LOS ANGELES COUNTY
COMMISSION ON HIV

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PLANNING, PRIORITIES & ALLOCATIONS COMMITTEE MEETING

Tuesday, June 17, 2025
1:00pm – 3:00pm (PST)

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/ree27ae8f3f4c4f9522ec8e1eaea9165d

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, JUNE 17, 2025 | 1:00 PM – 3:00 PM
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/ree27ae8f3f4c4f9522ec8e1eaea9165d
To Join by Telephone: 1-213-306-3065
Password: PLANNING Access Code: 2531 064 6502

Planning, Priorities, and Allocations Committee Members:			
Kevin Donnelly, Co-Chair Carlos Vega-Matos *(Alternate)*	Daryl Russell Co-Chair	Al Ballesteros, MBA	Lilieth Conolly (LOA) Gerald Green *(Alternate)*
Felipe Gonzalez Rita Garcia *(Alternate)*	Michael Green, PhD	William King, MD, JD	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: 8			

AGENDA POSTED: June 12, 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. Executive Director/Staff Report 1:16 PM—1:23PM
    a. Operational and Commission Updates

8. Co-chair Report 1:24 PM—1:29 PM

a. Program Years 35-37 (PY35-37) Directives
b. Women's Caucus Listening Session Updates

9. Division on HIV and STD Programs (DHSP) Report 1:30 PM—2:20 PM
   a. Unmet Needs in Los Angeles County Report

V. DISCUSSION 2:21 PM—2:55 PM

10. 2027-2031 Integrated HIV Plan Overview & Preparation

VI. NEXT STEPS 2:56 PM – 2:57 PM

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

VII. ANNOUNCEMENTS 2:58 PM – 3:00 PM

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

VIII. ADJOURNMENT 3:00 PM

14. Adjournment for the meeting of June 17, 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

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

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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

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 6/3/25

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

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

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

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention
			Community Engagement/EHE
			Oral Healthcare Services
NELSON	**Katja**	APLA Health & Wellness	High Impact HIV Prevention
			Benefits Specialty
			Nutrition Support
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Residential Care Facility - Chronically Ill
			Case Management
PATEL	**Byron**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			High Impact HIV Prevention
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
RAINES	**Aaron**	No Affiliation	No Ryan White or prevention contracts
RICHARDSON	**Dechelle**	No Affiliation	No Ryan White or prevention contracts
ROBINSON	**Erica**	Health Matters Clinic	No Ryan White or prevention contracts
RUSSEL	**Daryl**	Unaffiliated representative	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SALAMANCA	**Ismael**	City of Long Beach	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			HIV Testing & Sexual Networks
SAMONE-LORECA	**Sabel**	Minority AIDS Project	Benefits Specialty
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	No Ryan White or prevention contracts
SAN AGUSTIN	**Harold**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis and Treatment
			High Impact HIV Prevention
			Mental Health
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
			Data to Care Services
SAUNDERS	**Dee**	City of West Hollywood	No Ryan White or prevention contracts
SPENCER	**LaShonda**	Oasis Clinic (Charles R. Drew University/Drew CARES)	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
STALTER	**Kevin**	Unaffiliated representative	No Ryan White or prevention contracts
TALLEY	**Lambert**	Grace Center for Health & Healing	No Ryan White or prevention contracts
VALERO	**Justin**	No Affiliation	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
VEGA-MATOS	**Carlos**	Men's Health Foundation	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
			Data to Care Services
WEEDMAN	**Jonathan**	ViaCare Community Health	Biomedical HIV Prevention
YBARRA	**Russell**	Capitol Drugs	No Ryan White or prevention contracts

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
May 20, 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	P	Rob Lester	P
Daryl Russell, Co-Chair	EA	Miguel Martinez, MPH, MSW	P
Al Ballesteros, MBA	P	Ismael Salamanca	P
Lilieth Conolly	LOA	Harold Glenn San Agustin, MD	EA
Rita Garcia	A	Dee Saunders	EA
Felipe Gonzalez	P	LaShonda Spencer, MD	P
Reverend Gerald Green	P	Lambert Talley	P
Michael Green, PhD, MHSA	P	Carlos Vega-Matos	P
William King, MD, JD	EA	Jonathan Weedman	P
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Lizette Martinez			
DHSP STAFF			
Mario Perez, Victor Scott, Pamela Ogata, Anahit Nersisyan			

*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

Kevin Donnelly, Planning, Priorities and Allocations (PP&A) co-chair, called the meeting to order at approximately 1:01pm.

2. ROLL CALL & CONFLICT OF INTEREST STATEMENTS

C. Barrit, Executive Director, conducted roll call and committee members were reminded to state their conflicts.

ROLL CALL (PRESENT): A. Ballesteros, F. Gonzalez, G. Green, M. Green, R. Lester, M. Martinez, I. Salamanca, L. Spencer, L. Talley, C. Vega-Matos, K. Donnelly, J. Green

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

A. 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

B. Executive Director/Staff Report

- C. Barrit, reminded the committee that the June, August and September Commission on HIV (COH) full-body meetings are cancelled. She noted that all other committee and caucus meetings will continue as planned, unless otherwise noted. See COH meeting schedule for all other meeting dates/times. The next COH meeting will be on Thursday, July 10 from 9am-12pm at the Vermont Corridor. Meeting registration information will be posted on the COH website.
- C. Barrit announced that the next COH mandatory training will be on Wednesday, May 21 at 12pm-1pm and will cover Service Standards. All trainings are open to the public and invited all interested individuals to attend. See training schedule flyer for registration information.

C. Co-chair Report

a. Program Year 35-37 Directives

- K. Donnelly reported that the Commission on HIV (COH) is still waiting for a response from DHSP on the Program Year 35-37 (PY35-37) Directives. He recognized that the directives were developed in a time of expansion and all of the requests may not be able to be fulfilled but that continued dialogue needs to happen to reach common ground.

b. June and July Planning, Priorities and Allocations Committee Meetings

- K. Donnelly announced that, as of now, the June and July Planning, Priorities, and Allocations (PP&A) Committee will continue as scheduled but at least one PP&A Committee meeting may be cancelled during the summer. Committee members should notify staff of any potential conflicts due to planned vacations/time off that may conflict with committee meetings.

D. Division of HIV and STD Programs Report

a. DHSP Prevention and Care Funding Portfolio and Data Updates

i. DHSP staff, M. Green, provided a report on DHSP prevention services in LA County. The report outlined DHSP's current prevention programs and investments (CDC High Impact HIV Prevention and Surveillance Services and Ending the HIV Epidemic), priority populations and potential impact on new HIV diagnoses should HIV prevention funding be eliminated. See meeting packet for more details.

ii. DHSP announced that the HIV prevention contract terminations will be rescinded. He noted that DHSP still does not have prevention funding, but terminations are being rescinded to maintain the current infrastructure and rapidly invest resources into existing contracts if, and when, funding is received. Additionally, keeping the contracts active allows some agencies who rely on CDC funding to be eligible for the 340B drug pricing program to maintain their eligibility. Finally, contracts will be extended to December 31, 2025 but funding will not continue beyond May 31, 2025 unless DHSP receives HIV prevention from the CDC or alternate funding source. Further details will be outlined in each letter to HIV prevention providers.

iii. DHSP also provided an update to Health Resources and Services Administration (HRSA) Ryan White Part A and Minority AIDS Initiative (MAI), HRSA Ending the Epidemic (EHE), and California Department of Public Health (CDPH) Part B funding awards. Funding awards as of May 19, 2024 are $21.2 million for HRSA Part A and MAI, $3.7 million for HRSA EHE and $7.1 million for Part B. DHSP noted the amount of resources available would carry services through July without any changes to contracts.

iv. M. Martinez asked when DHSP would start to make cuts based on the contingency plans the COH has developed. M. Green noted that DHSP has already made cuts internally within DHSP and are currently layout out cuts to contracts and proposed plans are currently at the Board of Supervisors, but DHSP cannot take any action until June 17, 2025.

v. When asked if HIV and HCV tester training would continue, M. Green commented that DHSP will make every effort to maintain all basic trainings for as long as possible.

V. DISCUSSION ITEMS

E. Collaborative and Community-wide Strategies to Maintain HIV Prevention Services

- K. Donnelly opened the discussion by establishing ground rules for discussion; see meeting packet and reviewing discussion guiding questions on what HIV prevention services need

to be prioritized should funding become available and how the community can work together to support HIV prevention services.

- M. Martinez noted that the federal agency, Substance Abuse and Mental Health & Services Administration (SAMHSA) is a potential partner that does receive funding to do some HIV/STD prevention work.
- C. Vega-Matos asked DHSP to share what prevention services yield the best results based on data – namely which services help to identify new diagnoses and existing people living with HIV who are out of care. He added that many potential partners who receive federal funding are also begin subjected to large budget cuts and may be challenging to establish partnerships to help keep prevention services afloat.
- M. Perez, DHSP Director, noted that DHSP supports a large variety of prevention services, some of which perform better than others. He noted that DHSP does not have the resources to continue to support the current portfolio and that the new RFP was designed to better align contracts with resources but due to current uncertainty around funding, the RFP is on pause. He added that DHSP is seeking feedback from all stakeholders to be prepared to move forward with prevention efforts if resources start to become available. He noted new HIV infections are people who are not aware of their status and diagnosis and linkage to care is very important. He added that social sexual network testing is more cost effective than storefront testing and highlighted the importance of surveillance in any HIV prevention program helping to identify where new diagnoses are likely to occur and its use in cluster detection/data to action response programs. M. Perez commented that the impact of biomedical HIV prevention should not be underestimated but noted more work needs to be done to increase uptake among racial/ethnic minorities. Additionally, he noted focusing work in specific geographic locations within the county where new infections are prevalent is also a key strategy.
- I. Salamanca asked DHSP to explain the contents of the letter that went to funded prevention providers, noting that most of the committee does not know what is in the letter. M. Perez explained that the letter states that DHSP will rescind all 83 HIV prevention contracts that were intended to end early on May 31, 2025- noting that most contracts had an end date of June 30, 2025- and allow all contracts to go through the end of the term. Additionally, DHSP is using delegated authority to extend contracts to Dec. 31, 2025 allowing DHSP to support prevention services in the event that resources become available. DHSP is prepared to keep a nominal investment into programs to keep contracts open as a placeholder. Investments are not large enough to support staff.
- M. Perez clarified that DHSP would like feedback and consensus on what prevention strategies should be prioritized so that, should funding become available, DHSP has a clear direction of action on ensuring prevention services continue.
- M. Martinez commented that there is a need to identify resources in the community to link clients to services to ensure continuity of care which is particularly important for our priority populations. He also asked that navigation services remain as part of the prevention portfolio, noting that it is instrumental for helping queer and trans clients

engage in services.

- Xavier Laporte-Sanchez, member of the public, asked what the expectations of deliverables and scope of work would be for contracts that are extending into December. M. Perez noted that expectations around program deliverables would be greatly reduced and would fall in line with level of funding. He noted that large agencies have noted that they plan to continue the same level of services even if DHSP cannot provide funding but DHSP knows this is not feasible for small organizations. M. Perez added that DHSP will not be penalizing agencies that cannot maintain the same level of services.
- R. Lester asked where uninsured clients who depend on testing service programs going to be referred to. M. Perez noted that in LA County most new diagnoses occur in routine healthcare settings. All stakeholders should work together to ensure the healthcare structure is sustained while DHSP HIV testing services will need to become more targeted.
- C. Vega-Matos motioned that the committee work on creating a list of top prevention services to maintain in LA County in the event that funding become available. He recommended the following services, ranked from first priority to last:
    - Surveillance
    - Testing (screening) with linkage to care
    - Biomedical Prevention
    - Vulnerable Populations
    - Health Education and Risk Reduction
- M. Martinez expressed concern about included vulnerable populations and health education and risk reduction as the RFP (currently on pause) moved away from these categories.
- Jeff Bailey, member of the public, noted that for years LA County has consistently remained at 1,600 new infections per year for some time and suggested modifying the current prevention portfolio to have a greater return on investment. He recommended bringing in a consultant to look at what is working and looking into pockets of high prevalence within the county and working with community partners within these areas. He noted that work needs to extend beyond HIV providers and provide training to spread messaging and have a greater reach.
- A member of the public recommended surveillance to be removed from the priority list stating that surveillance was not included in contracts. Others asked how providers would target interventions or who to target. M. Perez added that the CDC requires a minimum of 14% and a maximum of 24% investment of the total prevention funding award amount to support surveillance activities – good public health starts with good surveillance. Surveillance data help to be able to pinpoint exactly where new diagnoses are happening.
- **MOTION #3 - Approve the outlined HIV prevention service priorities for Fiscal Year 2025, as presented or revised, to guide the implementation of effective and equitable HIV prevention strategies in Los Angeles County, with the understanding that, should funding be limited, the top three priorities Surveillance, HIV/STI Testing with Linkage to Care, and**

Biomedical Prevention (PREP/PEP/DoxyPEP) will be preserved and prioritized in implementation.

- **Surveillance**
- **Testing (screening) with linkage to care**
- **Biomedical Prevention**
- **Vulnerable Populations**
- **Health Education and Risk Reduction**

(A. Ballesteros -Y, R. Lester – Y, M. Martinez-Y, L. Spencer – Y, I. Salamanca, L. Talley – Y, J. Weedman, K. Donnelly- Y, J. Green – Y)

VI. NEXT STEPS

F. Task/Assignments Recap

a. Commission staff will forward the approved motion to the Executive Committee for their review and approval.

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

G. Agenda Development for the Next Meeting

a. Review the 2027 – 2031 Integrated HIV Plan and begin planning activities to support its development.

b. Review the DHSP Unmet Needs Report.

VII. ANNOUNCEMENTS

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

K. Nelson asked all attendees to mobilize around HIV prevention funding and encouraged everyone to reach out to local, state and federal officials to advocate for the importance of prevention funding.

VIII. ADJOURNMENT

I . Adjournment for the Regular Meeting of May 20, 2025.

The meeting was adjourned by K. Donnelly at 3:26pm.

LOS ANGELES COUNTY
COMMISSION ON HIV

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

Approved

PUBLIC COMMENTS FOR THE MAY 1, 2025 PLANNING, PRIORITIES, AND ALLOCATIONS COMMITTEE MEETING

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

Member of the Public	Comment(s)
Bridget Tweddell	Bridget Tweddell with Project New Hope. LA County currently has 60 RCFCI beds to serve clients who are too ill to attend to their own needs and have high viral loads when entering the program. These facilities are licensed and provide a non-institutional home-like environment for individuals requiring 24-hour care and supervision. The core objective of the program is to enhance the health status of the residents by offering the stable living environment and a comprehensive array of services designed to address the multifaceted needs of the residents. These services extend beyond basic care and supervision to include case management, nutritional support, guidance on crucial aspects such as housing, health benefits, financial planning. Furthermore, residents benefit from assistance with activities of daily livings such as bathing, dressing, eating, toileting, and mobility. Assisted medication management is also a key service provided. The facilities foster social engagement and offer practical support with housekeeping laundry and transportation arrangements and, for individuals with AIDS who approach the end of life, our RCFCIs provide hospice care, allowing residents to remain in a familial setting until the end of life. The daily environment within an RCFCI is intentionally designed to be less clinical and more akin to a private residence. The average resident age is between 40 and 55 and a hundred percent of the residents remain enrolled in care during their stay. I strongly encourage this advisory body to recommend funding for these programs and to work closely with the providers to ensure continuity and safety for one of the most marginalized groups of people in LA County. Once these homes are closed and the licenses are surrendered, these beds will be permanently gone during

	a time when homelessness is on the rise, and we are one step away from yet another health crisis. Thank you.
Katja Nelson	Hi, everyone, Katja Nelson, 3rd district representative and Public Policy Co-Chair. I have a couple things that I wanted to touch on as someone who does advocacy and policy work day and day out and a lot of my job is making sure that like this system is working and we are serving as many people as possible, preserving programs, making things robust, and reaching all the communities we want to reach. I have read the PRSA, I understand how this process is supposed to work, but we do need to still be thinking critically about both how allocations translate into dollars and translate into the community. I understand the division between DHSP and the Commission in terms of allocations, but we are in looking at a lot of categories that may not become viable anymore depending on how we choose to fund them when we really do need to be looking at the bigger picture. I think there's a lot of data out there and this committee hasn't necessarily looked at all the various like DPH delegated authority memos and things of the charge and there's a lot of things that we really want to be looking at and deliberating that can help factor into these decisions. I would be curious to hear from folks how we are considering public comment. Are we actually taking it into consideration in deliberations, or NO? Does that count as qualitative data as opposed to anecdotes and stories? You know, I just, I really think that we want to make sure we are having a robust conversation to make sure that we are protecting services especially in light of everything that's been transpiring in the last day or two and a lot of uncertainties. What can we do to make sure that we don't have to let go everybody and completely break our system and not be able to bring everybody back and serve people. That's not serving the greatest need and the greatest good.
Scott Blackburn	Good afternoon, I'm Scott Blackburn, Director of Case Management at APLA Health. I'd like to direct my public comments today at PSS and MCC. Patient support services, or PSS, is a newly launched array of care coordination services that was introduced within the most recent core HIV services contract in March 2025, which bundled together PSS and MCC. While PSS is currently listed under the Non-Medical Case

	Management Service category, as the name of the program implies, it directly supports the treatment adherence and health outcomes of HIV positive medical patients and, largely, in the same manager that manner that MCC does. The most important difference between MCC and PSS lies in the structure and scalability of the two programs. MCC requires a structured team staffing model with each team comprised of an RN case manager, a social work case manager, and a caseworker. All positions are required for each team. PSS on the other hand, offers a menu of seven different positions, including an RN case manager and social work case manager. This allows providers to choose from a vast array of services depending on the needs of their population and internal budget priorities. When faced with diminished funding resources, providers need as much flexibility and choice to make the hard decisions about how best to martial resources in the most effective manner possible. However, the current proposed allocation for PSS represents a 70 % cut from the contract awards that DHSP issued for PSS. I strongly encourage the committee to consider the current ratio between PSS and MCC funding and weigh the advantages of increased funding for PSS to create as many options as possible when it comes to building care coordination services for our patients. Thank you.
Jeff Bailey	Good afternoon, my name is Jeff Bailey and I'm the Director of HIV Access at APLA Health and I would like to come back today and talk about the nutrition support category. First thing I want to point out is on your funding source in your document - I think the funded amount is incorrect. I think it's closer to $4 million and not $2.9 million only because I know one contract that is out there that's $2.9 million. I know there's other funding available for that. It's going to be critically important to take into account, similar to what Katya said, if a reduction is so much that it makes a program unsustainable. We have to really think about that. For Nutrition Support we would need to consider, does it go back to a supplemental food program? Do we reduce the income eligibility of clients? Do we reduce the number of sites where food can be picked up? I think that's really critical. Also, when you see the some of the charts and it talks about the cost per client, that's a unique client. We

	had 43,000 visits last year and if you take the number of visits by the amount of money, our meals cost DHSP $2.61 to provide a meal. We provided 1,021,000 meals last year. That's a lot of savings. Another thing to think about is that because these clients come once a week, there's a health navigation component to it. With prevention programs sunsetting, and that component going away, we connect our clients often to health care. During COVID we connected them to the [COVID] vaccine; during Mpox, we connected to them to the [Mpox] vaccine, we connect into oral health services and so forth. So that's kind of an unanticipated outcome of food and nutrition support because while a person may see their physician once every six months, we see them every week. That's why you also want to may rethink the allocation to PSS because those positions could maybe fill that gap and relook at the allocation for MCC, I think it's a bit high. Thank you.
Terry Goddard	Good afternoon everyone, my name is Terry Goddard, and I am the Director of the Alliance for Housing and Healing, a division of APLA Health and Wellness. I was a commissioner for many years and understand that this is a very difficult decision for you. I actually have a couple of technical questions. Right now, for RCFCI and for the Housing, there's an allocation of 9.33% and 1.33% for Part A, but we don't' know what Part B is. My question is for DHSP, if they are going to use Part B for Housing then this makes sense. If not, these numbers are far too low and they need to be reprogramed, perhaps the same way for MAI funds if they are going to be a hundred percent allocated to the Housing for Health Program and that program will be switched to DHS. That's $6 million in MIA funds that could be reprogrammed. I just wanted to bring that to your attention. Thank you.
Robert Bowler	Thank you very much, Robert Bowler, Project Angel Food. Speaking on behalf of Nutrition Support, but really for all supports on behalf of our HIV elders. One of the things I'm really worried about if Ryan White contracts are taken away is the HIV elder. About a 3rd of our clients are older. They've been with us 5, 10, 15, 30 years and I feel like the Ryan White supports is like a house of cards. As soon as you start pulling

	out pieces, the house could crumble and I really feel bad for these people. Many are medically fragile, they're emotionally fragile, they come through the pandemic, and they've seen all their friends and their support pass away and pass on. I feel like they may get lost in the shuffle and I wanted to put it out there that maybe this is a population we should look after. Thank you very much.

Los Angeles County Commission on HIV

REVISED 2025 TRAINING SCHEDULE

***SUBJECT TO CHANGE**

- All training topics listed below are mandatory for Commissioners and Alternates.
- All trainings are open to the public.
- Click on the training topic to register.
- Certificates of Completion will be provided.
- All trainings are virtual via Webex.
- For questions or assistance, contact: hivcomm@lachiv.org

Commission on HIV Overview	February 26, 2025 @ 12pm to 1:00pm
Ryan White Care Act Legislative Overview and Membership Structure and Responsibilities	~~March 26, 2025~~ @ 12pm to 1:00pm April 2, 2025
Priority Setting and Resource Allocations Process	April 23, 2025 @ 12pm to 1:00pm
Service Standards Development	May 21, 2025 @ 12pm to 1:00pm
Policy Priorities and Legislative Docket Development Process	June 25, 2025 @ 12pm to 1:00pm
Bylaws Review	July 23, 2025 @ 12pm to 1:00pm

Estimates of Unmet Need for HIV Care, Year 2022

Sona Oksuzyan, Supervising Epidemiologist
Janet Cuanas, Research Analyst III
Monitoring & Evaluation
Division of HIV and STD Programs

June 17, 2025

Agenda

- **Background:** Definitions and Reporting Requirements
- **Measures and Data Sources:**
  - HIV Surveillance
  - CaseWatch
- **Key Findings:**
  - Late Diagnoses
  - Unmet Need for Medical Care
  - Unmet Need for Viral Suppression
- **Conclusions**
- **Questions/Discussion**

Background: Unmet Need

Definition
Data Reporting Requirements

County of Los Angeles Public Health

What is Unmet Need?

Definition (HRSA HIV/AIDS Bureau)

- **The need for HIV-related health services by individuals with HIV who are aware of their status but are not receiving regular primary [HIV] health care**[1]

Reporting Requirements

- Data and methods to estimate unmet need have evolved with improvements in HIV care and data quality
  - Estimated Unmet Need has been a reporting requirement for RWHAP recipients since 2005
  - New and expanded methodology released 2021 and implemented in 2022 (for 2019 data)

1."HRSA/HAB Definitions Relate to Needs Assessment," prepared for the Division of Service Systems, HIV/AIDS Bureau by Mosaica: The Center for Nonprofit Development and Pluralism, June 10, 2002.

Methods

Unmet Need Framework

Jan 1, 2022-Dec 31, 2022

Indicators

- Late Diagnosis
- Unmet Need for Medical Care
- Unmet Need for Viral Suppression

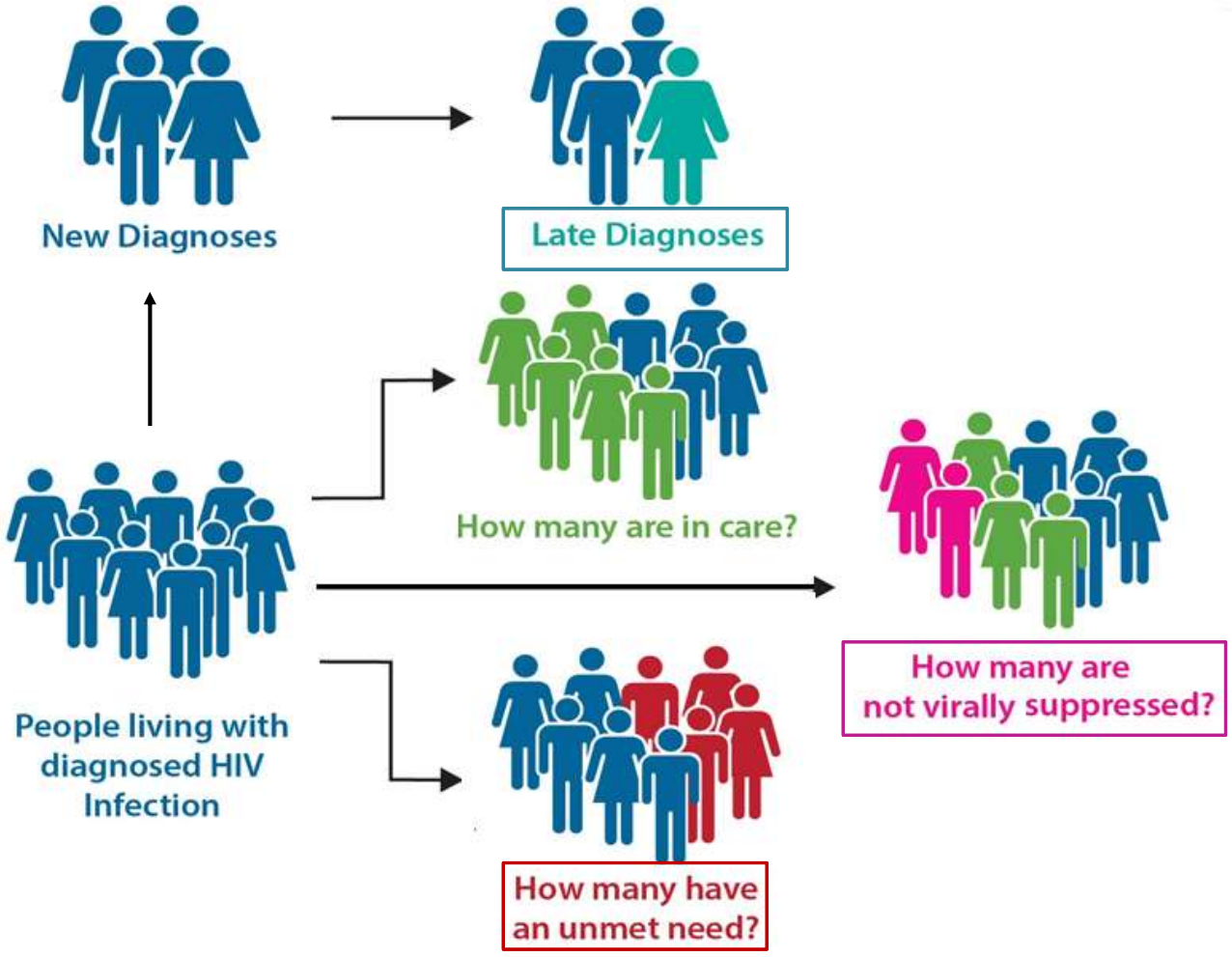
Definitions

- Late Diagnosis: People diagnosed with HIV in the past 12 months with LATE DIAGNOSIS (Stage 3 [AIDS] diagnosis or an AIDS-defining condition ≤ 3 month after HIV diagnosis)
- Unmet Need for Medical Care: PLWDH with NO EVIDENCE OF CARE (at least one VL or CD4 test) in the past 12 months
- Unmet Need for Viral Suppression: PLWDH that are NOT VIRALLY SUPPRESSED in the past 12 months (VL ≥ 200 copies/ml)

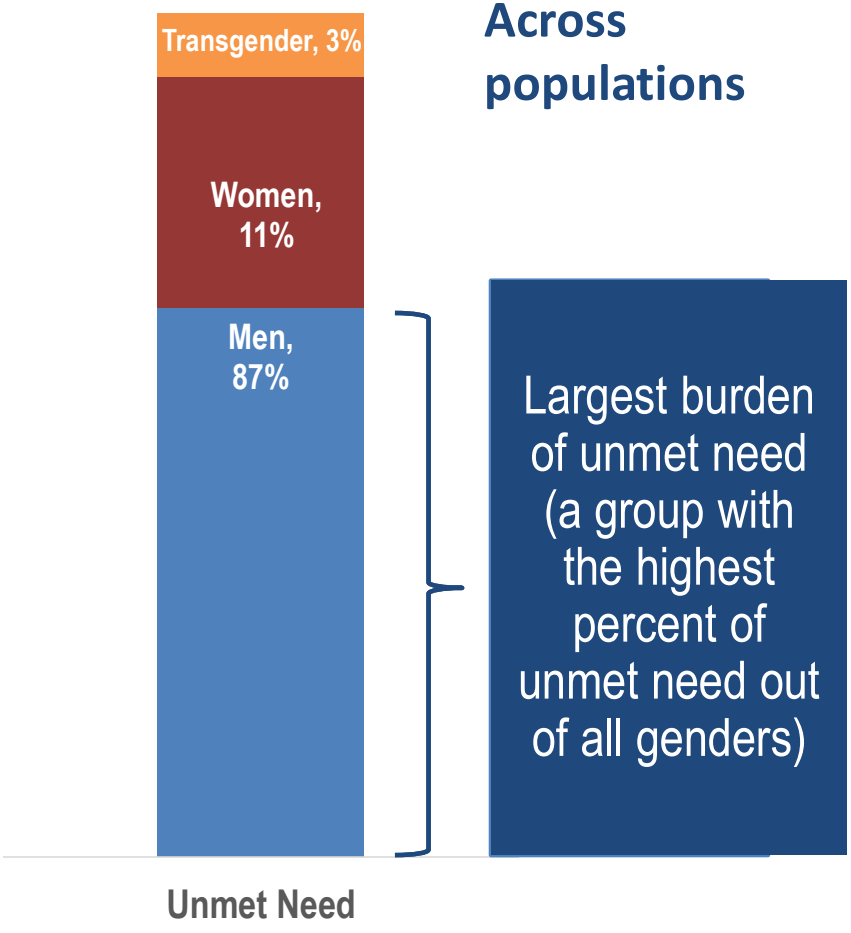
Data Sources

- HIV Surveillance: Viral load and CD4 tests – Late Diagnosis, Unmet Need for Medical Care and for Viral Suppression
- HIV Casewatch: Client characteristics and service use – Unmet Need for Medical Care and for Viral Suppression

LAC Populations for Estimates of Unmet Need

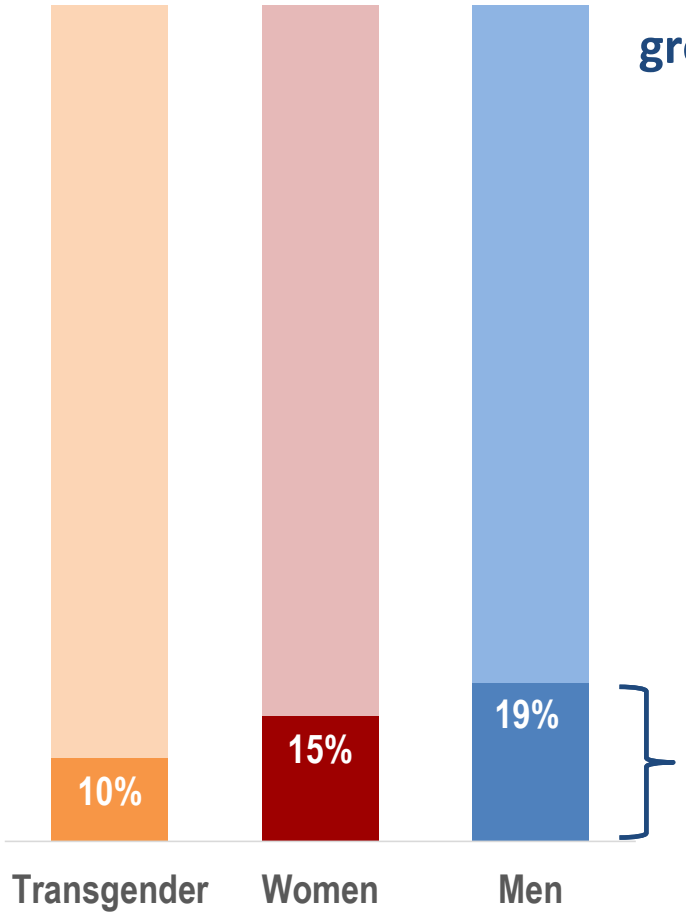


Interpretations of the data across populations and within population group



Across populations

Largest burden of unmet need (a group with the highest percent of unmet need out of all genders)



Within population groups

Disparity in unmet need within each population group (e.g. the percent of unmet need among men is higher than the percent of unmet need within other gender groups)

Late Diagnoses: Key Findings

County of Los Angeles Public Health

Context for Late Diagnoses

- **National goal: Reduce late diagnoses by 25%**
  - In LAC that means decreasing the percent of late diagnoses from 19% in 2022 to 15% by 2025[1]

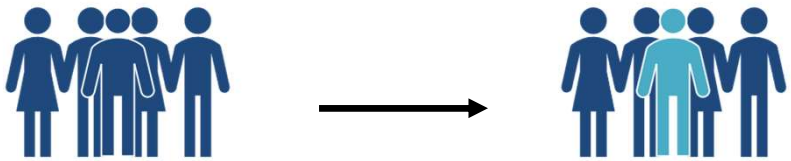
- On average, it takes 8 years to progress to late-stage disease from time of infection to diagnosis[2]

- **Helpful to track how well our care system is identifying infection early and across populations**
  - Identification of late diagnoses is not done at point of care – providers are not likely to know degree of disease progression at time of testing

1.Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2023. http://www.publichealth.lacounty.gov/dhsp/Reports/HIV/2023AnnualHIVSurveillanceReport.pdf

2.Lodi S, et al. Time from human immunodeficiency virus seroconversion to reaching CD4+ cell count thresholds <200, <350, and <500 cells/mm(3): assessment of need following changes in treatment guidelines. *Clin Infect Dis*. 2011;53(8):817–825.

In 2022, 18% percent of newly diagnosed clients in LAC were late diagnoses.

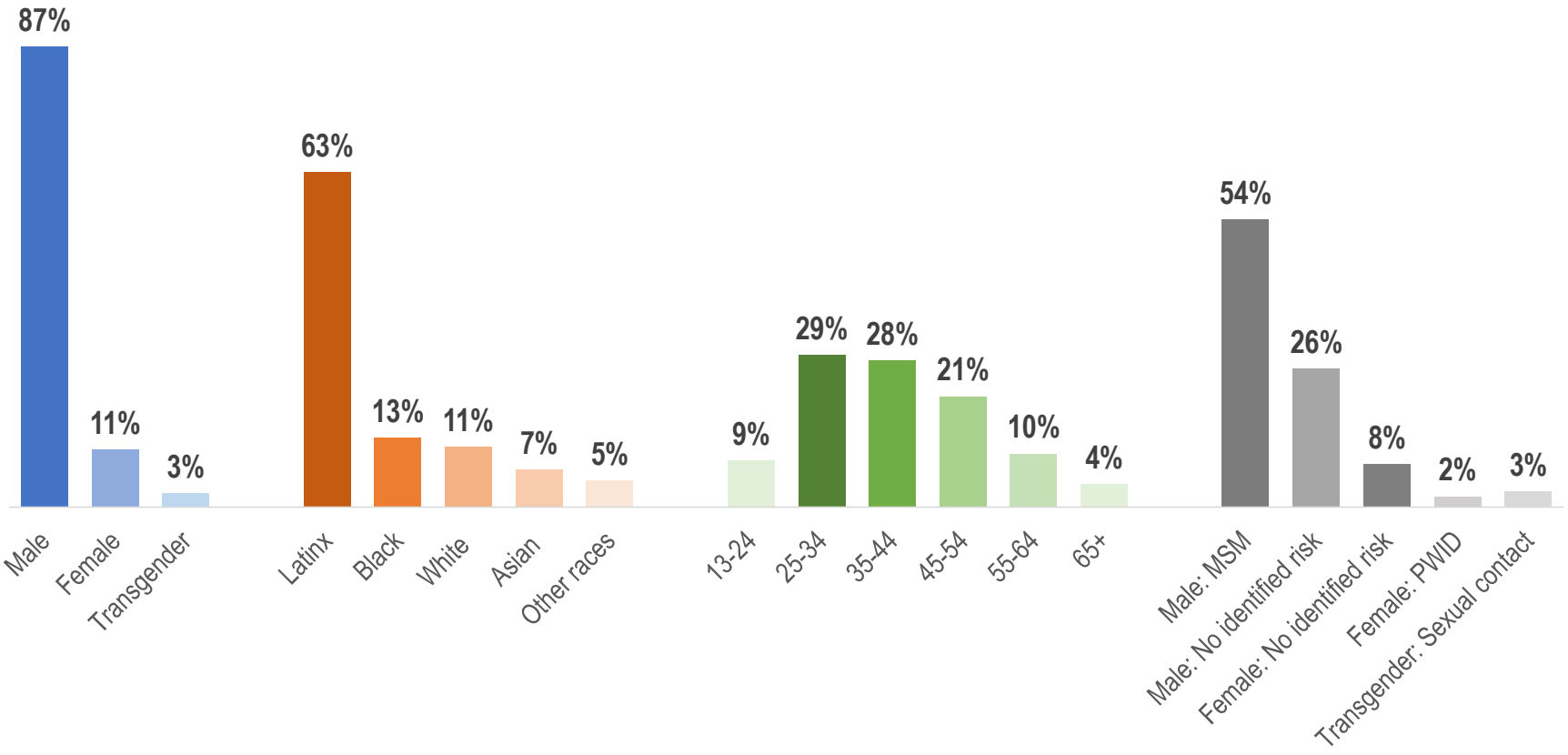


1,642 New Diagnoses

18% Late Diagnoses (N=298)

Burden of Late Diagnosis - Key Populations

Highest percentage of late diagnoses was among males, Latinx, aged 25-34, with transmission mode MSM among males, sexual contact among transgender persons, and no identified risk among females.



Disparities in Late Diagnoses - Priority Populations

How and where can we improve for priority populations?

Largest disparities in the percent of late diagnoses vs the percent of new diagnoses within each population group among *PLWDH in LAC* and *RWP clients* were detected among following priority populations:

- **Aged 50 and older**
- **Latino MSM**
- **Women of Color**

Unmet Need for Medical Care: Key Findings

County of Los Angeles Public Health

Context for Unmet Need for Medical Care

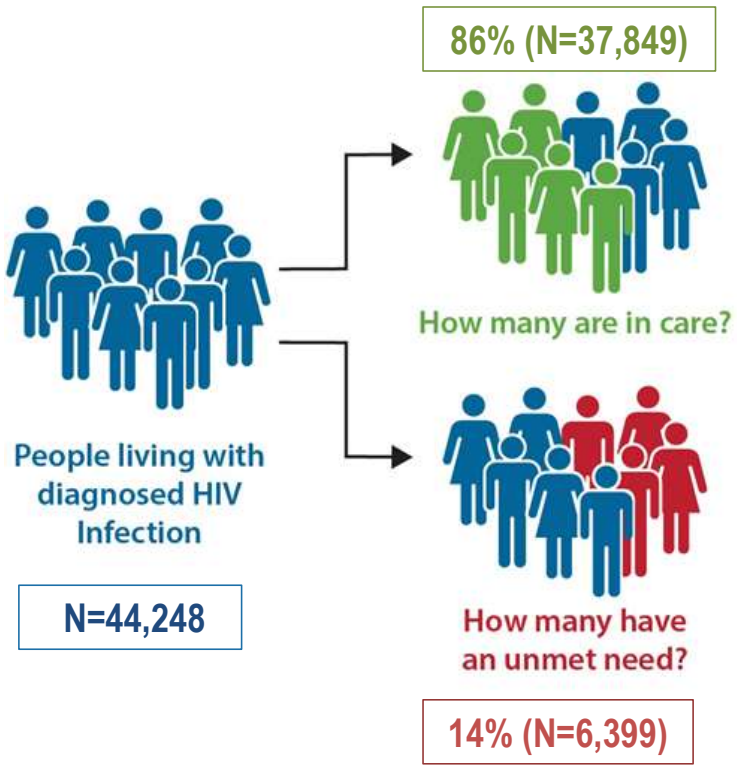
- **Local goal: increase engagement/receipt of care to 90% by 2025**
  - 72% of PLWDH were engaged in care in 2023[1]
- **Unmet need includes PLWH who may not have been linked to care or following diagnosis have fallen out of care**
  - Approximately 76% of new diagnoses were linked to care in ≤ 1 month[1]
  - On average, it takes 3.1 months to re-engage LRP clients into care and ranged from <1 month to 18 months[2]
- **Challenges to provider knowing care status**
  - No quality data for medical visit is available
  - Using HIV Surveillance lab data as proxy for medical visits

1.Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2023 http://www.publichealth.lacounty.gov/dhsp/Reports/HIV/2023AnnualHIVSurveillanceReport.pdf

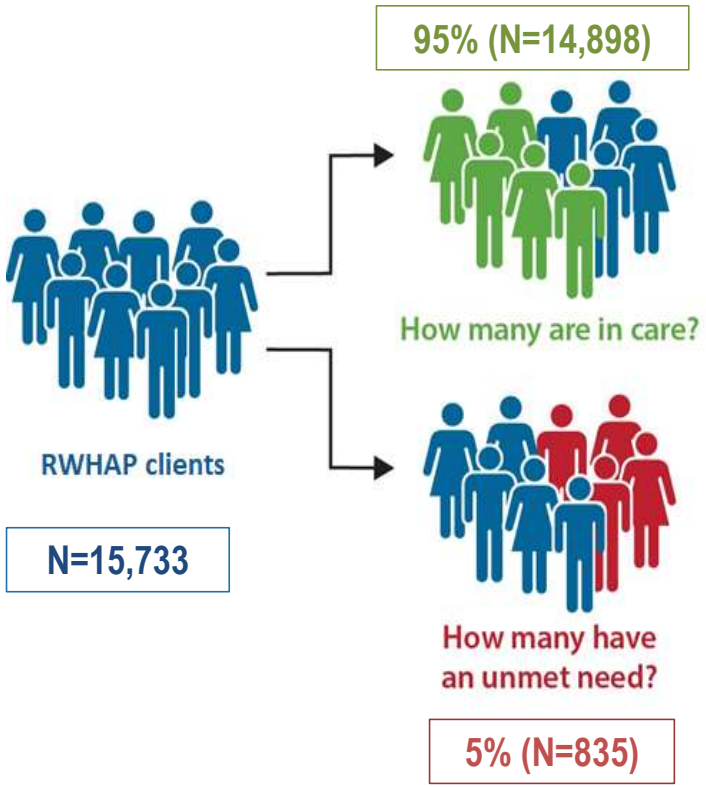
2.Division of HIV and STD Programs, Linkage and Re-Engagement Program, 2016-2019.

In 2022 unmet need was almost three times higher among LAC PLWDH than in RWP Clients.

LAC 5-Year Population

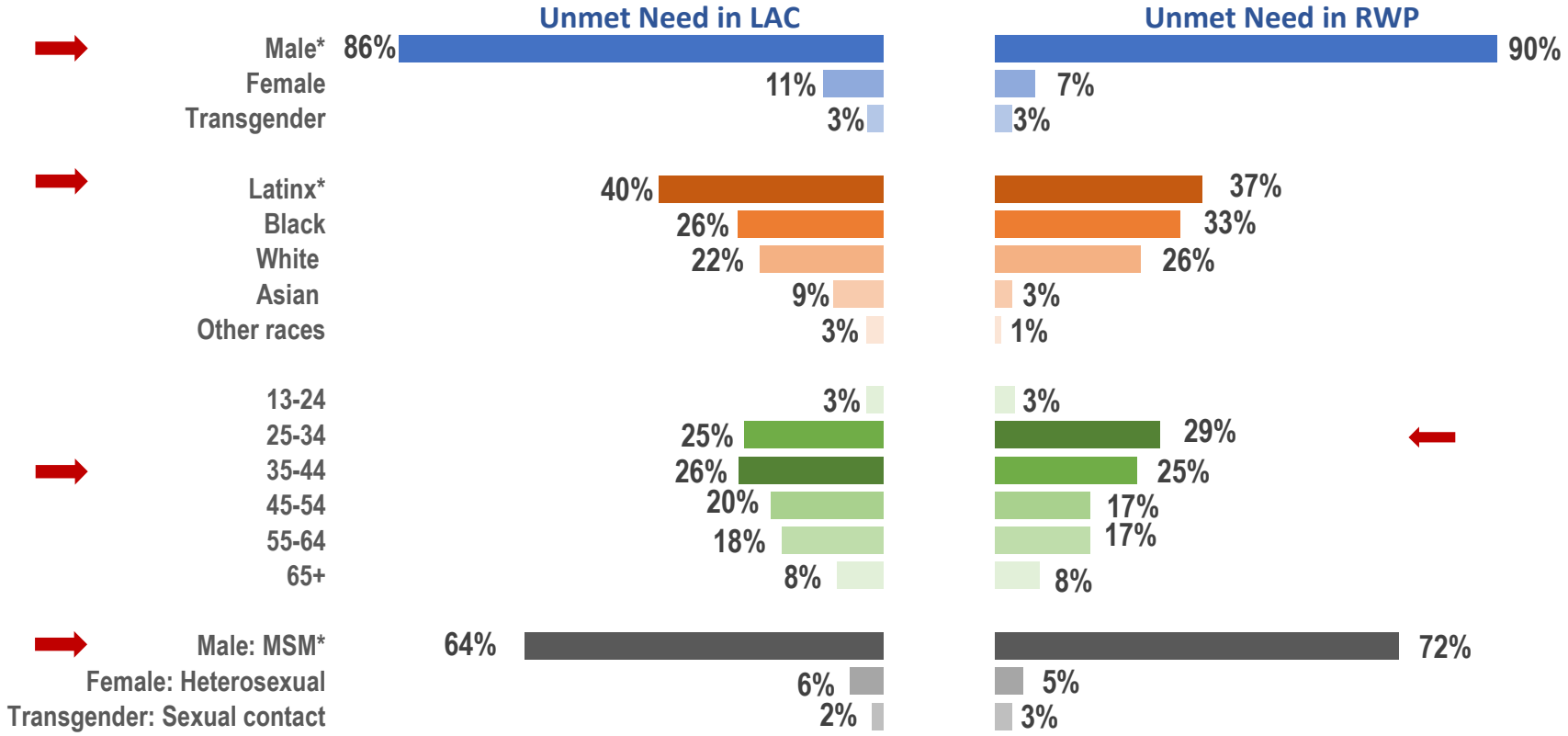


RWP Clients



Estimates of Unmet Need for Medical Care – Key Populations

Males, Latinx, and MSM had the highest percentages of unmet need among PLWDH in LAC and RWP clients. Age groups with the highest unmet need was 35-44 years olds among PLWDH in LAC and 25-34 years olds among RWP clients.



*Significant difference between LAC and RWP estimates.

Disparities in Unmet Need for Medical Care - Priority Populations

How and where can we improve for impacted populations?

Largest disparities in unmet need for medical care among *PLWDH in LAC* and *RWP clients* **within each population** were observed among following priority populations:

- **PLWH aged 13-29 years**
- **Black MSM**
- **PWID**

Unmet Need for Viral Suppression: Key Findings

County of Los Angeles Public Health

Context for Unmet Need for Viral Suppression

- **EHE Goal: Increase percentage of PLWDH with viral suppression to 95% by 2025**
  - 64% among all PLWDH in LAC regardless of care status[1]
  - 93% among PLWDH **with at least one VL test** in LAC[1]

- **Viral Suppression is the main HIV care outcome**
  - Undetectable viral suppression = Untransmittable infection
  - **U = U** [2]

- **Challenges to provider knowing viral suppression status**
  - No quality data on viral testing is available
  - Using HIV Surveillance lab data

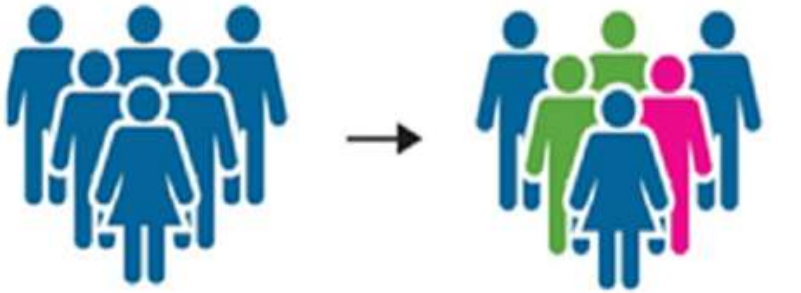
1.Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2023. http://www.publichealth.lacounty.gov/dhsp/Reports/HIV/2023AnnualHIVSurveillanceReport.pdf

2.https://www.nih.gov/news-events/news-releases/science-clear-hiv-undetectable-equals-untransmittable

In 2022 unmet need for viral suppression was higher for PLWDH in LAC compared to RWP clients.

- **Unmet need for viral suppression was higher for LAC overall than RWP**

LAC 5-Year Population



PLWDH in LAC

N=44,248

How many are not virally suppressed

25% (N=10,945)

RWP Clients

PLWDH in LAC

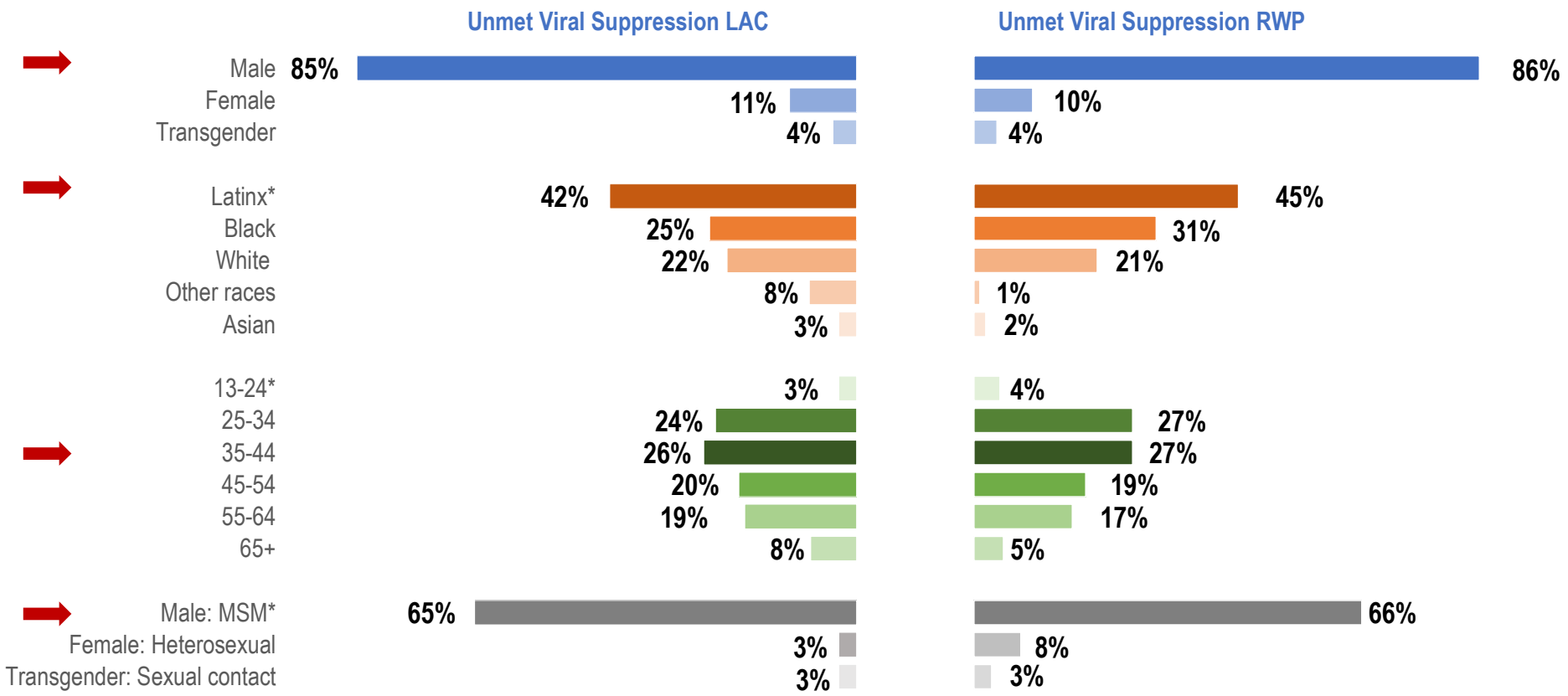
N=15,733

How many are not virally suppressed

17% (N=2,691)

Estimates of Unmet Need for Viral Suppression - Key populations

Both PLWDH in LAC and RWP clients had the highest percentages of unmet need for viral suppression among males, Latinx, aged 35-44, and MSM.



*Significant difference between LAC and RWP estimates.

Disparities in Unmet Need for Viral Suppression - Priority Populations

Among both PLWDH in LAC and RWP clients the largest disparity in unmet need for viral suppression **within each population** was observed among:

- **PLWH aged 13-29 years**
- **PWID**

LAC also had a large disparity within the **Transgender population,** while RWP had a large disparity within **Black MSM**.

Conclusions

County of Los Angeles Public Health

Summary

- **Differences in unmet need estimates exist between PLWDH LAC and RWP clients:**
  - The percent of PLWH with Unmet Need for Medical Care was significantly **higher in LAC vs. RWP**
  - The percent of people with Unmet Need for Viral Suppression was **higher in LAC vs. RWP**

- Across all unmet need indicators, **the largest burden was among the largest population groups** in both PLWDH in LAC and RWP clients:
  - **Males**
  - **Latinx**
  - **People aged 25-44 (25-34 and 35-44 years old)**
  - **Transmission risk:**
    - **MSM transmission among males**
    - **Sexual contact among transgenders**

Summary (continued)

- To reduce the overall unmet need among PLWDH in LAC and among RWP clients, **we would need to develop interventions addressing the largest population groups across unmet needs.**
  - The impact of interventions designed and implemented for these groups would be the largest among both PLWDH in LAC and RWP clients.

Summary (continued)

To reduce disparities between populations among both PLWDH in LAC and RWP clients, **interventions should be focused on the most impacted population groups within each population.** These population groups are identified as LAC priority populations:

- **Transgender people**
- **Women of color**
- **Black and Latino MSM**
- **PLWH aged 13-24 years** and **50 years and older**
- **PWID**

Questions and Discussion

Special thanks to the following people without whom this presentation would not be possible:

Siri Chirumamilla, MD, MPH
Virginia Hu, MPH
Kathleen Poortinga, MPH
Michael Green, PhD, MHSA

HIV PREVENTION in California

Since the late 1980s, **CDC has partnered with state and local health departments to expand the impact and reach of its HIV prevention activities.**

CDC awarded **$83.2M** in FY2024 to health departments, community-based organizations, and other organizations in California for HIV prevention and care activities, including **$16.2M** in *Ending the HIV Epidemic (EHE)* funding.

CDC collects and disseminates data on **6 key indicators.** Current data are available online at AtlasPlus* and on HHS AHEAD† for each jurisdiction.

157,600 people are living with HIV in California.

In California between 2018 and 2022, overall HIV incidence **decreased** by **14%**, preventing an estimated **2,200 new HIV infections** and **saving $1.2B** in lifetime medical costs.

DIAGNOSE all people with HIV as early as possible

Knowledge of Status (2022)

Across the country,

87.2%

of people living with HIV **were aware of their status,** meaning approximately **12.8% were unaware** and are not getting the HIV care they need.

87.4%

of Californians with HIV were **aware of their status,** meaning approximately **12.6% were unaware** and are not getting the HIV care they need.

Self-Testing

CDC is providing free HIV self-test kits to populations disproportionately affected by HIV. CDC and partners have sent out over **750,000** tests.

140,472

HIV tests were provided in California with CDC funding.

How CDC Dollars Are Improving Diagnosis

- **Expanding** routine screening of people in health care settings, including emergency departments
- **Increasing** testing in non-clinical settings (e.g., jails, community serving organizations, street-based services)
- **Increasing** access to and use of HIV self-tests
- **Integrating** sexually transmitted infections (STI) and viral hepatitis screening into HIV testing services

* https://www.cdc.gov/nchhstp/about/atlasplus.html

† https://ahead.hiv.gov/

TREAT people with HIV rapidly and effectively to reach sustained viral suppression

Viral Suppression (2022)

65.1%

of people across the country, with diagnosed HIV, **were virally suppressed.**

66.7%

of Californians, with diagnosed HIV, **were virally suppressed**.

How CDC Dollars Are Improving Treatment

- **Expanding** access to rapid HIV treatment including long-acting injectables
- **Linking** people with HIV to care within one month to facilitate rapid access to HIV medicine
- **Integrating** HIV, STI, and hepatitis treatment to provide efficient and cost-effective care

PREVENT new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP)

PrEP

PrEP is a medicine that people at risk for HIV take to prevent getting HIV from sex or injection drug use.

California's CDC-funded HIV testing programs identified **13,908 persons who were eligible** for PrEP in 2022.

How CDC Dollars Are Improving Prevention

- **Expanding** access to PrEP through innovations such as long-acting injectable PrEP, Post-Exposure Prophylaxis, and focused provider education
- **Implementing** a whole-person approach to HIV prevention and care to help overcome barriers

RESPOND early to potential HIV clusters or outbreaks

Cutting-edge public health approaches turn HIV data into action by **identifying areas with rapid transmission and expanding resources** to maximize prevention and treatment efforts.

404

clusters of HIV infections reported to CDC from 2022 through 2024.

How CDC Dollars Are Improving Response

- **Addressing** gaps in prevention and care contributing to rapid transmission
- **Engaging** communities and partners to respond to outbreaks

2027-2031 Integrated HIV Plan Overview and Preparation

Planning, Priorities and Allocations Committee

June 17, 2025

Background

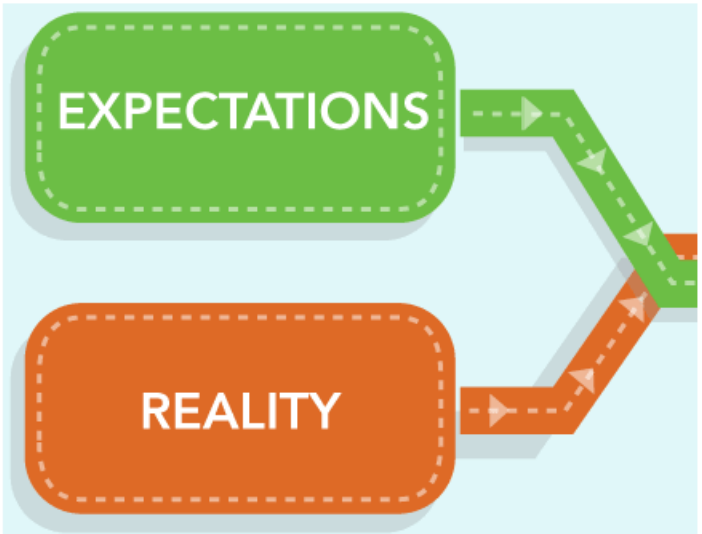
The Integrated Plan Guidance built upon CDC and HRSA's efforts to:

- Reduce reporting burden and ensure coordination across grant recipients,
- Streamline the work of health department staff and HIV planning groups, and
- Promote coordination and community engagement in designing systems of HIV prevention and care.

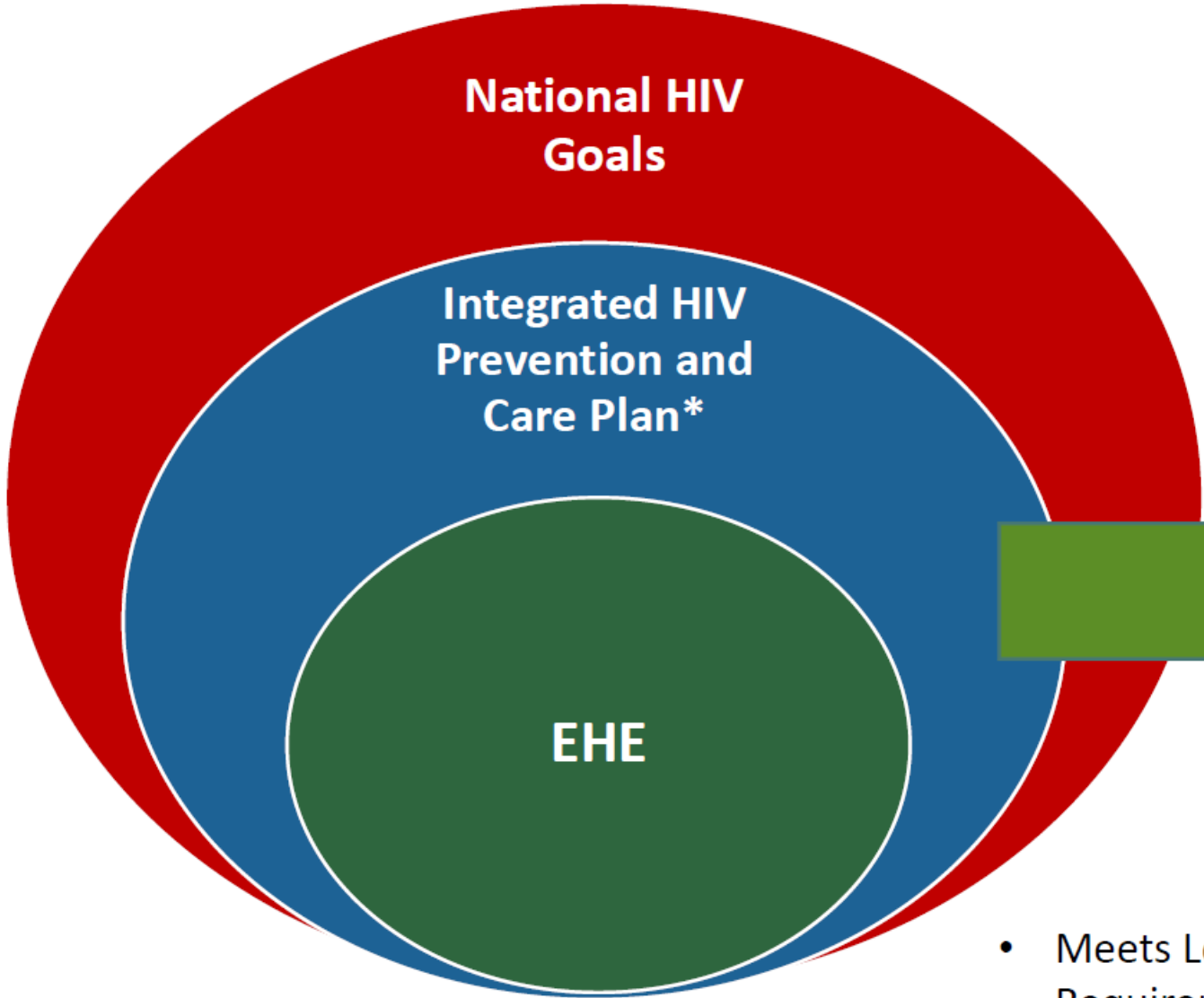
HRSA and CDC Joint Expectations

Your Integrated HIV Prevention and Care Plan should:

- Reflect the community's vision regarding how best to deliver HIV prevention, care, and treatment services.
- Details how various plans (including Ending the HIV Epidemic Plans) work together in a jurisdiction to further national HIV goals.
- Serve as a living document and roadmap to guide each jurisdiction's HIV prevention and care service planning throughout the year.



Connection to National Initiatives & Plans



Other Programmatic Applications or Submissions

- Meets Legislative and Programmatic Requirements for CDC DHP and HRSA HAB

Overview of Integrated HIV Prevention and Care Guidance

Standardization of templates

Suggested template for interactive Work Plan developed

Clarity on Letter of Concurrences (LOC)

Language and table included in the guidance and checklist to reiterate requirements for LOC

Guidance on page limit

MAXIMUM number of pages is 100. There is no minimum page requirement

IP 3.0 - Key Updates

Inclusion of Ryan White Program 2030 Vision

Guidance includes a new objective to prioritize reaching those with HIV who are undiagnosed or out-of-care

CY 2027-2031 Integrated Prevention and Care Plan

Integrated Plan Guidance Checklist Sections

- Section I: Introduction
- Section II: Community Engagement and Planning Process
- Section III: Contributing Data Sets and Assessments
- Section IV: Situational Analysis
- Section V: Goals and Objectives
- Section VI: Implementation, Monitoring, and Jurisdictional Follow Up
- Section VII: Letters of Concurrence

Section I: Introduction of Integrated Plan and SCSN

Purpose: To provide a description of the Integrated Plan, including the SCSN and the approach the jurisdiction used to prepare and package requirements for submission

SECTION COMPONENTS

- Description
- Approach
- Documents Submitted to Meet Requirements

Section II: Community Engagement and Planning Process

Purpose: To describe how the jurisdiction's planning approach engaged community members and key partners, fulfilled legislative and programmatic requirements, and addresses the HIV care and prevention needs of people with HIV and people vulnerable to HIV.

SECTION COMPONENTS

1. Jurisdiction Planning Process
2. Entities Involved in Planning Process
3. Role of RWHAP Part A Planning Council/Planning Body
4. Role of Planning Bodies and Other Entities
5. Collaboration with RWHAP Parts – SCSN requirement
6. Engagement of People with HIV – SCSN requirement
7. Priorities
8. Updates to Other Strategic Plans Used to Meet Requirements

Section III: Contributing Data Sets and Assessments

Purpose: To analyze qualitative and quantitative data used by the jurisdiction to describe how HIV impacts the jurisdiction; to determine the services needed by individuals to access and maintain HIV prevention, care and treatment services; to identify barriers for individuals accessing those services; and to assess gaps across the HIV Prevention and HIV Care Continuums of Care.

SECTION COMPONENTS

1. Data Sharing and Use
2. Epidemiologic Snapshot
3. HIV Prevention, Care and Treatment Resource Inventory
4. Strengths and Gaps
5. Approaches and Partnerships
6. Needs Assessment
   a. Priorities
   b. Actions Taken
   c. Approach

Section IV: Situational Analysis

Purpose: To provide an overview of strengths, challenges, and identified needs across the HIV prevention and care continuum. This snapshot should synthesize information from the Community Engagement and Planning Process in Section II and the Contributing Data sets and Assessments detailed in Section III.

SECTION COMPONENTS

1. Situational Analysis
2. People and Communities Disproportionately Impacted by HIV

Section V: Goals and Objectives

Purpose: To detail goals and objectives for the next 5 years. Goals and objectives should reflect strategies that ensure a comprehensive, coordinated approach for all HIV prevention and care funding.

Structured to include strategies that accomplish the following:

- *Diagnose* all people with HIV as early as possible
- *Treat* people with HIV rapidly and effectively to reach sustained viral suppression
- *Prevent* new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP) and syringe services programs (SSPs)
- *Respond* quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

Section VI: Implementation, Monitoring, and Jurisdictional Follow Up

Purpose: To describe the infrastructure, procedures, systems, and/or tools that will be used to support the key phases of integrated planning. In this section jurisdictions will detail how best to ensure the success of Integrated Plan goals and objectives through the following 5 key phases:

- Implementation
- Monitoring
- Evaluation
- Improvement
- Reporting and Dissemination

Section VII: Letters of Concurrence

Purpose: To provide letters of concurrence or concurrence with reservation. Each letter should specify how the planning body was involved in the Integrated Plan development. Include a letter of concurrence for each planning body in the state/territory or jurisdiction.

A letter of concurrence is required from Planning Councils regardless of the type of plan submitted.

Appendix 6

Sample Letter of Concurrence or Concurrence with Reservations between Planning Body and State or Local Health Department or Funded Agency

Dear (Name):

The [insert name of Planning Body, e.g. planning council, advisory council, HIV planning group, planning body] [insert ***concurs or concurs with reservations***] with the following submission by the [insert name of State/Local Health Department/ Funded Agency] in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV Prevention (DHP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2027-2031.

The planning body (e.g. planning council, advisory council, HIV planning group, planning body) has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The planning body [insert ***concurs or concurs with reservations***] that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

[Insert the process used by the planning body to provide input or review the jurisdiction's plan.]

[If applicable, insert how jurisdictions with directly funded states and cities plan to coordinate their HIV Planning process.]

The signature(s) below confirms the [insert ***concurrence or concurrence with reservations***] of the planning body with the Integrated HIV Prevention and Care Plan.

Signature: Date:

Planning Body Chair(s)

Submission Expectations

Each HRSA and CDC-funded jurisdiction needs to participate in the completion and submission of an Integrated Plan.

The Integrated Plan should include information on who is responsible for developing the Integrated Plan within the jurisdiction (i.e., RWHAP Part A planning councils/body(ies), RWHAP Part B advisory groups, and CDC HIV planning bodies).

The Integrated Plan should define and provide the goal(s), which allows the jurisdiction to articulate its approach for how it will address HIV prevention, care, and treatment needs in its service areas and accomplish the national HIV goals.

Submission Requirements

Submissions due to CDC DHP and HRSA HAB ***no later than 11:59 PM ET on June 30, 2026***

Submissions **should be no longer than 100 pages** not including the completed checklist and no smaller than 11pt font

Required components of submission

- Integrated HIV Prevention and Care Plan Submission
- Completed *CY 2027 – 2031 CDC DHP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist*
- Signed letter(s) from the HIV planning group/body indicating concurrence, concurrence with reservations, or non-concurrence with the plan

HRSA and CDC will provide more details at a later date about where to submit completed plans

Planning for 2027-2031 Integrated HIV Plan

Things to consider:

- Create new plan?
- Revise existing plan? What changes need to be made?
  - What are the top priorities?
- What data do we have? Do we need more data?
- What stakeholders are at the table? Who is missing?
- What needs assessments do we have? Is there anything missing?
- Timeline for completion
- Other thoughts?

Figure 33: Four Key Pillars and a Strong Foundation Necessary to Achieve HIV-Related Goals