LOS ANGELES COUNTY
COMMISSION ON HIV

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PLANNING, PRIORITIES & ALLOCATIONS COMMITTEE MEETING

Tuesday, November 18, 2025
1:00pm – 4:00pm (PST)
Extended Meeting

510 S. Vermont Avenue, 9th Floor, LA 90020
Validated Parking @ 523 Shatto Place, LA 90020
**As a building security protocol, attendees entering the building must notify parking attendant and/or security personnel that they are attending a Commission on HIV meeting.*

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

Register Here to Join Virtually

https://lacountyboardofsupervisors.webex.com/weblink/register/raadef25f9ab6ba1503ea67bfe768a98e

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.

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LOS ANGELES COUNTY
COMMISSION ON HIV

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

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

PLANNING, PRIORITIES, & ALLOCATIONS COMMITTEE

TUESDAY, NOVEMBER 18, 2025 | 1:00 PM – 4:00 PM

****EXTENDED MEETING****

510 S. Vermont Ave
Terrace Level Conference Room, Los Angeles, CA 90020

Validated Parking: 523 Shatto Place, Los Angeles 90020

MEMBERS OF THE PUBLIC:
To Register + Join by Computer:
https://lacountyboardofsupervisors.webex.com/weblink/register/raadef25f9ab6ba1503ea67bfe768a98e

To Join by Telephone: 1-213-306-3065
Password: PLANNING Access Code: 2533 182 7465

Planning, Priorities, and Allocations Committee Members:			
Kevin Donnelly, Co-Chair Carlos Vega-Matos *(Alternate)*	Daryl Russell Co-Chair	Al Ballesteros, MBA	Rev. Gerald Green *(LOA)*
Felipe Gonzalez	Michael Green, PhD	William King, MD, JD *(LOA)*	Rob Lester *(Committee-only)*
Miguel Martinez, MPH, MSW *(Committee-only)*	Ismael Salamanca	Harold Glenn San Agustin, MD	Dee Saunders
LaShonda Spencer, MD	Lambert Talley *(Alternate)*	Jonathan Weedman	
QUORUM: 7			

AGENDA POSTED: Nov 13, 2025

PUBLIC COMMENT: Public Comment is an opportunity for members of the public to comment on an agenda item, or any item of interest to the public, before or during the Commission's consideration of the item, that is within the subject matter jurisdiction of the Commission. To submit Public Comment, you may join the virtual meeting via your smart device and post your Public Comment in the Chat box -or- email your Public Comment to mailto:hivcomm@lachiv.org -or- submit your Public Comment electronically here. All Public Comments will be made part of the official record.

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.

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 a HIVComm@lachiv.org, por lo menos setenta y dos horas antes de la junta.

SUPPORTING DOCUMENTATION can be obtained at the Commission on HIV Website at: http://hiv.lacounty.gov. The Commission Offices are located at 510 S. Vermont Ave. 14th Floor, Los Angeles, CA 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.*

I. ADMINISTRATIVE MATTERS

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

II. PUBLIC COMMENT

1:10 PM – 1:15 PM

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

III. COMMITTEE NEW BUSINESS ITEMS

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

IV. REPORTS

7. Commission on HIV (COH) Staff Report 1:16 PM—1:21PM
    a. Operational and Commission Updates

8. Co-chair Report 1:22 PM—1:30 PM
    a. December Meeting Canceled
9. Division on HIV and STD Programs (DHSP) Report 1:31 PM—1:51 PM

- B R E A K - 1:51 PM—2:00 PM

V. DISCUSSION 2:00 PM—3:54 PM

10. Program Year 36 (PY36) Ryan White Program (RWP) Reallocation – Contingency Planning
11. PY35 - PY37 Directives Review

VI. NEXT STEPS 3:55 PM – 3:57 PM

12. Task/Assignments Recap
13. Agenda Development for the Next Meeting

VII. ANNOUNCEMENTS 3:58 PM – 4:00 PM

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

VIII. ADJOURNMENT 4:00 PM

15. Adjournment for the meeting of November 18, 2025.

PROPOSED MOTIONS	
MOTION #1	Approve the Agenda Order, as presented or revised.
MOTION #2	Approve the Planning, Priorities and Allocations Committee minutes, as presented or revised.

LOS ANGELES COUNTY
COMMISSION ON HIV

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

Approved by COH 6/8/23

CODE OF CONDUCT

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

All participants and stakeholders should adhere to the following:

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

HYBRID MEETING GUIDELINES, ETTIQUETTE & REMINDERS

(Updated 7.15.24)

☐ This meeting is a **Brown-Act meeting** and is being recorded.
- Turn off your ringers/notifications on your smart devices so as not to disrupt the meeting.
- Your voice is important and we want to ensure that it is captured accurately on the record. Please be respectful of one another and minimize crosstalk.

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

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

☐ **Public Comment** for members of the public can be submitted in person, electronically @ https://www.surveymonkey.com/r/public_comments or via email at hivcomm@lachiv.org. *Please indicate your name, the corresponding agenda item, and whether you would like to state your public comment during the meeting; if so, staff will call upon you appropriately. Public comments are limited to two minutes per agenda item. All public comments will be made part of the official record.*

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

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

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 10/20/25

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ALE-FERLITO	**Dahlia**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
ALVAREZ	**Miguel**	No Affiliation	No Ryan White or prevention contracts
ARRINGTON	**Jayda**	Unaffiliated representative	No Ryan White or prevention contracts
BALLESTEROS	**Al**	JWCH, INC.	Benefits Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Mental Health
			Oral Health
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HTS - Syphilis, DX Link TX - CSV
			Biomedical HIV Prevention
			Data to Care Services
			Medical Transportation Services
BLEA	**Leroy**	California Department of Public Health, Office of AIDS	Part B Grantee
BURTON	**Alasdair**	No Affiliation	No Ryan White or prevention contracts
CAMPBELL	**Danielle**	T.H.E. Clinic, Inc.	Core HIV Medical Services - AOM; MCC & PSS
			Medical Transportation Services
CIELO	**Mikhaela**	Los Angeles General Hospital	No Ryan White or prevention contracts
CUEVAS	**Sandra**	Pacific AIDS Education and Training - Los Angeles	No Ryan White or prevention contracts
CUMMINGS	**Mary**	Bartz-Altadonna Community Health Center	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
DAVIES	**Erika**	City of Pasadena	No Ryan White or prevention contracts
DAVIS (PPC Member)	**OM**	Aviva Pharmacy	No Ryan White or prevention contracts
DOLAN (SBP Member)	**Caitlyn**	Men's Health Foundation	Core HIV Medical Services - AOM; MCC & PSS
			Biomedical HIV Prevention Services
			Vulnerable Poplulations (YMSM)
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			Medical Transportation Services
DONNELLY	**Kevin**	Unaffiliated representative	No Ryan White or prevention contracts
FINLEY	**Jet**	Unaffiliated representative	No Ryan White or prevention contracts
FRAMES	**Arlene**	Unaffiliated representative	No Ryan White or prevention contracts
FRANKLIN*	**Arburtha**	Translatin@ Coalition	Vulnerable Populations (Trans)
GERSH (SBP Member)	**Lauren**	APLA Health & Wellness	Benefits Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Intensive Case Managemenet Services
			Nutrition Support (Food Bank/Pantry Service)
			Oral Health
			STD-Ex.C
			HERR
			Biomedical HIV Prevention Services
			Medical Transportation Services
			Data to Care Services
			Residential Facility For the Chronically Ill (RCFCI)
GONZALEZ	**Felipe**	Unaffiliated representative	No Ryan White or Prevention Contracts
GREEN	**Gerald**	Minority AIDS Project	Benefits Specialty
GREEN	**Joseph**	Unaffiliated representative	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
GUTIERREZ	**Joaquin**	Unaffiliated representative	No Ryan White or prevention contracts
HARDY	**David**	University of Southern California	No Ryan White or prevention contracts
HERRERA	**Ismael "Ish"**	Unaffiliated representative	No Ryan White or prevention contracts
JONES	**Terrance**	Unaffiliated representative	No Ryan White or prevention contracts
KOCHEMS	**Lee**	Unaffiliated representative	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
LESTER (PP&A Member)	**Rob**	Men's Health Foundation	Core HIV Medical Services - AOM; MCC & PSS
			Biomedical HIV Prevention Services
			Vulnerable Poplulations (YMSM)
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			Medical Transportation Services
MARTINEZ (PP&A Member)	**Miguel**	Children's Hospital Los Angeles	Core HIV Medical Services - AOM; MCC & PSS
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			Biomedical HIV Prevention Services
			Medical Transportation Services
MARTINEZ-REAL	**Leonardo**	Unaffiliated representative	No Ryan White or prevention contracts
MAULTSBY	**Leon**	In the Meantime Men's Group	Promoting Healthcare Engagement Among Vulnerable Populations
MENDOZA	**Vilma**	Unaffiliated representative	No Ryan White or prevention contracts
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	No Ryan White or prevention contracts

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

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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.

PLANNING, PRIORITIES, AND ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES
October 21, 2025

COMMITTEE MEMBERS P = Present | P* = Present as member of the public; does not meet AB 2449 requirements | A = Absent | EA = Excused Absence			
Kevin Donnelly, Co-Chair	EA	Miguel Martinez, MPH, MSW	P
Daryl Russell, Co-Chair	P	Ismael Salamanca	EA
Al Ballesteros, MBA	P	Harold Glenn San Agustin, MD	P
Felipe Gonzalez	P	Dee Saunders	A
Reverend Gerald Green	A	LaShonda Spencer, MD	EA
Michael Green, PhD, MHSA	EA	Lambert Talley	EA
William King, MD, JD	LOA	Carlos Vega-Matos	P
Rob Lester	P	Jonathan Weedman	P
COMMISSION STAFF AND CONSULTANTS			
Jose Garibay, Lizette Martinez			
DHSP STAFF			
Victor Scott, Anahit Nersisyan, Sona Oksuzyan, Amanda Wahnich			

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

Meeting agenda and materials can be found on the Commission's website. Click HERE.

I. ADMINISTRATIVE MATTERS

1. CALL TO ORDER AND MEETING GUIDELINES/REMINDERS

D. Russell, Planning, Priorities and Allocations (PP&A) co-chair, called the meeting to order at approximately 1:05pm.

2. ROLL CALL & CONFLICT OF INTEREST STATEMENTS

L. Martinez, Commission staff, conducted roll call and committee members were reminded to state their conflicts.

ROLL CALL (PRESENT): D. Russell, A. Ballesteros, F. Gonzalez, R. Lester, M. Martinez, H. San Agustin, C. Vega-Matos, J. Weedman

3. Approval of Agenda

MOTION #1: Approve the Agenda Order **(✓Passed by Consensus)**

4. **Approval of Meeting Minutes**
   MOTION #2: Approval of Meeting Minutes **(✓Passed by Consensus)**

II. PUBLIC COMMENT

5. **Opportunity for members of the public to address the Committee on items of interest that is within the jurisdiction of the Committee.**
   There was no public comment.

III. COMMITTEE NEW BUSINESS

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

   There was no committee new business.

IV. REPORTS

7. **Commission on HIV Staff Report**
   - L. Martinez announced that the Commission on HIV (COH) Annual Conference will take place next month on November 13, 2025 from 9am to 4pm at St. Anne's Conference and Events Center. A Save the Date memo was sent out and additional details will be forthcoming.
   - L. Martinez reminded the group that the COH continues to have discussions regarding by-laws updates and that recommendations will be presented at the December 11 COH meeting. Review and approval of the bylaws was postponed earlier this month to allow for continued discussion regarding the role of prevention planning within the COH.
   - L. Martinez reported that COH staff met with the California Office of AIDS (OA) representative LeRoy Blea on Oct. 20 to begin planning around the 2027-2031 Comprehensive HIV Plan. Commission staff will be meeting with the OA and the Division of HIV and STD Programs (DHSP) to work collaboratively on the plan. Commission staff are gathering needs assessments that will be used to inform the plan and will be collaborating with the Division of HIV and STD Programs (DHSP) to develop SMART objectives and social determinants of health indicators for LA County. Commission staff and DHSP staff will be meeting with the OA bimonthly to work on the plan.

8. **Co-chair Report**
   a. **November and December Meetings**
      - D. Russell reported that the December Planning, Priorities and Allocations (PP&A) Committee meeting is canceled. The next PP&A Committee meeting will be on January 20, 2026 at the

Vermont Corridor.

9. Division of HIV and STD Programs Report

a. Program Year 34 (PY34) Ryan White Program Utilization Report – Support Services

- DHSP staff, S. Oksuzyan, provided a PY34 Ryan White Program Utilization Report to the committee focusing on Ryan White Program support services; see meeting packet for presentation slides.
- The report showed an increased utilization in Emergency Financial Assistance, Housing Support, and Nutrition Support services and a decreased utilization in Benefits Specialty services and the Linkage and Re-Engagement Program services. The highest expenditures per client were attributed to the Linkage and Re-engagement Program followed by Housing Support Services and Substance Use Residential services. The lowest expenditures per client were seen in Benefits Specialty services followed by Nutrition Support services and Emergency Financial Assistance services.
- Engagement, retention in care and viral suppression percentages were higher in RWP clients using Substance Use Residential, Benefits Specialty and Housing Support services.

V. DISCUSSION

10. Women's Caucus Recommendations for Women-Centered Programming

- Commission staff provided a brief overview of recommendations for women-centered programming created by the Women's Caucus. Recommendations were developed from various women-only listening sessions (see Commission on HIV website for reports for each listening session) and discussions held at Women's Caucus meetings over the course of the past two years. See meeting packet for more details on recommendations.
- The Women's Caucus emphasized the importance of peer support groups and noted that the recommendation to expand peer support groups was their top need/priority ahead of all other recommendations.
- C. Vega-Matos noted many of the recommendations are related to best practices and standards of care. A recommendation was made to forward the recommendations to the Standards and Best Practices Committee for review and incorporation into their standards of care and best practices guidelines.
- M. Martinez suggesting having the local Part D provider or Christy's Place (San Diego) present on their peer support models of care to hear more information that would be relevant to the PP&A committee if the committee wants to allocate funds for this service category. C. Vega-Matos noted that the committee needs to really think about allocating funds to another service category that is not currently allocated funding, noting that funds will be taken from other services in a time of an overall reduction in services across various providers, not just Ryan White providers. He recommended learning what other models of care currently exist that can be leveraged because adding another service category for funding may not be feasible at this time.
- P. Zamudio commented that DHSP has heard about the need for peer support services and noted that peer support was added to the Core HIV request for proposal that is under Patient Support

Services as an opportunity for providers to add peer support to their HIV core services and only two agencies applied to add that to their services. She noted that DHSP recognizes that there is a need for peer support services but that there is a disconnect between the needs of the clients and providers not having the capacity to looking to implement peer support services. She suggested exploring a wider conversation with both providers and consumers to identify barriers and strategies to overcome the barriers.

- P. Zamudio suggested use of volunteers noting that in the past many of the peer support programs were created through volunteers. She noted that agencies do, however, need capacity to create and support volunteer peer programs but this type of program may be worth exploring as a potential option to fulfill new work requirements under Medicaid. Exploring the possibility of a volunteer peer support program in the future may be beneficial, particularly if funding is not available.
- R. Lester noted that the foundation of the HIV movement was built on volunteer work and that much of the work has moved to the professional side. He noted that creating volunteer opportunities is a great way to reconnect with the community and there is an opportunity to build capacity by funding volunteer coordinators to establish and build volunteer programs.
- C. Vega-Matos suggested creating a program that is status neutral to address concerns about disclosure among participants.
- V. Mendoza, member of the public, noted that there are additional considerations that need to be taken into account for women to access peer support services such as the needs for childcare, transportation support, and work commitments. She needed that more needs to be done to understand and overcome the barriers that women face in their regular lives to be able to access peer support programs.
- C. Vega-Matos asked if there was a standard of care for volunteers and if there are not currently standards in place that the Standards and Best Practices committee consider developing these standards. He noted there will be risk management issues that will need to be addressed.

11. 2026 PP&A Committee Meeting Calendar

- D. Russel opened the discussion by sharing that PP&A committee co-chairs, Commission staff and DHSP staff have been discussing the committee calendar for the upcoming year. The goal is to create a meeting calendar that addresses staffing capacity while ensuring the committee meets its mandated requirements and can review data in a timely manner that better aligns with the priority setting and resource allocation (PSRA) process and important Health Resources and Services Administration (HRSA) reporting and/or application due dates. DHSP has noted that budget cuts are impacting staff and staff may not be available to attend all meetings next year.
- Commission staff created a list of annual key activities the committee needs to accomplish that include data and reports from DHSP. From these key activities, three committee meeting calendars were created to guide discussions to help determine the committee meeting schedule for the next year and set clear expectations for both the committee and DHSP. Calendar option #1 meets monthly, calendar option #2 meets bimonthly with increased meetings during June and July that focus on data presentations and calendar option #3 meets bimonthly with a virtual data summit over the course of several days to be held in June. See meeting packet for list of key

activities and proposed meeting calendars. The third calendar option presents data just ahead of the PSRA process, allows committee members, commissioners and the broader public to view data presentations online if they are not able to attend the day of the scheduled presentation, and allows time to generate data summaries in time for the PSRA process.

- C. Vega-Matos raised concerns about meeting bimonthly noting that federal budget cuts continue to threaten funding for programs outside of the Ryan White Program, such as Medicaid and HIV prevention funding cuts, and that the committee needs to remain nimble to quickly address shifts in funding.
- M. Martinez noted that having a data summit in the summer is beneficial for the committee noting that current data reports are spread throughout the year, and it can be challenging to recall information from months prior.
- A. Ballesteros commented that the committee can meet quarterly and still accomplish all the required mandates. He stated that, as a former committee chair, the committee needs to streamline their objectives and goals and work more efficiently. He noted that there was a precedent for both quarterly and bimonthly meetings and that the committee can call special meetings if needed. He added that there have been reductions in funding, services and staffing across the country, state and county and advised that a reduction in meetings shows that the Commission is in line with these reductions and is being mindful of people's time and capacity.
- Commission staff reminded the group that the committee meeting schedule does not have to align with the proposed full-body Commission meeting schedule under the restructuring. Committee are allowed to develop their own meeting schedule to fit their needs as long as they fulfill their legislative requirements. Special meetings can also be called if the committee needs to address urgent matters.
- M. Martinez commented that quarterly meetings were not frequent enough but asked the broader committee about their thoughts on having a data summit versus receiving reports throughout the year.
    - R. Lester commented that he would prefer to have a data summit over the course of a few days and more spread-out meetings noting that it is hard to recall reports from months prior. He stated he would be better positioned to make better informed decisions around priority setting and resource allocation.
    - S. Oksuzyan, DHSP staff, expressed concerns about hosting a data summit in June noting that it would be impossible to present on data for the most recent year as the data needs time to mature and also cited staff shortages.
- Commission staff will work with co-chairs and DHSP to incorporate feedback from the discussion and revise the proposed meeting calendars for further discussion at a future meeting.

VI. NEXT STEPS

12. Task/Assignments Recap

a. Commission staff will work with co-chairs to develop the agenda for the November PP&A Committee meeting.

b. The recommendations from the Women's Caucus will be shared with the Standards and Best

Practices Committee for review and future incorporation into best practices.

c. Commission staff will work with the co-chairs and DHSP to refine a proposed committee meeting schedule for 2026 for future discussion.

13. Agenda Development for the Next Meeting

a. DHSP to report back to the committee on feasibility of the proposed PY35-PY36 Directives.

VII. ANNOUNCEMENTS

14. Opportunity for Members of the Public and the Committee to Make Announcements

There were no announcements.

VIII. ADJOURNMENT

15. Adjournment for the Regular Meeting of October 21, 2025.

The meeting was adjourned by D. Russell at 3:00pm.

DRAFT

Commission on HIV Restructure & Bylaws Revision Process — FAQ

FAQ OVERVIEW

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

BYLAWS AND ORDINANCE IN THE RESTRUCTURE

Q: What is an ordinance?

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

Q: What are bylaws?

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

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

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

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

COMMISSION ON HIV RESTRUCTURE & BYLAWS REVISION PROCESS — FAQ

WHY IS THE COMMISSION RESTRUCTURING?

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

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

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

HOW WAS COMMUNITY INPUT INCLUDED?

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

WHAT HAPPENS TO CAUCUSES AND CONSUMER VOICE?

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

WHAT ABOUT STIPENDS?

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

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

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

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

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

HOW WILL CURRENT MEMBERS BE AFFECTED?

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

HOW WILL CONFLICTS OF INTEREST BE MANAGED?

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

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

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

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

Los Angeles County Commission on HIV

Program Year 36 (PY36) Reallocations - Part A

Service Category	Service Ranking	Approved PY 35 Allocations[1]	Revised PY 36 Allocations[2]
ADAP Treatments	**9**	0.00%	0.00%
Child Care Services	**18**	0.00%	0.00%
Early Intervention Services (Testing Services)	**11**	2.07%	2.07%
Emergency Financial/Rental Assistance	**2**	4.29%	4.29%
Health Education/Risk Reduction	**13**	0.00%	0.00%
Health Insurance Premium & Cost Sharing Assistance	**15**	0.00%	0.00%
Home and Community-Based Services (Intensive Case Management Home Based)	**17**	3.96%	3.96%
Home Health Care	**16**	0.00%	0.00%
Hospice Services	**28**	0.00%	0.00%
Housing: RCFCI TRCF (Part B)	**1**	11.75%	11.75%
Legal Services	**23**	2.68%	2.68%
Linguistic Services (Language Services)	**27**	0.00%	0.00%
Local AIDS Pharmaceutical Assistance Program	**22**	0.00%	0.00%
Medical Case Management (Medical Care Coordination)	**6**	16.05%	16.05%
Medical Nutritional Therapy	**26**	0.00%	0.00%
Medical Transportation	**10**	1.86%	1.86%
Mental Health Services	**3**	3.64%	3.64%
Non-medical Case Management: Benefits Specialty Services	**5**	2.96%	2.96%
Non-medical Case Management: Patient Support Services	**5**	9.60%	9.60%
Non-medical Case Management: Transitional Case Management-Jails	**5**	0.00%	0.00%
Nutrition Support: Food Bank Home Delivered Meals	**7**	8.27%	8.27%
Oral Health: General Specialty	**8**	18.16%	18.16%
Outpatient Medical Health Services (Ambulatory Outpatient Medical)	**20**	14.71%	14.71%
Outreach Services: Linkage Re-engagement Program (LRP)	**14**	0.00%	0.00%
Psychosocial Support Services	**4**	0.00%	0.00%
Referral	**24**	0.00%	0.00%
Rehabilitation	**25**	0.00%	0.00%
Respite Care	**21**	0.00%	0.00%
Substance Abuse Residential	**19**	0.00%	0.00%
Substance Abuse Services Outpatient	**12**	0.00%	0.00%
Total		100.00%	100.00%

1) Approved by Planning, Priorities, and Allocations Committee on 8/19/25; Approved by Exec. Committee on 8/28/25

2) Recommended by Planning, Priorities, and Allocations Committee on 9/16/25; Approved by Exec. Committee on 9/25/25

Los Angeles County Commission on HIV

Program Year 36 (PY36) Reallocations - Minority AIDS Initiative (MAI)

Service Category	Service Ranking	Approved PY 35 Allocations[1]	Revised PY 36 Allocations[2]
ADAP Treatments	**9**	0.00%	0.00%
Child Care Services	**18**	0.00%	0.00%
Early Intervention Services (Testing Services)	**11**	0.00%	0.00%
Emergency Financial Assistance	**2**	0.00%	0.00%
Health Education/Risk Reduction	**13**	0.00%	0.00%
Health Insurance Premium & Cost Sharing Assistance	**15**	0.00%	0.00%
Home and Community-Based Services (Intensive Case Management Home Based)	**17**	0.00%	0.00%
Home Health Care	**16**	0.00%	0.00%
Hospice Services	**28**	0.00%	0.00%
Housing: Transitional (Rampart Mint)	**1**	100.00%	100.00%
Legal Services	**23**	0.00%	0.00%
Linguistic Services (Language Services)	**27**	0.00%	0.00%
Local AIDS Pharmaceutical Assistance Program	**22**	0.00%	0.00%
Medical Case Management (Medical Care Coordination)	**6**	0.00%	0.00%
Medical Nutritional Therapy	**26**	0.00%	0.00%
Medical Transportation	**10**	0.00%	0.00%
Mental Health Services	**3**	0.00%	0.00%
Non-medical Case Management: Benefits Specialty Services	**5**	0.00%	0.00%
Non-medical Case Management: Patient Support Services	**5**	0.00%	0.00%
Non-medical Case Management: Transitional Case Management-Jails	**5**	0.00%	0.00%
Nutrition Support: Food Bank Home Delivered Meals	**7**	0.00%	0.00%
Oral Health: General Specialty	**8**	0.00%	0.00%
Outpatient Medical Health Services (Ambulatory Outpatient Medical)	**20**	0.00%	0.00%
Outreach Services: Linkage Re-engagement Program (LRP)	**14**	0.00%	0.00%
Psychosocial Support Services	**4**	0.00%	0.00%
Referral	**24**	0.00%	0.00%
Rehabilitation	**25**	0.00%	0.00%
Respite Care	**21**	0.00%	0.00%
Substance Abuse Residential	**19**	0.00%	0.00%
Substance Abuse Services Outpatient	**12**	0.00%	0.00%
Total		100.00%	100.00%

1) Approved by Planning, Priorities, and Allocations Committee on 8/19/25; Approved by Exec. Committee on 8/28/25

2) Recommended by Planning, Priorities, and Allocations Committee on 9/16/25; Approved by Exec. Committee on 9/25/25

LOS ANGELES COUNTY COMMISSION ON HIV

Ryan White Program Year (PY) 35 Service Rankings and Allocations Table - Scenario #1 Full Funding

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

Footnotes:

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

LOS ANGELES COUNTY COMMISSION ON HIV

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

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

					FY 2025 (PY 35) [2]
Service Type	Service Ranking	Service Category	Estimated Part A & MAI PY34 Expenditures $	Estimated Part B PY34 Expenditures $	Part A, MAI, & Part B %
Core	6	Medical Case Management (Medical Care Coordination)	$ 11,660,438.00	$ -	32.30%
Core	8	Oral Health	$ 8,751,232.00	$ -	0.00%
Core	20	Outpatient/Ambulatory Medical Health Services (Ambulatory Outpatient Medical)	$ 6,860,111.00	$ -	52.31%
Core	11	Early Intervention Services (Testing Services)	$ 2,332,127.00	$ -	0.00%
Core	17	Home and Community-Based Health Services	$ 2,345,241.00	$ -	0.00%
Support	2	Emergency Financial Assistance	$ 1,539,288.00	$ -	0.00%
Support	7	Nutrition Support (Food Bank/Home-delivered Meals)	$ 2,783,905.00	$ -	0.00%
Support	5	Non-Medical Case Management			
		Benefits Specialty Services	$ 1,517,835.00	$ -	11.54%
		Transitional Case Management - Jails	$ 26,720.00	$ -	0.00%
Support	10	Medical Transportation	$ 715,013.00	$ -	3.85%
Support	23	Legal Services	$ 1,049,695.00	$ -	0.00%
Support	1	Housing		$ 5,287,873.00	
		Housing Services RCFCI/TRCF (Home-Based Case Management)	$ 571,410.00	$ -	0.00%
		Housing for Health	$ 5,375,220.00	$ -	0.00%
Core	3	Mental Health Services	$ 85,420.00	$ -	0.00%
Core	9	AIDS Drug Assistance Program (ADAP) Treatments	$ -	$ -	0.00%
Core	22	Local AIDS Pharmaceutical Assistance Program (LPAP)	$ -	$ -	0.00%
Core	15	Health Insurance Premium & Cost Sharing Assistance	$ -	$ -	0.00%
Core	16	Home Health Care	$ -	$ -	0.00%
Core	28	Hospice Services	$ -	$ -	0.00%
Core	26	Medical Nutritional Therapy	$ -	$ -	0.00%
Core	12	Substance Abuse Services Outpatient	$ -	$ -	0.00%
Support	18	Child Care Services	$ -	$ -	0.00%
Support	13	Health Education/Risk Reduction	$ -	$ -	0.00%
Support	27	Linguistic Services (Language Services)	$ -	$ -	0.00%
Support	14	Outreach Services (LRP)	$ -	$ -	0.00%
Support	4	Psychosocial Support Services	$ -	$ -	0.00%
Support	24	Referral	$ -	$ -	0.00%
Support	25	Rehabilitation	$ -	$ -	0.00%
Support	21	Respite Care	$ -	$ -	0.00%
Support	19	Substance Abuse Residential	$ -	$ -	0.00%
		Overall Total	**$ 45,613,655.00**	**$ 5,287,873.00**	**100.00%**

Footnotes:

(1) DHSP recommended PP&A Committee to consider $5 million in Part B funds into allocations

(2) Factors taken into consideration for proposed allocations include:

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

LOS ANGELES COUNTY COMMISSION ON HIV

Ryan White Program Year 35 (FY2025-2026) Service Rankings and Allocations Table - Scenario #3 (1)

Partial Award: $24,448,952 in Part A funds and $3,150,000 in MAI funds

Priority Ranking	Core Service Categories	Service Type	Part A %	MAI %
9	**AIDS Drug Assistance Program** (ADAP) **Treatment**	Core	0%	0%
22	**AIDS Pharmaceutical Assistance** (LPAP)	Core	0%	0%
11	**Early Intervention Services (Testing Services)**	Core	0%	0%
15	**Health Insurance Premium & Cost Sharing Assistance**	Core	0%	0%
17	**Home & Community Based Health Service (Intensive Case Management-Home Based)**	Core	**6.67%**	0%
16	**Home Health Care**	Core	0%	0%
28	**Hospice**	Core	0%	0%
6	**Medical Case Management** (Medical Care Coordination)	Core	**27.91%**	0%
3	**Mental Health Services**	Core	0%	0%
8	**Oral Health Care**	Core	**20.31%**	0%
20	**Outpatient/Ambulatory Health Services**	Core	0%	0%
12	**Substance Abuse Outpatient Care**	Core	0%	0%
	Core Services Total		**54.89%**	0%
Priority Ranking	**Support Service Categories**	**Service Type**	**Part A %**	**MAI %**
18	**Child Care Services**	Support	0%	0%
2	**Emergency Financial Assistance (Emergency Rental Assistance)**	Support	**8.16%**	0%
7	**Food Bank/Home Delivered Meals**	Support	**8.82%**	0%
3	**Health Education/Risk Reduction**	Support	0%	0%
1	**Housing Services** (RCFCI)	Support	**8.33%**	0%
1	**Housing Services** (TRCF)	Support	**1.31%**	0%
1	**Housing Services** (Rampart Mint/Transitional/Permanent)	Support	0%	**84.13%**
27	**Linguistics Services**	Support	0%	0%
10	**Medical Transportation**	Support	0%	**15.87%**
5	**Non-Medical Case Management Services** (Benefits Specialty Services)	Support	**3.91%**	0%
5	**Non-Medical Case Management Services** (Transitional Case Management - Jails)	Support	0%	0%
5	**Non-Medical Case Management Services** (Patient Support Service)	Support	**12.58%**	0%
23	**Other Professional Services** (Legal)	Support	**2.00%**	0%
14	**Outreach Services**	Support	0%	0%
4	**Psychosocial Support**	Support	0%	0%
24	**Referral For Health Care Supportive Services**	Support	0%	0%
25	**Rehabilitation Services**	Support	0%	0%
21	**Respite Care**	Support	0%	0%
19	**Substance Abuse - Residential**	Support	0%	0%
	Support Service Total		**45.11%**	**100%**
	Total		**100.00%**	**100%**

Footnotes

(1) DHSP recommendations; Approved by PP&A Committee on 5.1.25

Annual HIV/STD Update to the Los Angeles County Commission on HIV

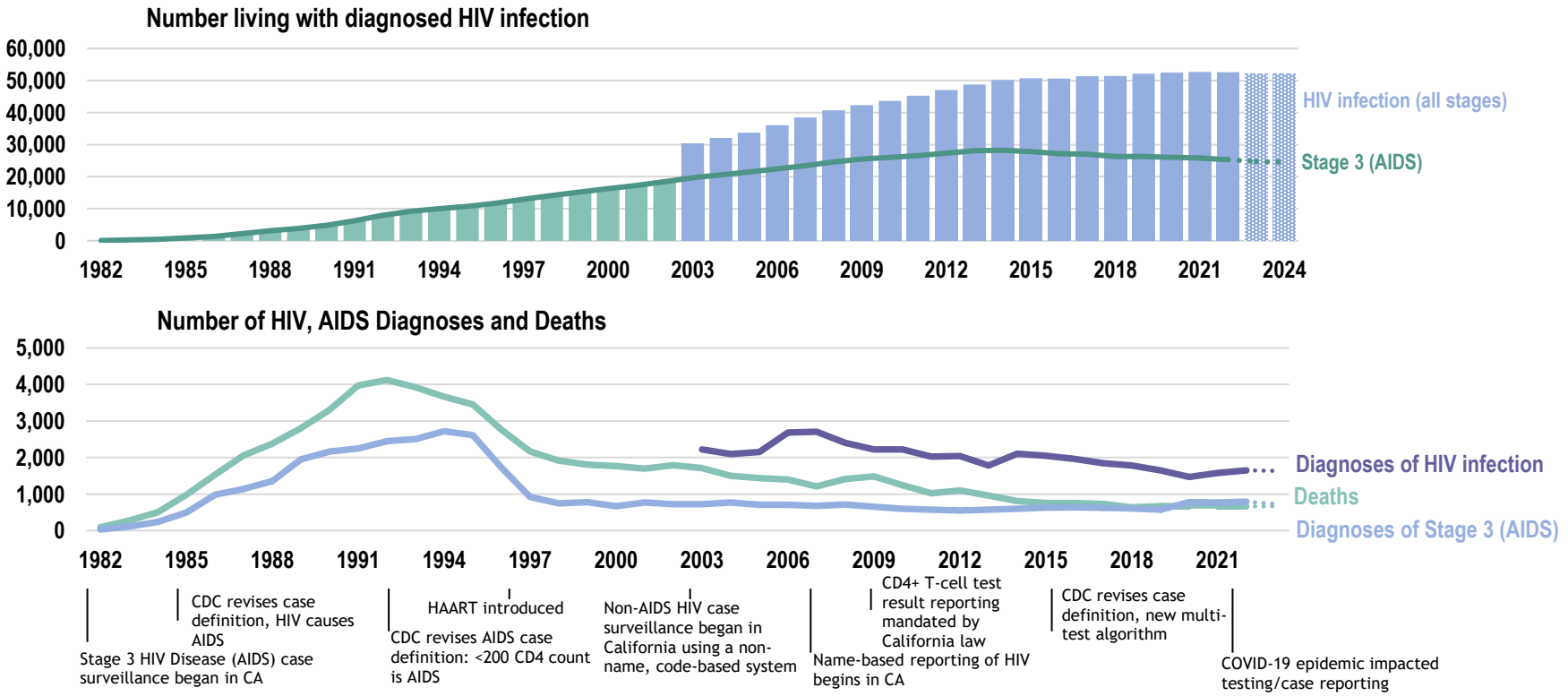
Mario J. Pérez, Director
Division of HIV and STD Programs
Los Angeles County Department of Public Health

November 13, 2025

1. HIV, STD, and Mpox Morbidity Trends
2. Federal Budget and Policy Updates
3. Workforce and Program Impacts
4. Priority Setting
5. Questions and Answers

HIV, STD, and Mpox Morbidity Trends

HIV Diagnoses, AIDS Diagnoses, Persons Living with AIDS and Non-AIDS HIV, and Deaths among Persons Living with Diagnosed HIV, Los Angeles County 1982-2024[1,2,3]

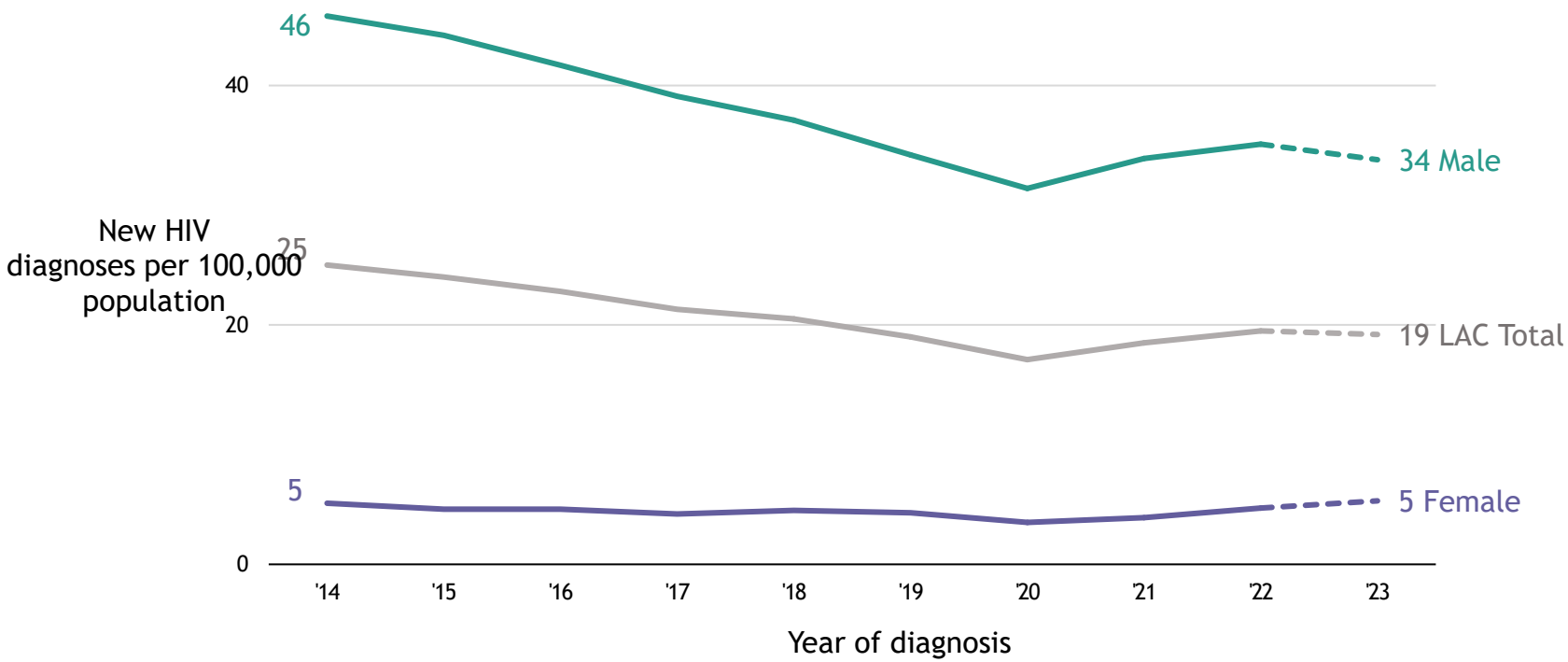


History of the HIV epidemic: In LAC, AIDS reporting began in 1982 and the annual number of cases peaked in 1992 with more than 4,000 cases reported that year. In 1994, deaths reached an all-time high followed by a significant decline that coincided with the introduction of highly active antiretroviral treatment (HAART) for HIV in 1996. In 2006, name-based HIV reporting began in California, allowing for better tracking of trends in diagnosed HIV irrespective of disease stage.

[1] Includes new diagnoses of HIV infection regardless of the disease stage at time of diagnosis.
[2] Includes persons whose residence at death was in LAC or whose most recent known address before death was in LAC, when residence at death is missing.
[3] 2023 data for diagnoses of HIV/AIDS and deaths and 2023/2024 data for persons living with non-AIDS HIV and AIDS are provisional as indicated by the dashed line and patterned bar. 2024 diagnoses of HIV/AIDS and deaths are underreported/unreliable due to significant reporting delay, and therefore are not shown.

Source: HIV Surveillance data as of December 2024

HIV diagnoses rates by sex[1] among persons aged ≥ 13 years, LAC 2014-2023[2,3]

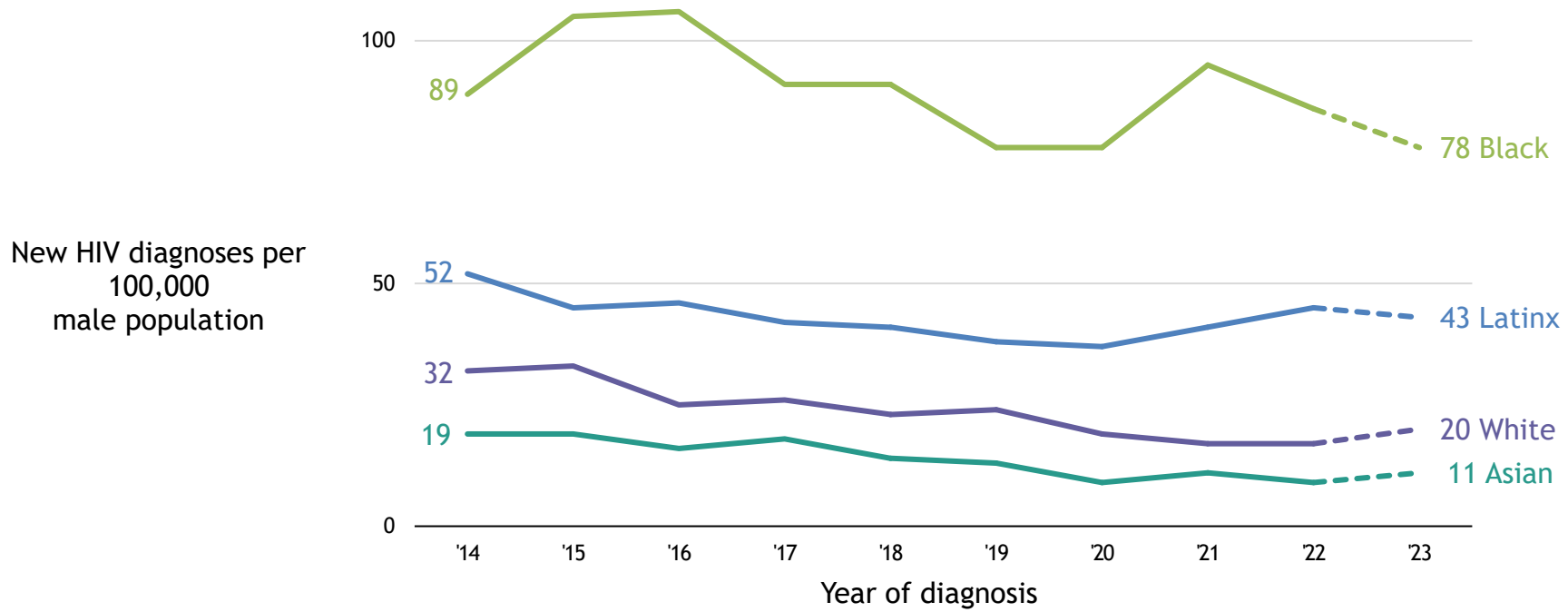


HIV diagnosis rates remain substantially higher among males compared with females. Over the past decade, HIV diagnosis rates among males have declined, while rates among females have remained stable.

[1] Rates are presented by sex at birth due to the unavailability of population size estimates in LAC by gender categories.
[2] Due to reporting delay, 2023 HIV diagnosis data are provisional as indicated by the dashed line.
[3] The decline in HIV diagnoses rates observed in 2020, a year in which the COVID-19 pandemic may have depressed HIV testing and reporting, seems to have been followed by a rebound in diagnoses in 2021 and 2022.

Source: HIV Surveillance data as of December 2024

HIV diagnoses rates among males[1] aged ≥ 13 years by race/ethnicity,[2] LAC 2014-2023[3,4]

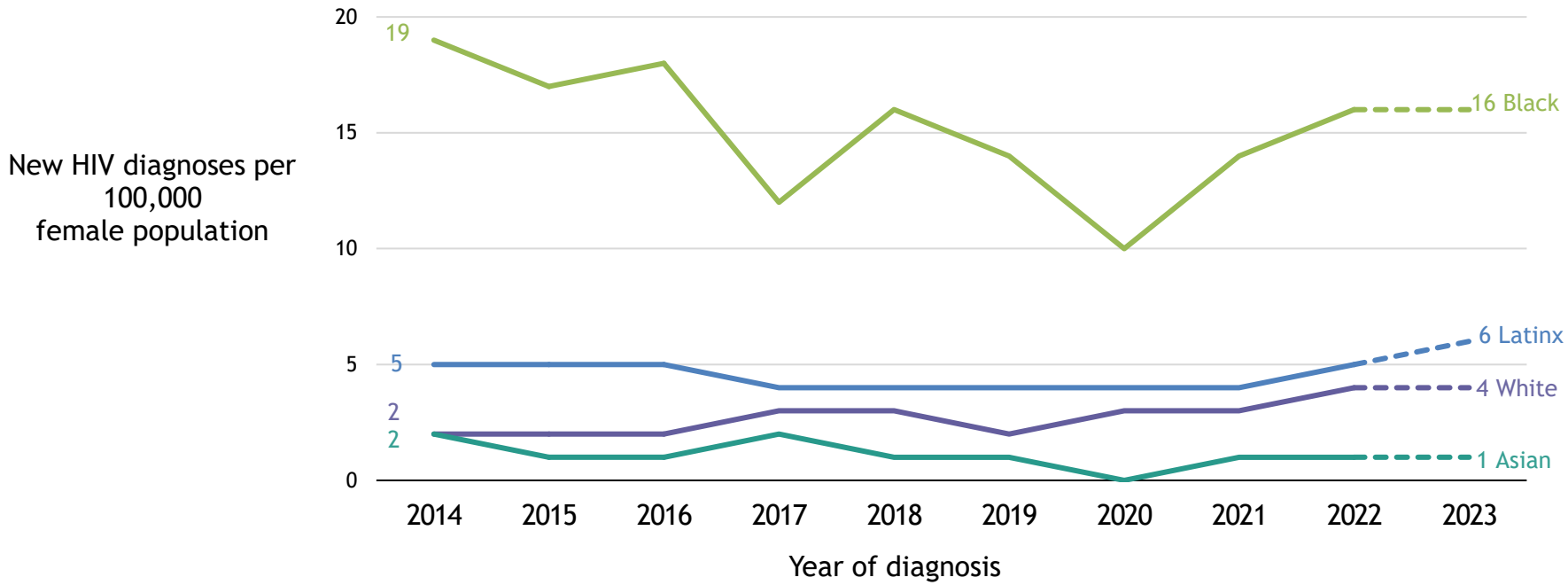


Over the past decade, HIV diagnoses rates have declined among LAC males across all race/ethnicity groups. However, stark disparities persist, with Black males experiencing significantly higher rates than other race/ethnicity groups.

[1] Based on sex at birth.
[2] Native Hawaiian and Pacific Islanders (NHPI) and American Indians and Alaska Natives (AIAN) were not included in the analysis due to small numbers, while persons of multiple race/ethnicities were not included due to lack of denominator data to calculate rates. In 2023, NHPI, AIAN, and multi-racial persons represented 0.3%, 0.4%, and 1.3% of males newly diagnosed with HIV, respectively.
[3] Due to reporting delay, 2023 HIV diagnosis data are provisional as indicated by the dashed line.
[4] The decline in HIV diagnoses rates observed in 2020, a year in which the COVID-19 pandemic may have depressed HIV testing and reporting, seems to have been followed by a rebound in diagnoses in 2021 and 2022.

Source: HIV Surveillance data as of December 2024

HIV diagnoses rates among females[1] aged ≥ 13 years by race/ethnicity,[2] LAC 2014-2023[3,4]



Over the past decade, HIV diagnosis rates have remained relatively low and stable among Latinx, White, and Asian women in LAC. By contrast, rates for Black females have consistently remained higher than other racial/ethnic groups and have increased in recent years, reaching 16 per 100,000 in 2023.

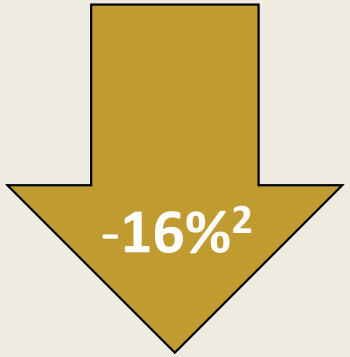
[1] Based on sex at birth.
[2] Native Hawaiian and Pacific Islanders (NHPI) and American Indians and Alaska Natives (AIAN) were not included in the analysis due to small numbers, while persons of multiple race/ethnicities were not included due to lack of denominator data to calculate rates. In 2023, NHPI, AIAN, and multi-racial persons represented 0.4%, 1.7%, and 1.3% of females newly diagnosed with HIV, respectively.
[3] Due to reporting delay, 2023 HIV diagnosis data are provisional as indicated by the dashed line.
[4] The decline in HIV diagnoses rates observed in 2020, a year in which the COVID-19 pandemic may have depressed HIV testing and reporting, seems to have been followed by a rebound in diagnoses in 2021 and 2022.

Source: HIV Surveillance data as of December 2024

LAC saw a 15% case reduction in 3 reported STIs from 2023–24, matching or surpassing national trends[1]

Chlamydia

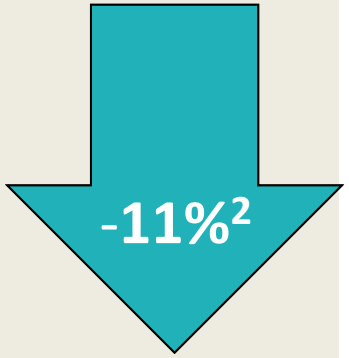
- Reductions since peak in 2019
- National: -8%



Gonorrhea

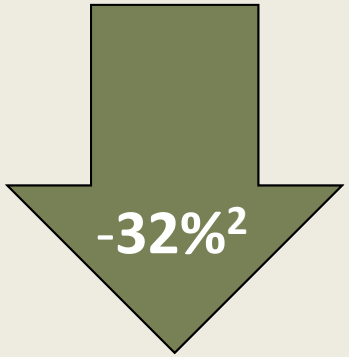
- Reductions since peak in 2021*
- National: -10%

Third year in a row



Early Syphilis[3]

- Reductions since 2021
  - Primary/secondary: -34%
- National
  - Primary/ secondary: -22%



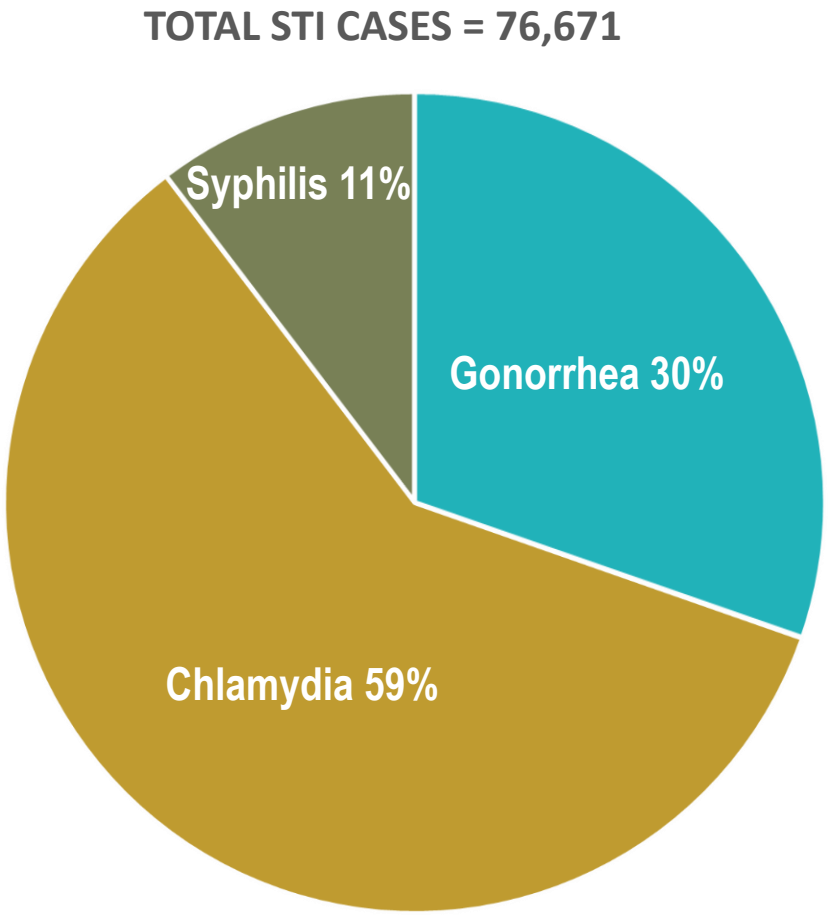
Congenital syphilis

- Reductions since 2022: -19%
- *Cases still >3x than a decade ago*
- National: increase

1. Data as of September 22, 2025 and excludes data from the cities of Long Beach and Pasadena. Preliminary 2024 data.
2. Reductions in number of cases from 2023 to 2024.
3. Early syphilis includes all cases staged as primary, secondary or early non-primary, non-secondary (early latent).

Source: LAC DPH Division of HIV and STD Programs

Preliminary Reported Sexually Transmitted Infections, Los Angeles County, 2024[1]



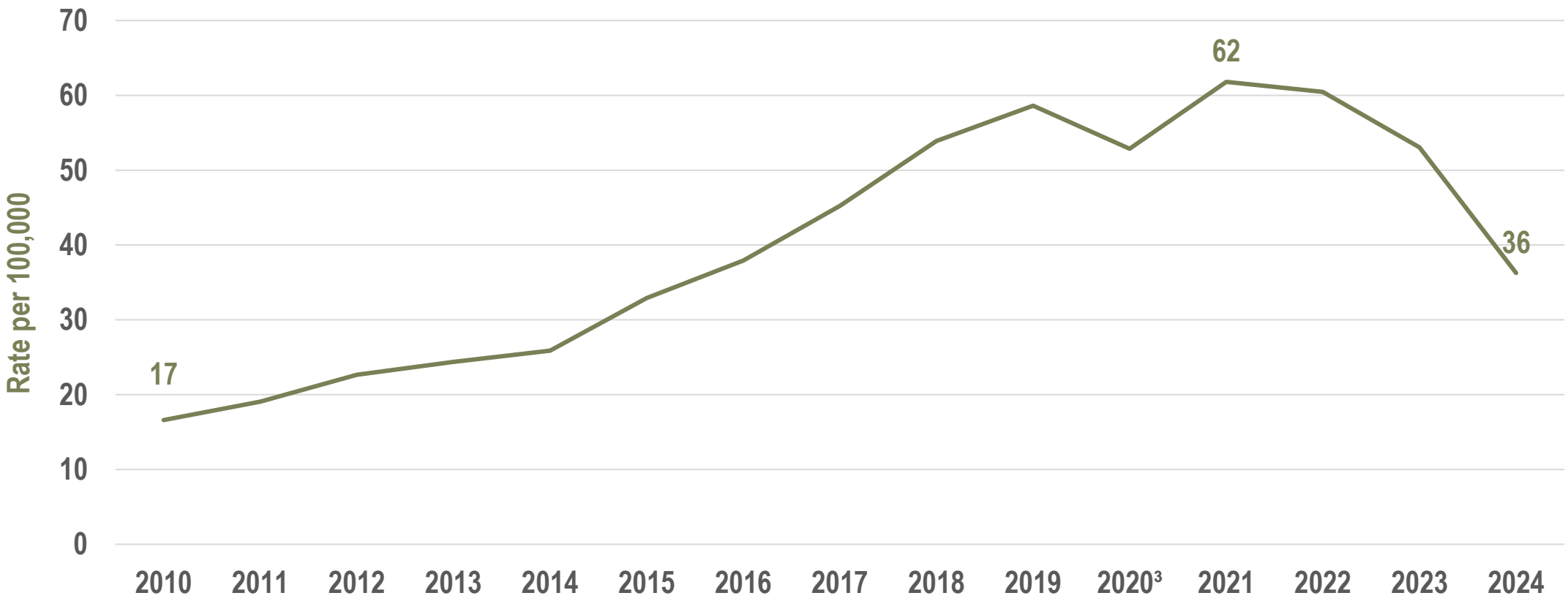
Although syphilis represents only 11% of STIs in LAC, the health consequences of untreated syphilis can be more severe than untreated chlamydia and gonorrhea.

Source: LAC DPH Division of HIV and STD Programs

1. Data as of September 22, 2025 and excludes data from the cities of Long Beach and Pasadena.

The early syphilis rate has been decreasing since its peak in 2021.

Preliminary Early Syphilis[1] Rates, Los Angeles County, 2010-2024[2]

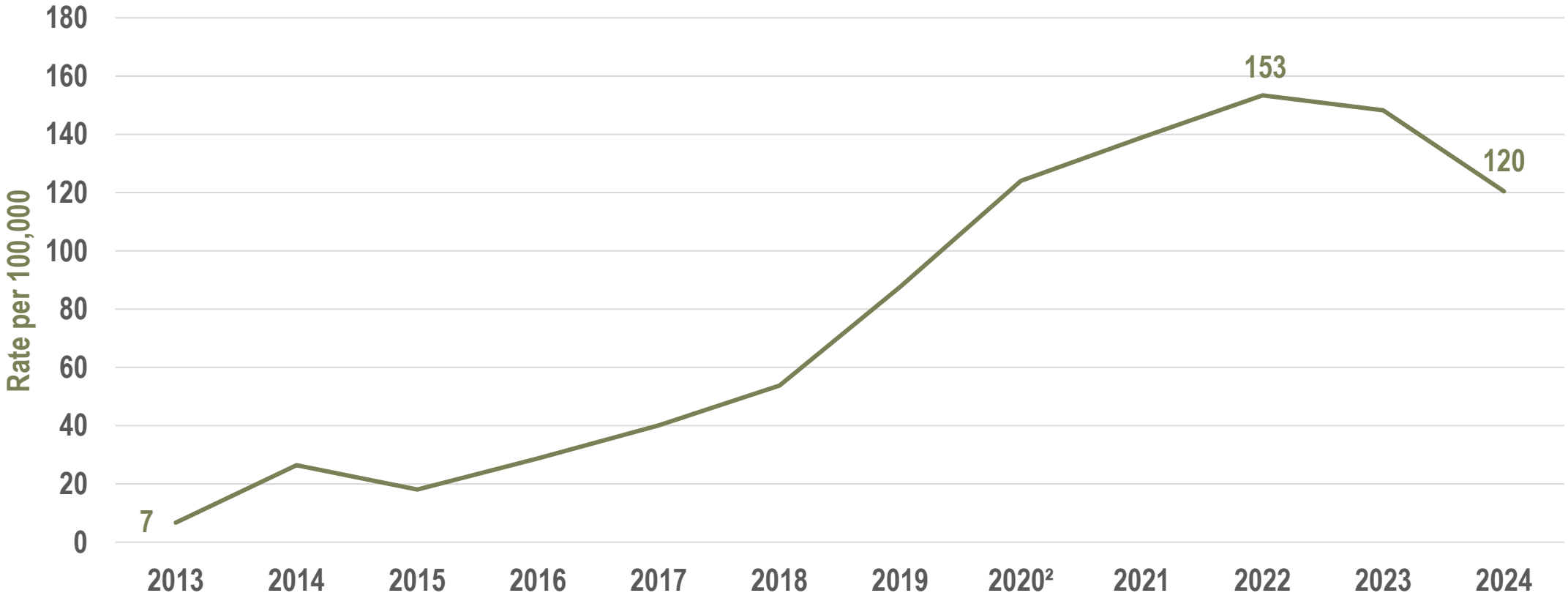


1. Early syphilis includes all cases staged as primary, secondary or early non-primary non-secondary (early latent).
2. Data as of September 22, 2025 and excludes data from the cities of Long Beach and Pasadena.
3. Note that the number of reported STIs for 2020 decreased as a result of decreased STI screening and increased use of telemedicine during the COVID-19 Stay at Home Health Officer Order.

Source: LAC DPH Division of HIV and STD Programs

The congenital syphilis rate has been decreasing since its peak in 2022.

Preliminary Congenital Syphilis Rates, Los Angeles County, 2013-2024[1]

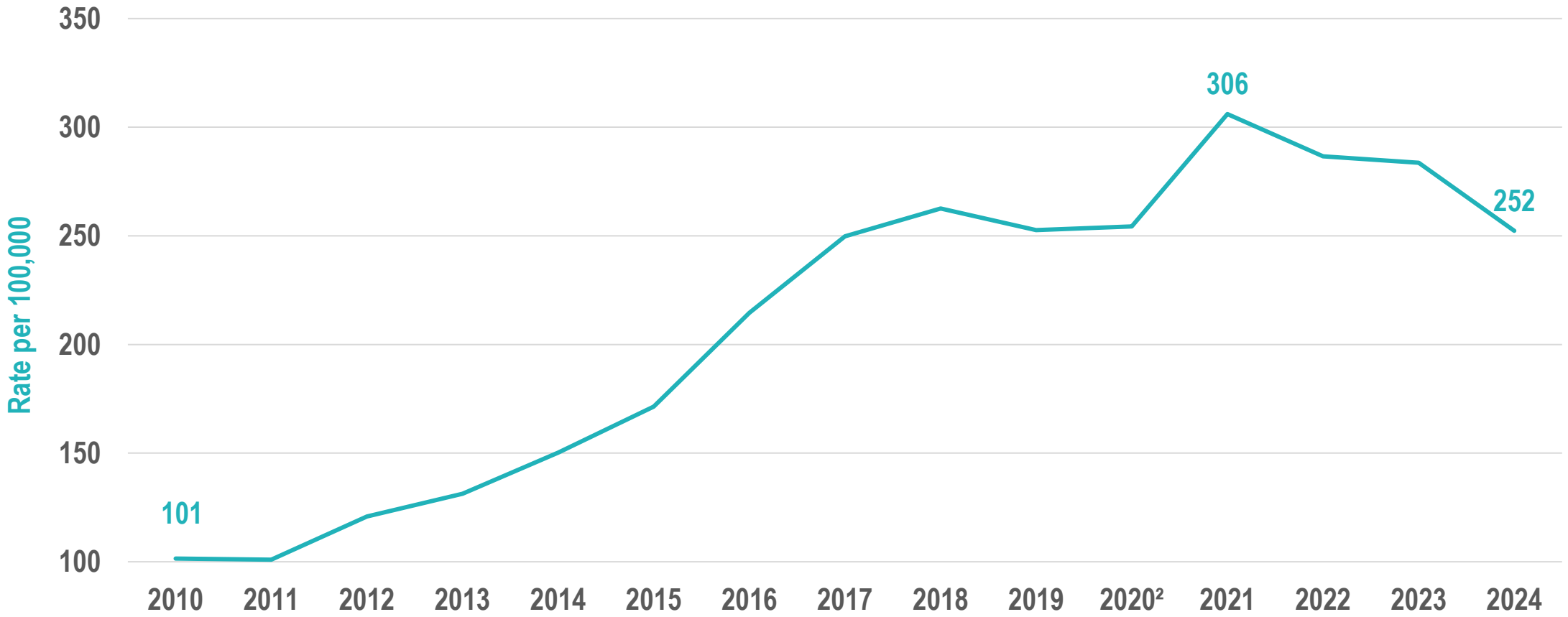


1. Data as of September 22, 2025 and excludes data from the cities of Long Beach and Pasadena.
2. Note that the number of reported STIs for 2020 decreased as a result of decreased STI screening and increased use of telemedicine during the COVID-19 Stay at Home Health Officer Order.

Source: LAC DPH Division of HIV and STD Programs

The gonorrhea rate has been decreasing since its peak in 2021.

Preliminary Gonorrhea Rates, Los Angeles County, 2010-2024[2]

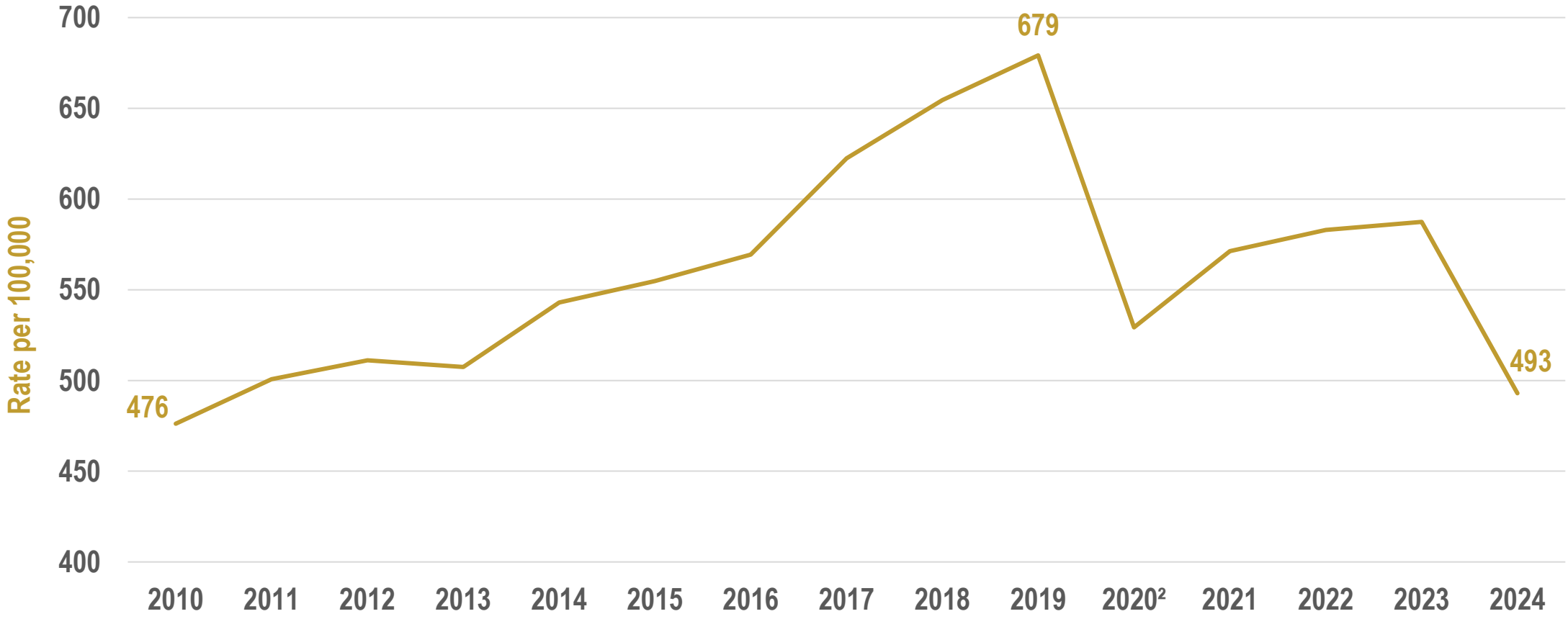


1. Data as of September 22, 2025 and excludes data from the cities of Long Beach and Pasadena.
2. Note that the number of reported STIs for 2020 decreased as a result of decreased STI screening and increased use of telemedicine during the COVID-19 Stay at Home Health Officer Order.

Source: LAC DPH Division of HIV and STD Programs

The chlamydia rate has been decreasing since its peak in 2019.

Preliminary Chlamydia Rates, Los Angeles County, 2010-2024[2]

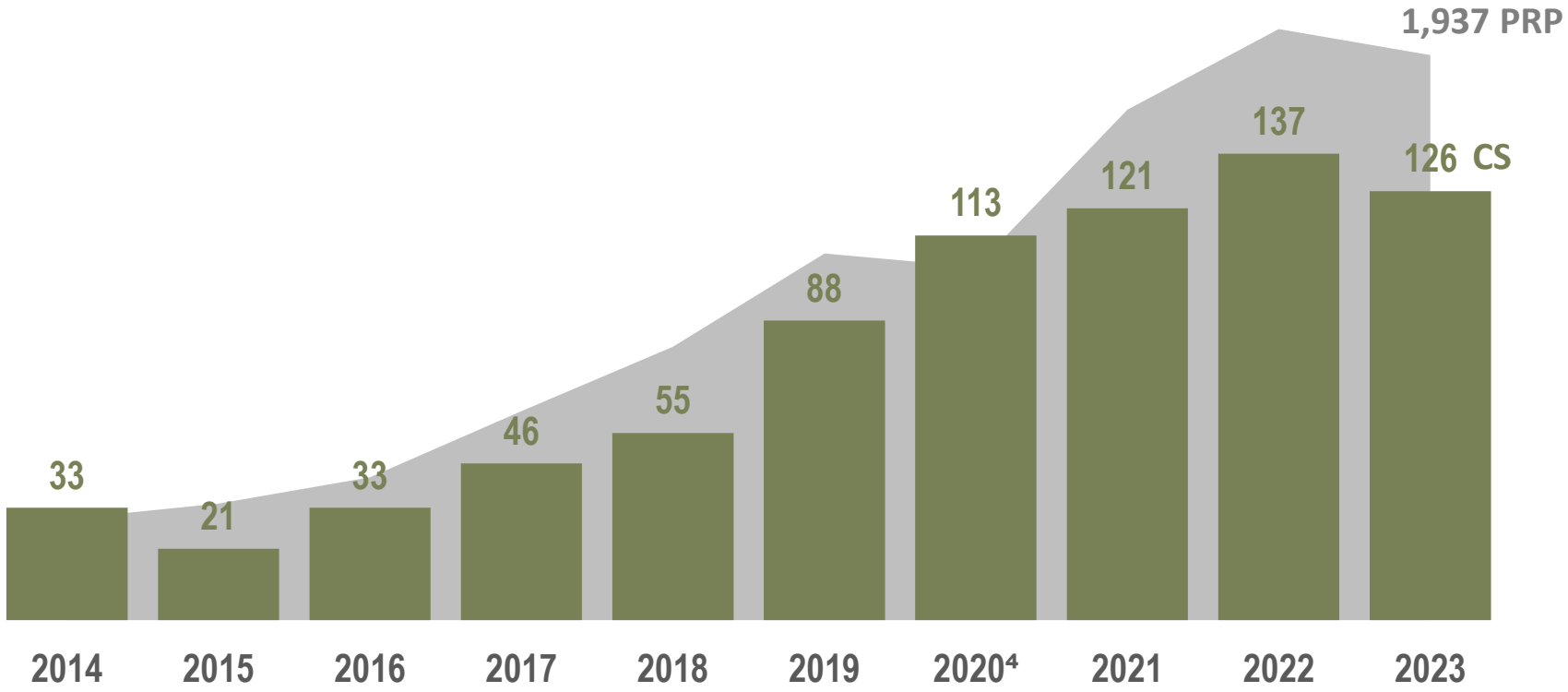


1. Data as of September 22, 2025 and excludes data from the cities of Long Beach and Pasadena.
2. Note that the number of reported STIs for 2020 decreased as a result of decreased STI screening and increased use of telemedicine during the COVID-19 Stay at Home Health Officer Order.

Source: LAC DPH Division of HIV and STD Programs

Syphilis among Persons of Reproductive Potential (PRP) and infants with congenital syphilis have increased substantially since 2014.

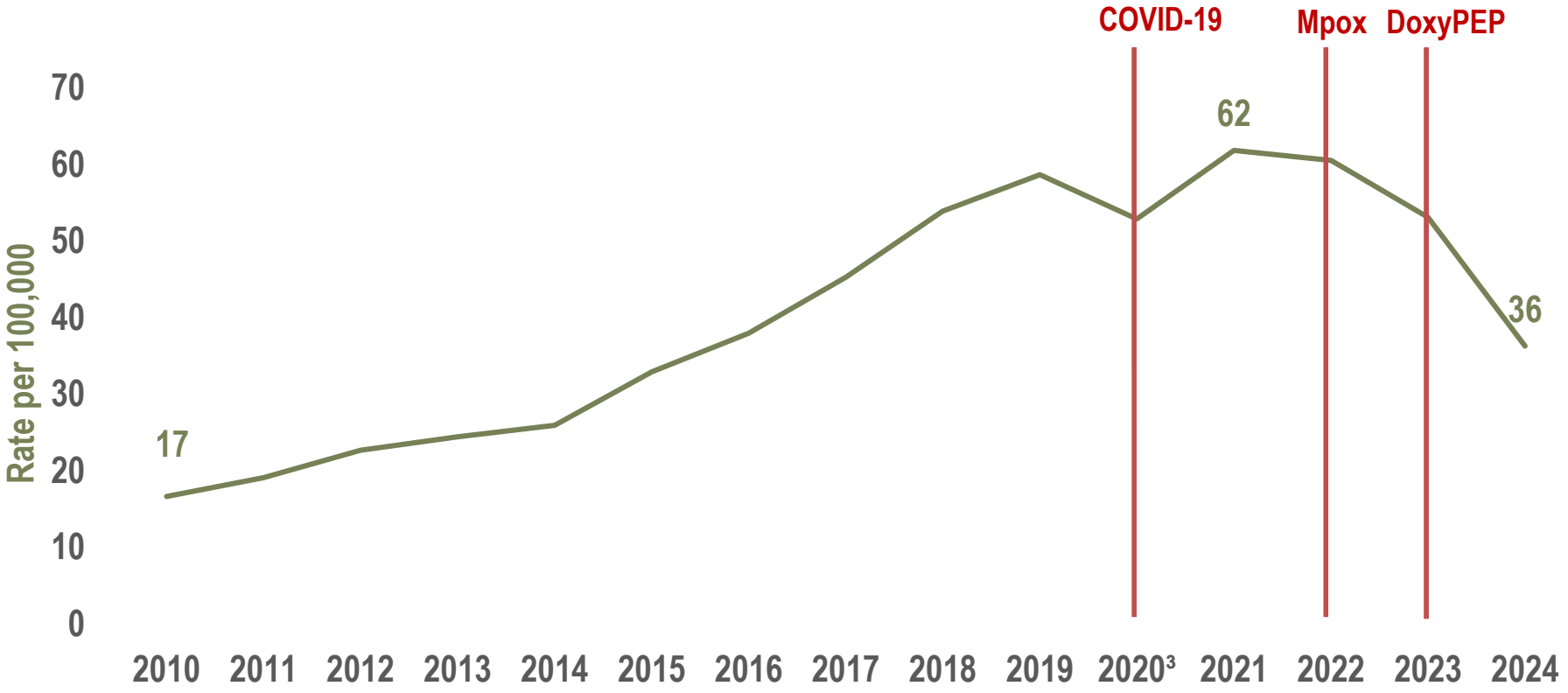
Provisional Number of PRP and Infants with Congenital Syphilis[1,2] Los Angeles County, 2014-2023[3]



1. Syphilis among females of childbearing age (ages 15-44) including all cases staged as primary, secondary, early non-primary non-secondary (previously early latent) and unknown duration/late (previously late latent). 2. Congenital syphilis includes syphilitic stillbirths and neonatal deaths. 3. Data as of September 27, 2024 and excludes cities of Long Beach and Pasadena. Data are preliminary and subject to further change. 4. Note that the number of reported STIs in 2020 decreased as a result of decreased STD screening and increased use of telemedicine during the COVID-19 Stay at Home Health Officer Order. Data sources: LAC DPH Division of HIV and STD Programs

The early syphilis rate has been decreasing since its peak in 2021.

Preliminary Early Syphilis[1] Rates, Los Angeles County, 2010-2024[2]



- DoxyPEP uptake & DoxyPEPLA
- ED/UCC screening & community-based testing
- Syphilis Outbreak Strategy: Clinical Field Team, Specialized Investigation Team, incentives & housing
- Benzathine penicillin delivery
- Provider education & training

1. Early syphilis includes all cases staged as primary, secondary or early non-primary non-secondary (early latent).
2. Data as of September 22, 2025 and excludes data from the cities of Long Beach and Pasadena.
3. Note that the number of reported STIs for 2020 decreased as a result of decreased STI screening and increased use of telemedicine during the COVID-19 Stay at Home Health Officer Order.

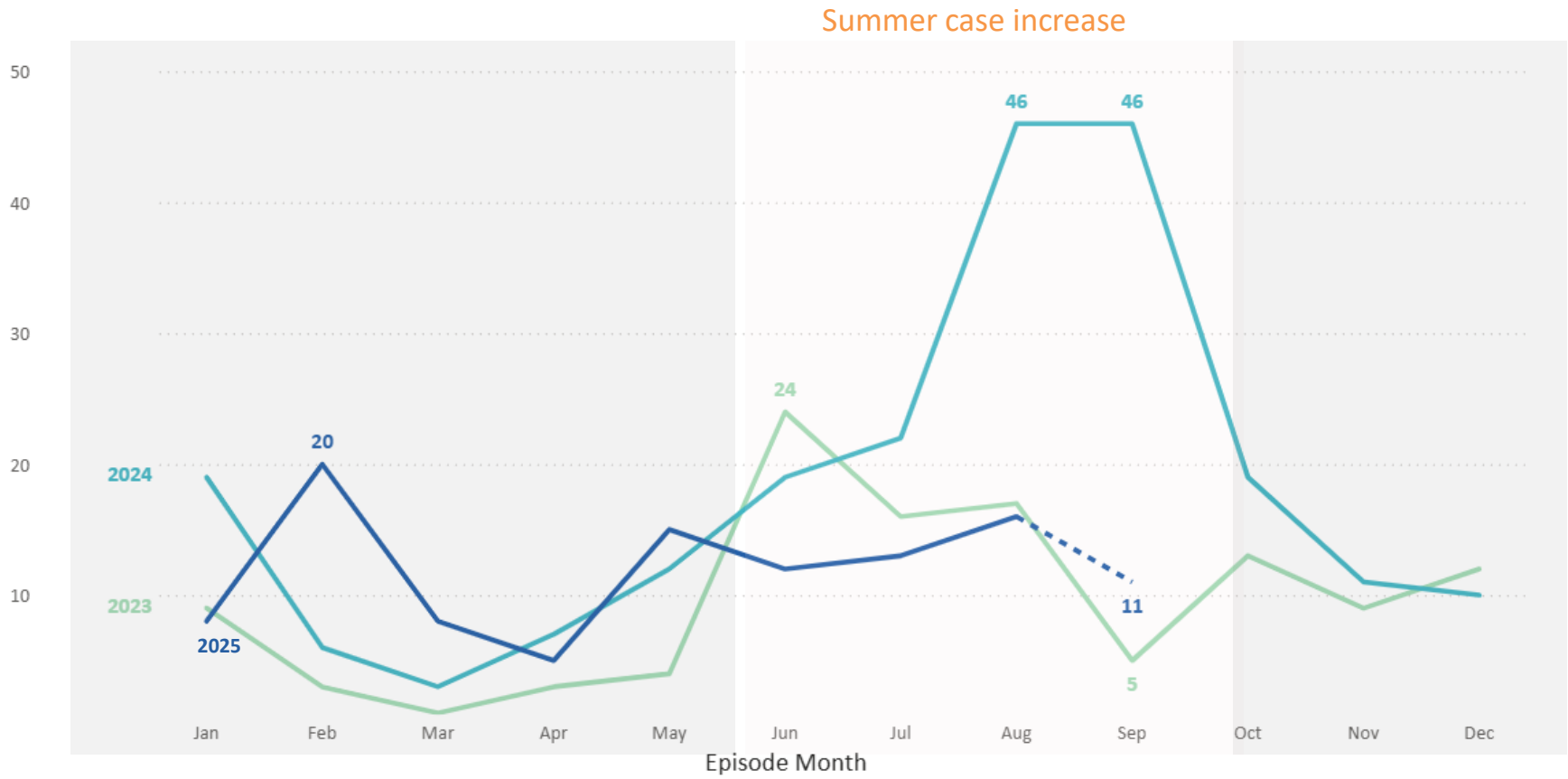
Source: LAC DPH Division of HIV and STD Programs

Mpox Epidemiology

- Global outbreak of mpox since 2022 has been Mpox Clade II
- Regional clusters, waxing and waning across the US and LAC since then
- Increasing 2-dose vaccination coverage and counseling re: other prevention strategies are best ways to prevent cases
- Deaths still being reported nationally, none in LAC since 2022

Mpox cases generally peak during summer months. We did not see a summer 2025 peak.

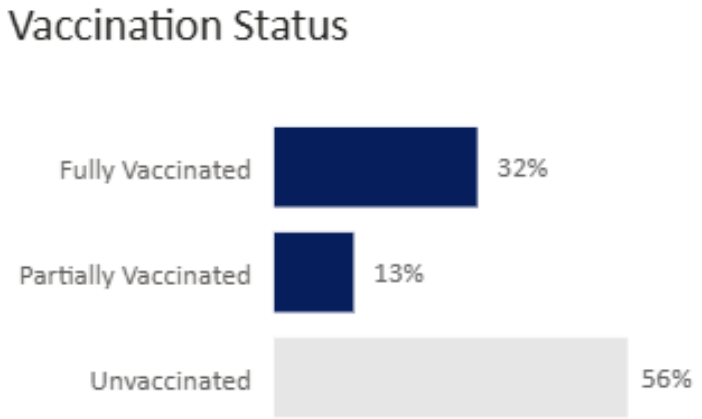
Monthly mpox cases by episode year

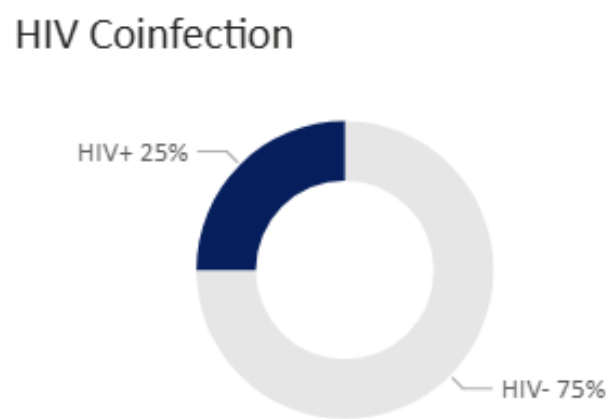


*Episode date: earliest existing value of: date of onset, date of diagnosis, date of death, date received, specimen collection date.
Recent dates may be incomplete due to lags in data reporting.

Over a recent 6 month period, most LAC mpox cases did not require hospitalization. Forty-five percent were partially or fully vaccinated and 25% were coinfected with HIV.

Clinical features of mpox cases with episode dates* from 4/1/25 – 9/30/2025 (N=72)

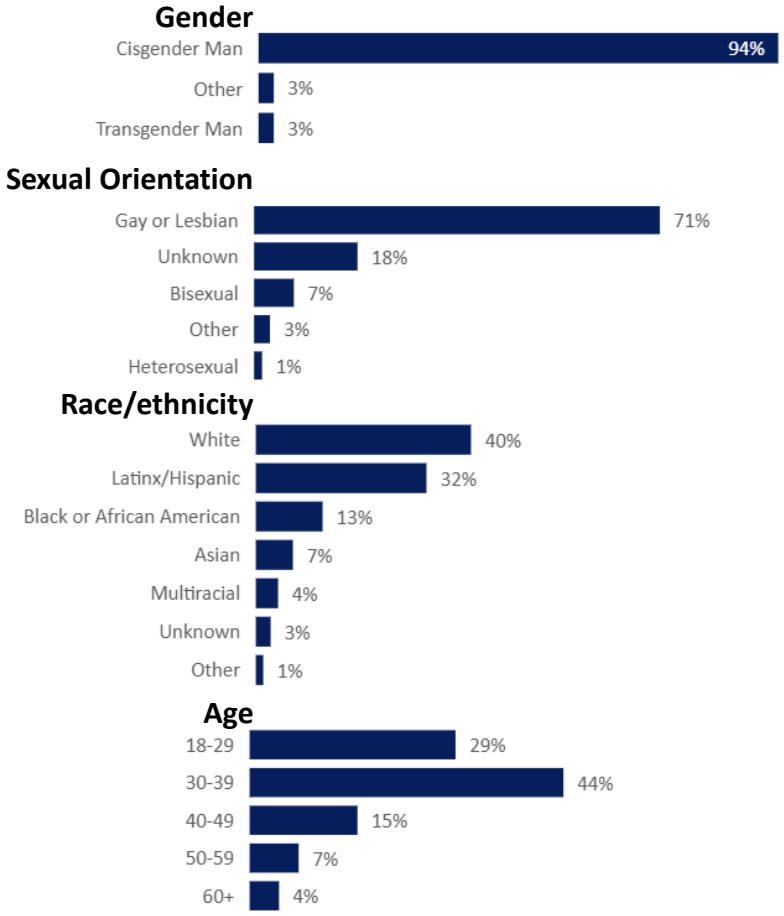


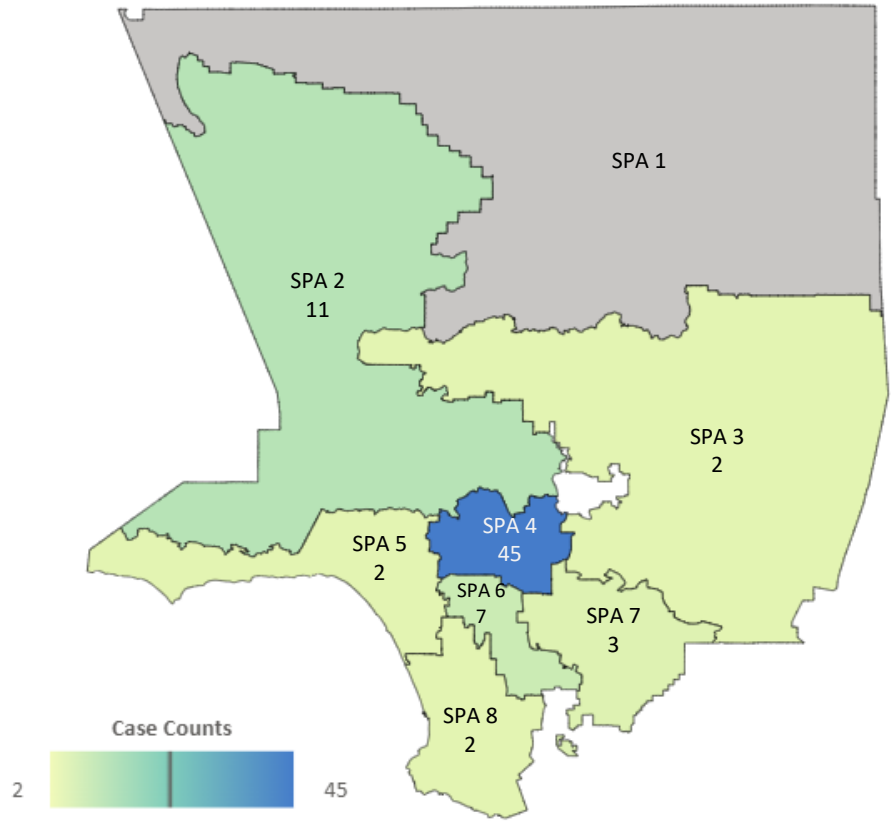


2 Hospitalizations**

***Episode date:** earliest existing value of: date of onset, date of diagnosis, date of death, date received, specimen collection date. ** Among two hospitalized cases, one person was HIV+, one was HIV-. Both were unvaccinated. Recent dates may be incomplete due to lags in data reporting.

Demographics of LAC mpox cases with episode dates* from 4/1/25 – 9/30/2025 (N=72)





*Episode date: earliest existing value of: date of onset, date of diagnosis, date of death, date received, specimen collection date.
Recent dates may be incomplete due to lags in data reporting.

Clade I Mpox Cases without Associated Travel Reported in southern California, October 2025

- As of October 21, 2025:
  - **Three confirmed Clade I mpox cases without associated travel reported in LA County**
  - These are the first Clade I mpox cases in the nation without travel to another country where Clade I has been known to be circulating

- Similarities:
  - Men who have sex with men
  - Report no international travel, no sexual contact, and no contact with one another in 21 days prior to symptom onset
  - **3 hospitalized (1 ICU); 2 immuno-compromised**
  - All isolating at home

- Public health investigation, including contact tracing and symptom monitoring is ongoing

About Clade I Mpox

- Community transmission of Clade I mpox within California is now occurring among gay, bisexual, and other men who have sex with men and their social networks.
- Overall risk of Clade I mpox to the general population in California and the US remains low.
- At this time, Clade I mpox has not been shown to be more transmissible than Clade II. Transmission studies are ongoing.
- Clade I and II mpox can both transmit through sexual or intimate contact (e.g., massage, cuddling), shared living spaces or personal items.
- Clade I mpox may be severe. Risk of severe mpox disease and hospitalization are highest for people with weakened immune systems.
- Jynneos vaccination is protective against both clade I and II; under-accessed resource.

Federal Budget and Policy Updates; Proposed Federal Cuts to the HIV and STD Portfolio; ADAP Rebate Fund and; Recent Executive Orders

Federal Budget and Policy Update

- **8 Senate Democrats voted for a Republican-backed continuing resolution that funds the federal government through January 2026**
  - **DOES NOT** include extension on ACA advanced premium tax credits.
  - Includes 3 appropriations bills (Military Spending/VA, Dept of Agriculture/FDA, Legislative Branch)

- **Budget proposals differ significantly between the Senate and the House**
  - Senate: Keeps funding flat or slightly reduced for CDC, HRSA, and SAMHSA, among other areas
  - House: Significant reductions to CDC budget and elimination of several HRSA funding areas
    - **Eliminates**: CDC HIV prevention funding (> $1B), EHE funding (HRSA+CDC), and HRSA Ryan White Program Parts C, D, and F funding

Looming Financial Threats

Direct Funding to DHSP - $31.7M

- CDC HIHPS (Program, Surveillance, EHE) - $19.7M
- CDC STD PCHD - $3.3M (potential 6% cut or ~$200,000)
- CDC NHBS - $620,000
- HRSA RWP MAI - $3.7M
- HRSA RWP EHE - $7.5M

Looming Financial Threats

Indirect, To DHSP Partners - $12.85M

- RWP Part C EIS and Cap Bldg Awards (HIV Specialty Clinics)
  - EIS: 14 clinics totaling $5,738,844
  - Cap Bldg: 3 clinics totaling $450,000

- RWP Part D (Agencies serving Women, Infants, Children, Youth)
  - USC, UCLA, AltaMed: $1,633,218

Looming Financial Threats

Indirect, To DHSP Partners (continued)

- RWP Part F Dental (Universities providing Oral Health Care)
  - USC, UCLA, Western Univ. of Health Services: $1,570,737

- Title X (Supports Sex & Repro Health/Fam Planning Services in CA)
  - Essential Access Health: $13,200,000 (~$3.5M LAC)
    - 679,454 family planning encounters
    - 227,362 GC tests
    - 113,537 syphilis tests
    - 173,328 HIV tests

ADAP Rebate Fund

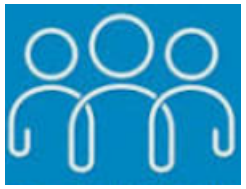
- Need for More Spending Flexibility and Additional Triggers
- Three-year Contingency Planning?
- Fund Replenishment

Executive Orders

- Sex/Gender
- Environmental Justice
- DEI (for federal agencies and government contractors)
- Immigration
- Homelessness and Harm Reduction
- Oversight of Federal Grantmaking
- Pharmaceuticals
- Make America Healthy Again
  - Establishing *MAHA Commission, Make Our Children Healthy Again Strategy*

Recent Workforce and Program Impacts

DHSP Key Actions (February 2025 and Ongoing)



76 DHSP Staff Layoffs or Reassignments to Other DPH Programs

- 38 Contractors
- 38 Permanent County Staff
- Additional Cost Containment Efforts

Aligned Contract Obligations with Projected FY 2025 Revenue

- Ryan White Program
- HIV Prevention Portfolio

Stakeholder, Provider, and Consumer Meetings

- Prevention, Housing, Oral Health, Food/Nutrition

Prioritization in an Era of Scarcity:

Perspectives from Dr. Matthew Golden

Possible Hierarchy of Priorities

Disease Control Activities in Order of Priority

1. Sustain (increase) HIV viral suppression among people with HIV
2. Prevention of congenital syphilis
   - Treatment and case-management of pregnant persons and pregnancy capable people
3. Maintain core HIV/STI surveillance
4. Sustain HIV linkage to care (integrated with surveillance)
5. Drug user health - Narcan and syringe distribution
6. Treating symptomatic STIs (particularly syphilis)
7. Promotion of HIV/STI control by healthcare system
8. High yield public health syphilis case-finding
9. Sustain high yield public health funded HIV case-finding
10. HIV PrEP

Possible Hierarchy of Priorities (continued)

Sustain the infrastructure to rebuild and strategize for longer term goals

- Sexual health clinics
- Low barrier HIV clinics - outreach to promote care?
- Surveillance
- Community collaboration - focus on healthcare organizations

Publicly Funded HIV Testing 2021

1,736,850
Total CDC-funded HIV tests conducted in 2021

18,244 had **a positive** HIV test result

8,149 were **newly diagnosed** with HIV (0.5% positivity)

78% of those newly diagnosed with HIV were **linked to HIV medical care within 30 days**

	TESTS (% POSITIVITY)
Health care setting	**1,278,274 (0.4%)**
Community Health Centers	410,981 (0.3%)
STD Clinics	395,934 (0.5%)
Emergency Departments	198,641 (0.3%)
Correctional Clinics	54,535 (0.2%)
Other[a]	218,183 (0.4%)

	TESTS (% POSITIVITY)
Non-health care setting	**436,304 (0.7%)**
HIV Testing Sites	226,834 (0.8%)
Community Settings[b]	105,970 (0.5%)
Correctional Facilities, Non-health care	15,250 (0.4%)
Other[c]	88,250 (0.5%)

* Not shown: 16,743 tests were conducted in mobile settings, 3,990 self-tests were reported, and 1,539 tests were missing information on site type.

~22% of new HIV diagnoses were a result of federally funded HIV testing

https://www.cdc.gov/hiv/library/reports/testing/2021/index.html#Table4

HIV Testing

- What publicly funded activities identify new cases of HIV
  - King County - ~21% of diagnoses from publicly funded testing - 2/3 in a single SHC

- Cost per case detected
  - Hard to calculate – what costs do you include
    - CBOs - funded >1 activities – how much is for testing?
    - Sexual health clinic - How much of the funding is related to HIV testing?
      - Not just the cost of the test

King County Program	Approximate Cost per New HIV+ Detected
CBO #1	∞ (no cases identified)
CBO #2	~$23,000
SHC*	~$44,000
Primary care+	~$40,000

*Assumes 20% SHC budget is for HIV testing
+0.1% positivity, $40/test, no other costs included

- Does publicly funded testing reach a population that would otherwise not get tested?
- Are there things you are not doing to promote routine testing that is not directly funded by public health?
  - Promotion of testing in primary care

New HIV diagnoses at DHSP contracted sites

HIV & STI Testing Contracted Agencies	HIV Testing Volume	HIV Positivity	HIV New Positivity	HIV Surveillance Report: New HIV Diagnoses	% New Positivity HIV from Contracted Agencies
2022	69,881	908 (1.3%)	419 (0.6%)	1641	25.5%
2023	82,058	1321 (1.6%)	400 (0.5%)	1635 (pending CSO review)	24.5%
2024	90,401	1105 (1.2%)	314 (0.3%)		
2025 (Jan-Oct 2025 except June 2025)	51,774	493 (1.0%), preliminary	184 (0.4%), preliminary		

DHSP Funded Testing

- Contracted Agencies
- DHSP Direct Testing (DCS, CFT)
- Self-Testing/At Home Testing
- Emergency Departments
- Public Health Clinics

HIV/Syphilis Testing in Jails

- SCORE
  - Private jail for misdemeanor offenses
  - Syphilis testing using rapid tests
  - Performed by HIV/STI/HCV program DIS
- KCJ/MRJC
  - More serious criminal offenses
  - Testing using conventional tests (blood draws)
  - Performed by Jail staff (includes DRIS) – Newly added HIV/STI prgm staff (2025)
- Outreach testing
  - 35 ½ day testing events
- **Sexual Health Clinic**
  - **242 syphilis diagnoses in 2024 - 67 (28%) in MSW and cisgender women**

	SCORE Jan 2023-July 2024 **18 Months**	KCJ/MRJC Jan-June 2024 **6 months**	Outreach Testing
Bookings	19,869	7321	NA
Tested (excluding symptomatics)	1,243 (6%)	1127 (15%)	174
New Syphilis Diagnoses	**42 (4%)**	**45 (4%)** ~135 over 18m	**6 (3.4%)**
New HIV Diagnoses	4 (0.3)	2 (0.2%)	0

- >1600 cases syphilis/year - ~50% in cis-MSW/ciswomen

Should we Continue to Provide Partner Services at the Current Level or Prioritize Jail Testing?

Syphilis rapid test positivity at CRDF was 11.5% in 2024.

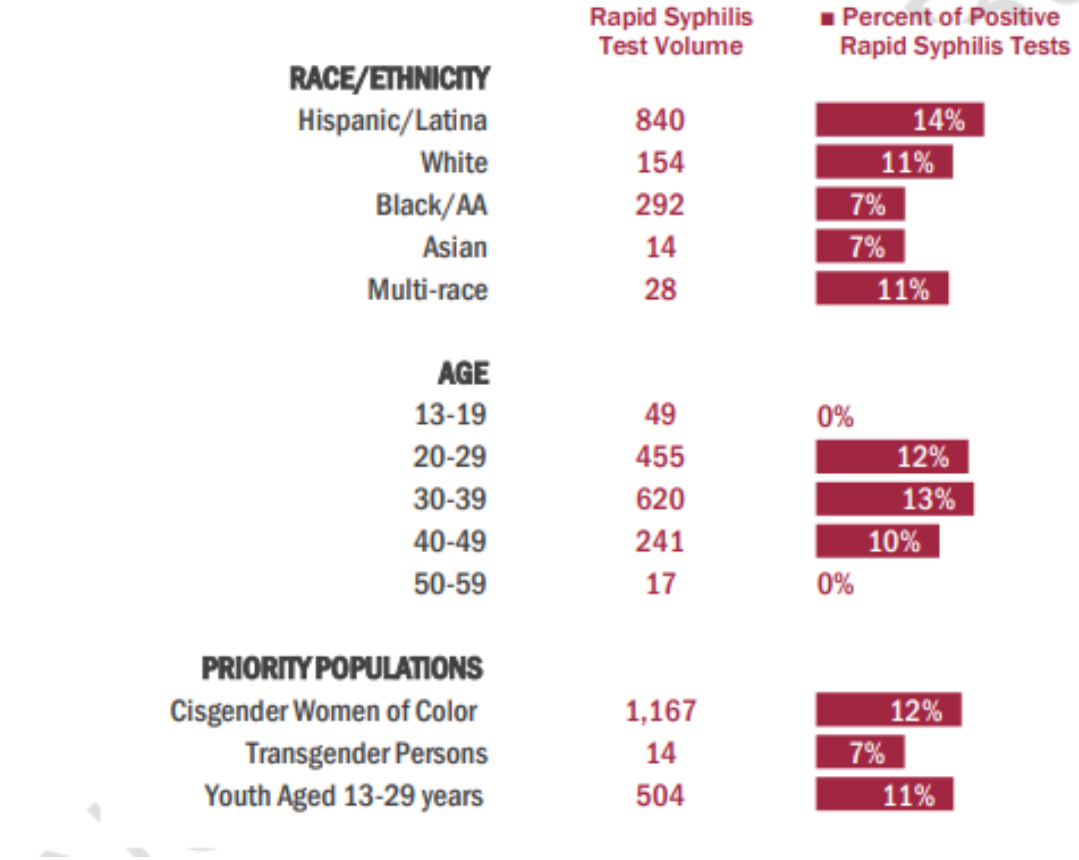
In 2024, **1382 women and transgender men** received rapid syphilis testing at Century Regional Detention Facility (CRDF).

- **Rapid Test Positivity: 159 (11.5%)**
  Confirmatory Lab Received: 79
  Confirmatory Lab Positivity: 54 (4%)

- **Treatment**
  54 confirmed syphilis positive clients*
  - 19 did not need treatment (serofast)
  - 33 of 35 new/untreated cases received treatment onsite
  - 2 released before treatment

  - **2 clients with only positive rapid test (no labs) received treatment**

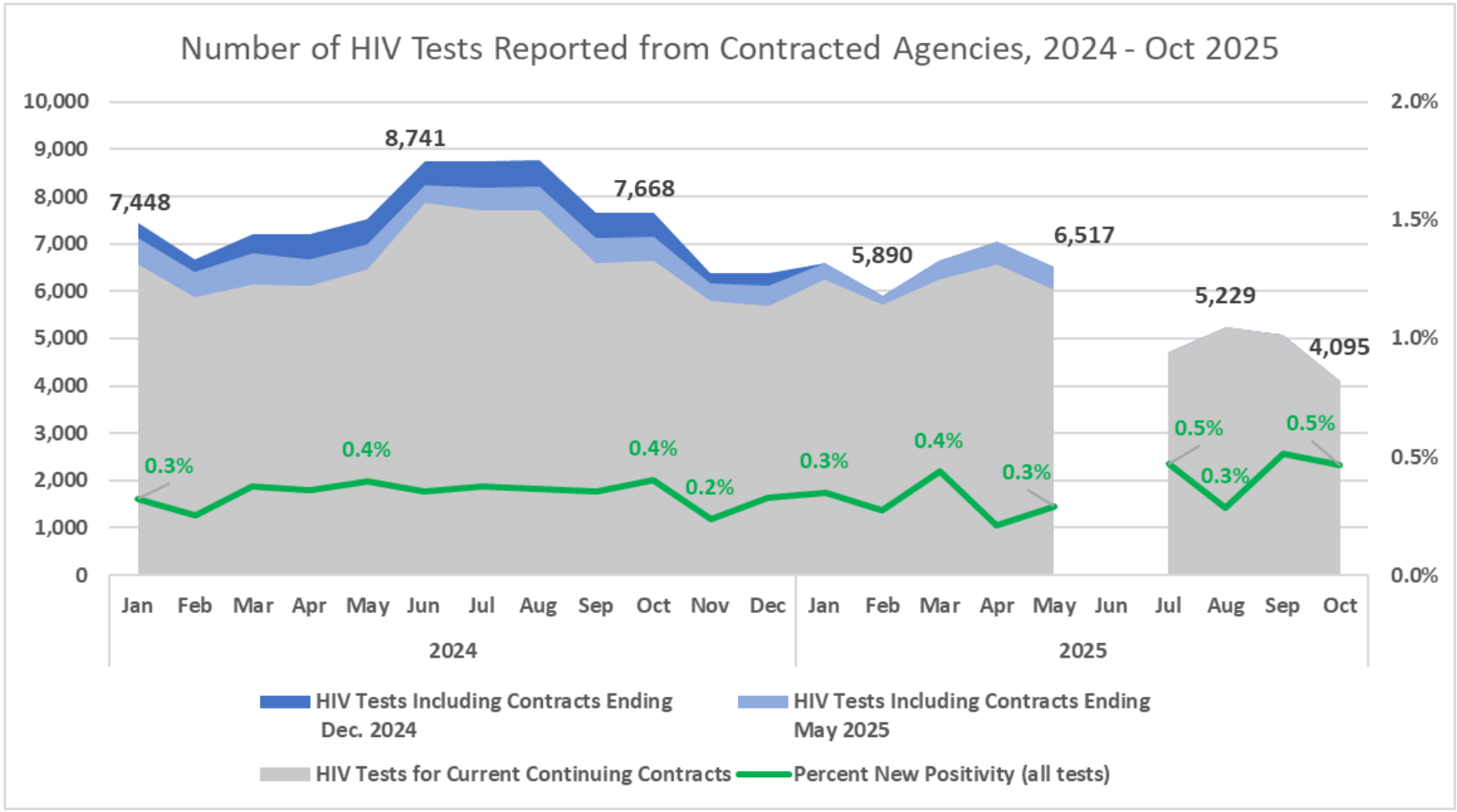
Figure 32. Percent of Positive Rapid Syphilis Tests[33] out of Tests with Results by Race/Ethnicity, Age, and Priority Population, Incarcerated Settings, 2024[34]



	Rapid Syphilis Test Volume	Percent of Positive Rapid Syphilis Tests
RACE/ETHNICITY		
Hispanic/Latina	840	14%
White	154	11%
Black/AA	292	7%
Asian	14	7%
Multi-race	28	11%
AGE		
13-19	49	0%
20-29	455	12%
30-39	620	13%
40-49	241	10%
50-59	17	0%
PRIORITY POPULATIONS		
Cisgender Women of Color	1,167	12%
Transgender Persons	14	7%
Youth Aged 13-29 years	504	11%

In 2025, agencies that had contracts had a decrease in HIV testing volume, with new HIV positivity has fluctuating between 0.3-0.5%

		HIV Tests Including Contracts Ending Dec. 2024	HIV Tests Including Contracts Ending May 2025	HIV Tests for Current Continuing Contracts	Percent New Positivity (all tests)
2024	Jan	7,448	7,114	6,569	0.3%
	Feb	6,660	6,411	5,875	0.3%
	Mar	7,204	6,796	6,147	0.4%
	Apr	7,202	6,660	6,109	0.4%
	May	7,528	6,985	6,467	0.4%
	Jun	8,741	8,238	7,857	0.4%
	Jul	8,745	8,192	7,696	0.4%
	Aug	8,774	8,205	7,709	0.4%
	Sep	7,651	7,113	6,592	0.4%
	Oct	7,668	7,152	6,639	0.4%
	Nov	6,375	6,159	5,802	0.2%
	Dec	6,382	6,111	5,692	0.3%
2025	Jan		6,583	6,241	0.3%
	Feb		5,890	5,707	0.3%
	Mar		6,643	6,255	0.4%
	Apr		7,044	6,563	0.2%
	May		6,517	6,040	0.3%
	Jun				
	Jul			4,693	0.5%
	Aug			5,229	0.3%
	Sep			5,080	0.5%
	Oct			4,095	0.5%



*Contract Performance/Cost-Analysis Available

Factors Influencing Prioritization

- **Stakeholders** – funders, elected officials, affected communities, people charged with implementing interventions
- **Scale & morbidity of the problem**
- **Effectiveness and scalability of the available interventions**
  - Cost per unit of outcome
- **Essential Role of Public Health**
  - Can someone other than Public Health provide the service?
- **Equity**
- **Influence on critical infrastructure** – Strategize for longer term goals
  - Are there things or capacity we might lose that will be particularly hard to rebuild?

Framing the Prioritization Process

1. What will make the biggest difference as we seek to advance the public's health?

2. Which core HIV/STD activities will be maintained, reduced, or terminated based on impact and cost?

3. What strategies will help leverage partnerships to sustain critical services?

Questions and Answers

Thank You!

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.

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November 17, 2025

Los Angeles County Commission on HIV
Ryan White Part A Planning Council
510 South Vermont Ave, 14th Floor
Los Angeles, CA 90020

SUBJECT: DHSP Response to COH 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, Approved by the COH on 3.13.25

Dear Commissioners on HIV:

Thank you for the opportunity to respond to the directives outlined in the COH Mult-Year Program Directives for Ryan White Part A and MAI Funds for Program Years 35, 36, and 37 document dated March 13, 2025, regarding how to meet the priorities established by the Commission on HIV.

Our itemized responses on the status of the directives issued by the Commission are provided below, and each point is addressed in the order it was presented in the directives document.

Directive 1 [Access and Service Improvements]: 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.
Directive 1 Response: We have already addressed this directive in our subrecipient contracts. For example, Linkage and Reengagement Program, Rapid and Ready, Benefits Specialty Services, Medical Care Coordination (MCC), and Patient Support Services all include patient navigation services to assist persons living with HIV (PLWH) through the continuum of healthcare and social services. While MCC provides patient support and case management to PLWH with high acuity, patient support services (PSS) provide similar services to all other RWP clients. PSS is a multidisciplinary team of specialists that may include Retention Outreach Specialists, Social Workers, Benefits Specialists, Housing Specialists, and or Substance Use Counselors to deliver interventions, link, and actively enroll PLWH into support services that address social determinants of health. The combined efforts of the PSS and MCC teams will help engage and retain RWP clients in care and achieve and maintain viral suppression.

Directive 2 [Access and Service Improvements]: 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.
Directive 2 Response: HRSA Ryan White Part A funds cannot be used for direct cash payments or cash-equivalent incentives to clients. However, non-monetary support services that promote adherence to Long-Acting Injectable (LAI) antiretroviral treatment may be allowable. Providers are encouraged to offer LAI to patients when appropriate, and staffing is allowed for nursing staff to provide the services.

Directive 3 [Access and Service Improvements]: 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.
Directive 3 Response: Activities to address these directives are currently in

process. However, in 2025, DHSP has reduced investments in media due to shifts in funding to services. DHSP is working with an outside vendor to maximize the impact of the reduced investments to social marketing.

Directive 4 [Access and Service Improvements]: 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).
Directive 4 Response: RWP subrecipients and prevention providers each have unique organizational policies, procedures, infrastructures, capacity, and resources (including staffing). Recent prevention and care and treatment Request for Proposals (RFPs) highly recommended the provision of services outside of traditional business hours. However, DHSP will not require expanded hours from subrecipients.

Directive 5 [Access and Service Improvements]: 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.
Directive 5 Response: As described in Directive Response 1, DHSP provided the flexibility for referrals and expanded case management through PSS. Additional expanded services will be considered where costs are allowable, and DHSP continues to partner with the County's SAPC program to expand access to these services.

Directive 6 [Access and Service Improvements]: 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.

Directive 6 Response: Given limited RWP administrative funding and the current fiscal situation in the County, it is not possible to hire a full-time staff person to convene and facilitate provider collaborations, cross-referrals and community-wide promotion of HIV services in the Antelope Valley. These duties and activities could be completed by the SPA 1 Area Health Officer rather than DHSP staff.

Directive 7 [Workforce Capacity and Training]: 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.
Directive 7 Response: DHSP continues to support this activity as funding allows.

Directive 8 [Workforce Capacity and Training]: 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.
Directive 8 Response: Through RFPs, DHSP has noted that providers with lived experience that reflect the populations being served is a best practice when possible. DHSP will continue to ask subrecipients to provide culturally appropriate and gender affirming care; however, DHSP does not control staffing for subrecipients.

Directive 9 [Workforce Capacity and Training]: Increase training on Medi-Cal eligibility, enrollment, and re-enrollment processes 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.
Directive 9 Response: DHSP staff are looking into training options for BSS providers.

Directive 10 [Community Engagement and Collaborations]: A) Instruct contracted providers to participate in Commission on HIV meetings, events and other COH-related activities, as specified in funding contracts, and 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.
Directive 10 Response: DHSP has met this directive. In response to recent changes and or proposed changes in healthcare policy, fiscal uncertainty, and need to align the RWP and prevention contracts with available funding, DHSP's Program Director, Mario Pérez, has asked subrecipients to participate in planning discussions. Also, the Chief of Contracted Community Services has asked community advisory board members to participate in the local planning process and promotes subrecipient participation in planning council meetings. DHSP will revisit attendance requirements in contract language following the completion of the restructuring of the planning council and its meeting schedule.

Directive 11 [Directives from Commission Caucuses]: Transgender: A) Housing services 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.
Directive 11 Response: DHSP continues to support improved access and representation through training and updates to contract language.

Directive 12 [Directives from Commission Caucuses]: 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.
Directive 12 Response: DHSP has two direct service programs that specifically serve the needs of women, infants and children. First is the Linkage and Reengagement Program that provides intensive case management for pregnant persons living with HIV. The second program is screening all pregnant women in the emergency department at three DHS hospitals for HIV and SY and providing patient care and follow-up to positive cases (women and infants).

These two programs are not currently funded with RWP Part A, MAI, or Part B funds. In addition, HRSA directly funds three RWP Part D providers in Los Angeles County to provide care and treatment services that meet the needs of women including, women who are pregnant or have children.

Directive 13 [Directives from Commission Caucuses]: 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.
Directive 13 Response: DHSP has met this directive. DHSP supports BSS in all eight SPAs, and services are available to aging populations (50+).

Directive 14 [Directives from Commission Caucuses]: 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.
Directive 14 Response: RWP Part A and Part B grants do not support research or "pilot" projects. RWP grant funds can only be used for allowable services listed in PCN 16-02. DHSP currently does not have resources or other funding for "pilot" projects, but we encourage our providers to explore funding from other sources that can be used to support pilot programs and demonstration projects.

Thank you for your ongoing commitment to service preservation and equity. Please do not hesitate to contact me if you require any further information or clarification.

Regards,

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