importance of collaboration and partnerships in sustaining HIV programs. Speakers highlighted that no organization could work in isolation; success relies on strong networks across community organizations, healthcare providers, researchers, and funders. Collaboration must be strategic, authentic, and inclusive, recognizing shared vision, mutual trust, and active participation beyond transactional interactions.

Key strategies discussed included:

- Leveraging partnerships to expand services, especially during crises like COVID-19.
- Integrating HIV education across all organizational programs, training staff and community advocates (promotoras) to amplify reach.
- Prioritizing relationship building as core work, not just pre-work, ensuring sustained community engagement.
- Using person-first language and elevating participant voices to reduce stigma and empower communities.
- Diversifying funding and technological resources, seeking nontraditional partners, and innovating to maintain program sustainability.
- Centering equity and representation, uplifting women, Black, Latino, trans, and other marginalized communities.

The panel concluded with calls to action: focus on collective effort ("if all of us do something, we don't have to do everything"), ensure consistent messaging, identify missing voices, and take meaningful individual and community action, even if it seems small—like the "starfish story" analogy. The overarching message was resilience, joy, and active engagement in the face of challenges.

12. COMMISSION ON HIV: A YEAR IN REVIEW

A pre-recorded narration by Cheryl A. Barrit, MPIA, Former Executive Director, COH

1. Opening & Reflection

- A video from the 2025 LA County Commission on HIV is shared, celebrating a year of collaboration, compassion, and community-focused work.

2. Commission Achievements & Initiatives

- Focus on strengthening systems that strengthen people, including a comprehensive effectiveness review and restructuring of the Commission.
- Updates on committees:
  - Public Policy Committee: Advocacy and legislative priorities.
  - Planning, Priorities, and Allocations: Program planning and contingency strategies.
  - Standards & Best Practices: Updated service standards for medical care, housing, support, and transitional case management.

- Operations Committee: Streamlining processes, improving training, and maintaining consumer representation.

- Caucus highlights:
  - Consumer Caucus: Engagement through listening sessions and resource fairs.
  - Black Caucus: Awareness campaigns, uplifting Black and Black transgender voices.
  - Aging Caucus: Focus on long-term survivors and older adults.
  - Transgender & Women's Caucuses: Advocacy, listening sessions, and recommendations for care programs.
- Recognition of departing former commissioners Dean Page and Russell Ybarra for their contributions.
- Emphasis on partnership, resilience, and equity amidst challenging times.

13. COMMUNITY CALL TO ACTION

Facilitator: Commissioner Joaquin Guiterrez

Key Discussion Points & Action Plans:

1. **Group Discussions on HIV Awareness & Services:**
   - Unified Messaging: Agencies should collaborate on a single, consistent HIV awareness campaign across social media.
   - Letter-Writing Campaign: Some groups suggested old-school outreach via paper letters and postage to engage those without digital access.
   - Social media for Prevention: Promote preventive care and cost-effective strategies through social platforms to reach broader audiences.
   - Barriers to Access: Challenges include reaching people without phones or email, requiring creative outreach methods.
   - Community Engagement: Collaboration, trust-building, and multilingual outreach were emphasized.
   - Advocacy: Contacting policymakers, educating communities about legislation like the Labor HHS bill, and engaging elected officials.
2. **Common Themes Identified:**
   - Collaboration among agencies and community members.
   - Supporting frontline workers and fostering peer networks.
   - Listening to each other and following up on initiatives.
3. **Voting on Priorities / Call-to-Actions:**
   - Social Media Campaign: Promote HIV prevention as life-saving and cost-effective.
   - Universal Sexual Health Campaign: All agencies adopt shared messaging.
   - Strengthening Connections: Build relationships within the community and with commissioners.
   - Additional Calls: Letter-writing campaigns, policy engagement, educating on funding bills, and continued collaboration/support.

4. **Reflections:**

- Emphasis on mental health, support networks, and ongoing collaboration as a strategy to mitigate challenges.

14. PUBLIC COMMENTS & ANNOUNCEMENTS

- AIDS Monument Unveiling: November 16th, West Hollywood.
- Transgender Day of Remembrance: November 20th-21st, various locations.
- World AIDS Day: 1 Dec, faith-based events and community ceremonies.
- Commission Meeting: December 11th, Burton Chase Park; bylaws approval and recruitment launch.

Community Events:

- Carlos Sosa (City Youth Group): 23rd Annual Christmas Dinner for LGBTQIA+ homeless youth (December 7th) and Thanksgiving dinner meal deliveries. Also, a World Premiere Event: Storytelling on PrEP and DoxyPEP in LA (December 12th).

LOS ANGELES COUNTY
COMMISSION ON HIV

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

COMMISSION ON HIV (COH)

October 9, 2025 MEETING
MINUTES

JESSE OWENS REGIONAL PARK GYMNASIUM
9651 S. Western Ave., Los Angeles, CA 90047
CLICK HERE FOR MEETING PACKET

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

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

1. ADMINISTRATIVE MATTERS

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

Joe Green, Commission on HIV (COH) Co-Chair, called the meeting to order at 9:13 AM, and reviewed meeting guidelines and reminders; see packet. Staff conducted roll call.

ROLL CALL (PRESENT): D. Ale-Ferlito, M. Alvarez, J. Arrington, L. Blea, A. Burton, M. Cielo, S. Cuevas, E. Davies, K. Donnelly, K. Ferguson, A. Frames, A. Franklin, F. Gonzalez, T. Jones (online), W. King, L. Kochems (online), L. Martinez-Real, L. Maultsby, V. Mendoza, P. Nash, K. Nelson, B. Patel, M. Perez, D. Russell, I. Salamanca, M. Sattah, L. Spencer, J. Weedman, Danielle Campbell (online), and J. Green.

B. APPROVAL OF AGENDA

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

C. COUNTY LAND ACKNOWLEDGEMENT

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

D. CONSENT CALENDAR

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

E. APPROVAL OF MEETING MINUTES

MOTION #3: Approve meeting minutes, as presented or revised. √ Passed by Consensus

2. HOLDING SPACE FOR OUR COMMUNITIES – REFLECTIVE SILENCE

The Commission held a moment of silence for Commissioner Russell Ybarra, who recently passed away from cancer. The Board of Supervisors and the Commission will adjourn upcoming meetings in his honor.

3. PUBLIC & COMMISSIONER COMMENTS

A. Public Comment

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

See addendum.

B. Commissioner Comment

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

See addendum.

4. ADMINISTRATIVE - I

A. COH Staff Report

Staff Report: Budget & Staffing

- The commission is operating with significant constraints while trying to improve operations.
- This year's budget was initially set at $975,000, but expenditures are projected to exceed that amount.
- After discussions with DHSP leadership, Mario Perez, assured the Commission that this year's overages will be absorbed, preventing further cuts.
- Due to earlier cuts, the Commission no longer has a parliamentarian and is down one staff member; Executive Director Cheryl Barrit retired on August 31.
- The Commission now operates with a team of four and holds intensive weekly meetings to streamline processes and increase efficiency. Staff are exploring:

1. Automated commission trainings using existing county platforms or new tools.

2. Streamlined membership management and routine operations.
3. Academic partnerships for student interns to expand capacity.

More detailed recommendations will be shared with the Co-chairs soon.

Countywide Commission Assessment

- The Board of Supervisors' Executive Office is conducting a countywide assessment of all commissions to identify efficiencies and shared resources due to fiscal challenges.
- The COH reminded the Executive Office that it is cost-neutral, funded through program dollars rather than county general funds.
- COH leadership met with executive office staff for the first time; they emphasized that many county departments do not understand the COH's role, so staff will provide a process diagram to clarify needs.
- The Executive Office cannot provide financial help but may provide operational resources, such as support with social media and other administrative needs.

Work Plan & Upcoming Meetings

- The Commission has completed all activities in its 2025 work plan.
- Planning is underway for the Annual Conference on November 13th at St. Anne's Conference Center.
- The vote on bylaws changes has been paused due to ongoing discussions about integrating HIV prevention within the commission's planning responsibilities.
- The goal is to bring the bylaws forward for a vote on December 11th, the final meeting of the year.

C. COH Co-Chair Report

Special Executive Committee Meeting – HIV Prevention Planning

- A special meeting on September 18th brought together prevention stakeholders, community members, experts, DHSP staff, and consumers to discuss how the commission should strengthen HIV prevention planning.
- Concerns were raised about:
  - The Commission's capacity to take on deeper prevention planning.
  - The perception that prevention is not always fully integrated into Commission discussions.
- Recommendations included:
  - Restoring prevention-focused educational series.
  - Adding a standing HIV prevention agenda item.
  - Ensuring strong prevention consumer representation and expanding those seats.
- Follow-up steps:
  - Seek guidance from HRSA about integrated planning mandates.
  - Form a small joint workgroup of prevention experts and DHSP staff.
  - Continue internal and community-based discussions before finalizing bylaw revisions.

Annual Conference – Proposed Agenda Overview (November 13th)

- The event runs from 9 AM–3 PM, with breakfast and networking starting at 8:30 AM.
- Themes include:
  - Reimagining the Commission amid restructuring.
  - State of HIV/STIs in LA County to be presented by Mario Perez.
  - Science & action: leveraging research and innovation.
  - Policy & legislation, led by Katja Nelson and others.
  - A possible keynote from Representative Maxine Waters on the HIV Prevention Now Act (HR 5126).
  - Community advocacy, engagement, and collective action panel.
  - Year-in-review moderated by the Commission Co-chairs.
- Special features:
  - Wellness breaks to encourage connection and movement.
  - Art legacy exhibition & networking reception after the conference.
  - Featuring HIV-related artwork commissioned over 20 years ago, previously displayed in the Wilshire office but now in storage.
  - Proposal to raffle art pieces to community partners to honor the artists' legacy.

Summary of Overarching Impact of DEI Changes

The DEI-related policy shifts are not merely bureaucratic; they strike at the core identity, mission, and community structure of the commission. The impacts are:

- Operational: Restricted meeting structure, unclear rules, disrupted workflows.
- Psychosocial: Fear of erasure, moral conflict, exhaustion, and anger.
- Political: Conflict between compliance and resistance; increased calls for activism.
- Strategic: Need for a new planning model, possibly dual systems, balancing compliance with authenticity.

The Commission is navigating a moment of intense identity renegotiation, balancing survival (funding) with principle (community representation).

D. Division of HIV/STD Programs (DHSP) (RWP Grantee/Part A Representative) Report

Mario Perez, Director. Division of HIV and STDs (DHSP) provided an extensive DHSP update, emphasizing severe and widespread federal funding threats, including proposed elimination of:

- Entire federal HIV prevention funding
- STD cooperative agreement cuts
- HIV behavioral surveillance
- Minority AIDS Initiative (MAI)
- Ending the HIV Epidemic (EHE) funding

- Ryan White Part C, D, and F (dental) programs
- Title X family planning funding

For Los Angeles County, these cuts would total tens of millions of dollars and impact HIV, STI, dental, housing, and prevention services. DHSP is preparing contingency plans, stressing:

- The need to shift more clients to Medi-Cal
- Prioritizing services only Ryan White can pay for
- Recalibrating the service portfolio for March 1, 2026
- Upcoming provider meetings on Oct. 21–22 to discuss data collection, system changes replacing CaseWatch, and funding instability

Staff layoffs (76 positions) and further internal reductions were also noted.

In response to a question regarding oral health, M. Perez clarified that specialty dental services are NOT eliminated, but some procedures may be temporarily paused due to resource limits, and the oral health program remains one of the nation's most robust.

In response to questions regarding Medi-Cal eligibility, M. Perez noted that estimates fluctuate, but up to 2,000 HIV-positive clients have been Medi-Cal-eligible yet enrolled in Ryan White instead. More accurate Numbers will be provided later.

M. Perez concluded the report by acknowledging the need for difficult decisions ahead, guided by the principle of serving the greatest good for the greatest number.

5. COMMUNITY PARTNER/ REPRESENTATION REPORTS – I

E. California Office of AIDS (OA) Representative

Introduction & Role

Leroy Blea is the Program Manager for Ending the Epidemics at the CA Department of Public Health (CDPH) Office of AIDS and oversees syndemic planning and the Ending the HIV Epidemic (EHE) initiative. Leory now serves as the Part B representative to the LA Commission on HIV (COH), as well as to other planning councils statewide. Leroy's role is to strengthen communication across California jurisdictions during a politically challenging time.

Key Themes & Content

1. Integrated Plan: Looking Back & Forward
    - Los Angeles was not a full co-author of the last integrated plan but provided inspiration and alignment.
    - California's approach centers HIV, STIs, and Hepatitis C under a unified syndemic, social determinants of health (SDOH) framework.

- The state maintains a strong commitment to naming and centering disproportionately impacted populations.

2. Two Versions of the Integrated Plan

Due to federal DEI-related restrictions:

- A "federal-facing" version using coded, non-DEI language (e.g., "populations with highest burden" instead of naming groups).
- A "California version" maintaining explicit, community-centered language (Black, Latinx, undocumented, transgender, drug-using populations, etc.).

California will not eliminate identity-based data or population naming in state work.

3. Syndemic Symposium
   - Recently held statewide, centered community voices.
   - Reaffirmed California's commitment to:
     - undocumented residents
     - transgender and gender-diverse people
     - drug users
     - Black and Brown communities
   - Reinforced harm reduction: 75% of integrated plan activities are harm-reduction related.
   - Highlighted recent CA policy wins (e.g., expanded vaccine access, gender-affirming care law updates).
4. Program Achievements & Innovations

CDPH has implemented statewide:

- Mobile and street-medicine expansions
- Rapid and self-testing (OraQuick statewide access)
- PrEP expansion pilots
- Statewide telePrEP rollout (to be expanded)
- Social media interventions targeting younger, Black, and Latinx communities
- Linkage and re-engagement innovations

5. New Integrated Planning Structure (2022–2026)
   - Co-authored with multiple counties; LA will now join as a full co-author.
   - 30 high-level strategies across major SDOH domains:
     - Racial equity
     - Housing First
     - Health access
     - Mental health & substance use
     - Economic justice
     - Stigma elimination

These informed a 156-strategy Implementation Blueprint, a technical assistance toolkit and language Bank meant for jurisdictions and CBOs.

6. Partnerships Beyond Public Health

- Strategy partners (e.g., CA Department of Social Services) included to leverage resources beyond the health sector.
- These partnerships are "pre-negotiated," easing collaboration for local jurisdictions like Los Angeles.

7. Concurrence Process & Timeline
   - Public review: February 2026
   - Concurrence meetings with each jurisdiction: March–May 2026
   - Final submission to HRSA/HAB/CDC: June 2026
   - Implementation period: 2027–2031

   Los Angeles will receive the full plan to upload as its own.
8. Language Shifts Due to Federal Guidance

   Recent federal guidance requires:
   - Removal of explicit racial/ethnic group naming in federal submissions
   - Substitution with "neutral" terms (e.g., "populations with highest burden")
   - Reframing health inequities as "barriers."

   California will comply only where required for federal acceptance; state-level work will retain its identity affirming language.

9. Funding Uncertainty & State Strategy
   - Funding and policy environments are worsening.
   - California intends to:
     - absorb costs of developing the statewide plan
     - reduce financial burden on local jurisdictions, including LA
     - maintain a full accounting of population-specific gaps

   Focus areas:
   - PrEP gap analysis (persistent disparities for Black/African American & Latinx populations)
   - ADAP gap analysis, especially for Medi-Cal–eligible individuals not enrolled
   - Meta-analysis of local needs assessments across all counties
10. TelePrEP & Insurance Barriers (Q&A)

    Question: Insurance plans and Medicare are ending reimbursement for telehealth visits. What will happen to telePrEP capacity?

    Blea's response:
    - TelePrEP remains a core strategy in the implementation blueprint.
    - He will raise the concern with state leadership (Dr. Ramos).
    - Notes need for closer alignment with DHCS (Medi-Cal administrators).
11. Medi-Cal Representation
    - Commissioners requested a Medi-Cal representative at Commission meetings.
    - Blea explained:
      - State is already pushing for this due to federal findings.
      - Barriers exist due to participation demands.

- Proposed exploring an ex officio or lower-bar participation option.
- State is working with offices that already engage with Medi-Cal (e.g., Office of Refugee Health) to pilot new models.

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

Program Performance (Q1)

- HOPWA has recorded 2,367 clients served so far this quarter.
- Most received supportive services, and some received housing subsidies.
- The program is on track to exceed annual goals if current pace continues.
- Awaiting data from a few remaining providers.

Contracts & Budget

- The contract year began July 1.
- All but one contract has been fully executed; the final contract is awaiting last-minute language revisions.
- All program budgets have been approved and integrated into the disbursement system.
- Payment processing is ready as invoices begin coming in.
- Minor final adjustments are still being made to the funding drawdown system.

Housing Authority (HACLA) Funding Increase

- HACLA funding increased by $2 million, bringing the total to $6.7 million.
- Goal: Serve 200 clients this year with tenant-based rental assistance (TBRA).
- Last year they served 175 clients.
- TBRA is used as permanent housing, with the long-term goal of transitioning clients to Section 8, depending on Section 8 slot availability.

CAPER Report

- The Consolidated Annual Performance and Evaluation Report (CAPER) for HUD is nearing completion.
- One final round of corrections is being made.
- The report will be submitted well before the mid-November deadline.

Government Shutdown Impacts

- Anticipated impact on HOPWA is minimal.
- Program funding is still available and accessible, and funds are actively being drawn down.
- HUD liaison is currently furloughed, which may delay:
  - Requests for waivers
  - Exceptions requiring HUD approval

- Day-to-day operations should continue without disruption.

Questions from Members

- Section 8 Transition:
  - Yes, transitioning TBRA clients to Section 8 still occurs, but is dependent on Section 8 availability.
  - TBRA remains stable permanent housing for clients who cannot yet transition.
- Long-Term Housing Stability:
  - Most clients housed through Tenant-Based Rental Assistance (TBRA), or other permanent programs remain housed long-term.
  - A small number experience challenges (e.g., significant mental/physical health issues) requiring referrals to other supportive services outside HOPWA.
  - Exact numbers on how many remain housed vs. exit housing will require data review; Matthew will research this.

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

Part C | Dr. L. Spencer provided the following report:

- Recent virtual audit completed in August.
- Awaiting final written report; preliminary feedback is very positive.
- Part C supports mental health services; both the program and clinic performed well.
- Oasis Community Advisory Board (CAB) was praised as the best CAB auditors had seen "in a long time."
- Received notice of award for the next grant cycle (slightly reduced).
- Ongoing concern about future Part C funding cuts and their impact.

Part D Report | Dr. M. Cielo provided the following report:

- Part D audit was recently completed.
- Awaiting full written report; verbal feedback was positive.
- Minor comments related to documentation processes.
- Strong performance in retention in care, viral suppression, and other clinical measures.

Part F Report | S. Cuevas

- UCSF received partial federal funding, resulting in dissolution of the previous local partner network.
  - Local partners like CDU, USC, UCR, and UCSD were eliminated from the structure.
  - Acknowledgment of their years of partnership.
- Southern California region was collapsed, and UCLA was selected to lead with a four-person team.
- Initial funding: $330,000, later supplemented by $698,000.
- LA County received ~$50,000 more than last year, but:

- UCLA team now covers a much wider region (L.A., Ventura, Orange, Riverside, San Bernardino, San Diego, Imperial, US–Mexico border) with much less total funding.

- Practice Transformation (PT) Projects:
  - Three sites: L.A. County, Moreno Valley, Imperial Beach.
  - Focus on building HIV care/prevention services from the ground up.
  - LA site is a brand new FQHC (SoCal Community Health Center) implementing PrEP services across multiple departments.
  - PT projects are 5-year initiatives.
- IPE Project (Interprofessional HIV Education):
  - Implementing HIV curriculum with UC Irvine and other health professional schools.
- Training and TA Activities:
  - Seven regional trainings planned.
  - Trauma-informed care online training Oct 29; full-day event to follow.
  - Clinical rotations shift from USC → UCLA.
  - Annual conference "Coping With Hope" continues next year.
  - Training calendar to be released.

H. Cities, Health Districts, Service Planning Area (SPA) Report

City of Long Beach| I. Salamanca reported:

- First quarterly comprehensive planning group meeting held.
- Strategic plan for harm reduction, HIV, STIs being revived after pandemic disruptions.
- Public announcement planned for World AIDS Day (December 1st).
- Funding and staffing cuts affecting local providers:
  - CARE Program furloughing staff; exploring ED partnerships for after-hours HIV testing.
  - LGBT Center down to two staff for testing; seeking help for referrals.
  - AHF expanded clinic days (2 → 5/week) but closed their mobile testing unit.
  - City Health Department mobile unit also non-operational.
- Sexual health clinic remains open Monday through Friday, from 8 AM–5 PM.
- Medical director Dr. Davis retiring, transitioning to Orange County.
- Government shutdown impacts:
  - Loss of two DIS workers and CDC fellows.
  - Reduced capacity for skilled nursing facility outbreak response.
- Noted increase in congenital syphilis cases and rising Mpox activity.
- Long Beach HIV planning group may shift to every-other-month schedule.

City of Los Angeles | D. Ale-Ferlito reported:

- Entering budget season; likely facing similar deficit as last year.
- Expectation of a 50/50 split in HIV funding (opioid settlement funds + general fund).

- Preparing departmental budget requests (November 14th & 21st deadlines).
- New opioid harm reduction RFP:
  - $3.5M for expanding harm reduction across seven regions.
  - Allocation and geographic targeting still in development.
- Planning for a new drop-in center near MacArthur Park, modeled after the Skid Row Care Complex (city–county partnership).
  - $3million already secured; timeline unclear.
- Fentanyl test kit distribution program being explored (CD 17):
  - Mail-order model similar to COVID test kits.
  - Not led by ACO, but they are aware; aiming for 50,000–75,000 initial units.
- City analyzing impacts of federal HIV cuts on local programs; report in progress.
- Technical assistance mini-grants ($3,000–$4,500) remain available to community groups.

City of Pasadena |E. Davies reported:

- Significant impact from funding cuts, combined with strain from local fires.
- Public Health Department:
  - Lost HIV counseling/testing contracts.
  - Exploring home test kits and alternate testing strategies.
- Multiple programs collapsed; vacant positions were eliminated to avoid layoffs.
  - Staff now "very bare bones."
- New Prop 47 grant awarded:
  - Expands street outreach to unhoused and justice-involved individuals.
  - Adds more medical navigation and may reintroduce HIV testing via outreach.
- National Coming Out Day event on Saturday at Memorial Park (11 am–1 pm).
  - Includes resource fair and two donated Chappell Roan concert tickets as giveaways.
  - Tabling slots available.

City of West Hollywood | D. Saunders reported:

- City recently launched $8–9 million in HIV-related contracts for the next 3 years.
- Increased budget by $1 million.
- New PrEP navigators funded.
- Increased funding for food and nutrition services.
- One of the few cities able to expand HIV investments during budget cuts.

6. STANDING COMMITTEE REPORTS – I

The following provides a summary of reports:

Planning, Priorities & Allocations (PP&A)

- Reviewed Ryan White utilization report (core services).
- DHSP requested review of Program Year (PY) 36 allocations, including new non-medical case management partner support services.
- Committee advanced placeholder reallocations for PY 35 and PY 36 to the Executive Committee.
- Executive Committee approved both sets without full body review due to meeting lapses.
- Full body urged to re-engage, especially given expected drastic reallocations for PY 36 (starting March).

Operations (OPS) Committee

- New co-chairs: Miguel Alvarez and Vilma Mendoza.
- Miguel's move creates a vacancy on the Executive Committee.
- Reviewed membership materials and updated application and interview documents.
- Recruitment workgroup delayed (lead member out of country), but strategies under discussion.
- Recruitment freeze remains in place during restructuring, except for key vacancies:
  - Unaffiliated consumer seats
  - SPA 1 & SPA 5 representatives
  - Supervisorial Districts 2 & 4 unaffiliated reps
  - At-large unaffiliated representative #1

Standards & Best Practices (SBP)

- Transitional Case Management (TCM) service standards approved (justice-involved, youth, and older adults).
- Patient Support Services (PSS) standards completed and moving to the Executive Committee.
- Beginning review of mental health service standards; next meeting in November.
- December meeting may be canceled due to World AIDS Day.

Public Policy (PPC) Committee

- October meeting canceled.
- November meeting: presentation from County Legislative Affairs (Nov 13, 1–3pm).
- December meeting may be moved due to World AIDS Day.
- Monitoring government shutdown; county funding currently stable, but long-term impact unknown.
- Following governor's bill-signing deadline; updates expected in November.
- Committee preparing:
  - Policy priorities for next year
  - A mission/activities handoff document given PPC will dissolve in March under restructuring.
- Noted leaked federal HUD proposals:

- Would cap permanent housing to 30% of CoC funds (currently 87%).
- Would penalize applicants who use racial or transgender-inclusive language.
- Status uncertain; being monitored.

Aging Caucus

- September meeting canceled.
- Hosted successful Power of Aging event on Sept 19.
- Highlighted Aging Awareness Day.
- Planning a November meeting.

Black Caucus

- Planning multiple listening sessions:
  - LA County Youth Commission.
  - Men who do not identify as MSM.
- Seeking volunteers for Taste of Soul on October 18th.
- World AIDS Day event scheduled for December 5th.
- October meeting date to be announced.

Consumer Caucus

- Reviewed Patient Support Services standards and encouraged community feedback.
- Clarified Emergency Rental Assistance eligibility:
  - Only for clients in an active eviction process.
  - Up to $5,000/year per client.
  - Processed via Benefits Specialty.
- Next meeting date TBD; planning training on navigating the Commission website.
- Encourages consumers to stay active and share feedback.

Transgender Caucus

- Last met August 26th; received updates from leadership.
- September meeting canceled; poll will be circulated to set October meeting date.

Women's Caucus

- Reviewed and synthesized results from three listening sessions.
- Top theme: Need for expanded peer support programs.
- Noted loss of funding for several effective programs.
- Completed all work plan items for the year.
- Exploring collaboration with the Women's HIV Task Force.

Housing Task Force

- Final meeting scheduled virtually for Friday, October 24th at 9 AM.

- Will finalize recommendations based on:
  - Summer housing survey findings
  - Presentations from the last 1–2 years
- Recommendations will feed into the next Integrated HIV Plan and other Commission functions.
- Members encouraged to attend or submit written input.

7. COMPREHENSIVE EFFECTIVENESS REVIEW & RESTRUCTURE PROJECT

- The restructuring workgroup has made strong progress and identified a proposed new Commission structure to bring for a full vote.
- The group decided to pause briefly to ensure clarity about the Commission's role as an integrated HIV care and prevention planning body.
- Emphasis placed on intentionally including prevention planning, not treating it separately.
- Staff prepared an FAQ explaining the differences between ordinances and bylaws.
- All members are asked to complete bylaws training before the restructuring vote.
- Revised timeline:
  - Small-group discussions on integrated planning at the Executive level.
  - Full Commission vote planned for December.

8. MISCELLANEOUS

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

See addendum.

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

No new committee business.

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

See addendum.

D. Adjournment and Roll Call: Adjournment for the meeting of October 8, 2025.

The meeting adjourned in memory of former Commissioner Russell Ybarra and Ethel, staff member Dawn McClendon's mother. Staff conducted roll call.

ROLL CALL (PRESENT): M. Alvarez, J. Arrington, L. Blea, A. Burton, M. Cielo, S. Cuevas, K. Donnelly, K. Ferguson, A. Frames, F. Gonzalez, T. Jones (online), W. King, L. Kochems (online), L. Martinez-Real, L. Maultsby, V. Mendoza, P. Nash, K. Nelson, B. Patel, M. Perez, I. Salamanca, M. Sattah, D. Saunders, L. Spencer, J. Weedman, Danielle Campbell (online), and J. Green.

MOTION AND VOTING SUMMARY		
MOTION 1: Approve meeting agenda, as presented or revised.	Passed by Consensus	**MOTION PASSED**
MOTION 2: Approve the July 10, 2025, Commission on HIV meeting minutes, as presented or revised.	Passed by Consensus.	**MOTION PASSED**
MOTION 3: Approve Consent Calendar, as presented or revised.	Passed by Consensus.	**MOTION PASSED**
MOTION 4: Approve seat change for Dr. Leon Maultsby from Part C Representative to Provider Representative #1, as presented or revised.	Passed by Consent Calendar.	**MOTION PASSED**
MOTION #5: Approve the Transitional Case Management Service Standards, as presented or revised.	Passed by Consent Calendar.	**MOTION PASSED**

LOS ANGELES COUNTY
COMMISSION ON HIV

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DRAFT

PUBLIC COMMENTS FOR THE OCTOBER 9, 2025 EXECUTIVE COMMITTEE MEETING

All public comments received become a part of the official record.

Member of the Public	Comment(s)
Brigitte Tweedell – Project New Hope	In person: The organization has closed three of its six residential care homes, two transitional residential care facilities (TRCFs), and one residential care facility for the chronically ill (RCFCI), reducing capacity by 15 beds. All ten TRCF residents were relocated successfully, with some entering shelters, one moving to the remaining TRCF, two going to Long Beach, and others securing permanent housing. Among the RCFCI residents, one moved in with family but later transferred to an open bed in Long Beach. Referrals to facilities have increased, and there are now 25 people on the TRCF waitlist and four on the Long Beach waitlist, though non-ambulatory beds are unavailable there. Eight staff members were laid off. The speaker notes the decision was difficult for everyone and expects conditions will not improve in the near future.
Kevin Donnelly	In person: The speaker addresses whether the group should remain an integrated body and whether it should continue planning for both HIV prevention and care. Although the Ryan White program focuses on care, the speaker argues that prevention, syndemic factors, and related health issues are inseparable from HIV outcomes. Regardless of funding, they believe the group should continue working as an integrated body because it is the most effective and appropriate approach for addressing the epidemic.
Shawn Pleasants – UCLA CDU CFAR CAB	Online: The speaker expressed concern about the proposed Department of Health Services cuts to key staff positions at the Positive Care Clinic. These cuts would significantly reduce wrap-around and supportive services, such as food assistance, housing and benefits referrals, mental health support, and recovery resources, that are crucial for patients, especially those experiencing homelessness. Drawing on personal experience with homelessness and limited access to care, the speaker warns that reducing these services will harm clinics like Oasis and the vulnerable populations they serve.
Gerardo Almazan	Online: The speaker stressed the need to avoid cuts to health services, highlighting how essential supportive staff, such as case managers and social workers, are for helping patients, especially those newly

	diagnosed, navigate emergency care, hospitals, and other vital services. He emphasized that maintaining these roles is critical to ensuring that patients receive appropriate guidance and support.
Frankie-Darling Palacios – Health Access California	In person: F. Palacios is a new coordinator and shared that Health Access California is gathering stories from Covered California enrollees, especially those in the HIV Insurance Program (HIP), because monthly premiums are expected to double in 2026 due to requirements to use maximum advanced premium tax credits. With over 3,000 HIP recipients in LA County, some could see premiums rise by as much as $4,000, depending on age. The coordinator is seeking community input to support statewide advocacy and hopes to partner with the Black Caucus to amplify these stories across platforms. They provided a QR code to make participation easy.
Carla Bailey	In-person: As a former commissioner, the speaker acknowledged that the Commission on HIV is not an advocacy or political body; however, she is volunteering to help start a letter-writing effort so senators and other public officials better understand the community's needs and concerns.
Jeanie Drummer	In-person: As an African American woman living with HIV for 23 years, Jeanie shared a deeply personal account of how repeated cuts to HIV services directly harm her and others, especially elderly women. She explains that social workers, nurses, therapists, doctors, food support, transportation, and mental-health care have been essential to her survival, stability, and recovery from homelessness. Proposed reductions mean fewer appointments, fewer supportive staff, and increased fear and isolation among women in her community. She emphasizes that every cut has real, painful consequences for people like her, "she feels every cut", and worries about losing the trusted providers who helped her stay alive. Despite fear and stigma, she speaks out to protect these services for herself and for newly diagnosed people who "look like her," stressing that mental-health support is inseparable from HIV care. She pledges to keep fighting for these lifesaving programs.
Shellye Jones – Charles Drew University	In-person: Shellye honored Jeanie for bravely sharing her HIV status publicly for the first time. Shellye explained that DHS clinics serve 4,500 HIV patients directly and around 10,000 who pass through emergency or urgent care each year. These patients often face homelessness, mental-health challenges, and substance-use disorders, and they rely heavily on social workers, case managers, and nurses, especially because many lack phones, addresses, transportation, or feel unsafe accessing care.

	Shellye cautions that providers cannot absorb these support roles, as they are already overburdened, and losing services after January 1st could leave patients unable to re-enroll. Despite requests for staffing ratios tied to patient volume, budget cuts mean that all 4,500 patients will have access to only one social worker, three medical caseworkers, and three RNs, an extremely small team for such a large, vulnerable population. Shellye calls this plan unrealistic, overwhelming, and unsustainable.
Meyerer (Myra) Perez – USC Oral Health	In-person: The speaker explains that uncertainty and proposed 30% budget cuts have already affected their oral-health program. Some specialty dental services were temporarily paused, and while oral surgery has resumed with current-year funding, implant services had to be permanently eliminated. They express concern about future DHSP funding cuts and note that a delegation from their dental school met with congressional representatives in Washington to raise awareness about how these uncertainties and reductions impact patient care.
Frank – Capitol Drugs	In-person: Frank from Capital Drugs pays tribute to his colleague of 13 years, Russell Ybarra, who recently passed away from cancer. He describes Russell as a deeply caring, dependable, and humble person whose loss has been felt profoundly by those who worked with him and by the broader community. Frank shares that Russell kept his illness private but was committed to the work, and Frank pledges to honor him by continuing that work and supporting others, even as he acknowledges the difficulty of filling Russell's shoes.

POLICY/PROCEDURE #08.2107	Consent Calendar	Page 1 of 3

NO PROPOSED CHANGES, 4/10/2008

ADOPTED, 1/10/2008

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

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

BACKGROUND:

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

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

POLICY:

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

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

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

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

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

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

PROCEDURE(S):

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

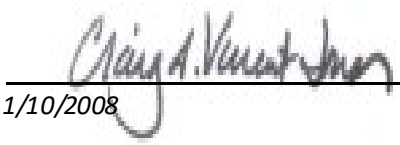
2. **Setting Aside Consent Calendar Items**: An item may be "pulled" from the Consent Calendar by any Commission member, member of the public, or staff member for any reason. The most common reasons for setting aside a Consent Calendar item are:
   a) There is a presentation that accompanies the item.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

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

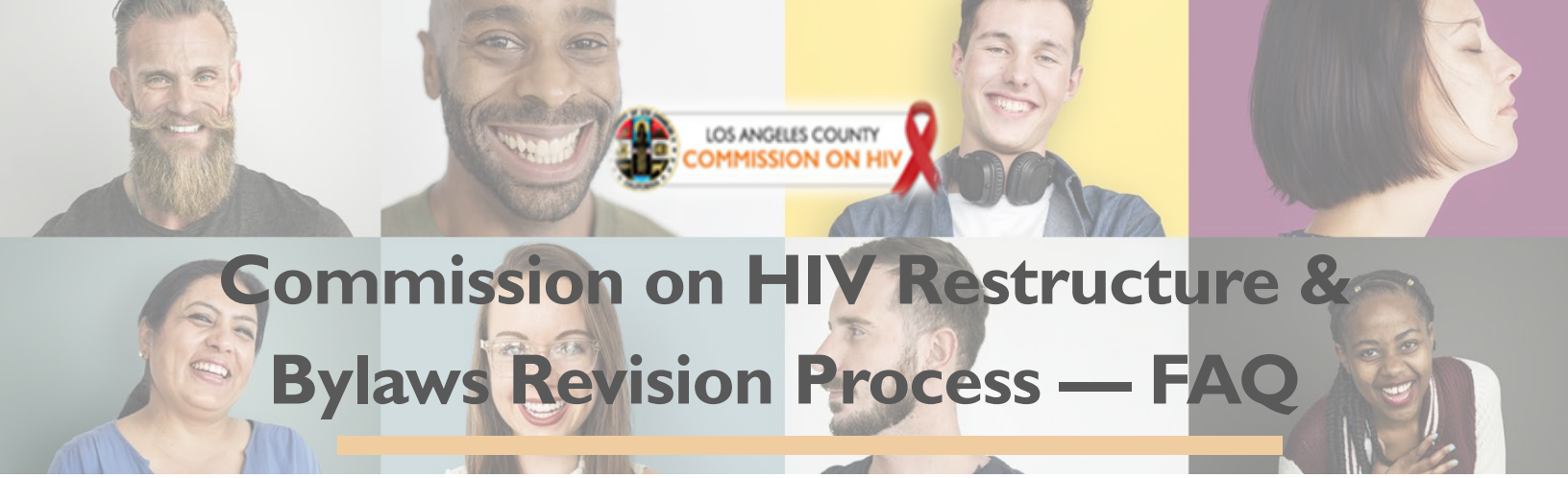
4. **Approving the Consent Calendar**: The Consent Calendar approval vote must be unanimous.
   a) There is no discussion about the Consent Calendar approval, except to pull specific items.
   b) As with all Commission motions, a quorum must be present to vote on it.
   c) As a vote without objections,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

DEFINITIONS:

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

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

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



Commission on HIV Restructure & Bylaws Revision Process — FAQ

****Updated 12.8.25****

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 32 seats
- Commission and committee meetings reduced from 10 to six annually.
- Term limits: Maximum 3 consecutive 2-year terms + 1-year break (effective Mar 2026).
- Committee co-chair terms extended to 2 years.
- Committees: Public Policy → Executive; Operations → Membership & Community Engagement
- Expanded committee-only membership 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 funding discussion/votes.
- Updated Code of Conduct to cover public/vendors and inclusion of the Commission's Inter-Personal Grievance Policy.
- DHSP, Part B and Medicaid/Medi-Cal representatives will serve as a non-voting members 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.

COMMISSION ON HIV RESTRUCTURE & BYLAWS REVISION PROCESS — FAQ

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

- 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?

- 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

Version 08.2524; 05.28.25; 06.04.25; 11.26.25; 12.7.25

POLICY/PROCEDURE #06.1000	Bylaws of the Los Angeles County Commission on HIV	Page 1 of 25

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:

1. **Los Angeles County Code, Title 3—Chapter 3.29.070 (Procedures)**: These Bylaws are adopted pursuant to the authority of Los Angeles County Code, Title 3, Chapter 3.29.070, which authorizes the Commission to establish rules and procedures regarding meetings, officers, terms, and other matters necessary for its operation.

2. **Health Resources and Services Administration (HRSA) Part A Guidance**: The Planning Council/Planning Body (PC/PB) — and its support staff — shall carry out the operational duties described in the RWHAP Part A Manual, including establishing and maintaining bylaws, policies and procedures, memoranda of understanding, grievance procedures, conflict-of-interest policies, training, and staff support, as needed to ensure fair, transparent, and effective operations, and to enable the PC/PB to fulfill its legislative and programmatic responsibilities. [Ryan White HIV/AIDS Program Part A Manual, September 2025, III Chapter 5 (Planning Council and Planning Body Operations; Ryan White HIV/AIDS Program Planning Council and Planning Body Requirements and Expectations Letter" (August 29, 2023).

3. **Centers for Disease Control and Prevention (CDC) Guidance:** Under current CDC requirements, jurisdictions must use an integrated planning process to develop their jurisdictional HIV prevention strategies. This integrated approach brings together community stakeholders, public health partners, and Ryan White Program planning bodies to inform the jurisdiction's HIV Prevention Plan and ensure alignment with CDC's Integrated HIV Prevention and Care Plan Guidance (CDC, 2027–2031).

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. Although not a HRSA requirement, the Commission will request that the Ryan White HIV/AIDS Program (RWHAP) Part A Project Officer review any proposed substantive changes to the Bylaws prior to Commission approval, to help ensure alignment with HRSA expectations and guidance.
    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 Integrated HIV Prevention and Care Plan 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) — defined as a geographic area disproportionately affected by HIV that receives federal Ryan White HIV/AIDS Program Part A funding — including how best to meet each priority and any additional factors to consider when allocating RWHAP Part A grant funds.
D. 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.
E. Participate in the development of the Statewide Coordinated Statement of Need initiated by the state public health agency, the California Department of Public Health (CDPH).
F. Establish methods for obtaining community input regarding needs and priorities.
G. Coordinate with other federal grantees that provide HIV-related service in the EMA.
H. Develop a local comprehensive HIV plan for Los Angeles County 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 HIV plan must contain the following:

    1. 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.
    2. 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).

3. compatibility with any State or local plan for the provision of services to individuals with HIV/AIDS; and
4. 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 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 STIs and other co-morbidities; plan the deployment of those best practices and innovative models in the County's STI clinics and related health centers; and strategize mechanisms for adapting those models to non-HIV-specific platforms for an expanded STI 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 detailing 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 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 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 approved 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 a total of 32 members, which includes three non-voting seats: the RWP Part A Recipient/Grantee (DHSP), the Part B representative (CDPH Office of AIDS), and the Medicaid/Medi-Cal agency representative. 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 15 specific membership categories that must be represented on the Commission, which 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/Medi-Cal 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. HIV Research Representative. One representative from a local academic research institution with subject matter expertise in HIV research and data translation.

D. BOS Representatives. Five BOS representatives, one recommended by each of the five Supervisorial offices.

F. Additional Government Representatives. Representatives of government agencies 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. Members — including Full, Alternate, and Committee-only — may serve a maximum of three consecutive two-year terms (six years total), as reflected on the Membership Roster. Committee-only members' terms begin on the date of appointment. After completing three consecutive terms, members may reapply following a one-year break, unless the Board of Supervisors waives this limitation. Term limits will be calculated from the approval date of these Bylaws. The Executive Committee may grant exceptions to term limits when necessary to meet representation requirements or to retain essential expertise.

B. All members shall submit a renewal application prior to the expiration of their respective terms. However, a member may continue serving in the seat, beyond term expiration, until such time as the member has resigned, is replaced, or the seat is vacated by the Board of Supervisors as recommended by Commission.

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 STI incidence and prevalence.

Section 6. Parity, Inclusion, and Representation (PIR). In accordance with the Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need (2027–2031), issued jointly by CDC and HRSA (February 2025), the planning process must engage communities equitably, meaningfully, and in a manner that reflects the diversity of people disproportionately impacted by HIV. This includes ensuring that planning body members can participate fully, are included in all stages of decision-making, and represent the communities most affected by HIV.

A. Parity. Parity means ensuring that all members of the planning body are supported to participate equitably in the planning process. The Commission shall provide all members with the information, training, and support needed to participate equally in discussions, voting, and planning activities.
B. Inclusion. Inclusion is defined by the federal requirement that community members must be meaningfully involved in all phases of HIV prevention and care planning. The Commission shall ensure that members — especially persons with lived experience — have meaningful opportunities to participate in discussions, shape priorities, and influence decisions throughout the planning process.
C. Representation. Representation is aligned with federal expectations that planning processes reflect the demographics of local HIV epidemics and the diversity of impacted communities. Commission membership shall reflect the demographic and cultural diversity of Los Angeles County communities disproportionately affected by HIV, including diversity in race, ethnicity, gender, sexual orientation, age, disability, lived experience, and professional background.

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. Consistent with the Los Angeles County Code 3.29.060 D (Meetings and committees), the Commission's standing committees may elect to nominate Committee-only members for approval 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 data (including surveillance) to guide the Commission's priority setting and resource allocation process. 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. To strengthen this partnership, 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, mandatory County and Commission trainings, and the Annual Conference.

In accordance with Los Angeles County Code 3.29.060 (Meetings and committees), the BOS shall be notified of member attendance on a quarterly 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, if 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. In accordance with the RWHAP Part A Manual, all planning council/planning body members must annually disclose any actual or perceived conflict of interest — including affiliations with RWHAP-funded providers or agencies. Members must recuse themselves from any discussion or vote in which their conflict could influence the outcome (e.g., resource allocations, funding decisions, service priorities for the affected agency).

Section 4. Code of Conduct. All Commission members, vendors and contractors, 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 Operations 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 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 Parliamentary Authority.

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 accessible through 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 and its committees shall meet a minimum of 6 times per year. Commission and committee meetings shall be held at a time and location to be determined by the Co-Chairs, the Executive Committee, or committee Co-Chairs. The Executive Committee, Co-Chairs, or 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. Parliamentary Authority. All meetings of the Commission shall be conducted according to appropriate parliamentary authority 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 HIV 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 the Executive Office of the Board of Supervisors (BOS) and 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 HIV 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 (DSO) 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:

A. Stipends: Unaffiliated consumer members may receive a stipend of *up to* $500 monthly contingent upon member eligibility and available funding and pursuant to policy.
B. Expense Reimbursement: Members may be reimbursed for reasonable and necessary expenses incurred in the performance of their official duties, in accordance with county policies governing reimbursement for county officers and employees and HRSA requirements. Reimbursable expenses may include:
    - Local travel and mileage.
    - Meals associated with Commission business.
    - Childcare during Commission activities.
    - Office supplies and computer-related expenses incurred in the performance of commission-related duties.
C. Service Provision in Lieu of Reimbursement: The Commission has the option to arrange for services (such as childcare or transportation) to be provided directly to members rather than offering reimbursement, or to seek alternative funding for member stipends.
D. Stipend Limits: The Executive Director or their designee may adjust stipends on a case-by-case basis for Unaffiliated Consumer members' participation in special meetings and pre-approved activities, depending on available funds.

It is important to note that a stipend is a form of financial support to offset incidental costs and is not considered regular income or employment compensation.

Section 6. Staffing. The Executive Director serves as the Commission's lead staff person and oversees all personnel, budgetary, and operational functions. If the Executive Director position is vacant, the Assistant Director — or, if necessary, the senior staff member — will serve as Acting Executive Director.

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 Review. HRSA does not require RWHAP Part A planning councils to submit their grievance procedures, conflict-of-interest policies, or bylaws for formal review. However, planning councils may share these documents with their HRSA Part A Project Officer for input and guidance, as appropriate, to support alignment with legislative expectations and effective operations.

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 serve two-year staggered terms. In the event of a vacancy, a new Co-Chair shall be elected to complete the remainder of the term. Nominations and elections to fill the vacancy will occur within 60 days of the Chair's resignation.

C. The Co-Chairs are elected by a majority vote of Commissioners or Alternates present at a regularly scheduled Commission meeting held at least four months before the start of the new term, following a nomination period opened at the prior meeting. The term of office begins at the start of the calendar year. Once elected, the incoming Co-Chair will serve as the Co-Chair-Elect and will have four months for mentoring and preparation before assuming the role. When circumstances make these timelines impracticable, the Executive Committee may adjust the nomination, election, or transition schedule as needed to ensure continuity of leadership.

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 on the California Department of Public Health, Office of AIDS, California Planning Group (CPG).
3. Represent the Commission at functions, events, and other public activities, as necessary.
4. Call special meetings, as necessary, to ensure that the Commission fulfills its duties.
5. Consult with and advise the Executive Director regularly, and the RWHAP Part A and CDC project officers, if applicable and as needed.
6. Conduct the performance evaluation of the Executive Director, in consultation with the Executive Committee and the Executive Office of the BOS.
7. Chair or co-chair committee meetings in the absence of both committee co-chairs.
8. Serve as voting members on all committees when attending those meetings.
9. Act on behalf of the Commission or Executive Committee on emergency matters.

10. 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 two years 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 vote 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 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, Committee-only members, and DHSP (non-voting member).

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 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. Advance public policies that support the County's HIV service delivery system and align with the comprehensive HIV plan, in coordination with the County's Legislative Affairs office, as appropriate.
M. Initiate and advance policy efforts that strengthen HIV care, treatment, prevention, and related services.
N. Facilitate communication and recommend policy positions to government and legislative officials, the Board of Supervisors, County departments, and other stakeholders, in alignment with County legislative protocols.
O. Educate and support Commission members, consumers, providers, and the public in engaging with public policy processes.
P. Conduct policy research and activities consistent with the County's adopted legislative agendas.; and
Q. Carrying out other duties and responsibilities, as assigned by the Commission or the BOS.
R. Addressing matters related to Commission office staffing, personnel, and operations, when needed.
S. Developing and adopting the Commission's annual operational budget.
T. Overseeing and monitoring Commission expenditures and fiscal activities.
U. 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 Member 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 (MCE):

Section 1. Voting Membership. The Membership and Community Engagement Committee (MCE) shall include:

A. the Executive Committee At-Large members (elected by the full Commission)
B. representatives from the Cities of Los Angeles, Pasadena, Long Beach, and West Hollywood*
C. a representative from the youth community*
D. members assigned by the Commission Co-Chairs
E. the Commission Co-Chairs, when attending

**Members of this Committee who are not elected by the full Commission may serve as Committee-only members. These individuals shall be nominated by the Committee and approved by the full Commission before serving*.

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

A. Ensuring that Commission membership adheres to all federal requirements for reflectiveness, representation, and community engagement, including the Ryan White HIV/AIDS Program (RWHAP) Part A legislative requirements for membership reflectiveness and the CDC/HRSA Integrated HIV Prevention and Care Plan Guidance expectations for meaningful engagement, representation, and inclusive participation.
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.

I. 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.
K. Working with local stakeholders to ensure their representation and involvement in the Commission and in its activities.
L. Identifying, accessing, and expanding other financial resources to support the Commission's special initiatives and ongoing operational needs.
M. 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 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 approved by the Commission, 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. Collaborating with the Standards & Best Practices (SBP) Committee to develop and define directives for implementation of services and service models.
D. Recommending to the Commission annual priority rankings among service categories and types of activities and determining resource allocations for Part A, , HIV prevention, and other HIV -related funding.
E. Ensuring that the priorities and implementation efforts are consistent with needs, the continuum of HIV services, and the service delivery system.
F. Monitoring the use of funds to ensure they are consistent with the Commission's allocations.
G. Recommending revised allocations for Commission approval, as necessary.
H. 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.

I. 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.
J. Collaborating with DHSP to ensure the effective integration and implementation of the continuum of HIV services.
K. Reviewing monthly fiscal reporting data for HIV-related expenditures by funding source, service category, service utilization and/or type of activity.
L. Monitoring, reporting, and making recommendations about unspent funds.
M. Identifying, accessing, and expanding other financial resources to meet Los Angeles County's HIV service needs.
N. Carrying out other duties and responsibilities, as assigned by the Commission or the BOS.

XII. STANDARDS AND BEST PRACTICES (SBP) COMMITTEE:

Section 1. Membership. Membership of the SBP Committee shall be comprised of members assigned by the Commission Co-Chairs; Committee-Only members as nominated by the Committee and approved by the Commission; 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 to support their clinical quality management (CQM) plan.
B. Identifying, reviewing, developing, disseminating, and evaluating service standards for HIV prevention and care services.
C. Reducing the transmission of HIV improving health outcomes and optimizing quality of life and self-sufficiency for all people living with 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 are adequately met.
E. Collaborating with the PP&A Committee to develop and define 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 HIV prevention and care 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 prevention and care 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 effectiveness of the administrative mechanism (AEAM), 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:

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.

Members who commit such acts may be subject to removal from the Commission.

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.

APPROVED: _____ **DATE:** _____

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; 12/11/25

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
8.28.25	Executive Committee Review
9.25.25	Executive Committee Review
10.23.25	Executive Committee Final Review
12.11.25	Commission Approval (Pending)

Version 08.2524; 05.28.25; 06.04.25; 11.26.25; 12.7.25
Key changes in blue highlight

LOS ANGELES COUNTY COMMISSION ON HIV

POLICY/PROCEDURE #06.1000	Bylaws of the Los Angeles County Commission on HIV	Page 1 of 25

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:

1. **Los Angeles County Code, Title 3—Chapter 3.29.070 (Procedures)**: These Bylaws are adopted pursuant to the authority of Los Angeles County Code, Title 3, Chapter 3.29.070, which authorizes the Commission to establish rules and procedures regarding meetings, officers, terms, and other matters necessary for its operation.

2. **Health Resources and Services Administration (HRSA) Part A Guidance**: The Planning Council/Planning Body (PC/PB) — and its support staff — shall carry out the operational duties described in the RWHAP Part A Manual, including establishing and maintaining bylaws, policies and procedures, memoranda of understanding, grievance procedures, conflict-of-interest policies, training, and staff support, as needed to ensure fair, transparent, and effective operations, and to enable the PC/PB to fulfill its legislative and programmatic responsibilities. [Ryan White HIV/AIDS Program Part A Manual, September 2025, III Chapter 5 (Planning Council and Planning Body Operations; Ryan White HIV/AIDS Program Planning Council and Planning Body Requirements and Expectations Letter" (August 29, 2023).

3. **Centers for Disease Control and Prevention (CDC) Guidance:** Under current CDC requirements, jurisdictions must use an integrated planning process to develop their jurisdictional HIV prevention strategies. This integrated approach brings together community stakeholders, public health partners, and Ryan White Program planning bodies to inform the jurisdiction's HIV Prevention Plan and ensure alignment with CDC's Integrated HIV Prevention and Care Plan Guidance (CDC, 2027–2031).

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. Although not a HRSA requirement, the Commission will request that the Ryan White HIV/AIDS Program (RWHAP) Part A Project Officer review any proposed substantive changes to the Bylaws prior to Commission approval, to help ensure alignment with HRSA expectations and guidance.
   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 Integrated HIV Prevention and Care Plan 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) — defined as a geographic area disproportionately affected by HIV that receives federal Ryan White HIV/AIDS Program Part A funding — including how best to meet each priority and any additional factors to consider when allocating RWHAP Part A grant funds.
D. 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.
E. Participate in the development of the Statewide Coordinated Statement of Need initiated by the state public health agency, the California Department of Public Health (CDPH).
F. Establish methods for obtaining community input regarding needs and priorities.
G. Coordinate with other federal grantees that provide HIV-related service in the EMA.
H. Develop a local comprehensive HIV plan for Los Angeles County 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 HIV plan must contain the following:

    1. 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.
    2. 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).

3. compatibility with any State or local plan for the provision of services to individuals with HIV/AIDS; and
4. 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 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 STIs and other co-morbidities; plan the deployment of those best practices and innovative models in the County's STI clinics and related health centers; and strategize mechanisms for adapting those models to non-HIV-specific platforms for an expanded STI 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 detailing 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 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 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 approved 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 a total of 32 members, which includes three non-voting seats: the RWP Part A Recipient/Grantee (DHSP), the Part B representative (CDPH Office of AIDS), and the Medicaid/Medi-Cal agency representative. 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 15 specific membership categories that must be represented on the Commission, which 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/Medi-Cal 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. HIV Research Representative. One representative from a local academic research institution with subject matter expertise in HIV research and data translation.

D. BOS Representatives. Five BOS representatives, one recommended by each of the five Supervisorial offices.

F. Additional Government Representatives. Representatives of government agencies 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. Members — including Full, Alternate, and Committee-only — may serve a maximum of three consecutive two-year terms (six years total), as reflected on the Membership Roster. Committee-only members' terms begin on the date of appointment. After completing three consecutive terms, members may reapply following a one-year break, unless the Board of Supervisors waives this limitation. Term limits will be calculated from the approval date of these Bylaws. The Executive Committee may grant exceptions to term limits when necessary to meet representation requirements or to retain essential expertise.

B. All members shall submit a renewal application prior to the expiration of their respective terms. However, a member may continue serving in the seat, beyond term expiration, until such time as the member has resigned, is replaced, or the seat is vacated by the Board of Supervisors as recommended by Commission.

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 STI incidence and prevalence.

Section 6. Parity, Inclusion, and Representation (PIR). In accordance with the Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need (2027–2031), issued jointly by CDC and HRSA (February 2025), the planning process must engage communities equitably, meaningfully, and in a manner that reflects the diversity of people disproportionately impacted by HIV. This includes ensuring that planning body members can participate fully, are included in all stages of decision-making, and represent the communities most affected by HIV.

A. Parity. Parity means ensuring that all members of the planning body are supported to participate equitably in the planning process. The Commission shall provide all members with the information, training, and support needed to participate equally in discussions, voting, and planning activities.
B. Inclusion. Inclusion is defined by the federal requirement that community members must be meaningfully involved in all phases of HIV prevention and care planning. The Commission shall ensure that members — especially persons with lived experience — have meaningful opportunities to participate in discussions, shape priorities, and influence decisions throughout the planning process.
C. Representation. Representation is aligned with federal expectations that planning processes reflect the demographics of local HIV epidemics and the diversity of impacted communities. Commission membership shall reflect the demographic and cultural diversity of Los Angeles County communities disproportionately affected by HIV, including diversity in race, ethnicity, gender, sexual orientation, age, disability, lived experience, and professional background.

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. Consistent with the Los Angeles County Code 3.29.060 D (Meetings and committees), the Commission's standing committees may elect to nominate Committee-only members for approval 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 data (including surveillance) to guide the Commission's priority setting and resource allocation process. DHSP plays a central role in conducting comprehensive planning, needs assessments, overseeing contracting and procurement of providers, evaluating service effectiveness, and performing quality management. Collaborating closely with DHSP, the Commission ensures effective development 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. To strengthen this partnership, 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, mandatory County and Commission trainings, and the Annual Conference.

In accordance with Los Angeles County Code 3.29.060 (Meetings and committees), the BOS shall be notified of member attendance on a quarterly 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, if 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. In accordance with the RWHAP Part A Manual, all planning council/planning body members must annually disclose any actual or perceived conflict of interest — including affiliations with RWHAP-funded providers or agencies. Members must recuse themselves from any discussion or vote in which their conflict could influence the outcome (e.g., resource allocations, funding decisions, service priorities for the affected agency).

Section 4. **Code of Conduct**. All Commission members, vendors and contractors, 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 Member and Community Engagement (MCE) 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 Commission membership shall be interviewed by the 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 Parliamentary Authority.

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 accessible through 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 and its committees shall meet a minimum of 6 times per year. Commission and committee meetings shall be held at a time and location to be determined by the Co-Chairs, the Executive Committee, or committee Co-Chairs. The Executive Committee, Co-Chairs, or 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. Parliamentary Authority. All meetings of the Commission shall be conducted according to appropriate parliamentary authority 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 HIV 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 the Executive Office of the Board of Supervisors (BOS) and 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 HIV 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 (DSO) 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:

A. Stipends: Unaffiliated consumer members may receive a stipend of *up to* $500 monthly contingent upon member eligibility and available funding.

B. Expense Reimbursement: Members may be reimbursed for reasonable and necessary expenses incurred in the performance of their official duties, in accordance with county policies governing reimbursement for county officers and employees and HRSA requirements. Reimbursable expenses may include:

- Local travel and mileage.
- Meals associated with Commission business.
- Childcare during Commission activities.
- Office supplies and computer-related expenses incurred in the performance of commission-related duties.

C. Service Provision in Lieu of Reimbursement: The Commission has the option to arrange for services (such as childcare or transportation) to be provided directly to members rather than offering reimbursement, or to seek alternative funding for member stipends.

D. Stipend Limits: The Executive Director or their designee may adjust stipends on a case-by-case basis for Unaffiliated Consumer members' participation in special meetings and pre-approved activities, depending on available funds.

It is important to note that a stipend is a form of financial support to offset incidental costs and is not considered regular income or employment compensation.

Section 6. Staffing. The Executive Director serves as the Commission's lead staff person and oversees all personnel, budgetary, and operational functions. If the Executive Director position is vacant, the Assistant Director — or, if necessary, the senior staff member — will serve as Acting Executive Director.

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 Review. HRSA does not require RWHAP Part A planning councils to submit their grievance procedures, conflict-of-interest policies, or bylaws for formal review. However, planning councils may share these documents with their HRSA Part A Project Officer for input and guidance, as appropriate, to support alignment with legislative expectations and effective operations.

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 serve two-year staggered terms. In the event of a vacancy, a new Co-Chair shall be elected to complete the remainder of the term. Nominations and elections to fill the vacancy will occur within 60 days of the Chair's resignation.
C. The Co-Chairs are elected by a majority vote of Commissioners or Alternates present at a regularly scheduled Commission meeting held at least four months before the start of the new term, following a nomination period opened at the prior meeting. The term of office begins at the start of the Ryan White Program year (March 1st). Once elected, the incoming Co-Chair will serve as the Co-Chair-Elect and will have four months for mentoring and preparation before assuming the role.

When circumstances make these timelines impracticable, the Executive Committee may adjust the nomination, election, or transition schedule as needed to ensure continuity of leadership.

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 on the California Department of Public Health, Office of AIDS, California Planning Group (CPG).
3. Represent the Commission at functions, events, and other public activities, as necessary.
4. Call special meetings, as necessary, to ensure that the Commission fulfills its duties.
5. Consult with and advise the Executive Director regularly, and the RWHAP Part A and CDC project officers, if applicable and as needed.
6. Conduct the performance evaluation of the Executive Director, in consultation with the Executive Committee and the Executive Office of the BOS.
7. Chair or co-chair committee meetings in the absence of both committee co-chairs.
8. Serve as voting members on all committees when attending those meetings.
9. Act on behalf of the Commission or Executive Committee on emergency matters.
10. 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 two years 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 RWP 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 vote 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.
C. Workgroups are short-term, task-focused bodies created to complete a specific project, develop recommendations, or produce deliverables that support the Commission's work. Workgroups dissolve upon completion of their assigned task.

X. EXECUTIVE COMMITTEE:

Section 1. Membership. The 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, Committee-only members, and DHSP (non-voting member).

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 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. Advance public policies that support the County's HIV service delivery system and align with the comprehensive HIV plan, in coordination with the County's Legislative Affairs office, as appropriate.
M. Initiate and advance policy efforts that strengthen HIV care, treatment, prevention, and related services.
N. Facilitate communication and recommend policy positions to government and legislative officials, the Board of Supervisors, County departments, and other stakeholders, in alignment with County legislative protocols.
O. Educate and support Commission members, consumers, providers, and the public in engaging with public policy processes.
P. Conduct policy research and activities consistent with the County's adopted legislative agendas.; and
Q. Carrying out other duties and responsibilities, as assigned by the Commission or the BOS.
R. Addressing matters related to Commission office staffing, personnel, and operations, when needed.
S. Developing and adopting the Commission's annual operational budget.
T. Overseeing and monitoring Commission expenditures and fiscal activities.
U. 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 Member Duty Statement*, the At-Large members shall serve as members of both the Executive and MCE Committees.

XI. MEMBERSHIP AND COMMUNITY ENGAGEMENT COMMITTEE:

Section 1. Voting Membership. The membership of the Membership and Community

A. The Membership and Community Engagement Committee (MCE) shall include:
1. the Executive Committee At-Large members (elected by the full Commission)
2. representatives from the Cities of Los Angeles, Pasadena, Long Beach, and West Hollywood*
3. a representative from the youth community*
4. members assigned by the Commission Co-Chairs
5. the Commission Co-Chairs, when attending

*Members of this Committee who are not elected by the full Commission may serve as Committee-only members. These individuals shall be nominated by the Committee and approved by the full Commission before serving.

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

A. Ensuring that Commission membership adheres to all federal requirements for reflectiveness, representation, and community engagement, including the Ryan White HIV/AIDS Program (RWHAP) Part A legislative requirements for membership reflectiveness and the CDC/HRSA Integrated HIV Prevention and Care Plan Guidance expectations for meaningful engagement, representation, and inclusive participation. 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.
B. 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.
C. 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.
J. 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.
K. Working with local stakeholders to ensure their representation and involvement in the Commission and in its activities.
L. Identifying, accessing, and expanding other financial resources to support the Commission's special initiatives and ongoing operational needs.
M. 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 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 approved by the Commission, 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. Collaborating with the Standards & Best Practices (SBP) Committee to develop and define directives for implementation of services and service models.

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

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

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

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

H. 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.

I. Recommending service system and delivery improvements to the grantee (DHSP) to ensure that the needs of people living with HIV are adequately met.

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

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

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

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

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

XII. STANDARDS AND BEST PRACTICES (SBP) COMMITTEE:

Section 1. Membership. Membership of the SBP Committee shall be comprised of members assigned by the Commission Co-Chairs; Committee-Only members as nominated by the Committee and approved by the Commission; 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 support DHSP's clinical quality management (CQM) plan.

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

C. Reducing the transmission of HIV improving health outcomes and optimizing quality of life and self-sufficiency for all people living with 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 are adequately met.

E. Collaborating with the PP&A Committee to develop and define 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 HIV prevention and care 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 prevention and care 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 effectiveness of the administrative mechanism (AEAM), 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:

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.

Members who commit such acts may be subject to removal from the Commission.

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.

APPROVED: _____ **DATE:** _____

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; 12/11/25

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
8.28.25	Executive Committee Review
9.25.25	Executive Committee Review
10.23.25	Executive Committee Final Review
12.11.25	Commission Approval (Pending)

ORDINANCE NO._____

An ordinance amending Title 3 – Advisory Commissions and Committees of the Los Angeles County Code, relating to definitions, membership, terms, meetings, duties, and compensation of the Los Angeles County Commission on HIV.

The Board of Supervisors of the County of Los Angeles ordains as follows:

SECTION 1. Section 3.29.010 is hereby amended to read as follows:

3.29.010 Definitions.

A. "Administrative agency" indicates the Division of HIV and STD Programs (DHSP), Department of Public Health (~~DPH~~Public Health) and the County of Los Angeles.

B. "Administrative mechanism" refers collectively to the partnership of the Board of Supervisors, the Commission, grantee and administrative agency, and other participants in the Ryan White-funded service delivery system.

C. "AIDS" means Acquired Immune Deficiency Syndrome, and is a diagnosis of late-stage HIV disease.

D. "Allocations" are the funds to be expended for HIV services and related purposes to be determined by the Commission.

E. "Candidate" refers to a person who has submitted a completed membership application and is seeking appointment to the Commission.

F. "Centers for Disease Control and Prevention (CDC)" is the federal agency that manages HIV and STD prevention programs, surveillance, and related communicable disease and co-morbidity activities.

G. "Community Health Center (CHC)" or "Federally Qualified Health Center (FQHC)" is a public or community-based medical clinic that provides primary care services to low-income populations through Section 330 of the Public Health Service Act.

H. "Consumer" is ~~an HIV-positive~~a person living with HIV and/or AIDS~~-diagnosed individual~~ who uses Ryan White-funded services or is the caretaker of a minor with HIV/AIDS who receives those services, or an HIV-negative prevention services client.

I. "Continuum of HIV Services" is the local operational strategy for providing high-quality HIV prevention, counseling and testing, linkage, and care and treatment services in response to the needs of those living with HIV and/or at risk of exposure to HIV.

J. "Division of HIV and STD Programs (DHSP)" is the administrative agency within ~~DPH~~Public Health to whom ~~DPH~~Public Health delegates authority for the administration of HIV and STD programs and surveillance.

K. "Eligible Metropolitan Area (EMA)" is a jurisdiction eligible to receive Ryan White Part A funds; the County of Los Angeles is the local EMA.

L. "Executive director" is the executive staff member of the Commission.

M. "Grantee" indicates the Department of Public Health (~~DPH~~Public Health), County of Los Angeles, which receives federal, state and county funding for HIV services.

N. "Health Resources and Services Administration (HRSA)" is the federal agency that manages and administers the Ryan White program nationally, including the use of Ryan White funds.

O. "HIV" means Human Immunodeficiency Virus.

P. "HIV disease" is the disease caused by HIV infection.

Q. "HIV Health Services Planning Council (Planning Council)" is the term used in Ryan White Act legislation that refers to the local community planning body for HIV care and treatment services.

R. "HIV Planning Group (HPG)" is the term used ~~in~~by the CDC ~~HIV Planning Guidance~~ that refers to the local community planning body for HIV prevention services.

S. "HIV Planning Guidance" details CDC's planning and prevention service delivery requirements and expectations for HPGs and local health departments.

T. "Integrated Prevention and Care Guidance" refers to a collaborative, five-year strategy developed by the CDC and HRSA for states and localities to coordinated HIV services, aligning prevention and treatment to end the HIV epidemic by 2030.

~~T~~U. "Nominating body" refers to the Commission in its role of designating candidates as nominees for appointment to the Commission by the Board of Supervisors.

~~U~~V. "Open nominations" refers to the process, requirements and guidelines developed by HRSA, and consistent with the CDC's HIV Planning Guidance, governing how Part A planning councils identify, select, and nominate their members.

~~V~~W. "Organization" refers to service agencies and/or groups or coalitions of people affected by HIV.

~~W~~X. "Parity, Inclusion and Representation (PIR)" is the CDC principle to ensure that all HPG members can participate equally (parity), that the planning process actively includes a diversity of views, perspectives and stakeholders (inclusion), and that HPG members should represent the range of ethnicities, gender, backgrounds and other characteristics of people affected by HIV (representation).

~~X~~Y. "Part A" refers to the Ryan White grant funds awarded to EMAs from which the County of Los Angeles directly receives its largest share of Ryan White resources.

~~Y~~Z. "Part B" refers to the Ryan White grant funds awarded to states, most of which support the statewide AIDS Drug Assistance Program (ADAP), and a portion of which the State of California disburses to the County of Los Angeles.

~~Z~~AA. "Priorities" are service categories, ranked in order of consumer need and importance that guide the Commission in the allocation of financial resources.

~~AA~~BB."Provider" is an agency/organization that provides HIV care, treatment and/or prevention services in the EMA, and may or may not be supported by Ryan White, CDC, state, county or other funding.

~~BB~~CC. "Recommending entity" is an organization, agency, institution, entity or person entitled to propose candidates for consideration as nominees for appointment to the Commission pursuant to 3.29.030.

~~CC~~DD. "Representation and Reflectiveness" are Ryan White legislative requirements for a planning council's membership to include members who represent specific interests identified in the legislation (representation), and that the planning

council membership and its subset of unaffiliated consumer members reflect the ethnic, racial and gender proportions of local HIV prevalence (reflectiveness).

~~DD~~EE. "Ryan White" is the program providing the largest non-entitlement source of federal funding for HIV care and treatment services, as authorized by the Ryan White Treatment Extension Act of 2009.

~~EE~~FF. "Service Planning Area (SPA)" is one ~~(1)~~ of eight ~~(8)~~ subdivided areas of the County intended to facilitate and improve local service and healthcare planning.

~~FF~~GG. "Sexually Transmitted Disease(s) (STD~~s~~)" are an assortment of communicable infections and diseases that are primarily transmitted through sexual relations or contact.

~~GG~~HH. "Stakeholder" is any party receiving or providing HIV services or affected by HIV.

~~HH~~II. "Unaffiliated consumer" means ~~an HIV-positive~~a person living with HIV and/or AIDS who is a user of Ryan White-funded HIV services who does not serve in a decision-making capacity (including but not limited to an employee, consultant and/or board of directors member) at any Part A funded organization or agency.

SECTION 2. Section 3.29.030 is hereby amended to read as follows:

3.29.030 Membership.

All members of the Commission shall serve at the pleasure of the Board of Supervisors. The Commission shall consist of ~~fifty-one (51)~~a total of 32 members, including the following three non-voting seats: the Ryan White Program Part A Recipient/Grantee (Public Health Division of HIV and STD Programs [DHSP]), the Part B representative (California Department of Public Health, Office of AIDS), and the

Medicaid/Medi-Cal agency representative. Members are nominated by the Commission and appointed by the Board of Supervisors. Consistent with the open nominations process, the following recommending entities may forward candidates to the Commission for membership consideration: ~~voting members nominated by the Commission and appointed by the Board of Supervisors. Consistent with the open nominations process, the following recommending entities shall forward candidates to the Commission for membership consideration:~~

~~A. Five (5) members who are recommended by the following governmental, health and social service institutions, among whom shall be individuals with epidemiology skills or experience and knowledge of Hepatitis B, C and STDs:~~

~~1. Medi-Cal, state of California;~~

~~2. The city of Pasadena;~~

~~3. The city of Long Beach;~~

~~4. The city of Los Angeles;~~

~~5. The city of West Hollywood.~~

~~B. The Director of DHSP, representing the Part A grantee (DPH);~~

~~C. Four (4) members who are recommended by Ryan White grantees as specified below or representative groups of Ryan White grant recipients in the County, one from each of the following:~~

~~1. Part B (State Office of AIDS);~~

~~2. Part C (Part C grantees);~~

~~3. Part D (Part D grantees);~~

4. Part F [grantees serving the County, such as the AIDS Education and Training Centers (AETCs) or local providers receiving Part F dental reimbursements];

D. Eight (8) representatives who are recommended by the following types of organizations, in the County and selected to ensure geographic diversity and who reflect the epicenters of the epidemic:

1. An HIV specialty physician from an HIV medical provider;

2. A CHC/FQHC representative;

3. A mental health provider;

4. A substance abuse treatment provider;

5. A housing provider;

6. A provider of homeless services;

7. A representative of an AIDS Services Organization (ASO) offering federally funded HIV prevention services;

8. A representative of an ASO offering HIV care and treatment services.

E. Seventeen (17) unaffiliated consumers of Part A services, to include:

1. Eight (8) consumers, each representing a different Service Planning Area (SPA) and who are recommended by consumers and/or organizations in the SPA;

2. Five (5) consumers, each representing a supervisorial district, who are recommended by consumers and/or organizations in the district;

3. Four (4) consumers serving in an at-large capacity, who are recommended by consumers and/or organizations in the County;

F. Five (5) representatives, with one (1) recommended by each of the five (5) supervisorial offices;

~~G. One (1) provider or administrative representative from the Housing Opportunities for Persons with AIDS (HOPWA) program, nominated by the City of Los Angeles Department of Housing;~~

~~H. One (1) representative of a health or hospital planning agency, who is recommended by health plans in Covered California;~~

~~I. One (1) behavioral or social scientist recommended from among the respective professional communities.~~

~~J. Eight (8) representatives of HIV stakeholder communities, each of whom may represent one or more of the following categories. The Commission may choose to nominate several people from the same category or to identify a different stakeholder category, depending on identified issues and needs:~~

~~1. Faith-based entities engaged in HIV prevention and care;~~

~~2. Local education agencies at the elementary or secondary level;~~

~~3. The business community;~~

~~4. Union and/or labor;~~

~~5. Youth or youth-serving agencies;~~

~~6. Other federally-funded HIV programs;~~

~~7. Organizations or individuals engaged in HIV-related research;~~

~~8. Organizations providing harm reduction services;~~

~~9. Providers of employment and training services; and~~

~~10. HIV-negative individuals from identified high-risk or special populations.~~

A. Specific Membership Required by the Ryan White Care Act. Section 2602(b)(2) of the Public Health Service Act lists 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 (DHSP in Los Angeles County);

7. Hospital planning agencies or health care planning agencies;

8. Affected communities, including people with HIV and/or 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/Medi-Cal agency);

11. The agency administering the Ryan White program under Part B;

12. Recipients under subpart II of Part C;

13. Recipients under Section 2671 of 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 of which the individual were so released.

B. Unaffiliated Consumer Membership. In accordance with Ryan White Program Part A legislative requirements outlined in Section 2602(b)(5)(C) of the Public Health Service Act, the Commission shall ensure that at least 33% (at least 11) of its members are consumers of Ryan White Program Part A services who are not aligned or affiliated with Ryan White Program 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. HIV Research Representative. One representative from a local academic research institution with subject matter expertise in HIV research and data translation.

D. Board of Supervisors' Representatives. Five Board of Supervisors' representatives, one recommended by each of the five Supervisorial offices.

In all the above membership categories where not specifically required, recommending entities and the nominating body are strongly encouraged to nominate candidates living with HIV ~~disease~~ or members of populations disproportionately ~~affected~~impacted by the HIV epidemic. Members are expected to report to and represent their recommending entities and constituencies. Members may, at times, represent multiple constituencies.

In accordance with Ryan White Care Act and CDC requirements, the Commission shall ensure that its full membership and its subset of unaffiliated consumer members shall proportionately reflect the ethnic, racial and gender proportions of HIV disease prevalence in the EMA. ~~In accordance with Ryan White requirements, at least one (1) unaffiliated consumer must be co-infected with Hepatitis B or C, and at least one (1) unaffiliated consumer must be recently incarcerated or an advocate for the recently incarcerated.~~

In forwarding nominations for appointment by the Board of Supervisors, the Commission shall ensure that its membership fully conforms to Ryan White Part A planning council requirements on representation, reflectiveness and consumer membership, and the CDC's HPG requirements on Parity, Inclusion, and Representation.

SECTION 3. Section 3.29.040 is hereby amended to read as follows:

3.29.040 Alternate members.

One ~~(1)~~ alternate may be nominated by the Commission for appointment by the Board of Supervisors for each member who has disclosed that ~~he/she is~~they are living with HIV ~~disease~~. An alternate shall attend meetings of the Commission and vote in the absence of the person for whom ~~he/she is~~they are designated as an alternate. Nominations of the alternates shall be made from the pool of candidates recommended for membership. The Commission shall ensure that the composition of alternate members conforms to any Part A planning council requirements which apply to alternates.

SECTION 4. Section 3.29.045 is hereby amended to read as follows:

3.29.045 Nominations.

Nominations for membership shall be conducted through an open process and candidates selected based on delineated and publicized criteria which include a ~~conflict of interest~~conflict-of-interest standard as set out in Section 3.29.046. The Commission shall maintain a standing ~~operations~~Membership and Community Engagement committee which shall review the composition of the Commission, and conduct broad-based recruitment and initial screening of applicants on an ongoing basis. The ~~operations~~Membership and Community Engagement committee is responsible for the following: processing membership applications; selecting the candidates based on their qualifications to meet general membership and specific seat requirements and in order to help the Commission meet other membership mandates and requirements; and forwarding its membership recommendations to the Commission for nomination. Upon approval by the Commission, candidate nominations are sent to the Board of Supervisors for its consideration for appointment to the Commission. This process will be conducted prior to expiration of membership terms and during the year in the event of mid-term vacancies.

SECTION 5. Section 3.29.046 is hereby amended to read as follows:

3.29.046 Conflict of interest.

A. Ryan White Act legislation requires certain constituencies and entities to be represented on the Commission. Ryan White Act legislation also requires the Commission to establish priorities and allocate funds within the EMA. Therefore, Commission members, regardless of their private affiliations, may participate in the process to determine funding priorities and to allocate Ryan White Part A ~~and B~~ and

CDC HIV prevention funds in percentage and/or dollar amounts to various service categories or other types of activities, with the following limitations: as specified in Section 2602(b)(5) (42 U.S.C. § 300ff-12) of Ryan White Act legislation, the Commission shall not be involved directly or in an advisory capacity in the administration of Ryan White, CDC, or other funds and shall not designate or otherwise be involved in the selection of particular entities as recipients of those grant funds.

B. All members and alternates of the Commission and participants in the Commission's community planning process shall act in accordance with the Commission's adopted code of conduct, which includes adherence to ~~conflict of interest~~conflict-of-interest rules and requirements.

SECTION 6. Section 3.29.050 is hereby amended to read as follows:

3.29.050 Term of service.

A. All members and alternates shall serve at the pleasure of the Board of Supervisors. Any member whose employment, status or other factors no longer fulfill the requirements of the membership seat to which ~~he/she was~~they were appointed shall be removed from the Commission as determined by the Board of Supervisors.

B. At the first meeting of the HIV Commission in ~~2013~~March of 2026, after this ordinance ~~is effective~~has been amended, the terms of the current members of the Commission on HIV ~~and the Prevention Planning Committee (PPC)~~ shall expire. When the revised ordinance ~~unifying the Commission on HIV and the Prevention Planning Committee~~ becomes effective, the new members appointed by the Board of Supervisors will be seated. The Commission shall classify its members by lot so that ~~twenty-five (25)~~16 members' terms will expire after one ~~(1)~~ year and ~~twenty-six (26)~~16 members'

terms will expire after two ~~(2)~~ years. Thereafter, each membership term shall be two ~~(2)~~ years. The new term for members shall begin on March 1, 2026.

C. ~~No member may serve on the Commission for more than two (2) full consecutive terms, unless such limitation is waived by the Board of Supervisors.~~All members, Commissioners, Alternate Members, and Committee-Only Members, may serve a maximum of three consecutive two-year terms (six years total). Terms for Commissioners and Alternates are reflected on the Membership Roster; terms for Committee-Only Members begin on the date they are approved by the Commission. At the end of each term, members may reapply. After completing six consecutive years, a one-year break is required before reapplying, unless waived by the Board of Supervisors.

D. All members shall complete and submit renewal applications prior to the expiration of their respective terms. However, a member may continue serving in the seat, beyond term expiration, until such time as the member has resigned, is replaced, or the seat is vacated by the ~~executive director in consultation with the co-chairs and the operations committee~~Board of Supervisors as recommended by the Commission.

E. In addition to their Commission service, members are required to serve on at least one ~~(1)~~ of the Commission's standing committees.

F. During the course of a year, absence from any combination of six ~~(6)~~ regularly scheduled Commission meetings and/or regularly scheduled meetings of the committee to which the member has been assigned may result in the Board of Supervisors removing the member from the Commission. Reinstatement or replacement may occur with subsequent nomination from the Commission and appointment by the

Board of Supervisors. An alternate's attendance in a member's place is considered attendance by the member at the meeting.

SECTION 7. Section 3.29.060 is hereby amended to read as follows:

3.29.060 Meetings and committees.

A. The Commission shall meet at least ~~ten (10)~~six times a year.

B. The Commission shall establish an executive committee to set agendas for meetings, and conduct business between Commission meetings. The executive committee shall include the Director of DHSP or ~~his/her~~their permanent designee as a non-voting member, the co-chairs of the Commission and three ~~(3)~~ at-large members elected by the Commission. For purposes of this subsection, the authority of the executive committee to conduct business shall include acting on behalf of the Commission in time-sensitive circumstances, which action(s) shall be ratified by the Commission at its next regularly scheduled meeting.

C. In addition to the executive and ~~operations~~Membership and Community Engagement committees, the Commission may establish other standing committees in its bylaws in order to carry out its mission and responsibilities. The Commission may also create other working groups, as allowed by its policies and procedures.

D. On a ~~semi-annual~~quarterly basis, the Board of Supervisors shall be notified of member attendance at Commission meetings and meetings of standing committees.

E. As needed by committees and appropriate for added professional expertise, as a means of further engaging community participation in the planning process, and/or as necessary to meet the requirements of the CDC's ~~HIV Planning~~

Integrated HIV Prevention and Care Plan Guidance, the ~~Commission is empowered to nominate candidates who are not commission members for appointment by the Board of Supervisors as members of the Commission' s established standing committees. The term of each such member shall be two (2) years.~~Commission's standing committees may elect to nominate Committee-only members for approval 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.

F. Commission meetings shall be chaired by the Commission's two ~~(2)~~ co-chairs, with the support of the executive director and staff. The co-chairs shall be elected by the Commission and have staggered two~~-~~ ~~(2)~~ year terms.

SECTION 8. Section 3.29.080 is hereby amended to read as follows:

3.29.080 Compensation.

When required to travel outside ~~the county~~of Los Angeles County in performance of commission duties, members may be reimbursed from Ryan White or other funds for necessary travel expenses, including transportation, meals and lodging. To be reimbursable, such travel must receive prior written approval from the executive director or ~~his/her~~their designee.

Corresponding with Ryan White Act legislation and HRSA and CDC guidelines, members of the Commission may also be reimbursed for local travel and mileage, meals associated with Commission business, child care during Commission activities, and computer-related expenses if those costs were incurred in the performance of commission-related duties. The Commission may, in addition to reimbursing those

expenses, also provide these services directly to members and/or pay monthly stipends to unaffiliated consumer members of Ryan White Part A services or HIV-negative individuals from identified high-risk or special populations who, if positive, would be eligible for Ryan White services, provided that the stipends are not paid with Ryan White funds. Eligible members must maintain a required level of participation and other performance requirements, as defined in Commission policy.

The Commission will establish, and the executive director will implement, procedures for eligibility and utilization of the foregoing described reimbursements, member services and/or stipends, including stipend amounts ~~of at least $25 and no more than $150~~up to $500 per month as determined by Commission policy and reported to the ~~b~~Board of Supervisors, and the availability of funding.

SECTION 9. Section 3.29.090 is hereby amended to read as follows:

3.29.090 Duties.

Consistent with Section 2602(b)(4) (42 U.S.C. § 300ff-12) of Ryan White Act legislation, HRSA guidance, and requirements of the CDC's HIV Planning Guidance, the Commission is authorized to:

A. Develop a 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 DHSP to update the plan on a regular basis;

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

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

D. 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' s delivery of HIV services;

E. Plan and develop HIV and public health service responses to address the frequency of HIV infection concurrent with STDs and other co-morbidities; deploy 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;

F. Study, advise and recommend to the Board of Supervisors, the grantee and other departments' policies and other actions/decisions on matters related to HIV;

G. Inform, educate, and disseminate information to consumers, specified target populations, providers, the general 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;

H. Provide a report to the Board of Supervisors annually, ~~no later than June 30th,~~ describing Los Angeles County's progress in ending HIV ~~as a threat to the health and welfare of Los Angeles County residents~~, with indicators determined by the Commission in collaboration with DHSP; and make other reports as necessary to the Board of Supervisors, the grantee and other departments on HIV-related matters referred for review by the Board of Supervisors, the grantee, or other departments;

I. Act as the planning body for all HIV programs in the Department of Public Health or funded by the County; and

J. Make recommendations to the Board of Supervisors, the grantee, and other departments concerning the allocation and expenditure of funding other than Ryan White Part A ~~and B~~ and CDC prevention funds expended by the grantee and the County for the provision of HIV-related services.

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LOS ANGELES COUNTY
COMMISSION ON HIV

2025 Annual Conference Summary

"Resilience in Uncertain Times: Advancing HIV Science, Policy, and Community Together"

November 13, 2025 | St. Anne's Event & Conference Center

On November 13, 2025, the Los Angeles County Commission on HIV held its Annual Conference at St. Anne's Conference & Event Center, bringing together community members, partners, Commissioners, service providers, researchers, and policymakers for a day of honesty, connection, and collective purpose. The conference opened with a welcome, moment of silence, and land acknowledgment led by Commission Co-Chairs, Dr. Danielle Campbell and Joseph Green, grounding the room in reflection and community care.

Opening Remarks & Congressional Message

Dr. Marisa Ramos, Chief of the California Department of Public Health's Office of AIDS, offered opening remarks that were both grounding and forward-looking, reminding participants that partnership, courage, and alignment are essential during times of uncertainty.

Although unable to attend in person, Congresswoman Maxine Waters provided a written statement celebrating the conference theme and reaffirming her commitment to protecting HIV prevention, care, housing, and research programs. She highlighted her decades of advocacy and shared updates on two new federal bills designed to strengthen HIV prevention and sustain public health programs.

Reimagining the Commission

Commission Co-Chair, Joseph Green, and consultant, AJ King, walked attendees through the Commission's restructure, framing the vision behind this new era of impact and how it strengthens the Commission's ability to respond to community needs with clarity and purpose.

State of HIV & STIs in Los Angeles County

Mario J. Pérez, MPH, Director of the Division of HIV and STD Programs (DHSP), delivered an overview of the local HIV and STI landscape, grounding the room in where Los Angeles County stands, where gaps persist, and what coordinated, community-centered action is needed.

Panel Discussion: Science in Action, Research for Change - Advancing Global and Local Efforts to End HIV

Moderated by Dr. Danielle Campbell, this panel brought together Dr. Judith Currier, Dr. William King, Dr. Rhodri Dierst-Davies, and Dr. Leon Maultsby, who bridged innovation, implementation, and equity. They

emphasized that scientific breakthroughs matter only when communities can access them—and when research is guided by real-world lived experience.

Panel Discussion: Policy & Legislation - Safeguarding HIV Programs Amid Censorship and Funding Threats

Moderated by Commissioner Arburtha Franklin, panelists Katja Nelson, Bee Curiel, and Darryn Harris discussed funding cuts, Diversity, Equity and Inclusion (DEI) rollbacks, and censorship, emphasizing that policy determines who gets access, who gets protected, and who gets left behind. They centered on protecting essential programs through coalition-building and strategic advocacy.

Keynote Address: Resilience Through Policy – Advancing Equity and Access with the PrEP and PEP Are Prevention Act (H.R. 5127)

Keynote speaker Robert Gamboa of the Los Angeles LGBT Center delivered Resilience Through Policy – Advancing Equity and Access with the PrEP and PEP Are Prevention Act (H.R. 5127). He connected science, policy, and community in a way that helped the room see both the challenges and the path forward, emphasizing that we do not build systems of care *for* communities, but *with* communities. His address was powerful, timely, and deeply grounding for the work ahead.

Commission on HIV: A Year in Review

Midway through the afternoon, attendees viewed a special Commission highlight reel — a pre-recorded narration by former Commission on HIV Executive Director, Cheryl A. Barrit. The reel reflected on a year marked by major structural shifts, community-driven initiatives, and collective perseverance.

The video uplifted key accomplishments across the Commission's working committees and caucuses, including advancements in integrated planning, the launch of new community listening sessions, strengthened partnerships with DHSP, and progress on the Commission's comprehensive restructure.

It also highlighted the extraordinary work of Commissioners, staff, and community partners who continued to push forward in a year defined by both innovation and challenge. The reel served as a moment to pause, honor shared progress, and acknowledge the leadership, adaptability, and dedication that moved the work forward.

This segment grounded the room in the truth that the Commission's impact is the result of many hands and voices working together — a theme that echoed throughout the rest of the conference.

Panel Discussion: Community Engagement & Advocacy - Strategies for Collective Action

Moderated by Commissioner Miguel Alvarez, panelists Gerald Garth, Shellye Jones, Kevin Pizarro, and Thelma Garcia uplifted what it means to authentically engage community, centering care, trust, and

shared power. Gerald Garth reminded the room: “None of us have to do everything if all of us do something.”

Community Call to Action: From Reflection to Action

In the closing session, Commissioner Joaquin Guiterrez guided attendees through a democratic process to identify and vote on shared priorities. The final Calls to Action were:

- Strengthen authentic relationship-building across community, Commissioners, partners, and policymakers.
- Develop a universal sexual health marketing campaign that agencies can adapt and use countywide.
- Create a coordinated, all-agency social media campaign to expand awareness of HIV prevention services throughout Los Angeles County.

Community Moments

Michael Barajas of Gilead Sciences delivered a lunch presentation on Cultural Humility, anchoring the day in the reality that HIV work is rooted in people and relationships. Attendees also viewed LA Cumbia Del Movimiento by Bamby Salcedo, and the day closed with an Art Legacy Exhibition featuring artwork created by artists living with HIV more than two decades ago.

Closing Appreciation

The Commission expressed deep gratitude to all speakers, panelists, Commissioners, DHSP partners, community members, and Commission staff—Dawn, Jose, Lizette, and Sonja—whose support, leadership, and coordination made the day possible. Special thanks were extended to Gilead Sciences for sponsoring lunch and supporting the conference.

The 2025 Commission on HIV Annual Conference was a reminder that this work only moves forward when we move together—aligned, informed, and rooted in community.

CLICK HERE TO VIEW 2025 ANNUAL CONFERENCE

CLICK HERE TO VIEW PHOTOS

PARTICIPANT BIOS

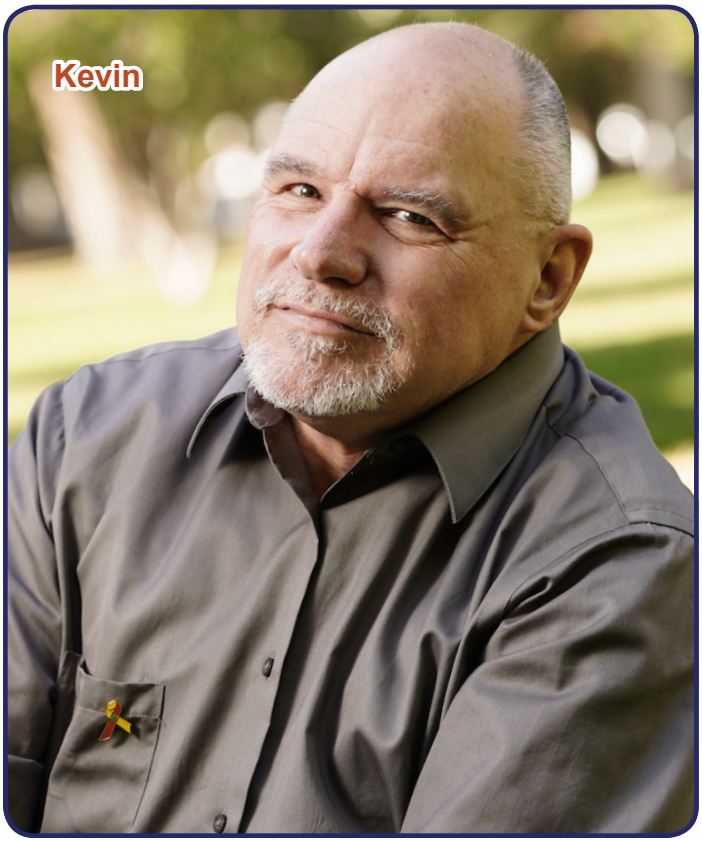
the OA Voice
CDPH California Department of Public Health
Issue: November 2025

INSIDE:

This newsletter is organized to align with the six Social Determinants of Health found in the *Ending the Epidemics Integrated Statewide Strategic Plan*, addressing the syndemic of HIV, HCV, and STIs in California. More about the *Strategic Plan* is available on the Office of AIDS (OA) website.

STAFF HIGHLIGHT

A Letter From Kevin Sitter



To the OA Family – Staff, Contractors, Consumers, and Allies:

While I finished working full-time for OA in the Fall of 2022, I have had a part-time (8 hours/ week) retired annuitant role for the last few years at OA. This ended October 31, 2025, and I gain additional “me time” for retirement!

Although people tell me I still must learn what real retirement is – as my calendar seems to stay densely packed with work for the Minnesota HIV Planning Council, developing the Minnesota HIV and Aging Coalition, helping pass legislation giving protection to LGBTQ+ and PLWH in long-term care- and transitional-care facilities, and in-home and community-based services.

This is the trend of the future, as more of us age with HIV. Once again, we are building the plane as we fly it. There has never been such a large cohort of people over the age of 50 living with HIV. Death will become more common again, but this time it won’t be the young people who died of AIDS-related complications, but older people dying similar to their non-infected peers.

AIDS-related deaths have decreased significantly, replaced by complications of diabetes, cardiac events, kidney failure, and other non-AIDS related reasons. Sadly, a significant percentage continue to die from drug overdoses. It is critical we continue our harm reduction approaches to address the multiple needs of people who use drugs, including housing, emotional and mental health support, decreasing isolation, and increasing respect of those who use drugs.

Despite the current challenges faced by Federal Administration policies, it is critical we continue to collect data that captures comprehensive demographics of people living with HIV and

PrEP-eligible individuals. This should include housing status, incarceration history, and more refined racial and ethnic categorization. I suggest it is also time to monitor causes of death among people living with HIV in order to consider if more can be done to decrease premature deaths from causes other than AIDS, including lowering drug overdose rates among PLWH.

So, despite retiring a bit further from the front lines and OA, I will continue to advocate on behalf of our communities (and myself!) and make sure our policymakers know the experience of living of HIV in this 21st century.

I want to say thank you for all you do. ***It makes a difference***. In my opinion, the phrase, "I'm from the government, I am here to help," is not satirical but is the mantra of all the colleagues I have worked with throughout California. Your dedication provides people with HIV, people at risk of HIV, and people affected by HIV, assurance that they matter and that you do everything possible to help people obtain the services and resources needed to live healthy, dignity-filled lives free of stigma.

I admire you all and wish you the best in life.

Thank you!

Sincerely,

Kevin Sitter

HIV AWARENESS

We celebrate the **transgender and gender nonconforming communities throughout the month of November**. Communities host educational and advocacy activities to help raise awareness of transgender and gender nonconforming individuals and the growing issues they face including escalated violence and continuous legislative attacks. In this moment, it is imperative to support, empower, and unite with the transgender and gender nonconforming communities spotlighting the need for allyship, education, and empowerment to combat ongoing attacks on trans rights. To learn more about the Transgender community and ways to support the community, please view our OA Transgender Community Health in California website.

Transgender Awareness Week is celebrated the week of November 13th–19th. This week provides an opportunity for educators, students, and community members to learn about the experiences of transgender and gender nonconforming individuals and to honor and uplift them.

Transgender Day of Remembrance is observed on November 20th, to honor the memory of transgender individuals whose lives were lost due to acts of anti-transgender violence that year.

In addition, we celebrate **Native American Heritage Month** to honor culture, traditions, languages, and achievements of Native Americans, Alaska Natives, Native Hawaiians, and affiliated Island communities.

This month is celebrated to ensure histories, stories, and contributions are shared and passed-on with each generation. Check out the National Native American Heritage Month webpage to learn more.

GENERAL UPDATES

Mpox

OA is committed to providing updated information related to mpox. We have partnered with the Division of Communicable Disease

Control (DCDC), a program within the Center of Infectious Diseases and have disseminated a number of documents in an effort to keep our clients and stakeholders informed.

On October 29, 2025, CDPH held an LGTBQ+ community stakeholder listening session about mpox in California. Community-based organizations, local health departments, and community advocates were invited to participate.

The purpose of this webinar was to provide updates about the recent reports of community spread of clade I mpox in California, what CDPH is doing to address it, and what you need to know. CDPH would like to thank everyone who registered and attended the session.

If you were unable to attend, the recording of the listening session can be accessed utilizing the following passcode: **CD@+2MM1**

Mpox digital assets continue to be available for LHJs and CBOs on DCDC's Campaign Toolkits website.

Other Tools and Resources:

- Health Advisory: Community Spread of Clade I Mpox Within California (CDPH)
- Mpox Information: Basics, Current Situation in California, and Resources (CDPH)
- Mpox Vaccine Recommendations (CDPH)
- Mpox Vaccine Locator Map (Bavarian Nordic)
- Provider and Health System Access to Commercially Available JYNNEOS Vaccine in California (CDPH)

For questions, or to provide additional information about challenges accessing mpox vaccine, please contact mpoxadmin@cdph.ca.gov.

Also, please refer to the DCDC website to stay informed of mpox updates.

HIV/STI/HCV Integration

We're excited to share an update on the progress of our integration of CDPH HIV, STI, and HCV programs into a single new Division.

We've gotten all needed approvals for "Phase 1" and are ready to take our next big steps toward integration – the creation of a single new Division of HIV, HCV, and STIs and the new position to lead the Division.

On October 16, 2025, the position announcement for the new Chief of the Division of HIV, HCV, and STIs was released with a final closing date of November 15, 2025. This position can be based out of Sacramento or Contra Costa Counties (there is a posting for each location which are both for this single position). Both MDs and PhDs with relevant experience are encouraged to apply and the most qualified applicants will be interviewed.

We are taking a slow and steady approach, starting with the creation of this new Division, the hiring of the Division Chief, and moving both Office of AIDS and the STD Control Branch into the new Division but in their current organizational structures – what we're calling "Phase 1." The STD Control Branch name will ultimately change to the Office of STIs and Hepatitis C.

We anticipate you won't see many immediate changes or impacts to existing contracts/ grants or points of contacts from this first step and that more changes will unfold as planning continues.

As we begin planning for further integration, we will rely on the expertise of our teams to inform the direction and pace of our changes. We also see opportunities for our many partners to weigh in on the integration of our teams.

We will continue to keep you apprised on our journey as we move forward and more information develops. We are excited for the accomplishment of this huge milestone and are committed to

continuing to align our services in a coordinated syndemic manner to better serve individuals at risk of acquiring HIV, STIs, and HCV.

OA's Revamped HIV Laws Webpage

In an effort to improve awareness of important legislative information relating to HIV, OA has recently updated its HIV Laws webpage. This page contains organized links to state laws and regulations, as well as associated fact sheets and letters, all relating to OA's programs on HIV prevention, treatment, care, surveillance, and harm reduction. OA will continue to update this webpage with new links and resources in line with the passage of new legislative bills.

ENDING THE EPIDEMICS STRATEGIC PLAN OA/STD

The **visual below** is a high-level summary of our *Strategic Plan* that organizes 30 Strategies across six Social Determinants of Health.

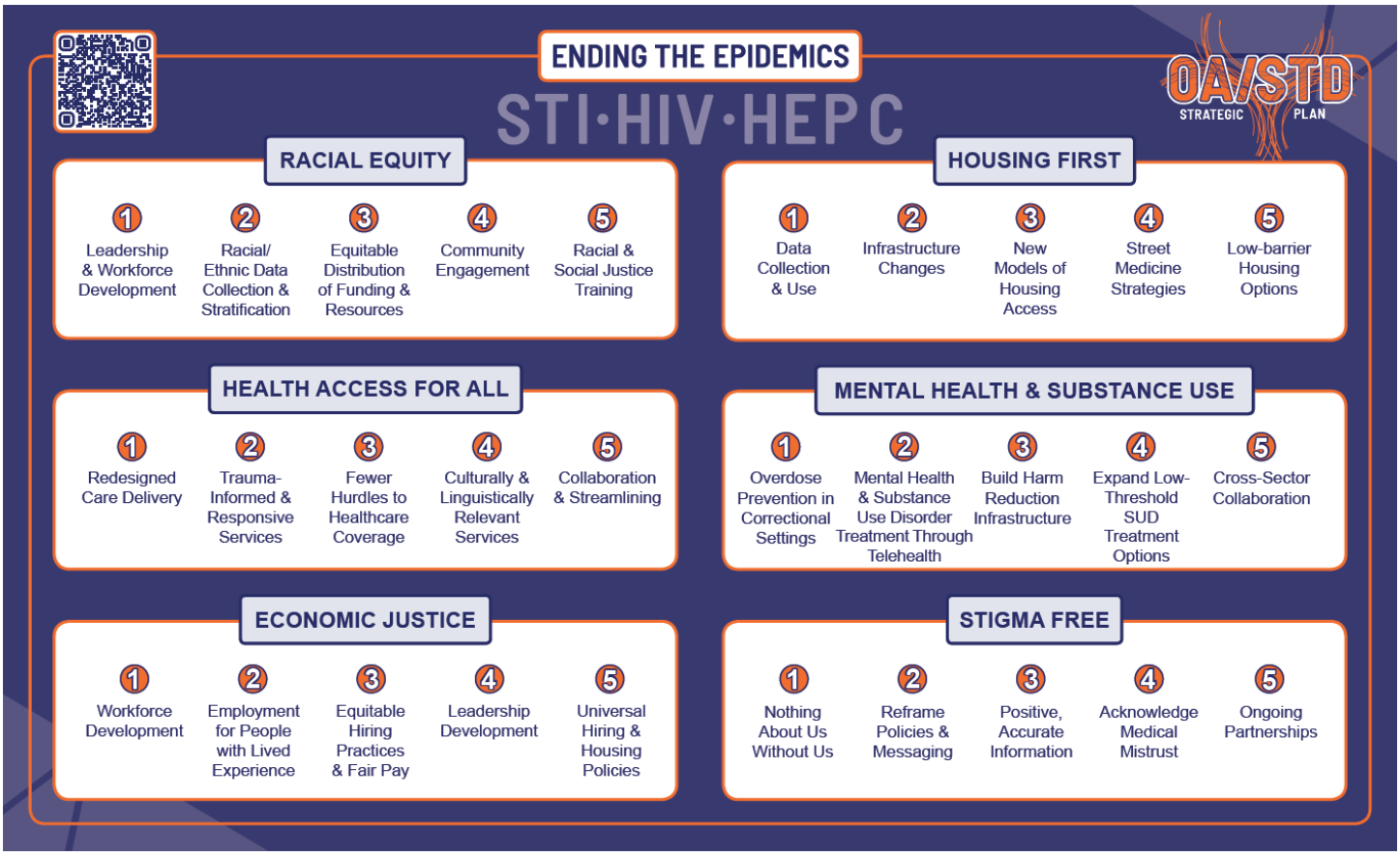
OA and STD Control Branch would like you to continue to use and share the *Strategic Plan* and the *Implementation Blueprint*. These documents address HIV as a syndemic with HCV and other STIs, through a Social Determinants of Health lens.

For technical assistance in implementing the *Strategic Plan*, California LHJs and CBOs can vist Facente Consulting's webpage.

HEALTH ACCESS FOR ALL

Strategy 1: Redesigned Care Delivery

OA continues to implement its **Building Healthy Online Communities (BHOC)** self-testing

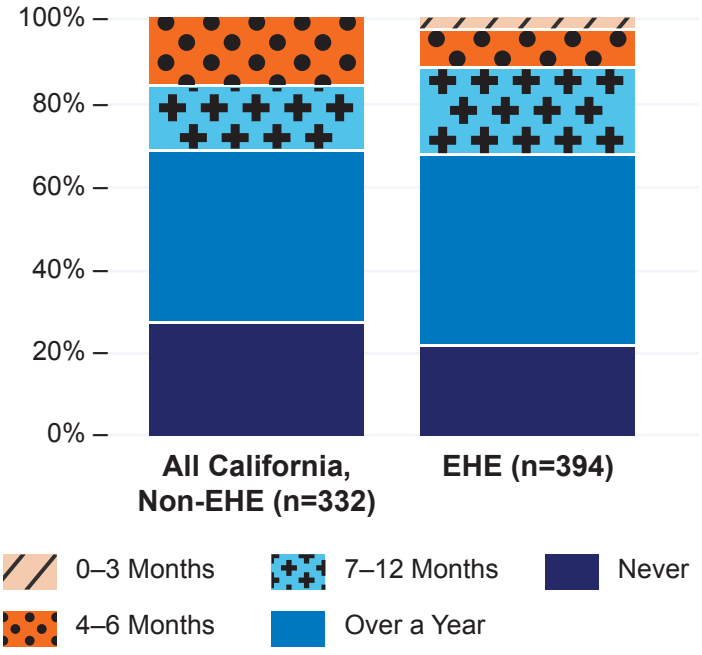


program to allow for rapid OraQuick test orders in all jurisdictions in California. The program, TakeMeHome, is advertised on gay dating apps, where users see an ad for home testing and are offered a free HIV-home test kit.

TAKEMEHOME

In September, 332 individuals in 39 counties ordered self-test kits, with 233 (70.2%) individuals ordering 2 tests. Additionally, OA's existing TakeMeHome Program continues in the six California Consortium Phase I Ending the HIV Epidemic in America counties. Between the program's initiation in September 1, 2020, and September 30, 2025, 19,324 tests have been distributed. This month, mail-in lab tests (including dried blood spot tests for syphilis, and Hepatitis C, as well as 3-site tests for gonorrhea and chlamydia) accounted for 175 (44.4%) of the 394 total tests distributed in EHE counties. Of those ordering rapid tests, 166 (75.8%) ordered 2 tests.

HIV Test History Among Individuals Who Ordered TakeMeHome Kits, Sept. 2025



Additional Key Characteristics	EHE	All California, Non-EHE
Of those sharing their gender, were cisgender men	45.7%	48.2%
Of those sharing their race or ethnicity, identify as Hispanic or Latinx	39.2%	38.4%
Were 17-29 years old	42.6%	37.1%
Of those sharing their number of sex partners, reported 3 or more in the past year	40.7%	39.6%

Since September 2020, 2,094 test kit recipients have completed the anonymous follow up survey from EHE counties; there have been 921 responses from the California expansion since January 2023.

Survey Highlights	EHE	All California, Non-EHE
Would recommend TakeMeHome to a friend	95.0%	94.6%
Identify as a man who has sex with other men	46.7%	51.0%
Reported having been diagnosed with an STI in the past year	8.3%	9.8%

HEALTH ACCESS FOR ALL

Strategy 3: Fewer Hurdles to Healthcare Coverage

As of October 31, 2025, there are 296 PrEP-AP enrollment sites and 232 clinical provider sites that currently make up the PrEP-AP Provider network.

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

As of October 31, 2025, the number of ADAP clients enrolled in each respective ADAP Insurance Assistance Program are shown in the **table below**.

Strategy 3: Fewer Hurdles to Healthcare Coverage

PrEP-AP Adds Lenacapavir (Yeztugo) to Formulary for Select Clients

The PrEP-AP program is pleased to announce the release of Management Memorandum 2025–13: *Addition of Long-Acting Injectable Lenacapavir (Yeztugo) to the PrEP-AP Formulary for Certain Client Types.*

Effective October 20, 2025, Lenacapavir (Yeztugo) has been added to the PrEP-AP formulary (927 mg via two 1.5-mL subcutaneous injections) and (600 mg via two 300-mg tablets). This addition is specifically intended for PrEP-AP clients who face confidentiality concerns that prevent them from using insurance through a parent, guardian, spouse, or registered domestic partner; minors aged 12 to 17; and uninsured individuals whose income falls between 500–600% of the Federal Poverty Level (FPL) and who do not qualify for Pharmaceutical Assistance Programs (PAP).

We encourage all PrEP-AP Enrollment Workers and Clinical Providers to read the full memorandum for complete details. Thank you for your continued commitment to supporting our clients and expanding access to HIV prevention options.

(continued on page 8)

ADAP Insurance Assistance Program	Number of Clients Enrolled	Percentage Change from September
Employer Based Health Insurance Premium Payment (EB-HIPP) Program	579	-1.70%
Office of AIDS Health Insurance Premium Payment (OA-HIPP) Program	5,783	0.07%
Medicare Premium Payment Program (MPPP)	2,341	-0.30%
Total	**8,703**	**-0.15%**

Source: ADAP Enrollment System

Active PrEP-AP Clients by Age and Insurance Coverage:

Current Age	PrEP-AP Only		PrEP-AP With Medi-Cal		PrEP-AP With Medicare		PrEP-AP With Private Insurance		TOTAL	
	N	%	N	%	N	%	N	%	N	%
18 - 24	308	12%	---	---	---	---	10	0%	318	12%
25 - 34	900	34%	---	---	---	---	132	5%	1,032	39%
35 - 44	669	25%	---	---	1	0%	105	4%	775	29%
45 - 64	357	13%	1	0%	4	0%	78	3%	440	16%
65+	26	1%	---	---	79	3%	7	0%	112	4%
TOTAL	**2,260**	**84%**	**1**	**0%**	**84**	**3%**	**332**	**12%**	**2,677**	**100%**

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

Current Age	Latinx		American Indian or Alaskan Native		Asian		Black or African American		Native Hawaiian/ Pacific Islander		White		More Than One Race Reported		Decline to Provide		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
18 - 24	174	6%	1	0%	39	1%	24	1%	1	0%	50	2%	4	0%	25	1%	318	12%
25 - 34	576	22%	3	0%	90	3%	85	3%	3	0%	202	8%	5	0%	68	3%	1,032	39%
35 - 44	475	18%	4	0%	63	2%	44	2%	2	0%	145	5%	6	0%	36	1%	775	29%
45 - 64	249	9%	---	---	31	1%	14	1%	---	---	111	4%	1	0%	34	1%	440	16%
65+	13	0%	---	---	4	0%	4	0%	---	---	83	3%	---	---	8	0%	112	4%
TOTAL	**1,487**	**56%**	**8**	**0%**	**227**	**8%**	**171**	**6%**	**6**	**0%**	**591**	**22%**	**16**	**1%**	**171**	**6%**	**2,677**	**100%**

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

Gender	Latinx		American Indian or Alaskan Native		Asian		Black or African American		Native Hawaiian/ Pacific Islander		White		More Than One Race Reported		Decline to Provide		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Female	37	1%	---	---	3	0%	14	1%	1	0%	11	0%	---	---	7	0%	73	3%
Male	1,387	52%	7	0%	203	8%	155	6%	4	0%	560	21%	15	1%	140	5%	2,471	92%
Trans	57	2%	---	---	17	1%	1	0%	1	0%	8	0%	1	0%	3	0%	88	3%
Unknown	6	0%	1	0%	4	0%	1	0%	---	---	12	0%	---	---	21	1%	45	2%
TOTAL	**1,487**	**56%**	**8**	**0%**	**227**	**8%**	**171**	**6%**	**6**	**0%**	**591**	**22%**	**16**	**1%**	**171**	**6%**	**2,677**	**100%**

All PrEP-AP charts prepared by: ADAP Fiscal Forecasting Evaluation and Monitoring (AFFEM) Section, ADAP and Care Evaluation and Informatics Branch, Office of AIDS. Client was eligible for PrEP-AP as of run date: 10/31/2025 at 12:01:10 AM Data source: ADAP Enrollment System. Site assignments are based on the site that submitted the most recent application.

MENTAL HEALTH & SUBSTANCE USE

Strategy 3: Build Harm Reduction Infrastructure

Harm Reduction Supply Clearinghouse Impact – Poster

The Harm Reduction Supply Clearinghouse was created to provide a baseline level of supplies to all authorized California Syringe Services Programs (SSPs). Continued participation in the Clearinghouse is contingent on completing an annual renewal application/survey. The annual Clearinghouse survey is sent out every January and measures the successes and challenges of SSPs for the previous year.

In 2016, when the Clearinghouse began, the main goal was to bring supply stability to SSPs, which it did. Since the Clearinghouse reached its initial goal, the survey evolved to ask questions that helped the Harm Reduction Unit assess, support and sustain the growth of all programs.

A new poster developed by OA's Leslie Knight and Rachael Malone demonstrates the impact of COVID-19 on SSPs and their participants, the effects of the Naloxone Distribution Project, the impact of the CA Overdose Prevention and Harm Reduction Initiative (COPHRI), and the drastic change in modes of consumption when we added smoking supplies to the Clearinghouse catalog.

View the Harm Reduction Supply Clearinghouse poster on our webpage.

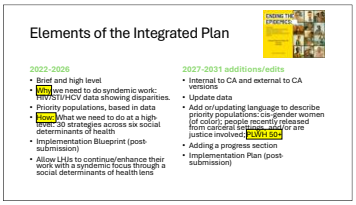
For questions regarding *The OA Voice*, please send an e-mail to angelique.skinner@cdph.ca.gov.

CDPH California Department of Public Health

Integrated Plan and other CDPH Updates December, 2025

A. Integrate Plan Update.

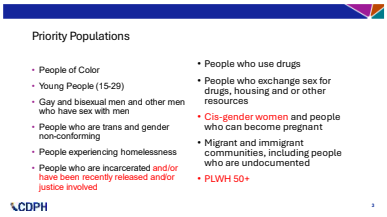
CDPH is pleased to collaborate with the Los Angeles EMA for the 2027-2031 integrated planning process. Attached to this narrative is a short slide deck summarizing some important information about the Integrated Plan. Leroy Blea was not available to attend today, but will be happy to answer process questions about these slides at the next regular Commission meeting or via email.



The "Elements of the Integrated Plan" (slide 2) shows the differences between the current plan and the revised plan currently in process. We are keeping many critical aspect of the last plan: it will be brief and high-level; it will out line the how and why we need to do syndemic work through a social determinants of health lens.

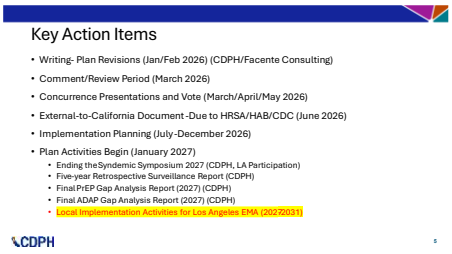
Additions and edits to the revised plan include the following:

1) We are currently updating the last plan with the most recent, mature surveillance data for HIV/AIDS, other STIs and HCV (2024).
2) We are updating language to the listed priority populations and adding an additional priority population (PLWH 50+) to the list of priority populations.
3) We are adding a "progress section" to highlight improvements in health outcomes.



Slide 3 "Priority Populations" shows current data-based priority populations populations with additions or current changes to language noted in red. As noted we are adding PLWH 50+ as a priority group. Language to describe other groups may be updated.

Slide 4, describes the roles and activities related to integrated planning that Part A planning commissions, groups and councils play. CDPH will detail what these roles entail in future updates.



Slide 5 describes key action items related to the Integrated Plan. As noted CDPH-OA in collaboration with Facente Consulting will be developing a draft plan for your review using data and key documents, reports and community engagement from all EMAs. This plan will be released to community review in March 2026. The HIV Commission will also have a presentation and a concurrence vote on this plan in April or May 2026. The external version of this plan will be submitted to HRSA/CDC in June of 2026. After we meet the deadline for submission, CDPH will work with each EMA to develop a more detailed implementation plan.

B. Medi-Cal Representative

CDPH-OA has met with the DHCS Medi-Cal eligibility unit to offer to pay for a portion of a position to serve as a Medi-Cal representative to all Part A planning Councils in California. They have agreed to provide assign a representative beginning in March/April 2026. Until then, a staff member of the DHCS Medi-Cal eligibility unit will be attending Part A planning councils, commissions and groups to observe informally and help develop the duty assignment for the staff person that will be long-term assigned to this role. This DHCS representative will be attending and coordinating with Leroy Blea's Part B role. A letter introducing this position will be sent jointly from CDPH-OA and DHCS by the end of December 2025.

C. Syndemic Symposium 2025

Dear Syndemic Partners- Thank you for helping to make this year's Ending the Syndemic Symposium a success! The Ending the Syndemic Symposium was co-sponsored annually by the California Department of Public Health, Office of AIDS and the California Planning Group.

This year's symposium focused on the themes of **Stigma Free Services**, **Economic Justice** and **Housing First**: three of the social determinants of health on which our work in California is organized. Over the three-day symposium, speakers addressed these themes and led participants to reflect on how they might implement work to center the health of the priority populations in our Ending the Epidemics: Integrated Statewide Strategic Plan and Ending the Epidemics: Implementation Blueprint.

Accessing conference materials. The event website will be live through December 2025, and we have published recordings and conference materials there in both English and Spanish. CDPH-OA is also building a permanent website to house this and previous years' symposium recordings and materials. This event is one of our annual community engagement events leveraged for the Integrated Plan scope of work.

Homepage: https://cvent.me/XyrV41

CDPH
California Department of Public Health

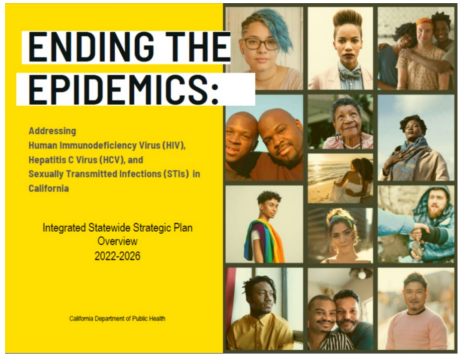
Integrated Plan and other CDPH Updates

Los Angeles County Commission on HIV

December 11, 2025

Leroy Blea, MPH
Ending the Epidemics Manager
California Department of Public Health, Office of AIDS

Elements of the Integrated Plan



2022-2026

- Brief and high level
- Why we need to do syndemic work: HIV/STI/HCV data showing disparities.
- Priority populations, based in data
- How: What we need to do at a high-level: 30 strategies across six social determinants of health
- Implementation Blueprint (post-submission)
- Allow LHJs to continue/enhance their work with a syndemic focus through a social determinants of health lens

2027-2031 additions/edits

- Internal to CA and external to CA versions
- Update data
- Add or/updating language to describe priority populations: cis-gender women (of color); people recently released from carceral settings, and/or are justice involved; PLWH 50+
- Adding a progress section
- Implementation Plan (post-submission)

Priority Populations

- People of Color
- Young People (15-29)
- Gay and bisexual men and other men who have sex with men
- People who are trans and gender non-conforming
- People experiencing homelessness
- People who are incarcerated and/or have been recently released and/or justice involved
- People who use drugs
- People who exchange sex for drugs, housing and or other resources
- Cis-gender women and people who can become pregnant
- Migrant and immigrant communities, including people who are undocumented
- PLWH 50+

HIV Planning Councils, Groups and Commissions: Roles

- Review the plan
- Concurrence
- Advise Implementation
- Communicate with community partners
- Help monitor the plan by reviewing updates and making suggestions to improve implementation

Key Action Items

- Writing- Plan Revisions (Jan/Feb 2026) (CDPH/Facente Consulting)
- Comment/Review Period (March 2026)
- Concurrence Presentations and Vote (March/April/May 2026)
- External-to-California Document -Due to HRSA/HAB/CDC (June 2026)
- Implementation Planning (July-December 2026)
- Plan Activities Begin (January 2027)
  - Ending the Syndemic Symposium 2027 (CDPH, LA Participation)
  - Five-year Retrospective Surveillance Report (CDPH)
  - Final PrEP Gap Analysis Report (2027) (CDPH)
  - Final ADAP Gap Analysis Report (2027) (CDPH)
  - Local Implementation Activities for Los Angeles EMA (2027-2031)

STANDING COMMITTEES AND CAUCUSES REPORT
KEY TAKEAWAYS | DECEMBER 2025

Operations Committee

Link to the October 23, 2025, Operations Committee meeting packet can be found HERE.

Key outcomes/results from the meeting:

- The Operations Committee devoted the majority of the meeting to revising and refining interview questions for prospective commission members.
- The goal of streamlining the questions is to improve efficiency and ensure consistency across all candidate interviews.
- Members discussed the importance of clearly communicating time commitments and preparation expectations to prospective commissioners.
- The group completed a detailed review of the interview questions to maintain uniformity and fairness in the selection process.
- The Committee asks all to please be mindful of the upcoming Committee Restructure timeline dates:
    - ❖ December 11, 2025: COH approve bylaws and submit ordinance to BOS for approval.
    - ❖ December 12, 2025 – January 9, 2026: Disseminate transitional membership application and open nominations process to all stakeholder constituencies (including current Commissioners).
    - ❖ Application deadline: January 9, 2026: Organize and verify applications for completeness and accuracy.
    - ❖ January 10–18, 2026 (includes weekend interviews due to short turnaround): Conduct membership interviews.
    - ❖ January 19, 2026: Select initial cohort of candidates to recommend for nomination.
    - ❖ January 23, 2026: Executive Committee approves initial cohort.
    - ❖ February 12, 2026: COH approves initial cohort.
    - ❖ February 12, 2026: Forward nominations to EO/BOS for appointment.
    - ❖ February – Early March 2026: BOS appointment of first cohort of new members to restructured COH.
    - ❖ March 12, 2026: First meeting of newly restructured Commission on HIV.

Action needed from full body:

- □ Please join the Operations Committee for its next meeting on Thursday, December 18th, from 10:00 a.m. to 12:00 p.m. The Committee will review sample language for evaluating and scoring membership interviews.

Executive Committee

The Committee last met on October 23, 2025; the November meeting was canceled due to the holidays.

<u>REMINDER:</u> Holiday meeting schedule: The regularly scheduled meetings in November and December have been canceled; a December 18 meeting date has been confirmed.

Action needed from full body:

- □ Attend the November 13, 2025 Annual Conference and support implementation of the final program.
- □ Prepare for the December 11, 2025 vote on the revised Bylaws; surface any final questions or clarifications ahead of the meeting.
- □ Support the launch of the membership drive immediately following Bylaws approval (target: December 12, 2025).
- □ Stay informed of potential federal, state and local funding cuts and impacts on the HIV service system and look to non-HIV-related partners to complement and support the RWP.
- □ Continue to remain engaged in committee business and discussions

Planning, Priorities, and Allocations Committee

Link to the November 18, 2025 Planning, Priorities, and Allocations Committee meeting packet can be found HERE.

Key outcomes/results from the meeting:

- The committee had a robust conversation on contingency planning for the next program year (PY36).
- DHSP staff provided a brief overview of projected funding for PY36 with a total amount of funding for direct services at approximately $33.5 million; this total includes approximately $24.8 million for Health Resources and Services Administration (HRSA) RWP Part A, $3.3 million for Minority AIDS Incentive (MAI), and $5.3 million for HRSA Part B (award from the state); see meeting packet for more details. This total does not include the supplemental award amount, which is not guaranteed. The proposed PY36 estimate of $33.5M represents a major reduction from PY35's $41M, requiring strategic prioritization and possible service reductions. DHSP also noted that delayed federal awards may severely affect service continuity due to the County's constrained financial situation.
- HOPWA staff provided an overview of current HOPWA program and portfolio and current investments. As of quarter one of this year, HOPWA has served a total of 2,922 clients; last year the number totaled 3,860 clients. Funds were shifted this current year to support more long-term housing via tenant-based rental assistance (TBRA) programs. HOPWA has continued to receive level funding for years and is at capacity with the number of clients and types of programs that it can support resulting in long wait times for placement into permanent housing. Any increases in permanent supportive housing will result in decreases in one or more of the other areas/programs HOPWA supports.

- Potential federal cuts may impact non-RWP federally funded partners, leading to downstream effects on the local HIV service network. The committee must consider the cumulative impact of potential changes to the HUD Continuum of Care, HOPWA, Measure A, Medicaid/Medi-Cal redeterminations (potential loss of Medi-Cal coverage may shift more clients back to the RWP system) and other federal/state support services programs (such as SNAP).
- Difficult decisions are expected regarding RWP services can be sustained under reduced funding. Committee members requested modeling of minimum funding level to avoid system destabilization, particularly around housing and oral health services. The committee anticipates more clarity on federal funding by January 2026.
- DHSP provided their response to the PY35-PY37 Directives; see meeting packet for more details. It was noted that some of the directives were not feasible.
- The committee canceled their December meeting. The next PP&A Committee meeting will be on January 20, 2026 at the Vermont Corridor.

Action needed from full body:

- □ Stay informed of potential federal, state and local funding cuts and impacts on the HIV service system and look to non-HIV-related partners to complement and support the RWP.
- □ Continue to remain engaged in committee business and discussions, especially on matters related to funding.
- □ Encourage consumers and providers to attend PP&A committee meetings.

Standards and Best Practices Committee

The SBP Committee did not meet in the month of December.

Link to the November 4, 2025, *Standards and Best Practices Committee* meeting packet can be found HERE.

Key outcomes/results from the meeting:

- Announced public comment period for the Mental Health service standards from November 17, 2025, to January 6, 2025. The document can be accessed on the COH website **HERE.**
- **Canceled the December 2, 2025, SBP Committee meeting;** The next SBP Committee meeting will be on Tuesday January 6, 2025, from 10am-12pm at the Vermont Corridor.

Action needed from full body:

- □ Review the **Mental Health service standards document** and provide comments to assist the Standards and Best Practices Committee in their review of the document. Public comments are due on January 6, 2025.

Public Policy Committee

The Public Policy Committee did not meet in the month of December.

Link to the November 3, 2025, *Public Policy Committee* meeting packet can be found HERE.

Key outcomes/results from the meeting:

- The PPC will sunset on February 3, 2025. The Executive Committee will assume the activities and responsibilities of the PPC. The PPC will develop a "PPC Activities Transition" document to support the Executive Committee.
- **Canceled the December 1, 2025, PPC meeting;** The next PPC meeting will be on Monday January 5, 2025, from 1pm-3pm at the Vermont Corridor.

Action needed from full body:

- □ Attend January 5 and February 2 PPC meetings and share feedback to help inform the development of the "PPC Activities Transition" document.

Aging Caucus

The Aging Caucus did not meet in the month of November.

Key outcomes/results from the meeting:

- Last month, the caucus shared an event summary and evaluation findings from the September 19th Power of Aging educational event via a newsletter. This event commemorated National HIV and Aging Awareness Day and brought together consumers, service providers, advocates, and community members for a day of learning, connection, and empowerment. See newsletter for more details.

Action needed from full body:

- □ Encourage participation in future Aging Caucus meetings and continue to collaborate and share information on services and resources impacting older adults living with HIV.

Black Caucus

Link to the November 20, 2025, Black Caucus meeting packet can be found HERE.

Key outcomes/results from the meeting:

- The Caucus discussed successful outreach efforts at the Taste of Soul (TOS) event on October 18th. The survey collected from individuals who stopped by the booth revealed there are still misconceptions about HIV transmission within the community.
- The Caucus was informed that planning for the youth listening session is underway, and commissioners from the Los Angeles County Youth Commission will participate.
- Grant funding for the World AIDS Day (WAD) event was secured.
- The event will feature a health resource fair, a DJ, and complimentary haircuts for the community.

Action needed from full body:

- □ Please support the Black Caucus at their World AIDS Day event on Friday, December 5th, from 11 AM – 2PM.

Consumer Caucus

The Consumer Caucus did not meet in November. The Caucus held its last meeting on December 4, 2025 for the year; meeting packet can be found HERE. The Caucus reviewed and discussed its proposed revised stipend policy corresponding to the impending stipend increase. The Caucus also discussed its

accomplishments for 2025 and set a preliminary work plan for 2026. The Caucus will meet again in January 2026; time to be determined.

Transgender Caucus

The Transgender Caucus did not meet in the month of November or December.

Key outcomes/results from the meeting:

- Caucus co-chairs will attend the "Caucus, Workgroup, and Taskforce Leadership Updates & Discussion" meeting on 12/3/25 to share feedback on upcoming changes to subordinate groups within the new COH structure.

Action needed from full body:

- □ Encourage participation in future Transgender Caucus meetings and continue to collaborate and share information on services and resources impacting the transgender, gender expansive, and intersex (TGI) community.

Women's Caucus

The Women's Caucus did not meet in the month of November.

Key outcomes/results from the meeting:

- The recommendations for women-centered programming were shared with the Planning, Priorities and Allocations committee for review and discussion at their October meeting.
- The caucus has completed their workplan for the year.

Action needed from full body:

- □ Encourage participation in future Women's Caucus meetings and continue to collaborate & share information on services/resources impacting women living with HIV.

Housing Task Force

The Housing Task Force did not meet in November. A meeting is planned for December or January, with the date still to be determined.

FY 2025: Planning for Tomorrow within a Changing Landscape

Planning Development and Research
PP&A Meeting
November 18, 2025

2026 Projected Funding

Projected resources for HIV care and treatment services for the grant year beginning March 1, 2026 comes from a letter HRSA issued to grantees in August of 2025 stating that grantees should expect funding for RWP to be equal to this year's formula and MAI awards. There is some uncertainty about the continuation of the Minority AIDS Initiative from the current administration. The letter does not include any supplemental funds:

$33,485,152

FY 2026 Projected Funding for HIV Care and Treatment Direct and Contracted Services (as of Nov 18, 2025)

County of Los Angeles Public Health

Grant	Amount From HRSA/State Communication	10% Admin	CQM	Total Available for RWP Direct and Contracted Services
HRSA Part A (Formula)	$ 28,459,565	$ 2,845,956	$ 750,000	$ 24,863,609
HRSA Part A Supplemental	$ -	$ -	$ -	$ -
HRSA MAI	$ 3,715,484	$ 371,548	$ -	$ 3,343,936
HRSA Part B	$ 5,864,007	$ 586,400	$ -	$ 5,277,607
	$ 38,039,056	$ 3,803,904	$ 750,000	$ 33,485,152

FY 2025 Current PC Approved Allocations (as of Sept 2025)

County of Los Angeles Public Health

SERVICE CATEGORY	Part A Amount	Part A Percent	MAI Amount	MAI Percent
6 Medical Case Management (MCC)	$ 6,029,346	16.05%	$ -	0.00%
8 Oral Health	$ 6,821,989	18.16%	$ -	0.00%
20 Outpatient/Ambulatory Medical Health Services (AOM)	$ 5,525,961	14.71%	$ -	0.00%
11 Early Intervention Services (Testing Services)	$ 777,617	2.07%	$ -	0.00%
17 Home and Community-Based Health Services (Intensive Case Mngt)	$ 1,487,614	3.96%	$ -	0.00%
2 Emergency Rental/Financial Assistance	$ 1,611,582	4.29%	$ -	0.00%
7 Nutrition Support (Food Bank/Home-delivered Meals)	$ 3,106,710	8.27%	$ -	0.00%
5 Non-Medical Case Management				
Patient Support Services	$ 3,606,338	9.60%	$ -	0.00%
Benefits Specialty Services	$ 1,111,954	2.96%	$ -	0.00%
10 Medical Transportation	$ 698,728	1.86%	$ -	0.00%
23 Legal Services	$ 1,006,769	2.68%	$ -	0.00%
1 Housing				
Housing Services RCFCI	$ 4,414,007	11.75%	$ -	0.00%
Housing for Health	$ -	0.00%	$ 3,350,149	100.00%
3 Mental Health Services	$ 1,367,403	3.64%	$ -	0.00%
TOTAL	**$ 37,566,016**	**100.00%**	**$ 3,350,149**	**100.00%**

FY 2025 Current Housing Allocations-All DHSP Funding Sources

Service Category	Allocation Amount	Funding Source
RCFCI	$ 4,414,007	Part A
TRCF	$ 630,000	Part B, HIV NCC (MH)
Rampart Mint/H4H	$5,530,775	MAI, HIV NCC
Substance Use Residential	$ 881,475	Part B, Non-DMC

$ 11,456,257

Housing services across the country may be under threat, leaving the RWP as one of the best remaining housing assistance resources for PLWH.

FY 2024 Housing Utilization and Expenditures

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units per client	Expenditures	Expenditures per client
Housing Services	**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 Sources:

- *Part A - $484,771 (RCFCI/TRCF MH)*
- *MAI - $3,305,635 (H4H)*
- *Part B – $4,396,698 (RCFCI, TRCF)*
- *HIV NCC - $2,225,120 (H4H)*

Thank you for your ongoing commitment in promoting and preserving HIV services in a changing landscape

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

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.

LOS ANGELES COUNTY
COMMISSION ON HIV

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PUBLIC COMMENT PERIOD FOR THE DRAFT MENTAL HEALTH SERVICES (MH) SERVICE STANDARDS

Posted: November 7, 2025.

The Los Angeles County Commission on HIV (COH) announces an opportunity for the public to submit comments for the draft **Mental Health Services (MH)** service standards revised by the Standards and Best Practices Committee. The public comment period begins on November 7, 2025, and ends on January 6, 2026. A copy of the document is posted to the COH website and can be found at: https://hiv.lacounty.gov/service-standards.

Comments can be submitted via email to HIVCOMM@LACHIV.ORG.

Sections in red text are additions to the document. Sections that are marked with a ~~strikethrough~~ are proposed revisions. For any questions, please contact COH staff.

After reading the document, consider responding to the following questions when providing public comment:

1. Are the MH service standards reasonable and achievable for providers? Why or why not?
2. Do the MH service standards meet consumer needs? Why or why not? Give examples of what is working/not working.
3. Is there anything missing from the MH service standards related to HIV prevention and care?
4. Do you have any additional comments related to the MH service standards and/or MH services?

Public comments are due by January 6, 2026.

MENTAL HEALTH SERVICES

(Draft as of 11/07/25)

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

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

HRSA HAB, Division of Metropolitan HIV/AIDS Programs: National Monitoring Standards for Ryan White Part A Grantees: Program – Part A

Service Standards: Ryan White HIV/AIDS Programs

Table of Contents

Introduction

Service standards outline the elements and expectations a Ryan White HIV/AIDS Program (RWHAP) provider follows when implementing a specific service category. The purpose of service standards is to ensure that all RWHAP 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 RWHAP-funded agency or provider may offer in Los Angeles County.

~~Service Description~~

~~Mental health treatment for PLWH attempts to improve and sustain a client's quality of life. Counseling and psychotherapy have been shown to be helpful in alleviating or decreasing psychological symptoms that can accompany a diagnosis of HIV. Psychiatric treatment for PLWH attempts to stabilize mental health conditions while improving and sustaining quality of life. Evidence based psychiatric treatment approaches and psychotherapeutic medications have proven effective in alleviating or decreasing psychological symptoms and illnesses that may accompany a diagnosis of HIV. Often, PLWH have psychological illnesses that pre-date their infection, but have been exacerbated by the stress of living with a chronic illness.~~

~~Mental health services include:~~

- ~~Mental health assessment~~
- ~~Treatment planning~~
- ~~Treatment provision~~
  - ~~Individual counseling/psychotherapy~~
  - ~~Family counseling/psychotherapy~~
  - ~~Group counseling/psychotherapy~~
  - ~~Psychiatric medication assessment, prescription and monitoring~~
  - ~~Drop-in psychotherapy groups~~
  - ~~Crisis intervention~~

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.~~

Clients must 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.

Service Description

Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessments, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such

professional typically include psychiatrists, psychologists, and licensed clinical social workers. Mental Health Services are allowed only for People Living with HIV (PLWH) who are eligible to receive HRSA RWHAP services.

Mental Health Service Components

~~HIV/AIDS~~ Mental Health Services are short-term or sustained therapeutic interventions provided by mental health professionals who specialize in HIV ~~(see Appendix B for a description of mental health professionals)~~ for clients experiencing acute and/or ongoing psychological distress. ~~This document describes the following service components for Mental Health Services: Mental health Assessment, Treatment Plans, Treatment Provision, Documentation, Informed Medication Consent, Crisis Intervention,~~ See Appendix A for a description of mental health professionals.

Mental Health Services include:

- Individual, Family, and Group counseling/psychotherapy
- Psychiatric medication assessment, prescription and monitoring
- Drop-in psychotherapy groups
- Crisis intervention

~~MENTAL HEALTH~~ SCREENING AND ASSESSMENT

Agencies contracted to provide mental health services will screen clients and conduct an assessment as appropriate. A mental health assessment is completed during a collaborative interview in which the client's biopsychosocial history and current presentation are evaluated to determine diagnosis and treatment plan. Reassessments are indicated when there is significant change in the client's status, or when the client re-enters treatment. To reduce client assessment burden, ~~mental health providers~~ agencies should utilize existing assessments such as those performed by Medical Care Coordination (MCC) teams, as a tool to inform treatment plan development. ~~Persons~~ Clients receiving crisis intervention or drop-in psychotherapy groups require a brief assessment of the presenting issues that supports the mental health treatment modality chosen.

~~MENTAL HEALTH SERVICES: MENTAL HEALTH ASSESSMENT~~ SCREENING AND ASSESSMENT	
STANDARD	DOCUMENTATION
Mental health assessments will be completed by mental health provider within two visits, but in no longer than 30 days.	Completed assessment in client file to include: • Detailed mental health presenting problem • Psychiatric or mental health treatment history • Mental status exam • Complete DSM five axis diagnosis
Reassessment conducted as needed or at a minimum of once every 12 months.	Progress notes or new assessment demonstrating reassessment in client file.
For closed group/drop-in group therapy, providers will pre-screen clients to determine if the client is good fit for the group and if the group would provide a service that meets the client's need(s).	Completed pre-screen assessment in client file to include documentation of Informed Consent, explanation of the limits of confidentiality of

	participating in group therapy, and description of client mental health needs.
Assessments and reassessments completed by unlicensed providers will be cosigned by licensed clinical supervisors.	Co-signature of licensed provider on file in client chart.

TREATMENT PLANS

Agencies should develop treatment plans for clients receiving mental health services with the exception of clients receiving drop-in psychotherapy groups and crisis interventions. Treatment plans outline the course of treatment and are developed in collaboration with the client and their mental health service provider. Mental health assessments and treatment plans should be developed concurrently. Treatment plans must be finalized within two weeks of the completion of the mental health assessment. Treatment plans must be developed by the same mental health provider that conducts the mental health assessments. Treatment plans will be reviewed and revised at a minimum of every 12 months.

~~Treatment plans are developed in collaboration with the client and outline the course of treatment and are required for clients receiving all mental health services, excluding drop-in psychotherapy groups and crisis intervention services. A treatment plan begins with a statement of problems to be addressed in treatment and follows with goals, objectives, timeframes, interventions to meet these goals, and referrals. Mental health assessment and treatment plans should be developed concurrently; however, treatment plans must be finalized within two weeks of the completion of the mental health assessment. Treatment plans must be developed by the same mental health provider that conducts the mental health assessment. Treatment plans will be reviewed and revised at a minimum of every 12 months.~~

~~MENTAL HEALTH SERVICES:~~ TREATMENT PLANS	
STANDARD	DOCUMENTATION
Mental health assessments and treatment plans are developed concurrently and collaboratively with the client. Treatment plans must be finalized within two weeks of the completion of the mental health assessment and developed by the same mental health provider that conducts the mental health assessment.	Completed, signed treatment plan on file in client chart to include: • Statement of problem(s), symptom(s) or behavior(s) to be addressed in treatment • Goals and objectives • Interventions and modalities proposed • Frequency and expected duration of services • Referrals (e.g. day treatment programs, substance use treatment, etc.)
Client treatment plans are reviewed and/or revised at a minimum of every 12 months. ~~Review and revise treatment plan not less than once every twelve months.~~	Documentation of treatment plan revision in client chart.
~~Assessments and reassessments~~ Treatment plans completed by unlicensed providers will be cosigned by licensed clinical supervisor.	Co-signature of licensed provider on file in client record.

TREATMENT PROVISION

Treatment provision consists of ongoing contact and clinical interventions with (or on behalf) of the client necessary to achieve treatment plan goals. All modalities and interventions in mental health treatment will be guided by the needs expressed in the treatment plan. ~~Practitioners shall be knowledgeable about outcome research and utilize clinically proven treatment for their client's presenting problems. Treatment provision should be documented through progress notes and include the date and signature of the mental health provider. Progress notes completed by unlicensed providers will be cosigned by licensed clinical supervisor.~~ See **Appendix B** for Descriptions of Treatment Modalities.

~~MENTAL HEALTH SERVICES:~~ TREATMENT PROVISION	
STANDARD	DOCUMENTATION
Interventions and modalities will be determined by treatment plan.	Treatment plan signed and dated by mental health provider and client in client file.
~~Mental health providers will use outcome research and published standards of care, as appropriate and available, to guide their treatment.~~	~~Progress note signed and dated by mental health provider detailing interventions in client file.~~
Treatment, as appropriate, ~~will~~ may include counseling about: • Sexual health including prevention and HIV transmission risk behaviors • Stigma • Substance use • Treatment adherence • Development of social support systems • Community resources • Maximizing social and adaptive functioning • The role of spirituality and religion in a client's life • Disability, death, and dying • Exploration of future goals	Progress note, signed and dated by mental health provider detailing counseling sessions in client file.
Progress notes for all mental health treatment provided will document progress through treatment provision.	Signed, dated progress note in client chart to include: • Date, type of contact, time spent • Interventions/referrals provided • Progress toward Treatment Plan goals • Newly identified issues • Client response
Progress notes completed by unlicensed providers will be cosigned by licensed clinical supervisor.	Co-signature of licensed provider on file in client record.

INFORMED MEDICATION CONSENT

Informed Medication consent is required of every patient receiving psychotropic medications. Providers will comply with state laws and licensing board policies related to Informed Medication Consent for psychotropic medications.

~~MENTAL HEALTH SERVICES:~~ INFORMED MEDICATION CONSENT

STANDARD	DOCUMENTATION
An informed Medication Consent will be completed for all patients receiving psychotropic medications. Whenever a new psychotropic medication is prescribed, the client will receive counseling on medication benefits, risks, common side effects, side effect management, and timetable for expected benefit.	Completed, signed, and dated Informed Medication Consent on file in client chart indicating the patient has been counseled on: • Medication benefits • Risks • Common side effects • Side effect management • Timetable for expected benefit
Informed Medication Consents completed by unlicensed providers will be cosigned by medical doctor board-eligible in psychiatry.	Co-signature of licensed provider on file in client record.

CRISIS INTERVENTION

Crisis intervention is an unplanned service provided to an individual, couple or family experiencing ~~bio~~psychosocial distress. These services focus on reversing and stabilizing crisis-related deterioration of functioning. Crisis intervention can be provided face-to-face or ~~by telephone.~~ via telehealth as appropriate. ~~It is imperative that~~ client safety ~~is~~ must be assessed and addressed under ~~these~~ crisis situations. Crisis intervention services may occur as often as necessary to ensure client safety and maintenance of baseline functioning.

~~MENTAL HEALTH SERVICES:~~ CRISIS INTERVENTION	
STANDARD	MEASURE
Crisis intervention services will be offered to clients experiencing psychological distress. Client safety will be continuously assessed and addressed.	Signed, dated progress notes in client chart to include: • Date, time of day, and time spent with or on behalf of the client • Summary of crisis event • Interventions and referrals provided • Results of interventions and referrals • Follow-up plan
Progress notes completed by unlicensed providers will be cosigned by licensed clinical supervisor	Co-signature of licensed provider on file in client record.

TRIAGE/REFERRAL/COORDINATION

Clients requiring a higher level of mental health intervention than a given agency is able to provide must be referred to another agency capable of providing the service. These services may include neuropsychological testing, day treatment programs, and in-patient hospitalization. Referrals to other services including case management, treatment advocacy, peer support, medical treatment, and dental treatment will be made as appropriate. Agencies will maintain regular contact with the client's primary care provider as clinically indicated.

~~In certain cases, clients will require a higher level of mental health intervention than a given agency is able to provide. Mental health providers are responsible for referring these clients to additional mental health~~

~~services including neuropsychological testing, day treatment programs and in-patient hospitalization. Referrals to other services including case management, treatment advocacy, peer support, medical treatment and dental treatment will also be made as indicated. Regular contact with client's primary care clinic and other providers will ensure integration of services and better client care.~~

~~**MENTAL HEALTH SERVICES:**~~ **TRIAGE/REFERRAL/COORDINATION**	
STANDARD	DOCUMENTATION
As needed, providers will refer clients to full range of mental health services including: • Neuropsychological testing • Day treatment programs • In-patient hospitalization	Signed, dated progress notes to document referrals in client chart.
As needed, providers will refer to other services including case management, treatment advocacy, peer support, medical treatment, and dental treatment.	Signed, dated progress notes to document referrals in client chart.
~~Providers will attempt to make contact with a client's primary care clinic at minimum once a year, or as clinically indicated, to coordinate and integrate care. Contact with other providers will occur as clinically indicated.~~ Providers will maintain regular contact with a client's primary care provider as clinically indicated.	Documentation of contact with primary medical ~~clinics and~~ providers ~~to be placed~~ in progress notes.

CASE CONFERENCES

Programs will conduct monthly interdisciplinary discussions of selected ~~patients~~ clients to assist in problem-solving related to a ~~patient's~~ client's progress toward mental health treatment plan goals and to ensure that professional guidance and high-quality mental health treatment services are being provided. All members of the treatment team available, including case managers, treatment advocates, medical personnel, etc., are encouraged to attend. Documentation of case conferences shall be maintained within each client record in a case conference log.

~~**MENTAL HEALTH SERVICES:**~~ **CASE CONFERENCES**	
STANDARD	DOCUMENTATION
Interdisciplinary case conferences will be held for each active client based on acuity and need.	Case conference documentation, signed by the supervisor, on file in client chart to include: • Date, name of participants, and name of client • Issues and concerns • Follow-up plan • Clinical guidance provided • Verification that guidance has been implemented

CLIENT RETENTION AND CASE CLOSURE

~~Provider~~ Agencies will strive to retain clients in mental health treatment. A broken appointment policy and procedure to ensure continuity of service and retention of clients is required. Follow-up can include telephone calls, written correspondence and/or direct contact, and efforts to maintain a client's participation in care.

Case closure is a systematic process for discharging clients from mental health services. The process includes the completion of a Case Closure Summary (CCS) to be maintained in the client record. Case closure will be initiated if the patient does not receive mental health services or is unable to be contacted within a one-year period.

~~MENTAL HEALTH SERVICES:~~ CLIENT RETENTION AND CASE CLOSURE	
STANDARD	DOCUMENTATION
~~Programs~~ Agencies will develop a broken appointment policy to ensure continuity of service and retention of clients.	Written policy on file at provider agency.
~~Programs~~ Agencies will provide regular follow-up procedures to encourage and help maintain a client in mental health treatment.	Documentation of attempts to contact in progress notes. Follow-up may include: • Telephone calls • Written correspondence • Electronic Medical Record • Direct contact
~~Programs~~ Agencies will develop case closure criteria and procedures.	Case closure criteria and procedures on file at provider agency. Cases may be closed when the patient: • Successfully attains psychiatric treatment goals • Relocates out of the service area • Becomes eligible for benefits or other third-party payer (e.g. Medi-Cal, private medical insurance, etc.) • Has had no direct program contact in a one-year period • Is ineligible for the service • No longer needs the service • Discontinues the service • Is incarcerated long term • Utilizes the service improperly or has not complied with the client services agreement • Had died
Regular follow-up will be provided to clients who have dropped out of treatment without notice.	Documentation of attempts to contact in progress notes.
A Case Closure Summary will be completed for each client who has terminated treatment.	Signed, and dated Case Closure Summary on file in client chart to include: • Course of treatment

	• Discharge diagnosis • Referrals made • Reason for termination
Case Closure Summaries completed by unlicensed providers will be cosigned by licensed clinical supervisor.	Co-signature of licensed provider on file in client chart.

STAFFING REQUIREMENTS AND QUALIFICATIONS

Providers of mental health services will be master's or doctoral level graduate students in counseling, marriage and family therapy, nursing (with specialized mental health training), psychiatry, psychology, or social work.

Psychiatric treatment services are provided by medical doctors' board-eligible in psychiatry or a Physician Assistant. A psychiatrist may work in collaboration with a psychiatric resident, or RN/NP. While state law governs prescription of medication, it is recommended that physicians licensed as such by the state of California shall prescribe all prescriptions for psychotropic medications. If an NP is utilized to provide medications, they must do so according to standardized protocol and under the supervision of a psychiatrist.

All staff ~~hired by provider agencies~~ will possess the ability to provide developmentally and culturally appropriate care to clients living with and affected by HIV. All clinical staff will have previous experience or training utilizing appropriate treatment modalities in practice.

All ~~hired~~ staff will participate in orientation and training before beginning treatment provision~~. Licensed providers are encouraged to seek consultation to address clinical, psychosocial, developmental, and programmatic issues, as needed.~~ If providers are unlicensed, they must be clinically supervised in accordance with the requirements of the licensing board of their respective professions. Graduate-level interns must be supervised according to the requirement of their respective programs and to the degree that ensures appropriate practice.

~~Practitioners~~ Mental health providers should have training and experience with HIV/AIDS related issues and concerns. Providers will participate in continuing education or Continuing Medical Education (CME) on the topics of HIV and mental health issues every two years.

Practitioners providing mental health services to people living with HIV should possess knowledge about the following:

- HIV disease and current medical treatments
- Medication interactions (for psychiatrists)
- Psychosocial issues related to HIV/AIDS
- Cultural issues related to communities affected by HIV/AIDS
- Mental disorders related to HIV and other medical conditions
- Mental disorders that can be induced by prescription drug use
- Adherence to medication regimens
- ~~Diagnosis and assessment of HIV-related mental health issues~~
- HIV/AIDS legal and ethical issues

- Sexuality, gender, and sexual orientation issues
- Substance use theory, treatment, and practice

Finally, practitioners and staff must be aware of and able to practice under the legal and ethical obligations as set forth by California state law and their respective professional organizations. Mental health services providers are advised to seek legal advice when they are unsure about issues and the level/ethical ramifications of their actions.

~~Psychiatrists shall comply with existing laws regarding confidentiality, informed consent and client's rights, and shall conform to the standards and guidelines of the American medical Association and the American Psychiatric Association regarding ethical conduct, including:~~

- ~~**Duty to treat:** Practitioners have an ethical obligation not to refuse treatment because of fear or lack of knowledge about HIV~~
- ~~**Confidentiality:** Maintenance of confidentiality is a primary legal and ethical responsibility of the psychiatric practitioner.~~
- ~~**Duty to warn:** Serious threats of violence against a reasonability identifiable victim must be reported. However, at present, in California, a person living with HIV engaging in behaviors that may put others at risk for HIV infection is not a circumstance that warrants breaking of confidentiality. Physicians, however, may notify identified partners who may have been infected, while other mental health providers are not permitted to do so.~~

~~Mental health services providers are advised to seek legal advice when they are unsure about issues and the level/ethical ramifications of their actions.~~

~~**MENTAL HEALTH SERVICES:**~~ **STAFFING REQUIREMENTS AND QUALIFICATIONS**	
STANDARD	MEASURE
~~Provider~~ Agencies will ensure that all staff providing psychiatric treatment services will be licensed, supervised by a medical doctor board-eligible in psychiatry, accruing hours toward licensure or a registered graduate student enrolled in counseling, social work, psychology or marriage and family therapy program.	Documentation of licensure/professional/student status on file.
~~It is recommended that physicians licensed as such by the state of California shall prescribe psychotropic medications.~~	~~Documentation of licensure on file.~~
~~New staff will completed orientation/training prior to providing services.~~	~~Documentation of training file.~~
~~Mental health staff are training and knowledgeable regarding HIV/AIDS and the affected community.~~	~~Training documentation on file maintained in each personnel record which includes:~~ ~~• Date, time, and location of the function~~ ~~• Function type~~ ~~• Name of the agency and staff members attending the function~~ ~~• Name of the sponsor or provider~~ ~~• Training outline, meeting agenda and/or minutes~~

~~Programs will provide and/or allow access to ongoing staff training and development of staff including medical, psychiatric and mental health HIV-related issues.~~	~~Training documentation on file maintained in each personnel record which includes:~~ • ~~Date, time, and location of the function~~ • ~~Function type~~ • ~~Name of the agency and staff members attending the function~~ • ~~Name of sponsor or provider~~ • ~~Training outline, meeting agenda, and/or minutes~~
Mental health providers are trained and knowledgeable in HIV/AIDS. Agencies will provide orientation prior to providing services.	Documentation of training on file.
~~Licensed staff are encouraged to seek consultation as needed.~~	~~Documentation of consultation on file.~~
Treatment providers will practice according to California state law and the ethical codes of their respective professional organizations.	Chart review will ensure legally and ethically appropriate practice.
Psychiatric treatment providers will possess skill, experience and licensing qualifications appropriate to provision of psychiatric treatment services.	Resume and current license on file.
Unlicensed ~~professional~~ psychiatric and mental health professionals will receive supervision in accordance with state licensing requirements. The Division on HIV and STD Programs (DHSP) will be notified immediately in writing if a clinical supervisor is not available.	Documentation of supervision on file.
Mental health service staff will complete documentation required by program.	Administrative supervisor will review documentation periodically.

ADMINSTRATIVE SUPERVISION

Programs will conduct client record reviews to assess that all required mental health documentation is completed properly in a timely manner and secured within the client records.

~~MENTAL HEALTH SERVICES:~~ ADMINISTRATIVE SUPERVISION	
STANDARD	MEASURE
Programs shall conduct record reviews to ensure appropriate documentation.	Client record review, signed and dated by reviewed on file to include: • Checklist of required documentation • Written documentation identifying steps to be taken to rectify missing or incomplete documentation • Date of resolution for omissions

UTILIZING INTERNS, ASSOCIATES, AND TRAINEES

A significant portion of mental health services are provided by interns, associates and trained (IATs). While this process expands capacity by developing a well-trained workforce and provides increased access through cost effective services, extra care must be taken to ensure that high quality, ethical counseling and psychotherapy services are maintained. See **Appendix C** for additional information on Utilizing Interns, Associates, and Trainees (IATs).

~~MENTAL HEALTH SERVICES:~~ UTILIZING INTERNS, ASSOCIATES, AND TRAINEES	
STANDARD	MEASURE
Programs using IATs will provide an orientation and training program of no less than 24 hours to be completed before IATs begin providing services.	Documentation of training/orientation on file at provider agency.
IATs will be assigned cases appropriate to experience and scope of practice and that can likely be resolved over the course of the IAT's internship.	Record of case assignment on file at provider agency.
Programs will provide IATs with clinical supervision in accordance with all applicable rules and standards.	Record of clinical supervision on file at provider agency.
IATs will inform clients of their status as an intern and the name of the supervisor covering the case.	Internship notification form, signed by the client and the therapist on file in client chart.
Termination/transition/transfer will be addressed at the beginning of assessment, treatment inception and six weeks prior to termination.	Signed, dated progress notes confirming termination/transition/transfer on file in client chart.
At termination the IAT and client will discuss accomplishments, challenges, and treatment recommendations.	Signed, dated progress notes detailing this discussion on file in client chart.
Clients requiring services beyond the IAT's internship will be referred immediately to another clinician.	Singed, dated, Client Transfer Form (CTF) in client chart.
All clients place don a waiting list will be offered the following options: • Telephone contact • Transition group • Crisis counseling	Signed, dated CTF that details the transfer plan on file in client chart.

Appendix A: Mental Health Service Providers

Providers of mental health services include licensed practitioners and unlicensed practitioners who practice under the supervision of a licensed mental health professional and as mandated by their respective licensing bodies. ~~HIV/AIDS~~ Mental health psychiatric treatment services are provided by medical doctors (MDs) board-eligible in psychiatry. A psychiatrist may collaborate with a psychiatric resident or registered nurse/nurse practitioner (RN/NP) under the supervision of a medical doctor board-eligible in psychiatry. All prescriptions shall be prescribed solely by physician licensed by the state of California.

Licensed Practitioners:

- **Licensed Clinical Social Workers (LCSW):** LCSWs possess a master's degree in social work (MSW). LCSWs are required to accrue 3,000 hours of supervised professional experience to qualify

for licensing. The Board o Behavioral Science Examiners regulates the provision of mental health services by LCSWs.

- **Licensed Marriage and Family Therapists (LMFT):** LMFTs possess a master's degree in counseling. LMFTs are required to accrue 3,000 hours of supervised counseling or psychotherapy experience to qualify for licensing. The Board of Behavioral Science Examiners regulates the provision of mental health services by LMFTs.
- **Nurse Specialists and Practitioners:** Registered nurses (RNs) who hold a master's degree as a nurse practitioner (NP) in mental health or a psychiatric nurse specialist (PNS) are permitted to diagnose and treat mental disorders. NPs may prescribe medications in accordance with standardized procedures or protocols, developed and approved by the supervising psychiatrist, NP and facility administrator. Additionally, the NP must furnish and order medications under a psychiatrist's supervision.

  To qualify for prescribing medications, NPs must complete:
  - At least six months of psychiatrist-supervised experience in the ordering of medications or devices
  - A course in pharmacology covering the medications to be furnished or ordered

  RNs who hold a bachelor's degree are permitted to provide psychoeducational services but are not allowed to diagnose or treat mental disorders independently. Nurses and NPs are regulated by the California State Board of Nursing.

- **Psychiatrists:** Psychiatrists are physicians (medical doctors or MDs) who have completed an internship and psychiatric residency ~~(most are three years in length)~~. They are licensed by the state medical board, which regulates their provision of services, to practice independently. They are certified or eligible for certification by the American Board of Psychiatry. They have ultimate clinical authority but function collaboratively with multidisciplinary teams, which may include psychiatric residents or NPs. They initiate all orders for medications.

  They provide HIV/AIDS mental health treatment services as follows:
  - Examination and evaluation of individual patients
  - Diagnosis of psychiatric disorders
  - Medication treatment planning and management
  - Medical psychotherapy
  - Supervision of allied health professionals through a defined protocol
  - Participation and leadership in interdisciplinary case conferences including signing off on diagnoses and treatment plans
- **Psychologists:** Psychologists possess a doctoral degree in psychology or education (PhD, PsyD, EdD). Psychologists are required to accrue 3,000 hours of supervised professional experience to qualify for licensing. The Board of Psychology regulates the provision of mental health services by psychologists.

Unlicensed Practitioners:

- **Marriage family therapist (MFT) interns; psychological assistants, post-doctoral fellows and trainees; and social work associates:** Interns, assistants, fellows, and associates are

accumulating supervised experience as part of their preparation for licensing or certification. They have completed graduate work in counseling, psychology or social work. These providers required direct supervision by a licensed mental health practitioner as mandated by their respective licensing bodies.

Marriage family therapist (MFT) trainees and social work interns: Trainees and interns are in the process of obtaining their master's degrees and completing the necessary practicum or field work in a site approved by their academic institutions. Trainees and interns require direct supervision by a licensed mental health practitioner at the approved site as mandated by their respective licensing bodies.

Appendix B: Description of Treatment Modalities

Ongoing psychiatric sessions: Mental health treatment should include counseling regarding knowledge of modes of transmission, prevention, risk and harm reduction strategies (as well as root causes and underlying issues related to increased HIV transmission behaviors). Substance use, treatment adherence, development of social support systems and community resources as indicated by the client's circumstance are important areas to be explored. Focus should also be placed on maximizing social and adaptive functioning. The role of and –when present in a client's life—spirituality and religion should be understood and utilized as a strength when present. If clients begin to deteriorate physically, emotional distress can be relieved by helping them prepare for disability, even death. For the client whose health has improved, exploration of future goals including returning to school or work is indicated. When a signed release has been completed, sources of support and care can be recommended to significant others and family members.

The provision of specific types of psychotherapy (behavioral, cognitive, post-modern, psychodynamic) is guided by the individual client's need and based on published practice guidelines and research. For those clients on psychotropic medications, side effects of these agents should be assessed at each visit, along with the provision of education regarding such medications, within the scope of the provider's practice. As indicated, these clients will be referred to the prescribing physician for further information.

Individual counseling/psychotherapy: Individual counseling or psychotherapy may be either short- or long-term in duration, depending on the needs outlined in the treatment plan. Short-term or brief therapy lasts up to 12 sessions and can be most useful when client goals are specific and circumscribed. Longer-term therapy provides a means to explore more complex issues that may interfered with a client's quality of life. Even in the case of longer-term therapy, specific, short-term, mutually defined goals are recommended to focus treatment and measure progress.

Family counseling/psychotherapy: ~~A family may be defined as either the family of origin or a chosen family (Bor, Miller & Goldman, 1993~~). The impact of HIV on the family system can be enormous. The overall goal of family counseling/psychotherapy is to help families improve their functioning, given the complications of living with HIV. Interventions with the family system can be especially effective in helping children and caregivers with behavioral problems and symptoms.

Couples counseling/psychotherapy: This modality is most appropriate where the presenting problem is dissatisfaction or conflict within a relationship that impacts a person living with HIV. In cases of domestic violence, couples counseling should not begin until the provider determines the appropriateness of this modality based upon the progress both parties have made in individual or group treatment and the fact that

current violence is no longer a risk. If these criteria are not met, members of such couples should be referred for individual or group treatment.

Group psychotherapy treatment: Group treatment can provide opportunities for increased social support vital to those isolated by HIV.

While groups may be led by a single leader, significant benefits arise when utilizing two co-facilitators:

- Fewer group cancellations due to facilitator absence
- Increased change that important individual and group issues will be explored
- Members can witness different skills and styles of the therapists
- Increased opportunity to work through transference relationships

Group treatment can be provided in a variety of formats:

- **Closed psychotherapy groups** typically require a process for joining and terminating. Closed groups usually have a set number of group members (between six and ten). This format provides an opportunity to build group cohesion and for members to take part in active interpersonal learning. These groups can be time limited or ongoing, issue specific or more general in content.
- **Open psychotherapy groups** do not require ongoing participation from clients. The group membership shifts from session to sessions, often requiring group leaders to be more structured and active in their approach. These groups can be especially useful to clients requiring immediate support, but unsure about making a commitment to ongoing treatment.

Drop-in groups can also be offered as a mental health service, as long as at least one of the leaders of the group is a mental health provider as defined in this standard.

- **Drop-in groups** do not have an ongoing membership. Instead of a psychotherapeutic focus, these groups focus on such functions as providing topic-specific education, social support and emotional encouragement. As such, they do not require inclusion in a client's treatment plan, nor is a full mental health assessment required to access this service.

Psychiatric evaluations, medication monitoring and follow-up: Psychiatrists shall use clinical presentation, evidence-based practice guidelines and specific treatment goals to guide the evaluation, prescription and monitoring of appropriate medication.

For medication monitoring and follow-up, visit frequency should be at a minimum:

- Once every two weeks in the acute phase
- Once every month in the sub-acute phase
- Once every three months in the maintenance phase

For those patients on psychotropic medication, side effects of these agents shall be assessed at each visit, along with the provision of education regarding their medications. In addition, these patients should regularly be counseled about the importance of adherence to psychotropic medications.

~~The American Psychiatric Association (2001) suggests the following general pharmacologic treatment guidelines, especially for those patients with symptomatic HIV disease:~~

- ~~Use lower starting doses and titrate more slowly~~
- ~~Provide the least complicated dosing schedules possible~~

- ~~Concentrate on drug side effect profiles to avoid unnecessary adverse effects~~
- ~~Be aware of drug metabolism/clearance pathways to minimize drug-drug interactions and possible organ damage~~

~~In general, refills shall not be written beyond three months of the last psychiatric visit. However, exception can be made in special circumstances or when the stability of the client warrants less frequent monitoring. Such exceptions shall be documented in client progress notes.~~

~~Psychiatrists must coordinate the provision of psychiatric care with primary care medical clinics and other related providers. Regular contact with a patient's primary care clinic and related providers will ensure integration of services and maintain care continuity.~~

Appendix C: Utilizing Interns, Associates, and Trainees (IATs)

Programs utilizing IATs will give thoughtful attention to:

- **Training:** Programs utilizing IATs will provide an orientation and training program of no less than 24 hours of instruction focusing on the specifics of providing HIV mental health services. This orientation/training will be completed before IATs begin providing services.
- **Case assignment:** IATs will only be assigned cases that are appropriate to their experience and scope of practice. Additionally, IAT should not be assigned cases that require an intervention that is longer term than the IAT's internship. Such cases should be referred to staff clinicians or referred out.
- **Supervision:** Programs will provide IATs with clinical supervision in accordance with all applicable rules and standards. Supervisors, or other appropriate mental health staff will always be available to IAT that they are providing direct services to clients.

IATs will explicitly inform their clients of their intern status at the beginning of treatment. A document that acknowledges IAT status and details the case supervisor's name will be signed by the client and IAT and placed in the client record. The issue of termination/transition/transfer (due to a therapist's IAT status) will be addressed at the beginning of the assessment, at treatment inception and revisited six weeks prior to IAT termination.

IATs will consult with the clinical supervisor prior to the termination/transition intervention with a client. As part of the termination process, the IAT and client will discuss the client's treatment accomplishments, challenges, preference for future treatment and treatment recommendation. As is true throughout the treatment process, the clinical supervisor will provide oversight for the termination/transition process and cosign the IAT documentation.

While every effort should be made to ensure that IATs will not provider services for clients whose Treatment Plans extend past the internship term, it is recognized that in some cases, clients require unanticipated additional and/or ongoing treatment to meet the stated goals of their treatment plans. In such cases, special care must be given to the transfer of these clients.

Programs will endeavor to transfer IAT clients immediately to another clinician or outside program.

If a client must be placed on a waiting list for transfer to another clinician or IAT, programs will provide the following options for ongoing monitoring and crisis care:

- **Telephone contact:** Existing mental health staff or IAT will attempt contact at least twice a month to every client on the transfer waiting list to monitor current mental status and asses for emergent crises.
- **Transition group:** All clients on a transfer waiting list will be offered the opportunity to attend a transition group or another existing support group to monitor current mental status and assess for emergent crises.
- **Crisis counseling:** Utilizing both monitoring mechanisms noted above, all clients on a transfer waiting list will be informed of the availability of crisis counseling designated for them on an as needed basis.

Program will complete a Client Transfer Form (CTF) detailing the transfer plan for each IAT transfer.

Multi-Year Program Directives for Ryan White Part A and MAI Funds for Program Years (PY) 35, 36, and 37 and Centers for Disease Control and Prevention (CDC) Funding

(Final Draft for Executive Committee Approval 2.27.25)

Approval Dates: Approved by PP&A on 2.18.25

Purpose: These program directives approved by the Los Angeles County Commission on HIV (COH) on March 13,2025 articulate instructions to the Division of HIV and STD Programs (DHSP), Los Angeles County Department of Public Health on how to meet the priorities established by the Commission on HIV. The Ryan White PY Years 35, 36, and 37 service rankings and allocations table are found in Attachment A. The Commission looks forward to receiving formal reports on the status of the directives issued by the Commission at least twice a year from DHSP.

#	DIRECTIVE
	OVERARCHING DIRECTIVE: Across all funding sources for prevention and care, prioritize investments in populations most disproportionately affected and in geographic areas with the highest disease burden and prevalence, where service gaps and needs are most severe.
	ACCESS AND SERVICE IMPROVEMENTS
1	Provide ongoing patient navigation support for clients as they navigate the various services available to them (whether Ryan White Program (RWP) related or not). Patient navigation services are a support system designed to help patients navigate the complexities of the healthcare system by identifying and overcoming barriers to accessing timely and appropriate care, often including assistance with scheduling appointments, understanding medical information, finding financial resources, and coordinating transportation, all with the goal of improving overall health outcomes. Patient navigation services should guide patients through the continuum of healthcare and social services process and ensure timely receipt of services.
2	Incentivize the use of long-acting injectable (LAI) antiretroviral therapy (ART) and injectable PrEP to address issues with medication adherence such as forgetting or pill fatigue, inability to store medications due to being unhoused, substance use, and other factors that hinder optimal viral suppression.

** Needs identified during COH, Committee and/or Caucus meetings and align with priorities and allocations for PY35-37.*

3	A. Expand promotion of Get Protected LA | The Ryan White Program to foster broader community awareness of local Ryan White-funded services. B. Enhance the Get Protected LA website to include available services throughout the County and from various providers. C. Increase county-wide awareness of the I'm Positive LA website through partnerships with non-traditional and new partners outside of the HIV sphere.
4	Based on clinic capacity, geographic need and patient demand, instruct contracted providers to increase access to appointments outside of traditional business hours (i.e., evenings and weekends).
5	Expand services that address the unique needs of people living with HIV who use substances such as syringe service programs, offering free naloxone and drug testing resources, medication assisted treatment (MAT), referrals for mental/behavioral health, and support consistent antiretroviral therapy (ART) use. Additional examples include increased training for staff to avoid potential adverse drug reactions, case management services to facilitate coordinated care and timely referrals for additional services needed such as housing assistance, legal services, food assistance, Hepatitis C testing, contingency management, and peer support services to ensure ART adherence.
6	Fund a full-time staff for minimum of two years to convene and facilitate provider collaborations, cross-referrals and community - wide promotion of HIV services in the Antelope Valley. Listening sessions held by the Commission in Antelope Valley in October 2024, identified both provider and consumer lack of knowledge of existing services and the need for provider collaboration, and relationship building to ensure engagement and retention of clients.
	WORKFORCE CAPACITY AND TRAINING
7	Increase workforce capacity by providing ongoing training for frontline staff on reducing stigma in clinical settings such as creating more welcoming and inclusive physical environments. Examples include culturally, age, and gender-appropriate visuals and health education materials in waiting rooms and reception areas; text-based customer service satisfaction surveys to preserve anonymity; and offering language, reading and comprehension assistance (interpretation and translation services) to clients.

** Needs identified during COH, Committee and/or Caucus meetings and align with priorities and allocations for PY35-37.*

8	Instruct core medical and support service providers to increase opportunities to hire individuals with lived experience that reflect the populations being served particularly women, people of a trans experience, Black/AA MSM, Latine/x MSM, formerly incarcerated, former substance users.
9	Increase training on Medi-Cal eligibility, enrollment, and re-enrollment process and ensure staff are periodically screening clients for Medi-Cal and Denti-Cal eligibility. Counsel clients with undocumented status, or mixed status families, to dispel Public Charge inaccuracies and encourage enrollment in Medi-Cal.
	COMMUNITY ENGAGEMENT AND COLLABORATIONS
10	A. Instruct contracted providers to participate in Commission on HIV meetings, events and other COH-related activities, as specified in funding contracts. B. Instruct contracted providers to support their clients and/or community advisory board members to participate on the local planning process, whether formally or informally, as specified in funding contracts. Excerpt from DHSP Solicitation: *3.13 County's Commission on HIV - All services provided under the Contract should be in accordance with the standards of care as determined by the County of Los Angeles Commission on HIV (Commission). Contractor must actively view the Commission website (Commission on HIV lacounty.gov) and where possible, participate in the deliberations and respectful dialogue of the Commission to assist in the planning and operations of HIV prevention and care services in LAC. 3.14*
	DIRECTIVES FROM COMMISSION CAUCUSES
11	**Transgender:** A. Housing service providers must have policies in place that protect the rights of Transgender, Gender Non-Conforming, and Intersex (TGI) People Living with HIV (PLWH). B. Housing service providers must have staff trained in trauma-informed care strategies and practices. C. Core medical and support service providers must have staff qualified to provide gender-affirming/ appropriate services to Transgender, Gender non-conforming, and Intersex people. **These transgender-specific directives are already in approved Universal service standards or care*

** Needs identified during COH, Committee and/or Caucus meetings and align with priorities and allocations for PY35-37.*

12	**Women:** • Recipient to work with the Women's Caucus to develop services that meet the needs of women including, women who are pregnant or have children. Explore feasibility and process for funding at least two core medical providers that would offer comprehensive women's-centered services.
13	**Older Adults/Aging:** • Ensure that Benefits Specialty services are available within each Service Planning Area (SPA). Benefits Specialty services must also expand to include non-Ryan White services available for aging populations (50+) within Los Angeles County. • Develop formal partnership agreements with the local Area on Aging agencies to identify and promote services for older adults living with HIV.
14	**Black/African American:** • Develop pilot community engagement activities, e.g., incentivized coalition-building and ambassador programs that engage trusted influencers from diverse Black subpopulations, including transgender individuals, MSM, women, and youth. These initiatives will aim to foster connection, build trust, and raise HIV awareness by promoting available services and encouraging community-driven advocacy and support beyond traditional providers and spaces.

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