LOS ANGELES COUNTY
COMMISSION ON HIV

Visit us online: http://hiv.lacounty.gov

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EXECUTIVE COMMITTEE MEETING

Thursday, August 28, 2025

1:00PM – 4:15PM (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/executive-committee

Register Here to Join Virtually

https://lacountyboardofsupervisors.webex.com/weblink/register/r97ae0c95ffd9305bcfa895d7e448fc3d

To Join by Telephone: 1-213-306-3065

Password: EXECUTIVE Access Code: 2530 414 7045

Public Comments

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

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

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

Accommodations

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

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

together.

WE CAN END HIV IN OUR COMMUNITIES ONCE & FOR ALL

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

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

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

EXECUTIVE COMMITTEE

Thursday, August 28, 2025 | 1:00PM-4:15PM *Extended Meeting

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

MEMBERS OF THE PUBLIC:
To Register + Join by Computer:
https://lacountyboardofsupervisors.webex.com/weblink/register/r97ae0c95ffd9305bcfa895d7e448fc3d
To Join by Telephone: 1-213-306-3065
Password: EXECUTIVE Access Code: 2530 414 7045

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

AGENDA POSTED: August 22, 2025

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

PUBLIC COMMENT: Public Comment is an opportunity for members of the public to comment on an agenda item, or any item of interest to the public, before or during the Commission's consideration of the item, that is within the subject matter jurisdiction of the Commission. To submit Public Comment, you may submit in person, email to hivcomm@lachiv.org , or submit electronically here. All Public Comments will be made part of the official record.

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

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

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

I. ADMINISTRATIVE MATTERS

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

II. PUBLIC COMMENT 1:10 PM – 1:13 PM

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

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

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

IV. REPORTS

7. Executive Director/Staff Report 1:15 PM – 1:30 PM

A. Commission (COH)/County Operational Updates
   (1) July 10th COH Code of Conduct Corrective Action Plan Updates
   (2) 2025 COH Workplan & Meeting Schedule Updates & Reminders
   (3) PY 35 Operational Budget Updates & Staff Roles/Capacity
   (4) 2025 Annual Conference Planning

8. Co-Chair Report 1:30 PM – 1:45 PM

A. Subordinate Working Units Leadership Meeting Follow-Up & Next Steps
B. October 9, 2025 COH Meeting Agenda Development (Ongoing)
   (1) Venue TBD
   (2) PY 35 COH Operational Budget Updates
   (3) COH Effectiveness Review & Restructuring Project
      i. Proposed Changes to Bylaws for Approval
   (4) Annual Meeting Planning
C. Conferences, Meetings & Trainings (*An opportunity for members to share information and resources material to the COH's core functions, with the goal of advancing the Commission's mission*)

9. COH Effectiveness Review & Restructuring Project 1:45 PM – 3:15 PM

A. Final COH Organization Restructure Scenario Refresher
B. Proposed Changes to Bylaws
      i. Public Comments Review
C. COH x DHSP Memorandum of Understanding (MOU) Updates
D. Membership Materials Review Workgroup Updates (Operations Committee)
E. Outreach & Recruitment Workgroup Updates (Operations Committee)

10. Division of HIV and STD Programs (DHSP) Report 3:15 PM – 3:30 PM

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

11. Standing Committee Report 3:30 PM – 3:50 PM

A. Planning, Priorities and Allocations (PP&A) Committee
   (1) Revised Ryan White Program Year (PY) 35 Re-Allocations **MOTION #3**
   (2) PY 34 Utilization Report
   (3) 2027-2031 Integrated HIV Plan Overview & Preparation

B. Operations Committee
   (1) Co-Chair Open Nominations & Elections Updates
   (2) Revised Policy #09.7201 Compensation for Unaffiliated Consumer Commission Members **MOTION #4**
   (3) Membership Updates
      i. Seat Vacate | Aaron Raines **MOTION #5**

C. Standards and Best Practices (SBP) Committee
   (1) Transitional Case Management Service Standards **MOTION #6**
   (2) Patient Support Services (PSS) Service Standards | Public Comments Due 9/30/25
   (3) Service Standards Schedule

D. Public Policy Committee (PPC)
   a. County, State and Federal Policy & Budget Updates

12. Caucus, Task Force, and Work Group Reports: 3:50 PM – 4:00 PM

A. Aging Caucus
- "Power of Aging": September 19, 2025 National Aging & HIV Awareness Day Event

B. Black/AA Caucus
- Black Voices for HIV Health & Wellness Community Led Story-Telling Campaign

C. Consumer Caucus
D. Transgender Caucus
E. Women's Caucus
F. Housing Task Force

V. NEXT STEPS 4:00 PM – 4:05 PM

13. Task/Assignments Recap

14. Agenda development for the next meeting

VI. ANNOUNCEMENTS 4:05 AM – 4:15 PM

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

VII. ADJOURNMENT 4:15 PM

16. Adjournment of the regular meeting on August 21, 2025 in memory of former Commissioner, Dean Page.

PROPOSED MOTIONS	
MOTION #1	Approve the Agenda Order as presented or revised.
MOTION #2	Approve the meeting minutes, as presented or revised.
MOTION #3	Approve the Ryan White Program Year 35 re-allocations, as presented or revised, and grant the Division of HIV and STD Programs (DHSP) the authority to adjust allocations by up to ten percent (10%) per service category, as needed —without returning to this body for additional approval.

MOTION #4	Approve the amendment to Policy #09.7201 to incorporate an à la carte model into the existing stipend structure and amount, as presented or revised.
MOTION #5	Approve recommendation to vacate the seat of Commissioner Aaron Raines due to excessive absenteeism and forward to the Board of Supervisors for vacate.
MOTION #6	Approve the Transitional Case Management service standards, as presented or revised, and forward to the full body at its October 9, 2025 meeting for final approval.

LOS ANGELES COUNTY
COMMISSION ON HIV

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

Approved by COH 6/8/23

CODE OF CONDUCT

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

All participants and stakeholders should adhere to the following:

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

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

Updated 1/7/25

Meeting Schedule

LOS ANGELES COUNTY COMMISSION ON HIV

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

January - December 2025

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

The Commission on HIV (COH) convenes several caucuses and other subgroups to harness broader community input in shaping the work of the Commission around priority setting, resource allocations, service standards, improving access to services, and strengthening PLWH voices in HIV community planning. **The following COH subgroups meet virtually unless otherwise announced.*

Aging Caucus	Black Caucus	Consumer Caucus	Transgender Caucus	Women's Caucus	Housing Taskforce
1PM-3PM	4PM-5PM	1-3PM	10AM-11:30AM	2PM-3PM	9AM-10AM
**2nd Tuesday every other month*	**3rd Thursday monthly*	**2nd Thursday monthly, following COH meeting*	**3rd Thursday quarterly*	**3rd Monday bi-monthly*	**4th Friday monthly*

LOS ANGELES COUNTY COMMISSION ON HIV

2025 MEMBERSHIP ROSTER| UPDATED 7.29.25

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

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

LOA: Leave of Absence

Overall total: 46

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 7/22/25

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
BURTON	**Alasdair**	No Affiliation	No Ryan White or prevention contracts
CAMPBELL	**Danielle**	T.H.E. Clinic, Inc.	Core HIV Medical Services - AOM; MCC & PSS
			Medical Transportation Services
CIELO	**Mikhaela**	Los Angeles General Hospital	No Ryan White or prevention contracts
CUEVAS	**Sandra**	Pacific AIDS Education and Training - Los Angeles	No Ryan White or prevention contracts
CUMMINGS	**Mary**	Bartz-Altadonna Community Health Center	No Ryan White or prevention contracts

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
GUTIERREZ	**Joaquin**	Unaffiliated representative	No Ryan White or prevention contracts
HARDY	**David**	University of Southern California	No Ryan White or prevention contracts
HERRERA	**Ismael "Ish"**	Unaffiliated representative	No Ryan White or prevention contracts
JONES	**Terrance**	Unaffiliated representative	No Ryan White or prevention contracts
KOCHEMS	**Lee**	Unaffiliated representative	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
LESTER (PP&A Member)	**Rob**	Men's Health Foundation	Core HIV Medical Services - AOM; MCC & PSS
			Biomedical HIV Prevention Services
			Vulnerable Poplulations (YMSM)
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			Medical Transportation Services
MARTINEZ (PP&A Member)	**Miguel**	Children's Hospital Los Angeles	Core HIV Medical Services - AOM; MCC & PSS
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			Biomedical HIV Prevention Services
			Medical Transportation Services
MARTINEZ-REAL	**Leonardo**	Unaffiliated representative	No Ryan White or prevention contracts
MAULTSBY	**Leon**	Charles R. Drew University	Core HIV Medical Services - PSS
			HTS - Storefront
			HTS - Social and 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
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
RAINES	**Aaron**	No Affiliation	No Ryan White or prevention contracts
RICHARDSON	**Dechelle**	No Affiliation	No Ryan White or prevention contracts
ROBINSON	**Erica**	Health Matters Clinic	No Ryan White or prevention contracts
RUSSEL	**Daryl**	Unaffiliated representative	No Ryan White or prevention contracts
SALAMANCA	**Ismael**	City of Long Beach	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
STALTER	**Kevin**	Unaffiliated representative	No Ryan White or prevention contracts
TALLEY	**Lambert**	Grace Center for Health & Healing	No Ryan White or prevention contracts
VALERO	**Justin**	No Affiliation	No Ryan White or prevention contracts
VEGA-MATOS	**Carlos**	Men's Health Foundation	Core HIV Medical Services - AOM; MCC & PSS
			Biomedical HIV Prevention Services
			Vulnerable Poplulations (YMSM)
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			Medical Transportation Services
WEEDMAN	**Jonathan**	ViaCare Community Health	Biomedical HIV Prevention
			Core HIV Medical Services - AOM & MCC
YBARRA	**Russell**	Capitol Drugs	No Ryan White or prevention contracts

Division of HIV and STDs Contracted Community Services

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

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

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

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

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

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

COMMISSION ON HIV OPERATIONAL BUDGET: COST ANALYSIS & JUSTIFICATIONS

FY 2025-26 (Ryan White Program Year 35 - March 1, 2025-February 28, 2026)

Proposal submitted on 8.7.25 and approved by DHSP on 8.20.25

S&EB	FY 2024-25 (PY 34) Approved Budget FTE	FY 2024-25 (PY 34) Approved Budget Annual Cost	FY 2025-26 @ 32.5% Reduction FTE	FY 2025-26 @ 32.5% Reduction Annual Cost	Comments/Justification/Legislative Function/Impact
					The Planning Council staff support assists with fulfilling these activities and tasks by providing for the hiring of staff or consultants. (HRSA HAB Part A Manual, 2025, Sec. III, Chapter 5). Staff duties reflect legislative functions for COH.
Executive Director	1.0	$ 213,296	0.0	$ -	
Assistant Director	1.0	$ 143,682	1.0	$ 147,667	Staff supervision, budget monitoring, PO/RQNs, process unaffiliated consumer stipends, handle IRS 700 filing; lead Executive Committee, full Commission, Con for Commissioners; complete annual assessment of the administrative mechanism. Write meeting minutes.
Health Program Analyst II	1.0	$ 102,802	1.0	$ 111,097	Lead staff for Standards and Best Practices Committee and Public Policy (which will sunset with new restructured body); develop service standards and best pr Caucus and Aging Caucus; assist in ongoing needs assessments; provide administrative support as needed. Write meeting minutes.
Health Program Analyst I	1.0	$ 107,735	1.0	$ 111,346	Lead staff for Planning, Priorities and Allocations Committee; carry out needs assessments; develop and monitor Comprehensive HIV Plan; manage annual pric A applications; write letters of concurrence; support Women's Caucus and Housing Task Force, provide administrative support as needed. Write meeting minu
Senior Board Specialist	1.0	$ 88,265	1.0	$ 89,930	Coordinate membership applications and approval process with Commission Services/Board of Supervisors; track members' attendance; maintain reflectivene
Subtotal Salaries		$ 655,780		$ 460,040	
Full-time employee benefits (58.03%)	0.58	$ 380,549		$ 256,932	*Diminishing staffing levels would hamper the capacity of the COH to perform its legislatively-mandated core functions and make it extremely challenging to u Staff serve as the backbone support and primary technical and programmatic infrastructure for the COH.
Sub-Total S&EB	**5.0**	**$ 1,036,329**	**4.0**	**$ 716,972**	
S&S - Ongoing					
Travel, Local		$3,000		$1,500	To support local transportation costs, i.e., public transportation, ride-sharing, and mileage reimbursement @ $0.70 per mile and parking fees to support unaffi
Travel, Out of Town		$14,778		$0	
Supplies, Office		$1,200		$1,200	To support COH operations and meetings, and includes UC member requests for supplies as allowable per RWP.
Supplies, IT		$1,330		$0	
Equipment/Lease Maintenance (Copy machine)		$5,508		$5,508	Multifunction Xerox Copier for COH operations.
Printing & Printing Supplies		$1,992		$1,992	To support printing costs for COH membership, administrative and/or needs assessments/listening sessions. Anticipated print projects include COH meeting m
Postage		$1,560		$0	
Office Space Lease: Vermont Corridor		$35,000		$20,000	Lease quote for the Vermont Corridor is $36,000. Staff will vacate 3 workstations by the end of August 2025 if full funding for $36K is not approved by DHSP. A ability to reserve conference rooms, resulting in higher cost for meeting room reservations.
Meeting Room Rental (Vermont Corridor)		$6,300		$1,550	Room rental @ Vermont Corridor: the cost of using the conference rooms for COH meetings is set by CBRE which is set at $300 which includes cleaning fees, cc
Meeting Room Rental St. Anne's)		$17,032		$12,451	Room rental at St. Anne's Conference Center: To support the need for an alternate meeting space due to the unavailability of Vermont Corridor conference roc standard white table linens, tables and chairs, maintenance for set-up/break down, food, parking and attendees x 2 meetings. The room rental quote provided
Meeting Room Rental (MLK Behavioral Ctr)		$3,199		$0	
Telecommunications		$11,752		$752	To support cellular phone costs/fees for COH staff. Landlines were disconnected as a cost-saving measure in 2021-2022.
Commissioner Incentives (Gift Cards)		$34,800		$10,000	requirements. Eligible Alternates may earn a $100.00 monthly stipend if they fulfill the stipend requirements. Alternates who fill a Commissioner's role and m
Commissioner Reimbursements		$10,000		$14,400	consumers. Funds will not fully support incentives for UCs and will likely lead to failure to meet the minimum 33% of UC representation required by the RW CA
Audio Visual		$24,000		$24,160	To secure vendor to provide monthly A/V support for Commission meetings. Estimate based on County Master Agreement for vendor, Rainbow Sound & Light
Premium SurveyMonkey Subscription		$3,600		$3,600	To maintain annual SurveyMonkey subscription as primary survey tool for Commission operations and planning activities. Based on invoice for annual renewal
Public Awareness & Promotion		$2,223		$0	
Translation & Interpretation Services		$5,272		$3,000	To support accommodation requests for language and ALS interpretation and translation services to meet the needs of our community to attend Commission-
Revolving Fund (Food-related)		$22,548		$10,000	To support the provision of meals during monthly COH and the Consumer Caucus (CC) meetings; an allowable RWP expense. Estimated costs are based on a qu
Assessment of Administrative Mechanism (AAM) Consultant		$50,000		$0	
Restructuring Facilitators/Effectiveness Review				$47,000	To support costs/fees associated with procuring a consultant to lead and facilitate the COH's organizational restructuring. Findings from HRSA administrative a
Professional Services/Consultants					Professional services to fill capacity gaps with reduced staffing to fulfill planning council functions.
Capacity Building & Leadership Training		$2,500		$0	
County Counsel Consultation		$6,306		$6,306	To support consultations, bylaws, and ordinance reviews from County Counsel.
Parliamentarian		$8,400		$0	
Sub-Total S&S Ongoing		**$ 272,300**		**$ 163,419**	
Indirect Costs (15%)	15%	$ 155,449		$ 107,546	
Total Budget		**$ 1,464,078**		**$ 987,937**	

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

FOR DISCUSSION /PLANNING PURPOSES ONLY
12.04.24; 12.30.24; 01.06.25; 2.19.25; 03.09.25; 03.24.25; 03.30.25; 4.19.25; 4.28.25; 7.23.25
June, August and September Cancellations approved by the Executive Committee on 4/24/25

- **Bylaws:** Section 5. Regular meetings. In accordance with Los Angeles County Code 3.29.060 (Meetings and committees), the Commission shall meet at least ten (10) times per year. Commission meetings are monthly, unless cancelled, at a time and place to be designated by the Co-Chairs or the Executive Committee. The Commission's Annual Meeting replaces one of the regularly scheduled monthly meetings during the fall of the calendar year.

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

~~5/8/25 @ St. Anne's Conference Center~~	• ~~Year 33 Utilization Report for RW Support Services Presentation (DHSP/Sona Oksuzyan, PhD, MD, MPH)~~ ~~(Move to PP&A 5/1/25 meeting)~~ • ~~Unmet Needs Presentation (DHSP/Sona Oksuzyan, PhD, MD, MPH)~~ ~~(Move to PP&A meeting, date TBD)~~ • ~~Approve 20% RWP funding scenario allocations~~ • ~~COH Restructuring Workgroups Report and Discussion~~ • ~~Housing Task Force Report of Housing and Legal Services Provider Consultations~~
~~6/12/25~~	• ~~CANCELLED~~
~~7/10/25 @ Vermont Corridor~~	• ~~COH Restructuring/Bylaws Updates~~ • ~~Medical Monitoring Project (Dr. Ekow Sey, DHSP) CONFIRMED~~ • ~~PURPOSE Study (Requested by Suzanne Molino, PharmD, Gilead Sciences, Inc.); CONFIRMED~~
8/14/25	**CANCELLED**
9/11/25	**CANCELLED**
10/9/25 @ Location TBD	Vote on Revised COH Bylaws
11/14/24 @ Location TBD	ANNUAL CONFERENCE
12/12/24 @ Location TBD	TBD

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

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

2025 Commission on HIV Annual Meeting

Proposed Outline | For Discussion Purposes Only | Executive Committee 6.26.25

Unity and Compassion in Time of Political Uncertainty

DRAFT

Updated 07.30.25

November 13, 2025 | 9am to 4pm

St. Anne's Conference & Event Center

155 N. Occidental Blvd., Los Angeles CA 90026

PROGRAM OUTLINE	
8:30am - 9:00am	Breakfast / Registration
9:00am - 9:20am	**Welcome and Opening Remarks by Co-Chairs**
9:20am – 10:20am	**Keynote: Los Angeles County State of HIV/STIs | Mario Perez, Director (or designee), Division of HIV and STD Programs, Los Angeles County Department of Public Health**
10:20am - 11:00am	**Commission on HIV Restructuring and Enhanced Performance and Impact** Co-Chair, Joseph Green and Danielle Campbell Next Level Consulting and Collaborative Research
11:00am-12:15pm	**Science for Activism and Change| Global and Local Efforts to End HIV** Possible Topics (moderated panel discussion?) • CRISPR Gene Therapy for HIV (global) • Mobile Enhanced Prevention Support (MEPS) (local, UCLA, Dr. Nina Harawa) • Autonomy and Health Outcomes of Black/African Americans at Risk for and Living with HIV (local, UCLA CFAR, Dr. LaShonda Spencer) • Translating HIV Scientific Breakthroughs into Care: A Local Primary Care Physician's Perspective (Dr. William King)
12:15pm-1:15pm	**LUNCH AND NETWORKING**
1:15pm – 2:15pm	**Panel Discussion: Impact of Censorship and Funding Cuts to HIV Research** **Possible speakers ??:**

	1. Rhodri Dierst-Davies, PhD, MPH, Director, CA HIV/AIDS Research Program 2. Steve Shoptaw, PhD, Center Director, Administrative Core, Center for HIV Identification, Prevention, and Treatment Services (CHIPTS), University of California Los Angeles (UCLA) 3. Jeffrey Klausner, MD, MPH, Clinical Professor of Medicine, Infectious Diseases, Population and Public Health Sciences, Klausner Research Group, University of Southern California (USC) Moderator: ??
2:15pm-2:45pm	**Galvanizing Effectiveness Strategies for Community Action and Policy Advocacy** NMAC? End the Epidemics Coalition, Ryan Cleary? Others?
2:45pm-3:15pm	**Community Call to Action** - Opportunity for participants to brainstorm/identify ideas for collective action using information from morning keynote speaker and panel discussion. **Moderator:** ???
3:15pm - 3:30pm	**Public Comments & Announcements**
3:30pm-3:45pm	**Closing, Evaluations and Recognitions**

LOS ANGELES COUNTY
COMMISSION ON HIV

Subordinate Working Units Meeting Decision-Making Tool

(July 2025)

For Caucuses, Task Forces & Work Groups – refer to Policy #08.1102 for a description of the role(s), structures and governing rules of the Commission's various types of subordinate committees and working groups.

This tool is designed to help leadership for subordinate working units to decide when to hold a meeting and why, ensuring that meetings are intentional, legally compliant, and aligned with strategic Commission goals.

The PURGE Test

Use the acronym PURGE to determine whether a meeting should be scheduled. *All five criteria must be met.*

Decision Criteria	Guiding Questions	Proceed with Meeting?
Purpose	Is there a clear purpose or deliverable (e.g., planning an event, responding to a directive, presenting to full Commission)?	☐ Yes, if deliverable is identified
Urgency	Is there a time-sensitive issue that must be addressed before the next scheduled Commission meeting?	☐ Yes, if time-sensitive and cannot be addressed elsewhere
Readiness	Are the necessary materials, leadership, facilitators, or information available to conduct a productive meeting? Is there confirmed leadership capacity, including commitment from at least two Commissioners in good standing to lead the subgroup?	☐ Yes, if ready
Goal Alignment	Does the topic support the goals of the Commission, integrated plan, or specific motion/request? Can an existing committee fulfill the function or task?	☐ Yes, if aligned
Engagement	Will there be sufficient participation or community input to inform a meaningful discussion? Consider time, date, competing/conflicting events, meeting format (hybrid/in person/virtual)	☐ Yes, if members/stakeholders are confirmed

If one or more PURGE criteria are not met, consider using an alternative format—such as email, workgroup, or leadership/staff facilitation—instead of holding a full meeting.

Subordinate Working Unit Leadership Meeting Summary

Thursday, August 14, 2025

Attendees: Co-Chairs of Caucuses, Task Forces, and Workgroups

Overview & Purpose

The meeting was well-attended by leadership from across the Commission's subordinate working units, including caucuses and task forces. Staff opened the session with a brief overview and refresher on the purpose of subordinate working units. As outlined in Commission policy #08.1102, these units serve as extensions of the Commission, helping to fulfill its planning responsibilities by elevating consumer voice, developing recommendations, and supporting work around priorities such as the PSRA process, service standards, recruitment and outreach, the Assessment of the Effectiveness of the Administrative Mechanism (AEAM), and overall HIV service delivery planning in Los Angeles County.

Brown Act Compliance

Staff informed participants that as part of the guidance from County Counsel in reviewing the proposed changes to the Commission's bylaws, Caucuses are currently out of compliance with the Ralph M. Brown Act due to their standing monthly meeting schedules. Under Commission policy and public meeting laws, only formal legislative bodies—like standing committees—can hold regularly scheduled meetings. All other subordinate units (such as Caucuses and Task Forces) must meet on an as-needed basis to avoid triggering Brown Act requirements.

To address the Brown Act compliance concerns, it was recommended that all future meetings be scheduled on an as-needed basis, from one meeting to the next, rather than following preset or recurring calendars. This approach aligns with the newly introduced PURGE tool, which helps determine whether a meeting is necessary based on specific criteria. Additionally, it was recommended that staff consult with County Counsel to explore any alternative options or structures that may support compliance while preserving the intent of the working groups.

Introduction of the PURGE Tool

To assist working units in determining when a meeting is warranted, staff introduced the PURGE tool, which outlines five key criteria that must be met before a meeting is scheduled:

P – Purpose: Is there a defined objective or deliverable?
U – Urgency: Is the issue time-sensitive and unable to wait?
R – Readiness: Are materials and participants prepared, including commitment from at least two Commissioners in good standing?
G – Goal Alignment: Does the topic support Commission mandates or planning priorities?
E – Engagement: Is there meaningful community or stakeholder participation expected?

The recommendation is that all future meetings meet all five criteria, and that this tool be used to determine and justify each scheduled meeting, helping avoid automatic, standing schedules that can lead to compliance issues.

Federal Guidance on DEI Language and Impact on Caucuses

Staff also shared updates from a recent meeting with the Commission's HRSA Project Officer, where it was conveyed that under HR-1 and new Executive Orders, language referencing race, gender identity, sexual orientation, and other DEI-related categories must be sanitized from official government documents and planning frameworks.

This directive impacts the structure and naming of existing Caucuses, particularly the Black Caucus and Transgender Caucus, which will need to be reimagined in a way that aligns with federal guidance.

Co-Chairs were asked to share this information with their respective working groups and gather input on creative ways to continue the work in a compliant format. Staff acknowledged that while the structure may change, the core purpose of the Caucuses which is to support and uplift the voices of priority populations—must remain central to Commission planning.

Staff also noted that HRSA will be providing additional guidance on how to continue reflecting and engaging priority populations in planning without conflicting with current federal mandates.

Capacity Constraints & Recommendations

Given the reduction in staff, looming additional budget cuts in PY 36, and the broader Commission restructure, staff emphasized the need for subordinate working units to reimagine their structure and activities. Working groups must align their work with both the current staffing capacity and the intent outlined in Policy #08.1102, which centers on planning, analysis, and supporting Commission

priorities—not simply meeting to plan or host events. Staff encouraged all working units to assess whether their current functions and meeting schedules are responsive to Commission-driven objectives and whether they are sustainable considering available resources. While there was support for increasing working unit independence, several members expressed concerns and cautioned against removing staff support entirely, noting the vital role staff play in ensuring consistency, coordination, and continuity across the Commission's work.

Proposal to Create a Client/Consumer Committee

One proposal raised during the discussion was to establish a formal Client/Consumer Committee that would function under the Brown Act and explicitly focus on ensuring consumer participation is embedded in all Commission planning processes. However, it was noted that if such a committee is formed, it would be subject to Brown Act requirements, including in-person meetings, quorum, and formal notice provisions.

As part of that recommendation, there was discussion about the potential to sunset the existing affinity-based Caucuses and instead create an umbrella structure that consolidates them while still carving out dedicated planning space for each priority population. Staff acknowledged that the safe space created by these Caucuses has been essential for many community members who do not feel comfortable at the main Commission table.

Next Steps

Participants agreed to bring this information back to their respective working groups to gather feedback and ideas from members. The discussion will continue at the upcoming Executive Committee meeting and in subsequent planning meetings.

Commission staff and leadership remain committed to working collaboratively to ensure that the voices of communities most impacted by HIV remain centered in all aspects of Commission planning, regardless of structural adjustments that may be required moving forward.

Attachments: 8.14.25 Meeting Packet

LOS ANGELES COUNTY
COMMISSION ON HIV

Commission on HIV Restructuring for Enhanced Performance and Increased Impact

June 26, 2025

COLLABORATIVE RESEARCH

NEXT-LEVEL CONSULTING

Issues Driving the Restructure

- ✓ HRSA site visit findings
- ✓ Changes in the field requiring additional stakeholders, capacity, and skill sets
- ✓ Concerns about meeting quorum
- ✓ Measure G implementation: review of commissions to determine continued relevancy and/or potential cost savings and efficiencies
- ✓ Strained resources, time, and competing priorities

- ✓ **Current composition is unsustainable and needs to evolve with the demands of the HIV epidemic**

Review of Steps Taken to Date

- ✓ Meeting with DHSP 12/24
- ✓ COH meeting 1/25
- ✓ COH meeting 2/25
- ✓ Discussion/focus groups 3/25
- ✓ Report based on findings
- ✓ Executive Committee Vote 5/25

DHSP & Community Feedback Lec Recommendations

DHSP Meeting & COH Meeting	RECOMMENDATION
1. Dramatically reduce the number of people on the Commission and focus only on RW responsibilities. If there is capacity and skill set, then expansion of roles may be considered.	• Reduce membership composition to 31-32, focusing on mandatory RW seats plus data/research expert • RW seats allows for representation of prevention experts to fulfil comprehensive HIV prevention and care planning
2. Establish regular sunset reviews of the Commission	• Incorporated in the ordinance and bylaws • Sunset reviews conducted by Commission Services/Executive Office
3. Reduce the frequency of meetings	• Meet 6 times during the year for the full planning council • Meet 6 times during the year for standing committees
4. Complete critical deliverables like PSRA and Integrated Plans.	• Standing committee structure options elevates PSRA and other core functions to COH level or Executive Committee level • Reduced standing committees, absorption of policy functions under Executive Committee • Focus caucus functions on enhanced community engagement under Community Membership and Engagement Committee
5. Member Skills and Representation of Priority Populations	• Term limits and membership rotation included in updated bylaws • With the new COH structure, all seats will be up for applications and selections in 2025

Focus Groups: Process & Conter

Focus Group Sessions

- 5 In-Person Sessions
- 2 Virtual Sessions
- 36

Two Components Discussed:

1. **Committee Structure:** Samples from other areas
2. **Membership Structure:** HRSA guidance document

Focus Group Results: Recommendations

Based on Participant Feedback

- Two Recommendations on Committee Structure
- Two Recommendations on Membership Structure

EXHIBIT A

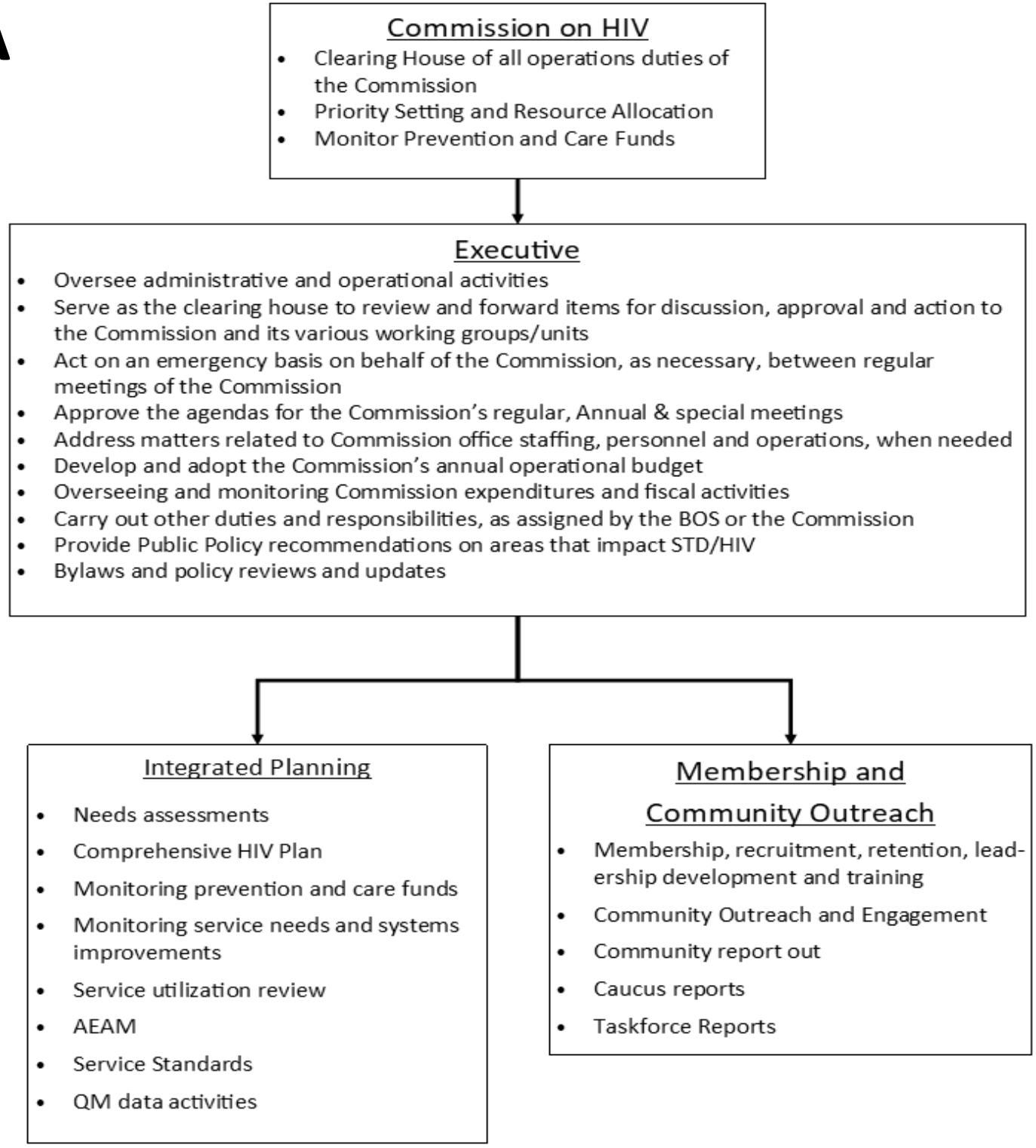
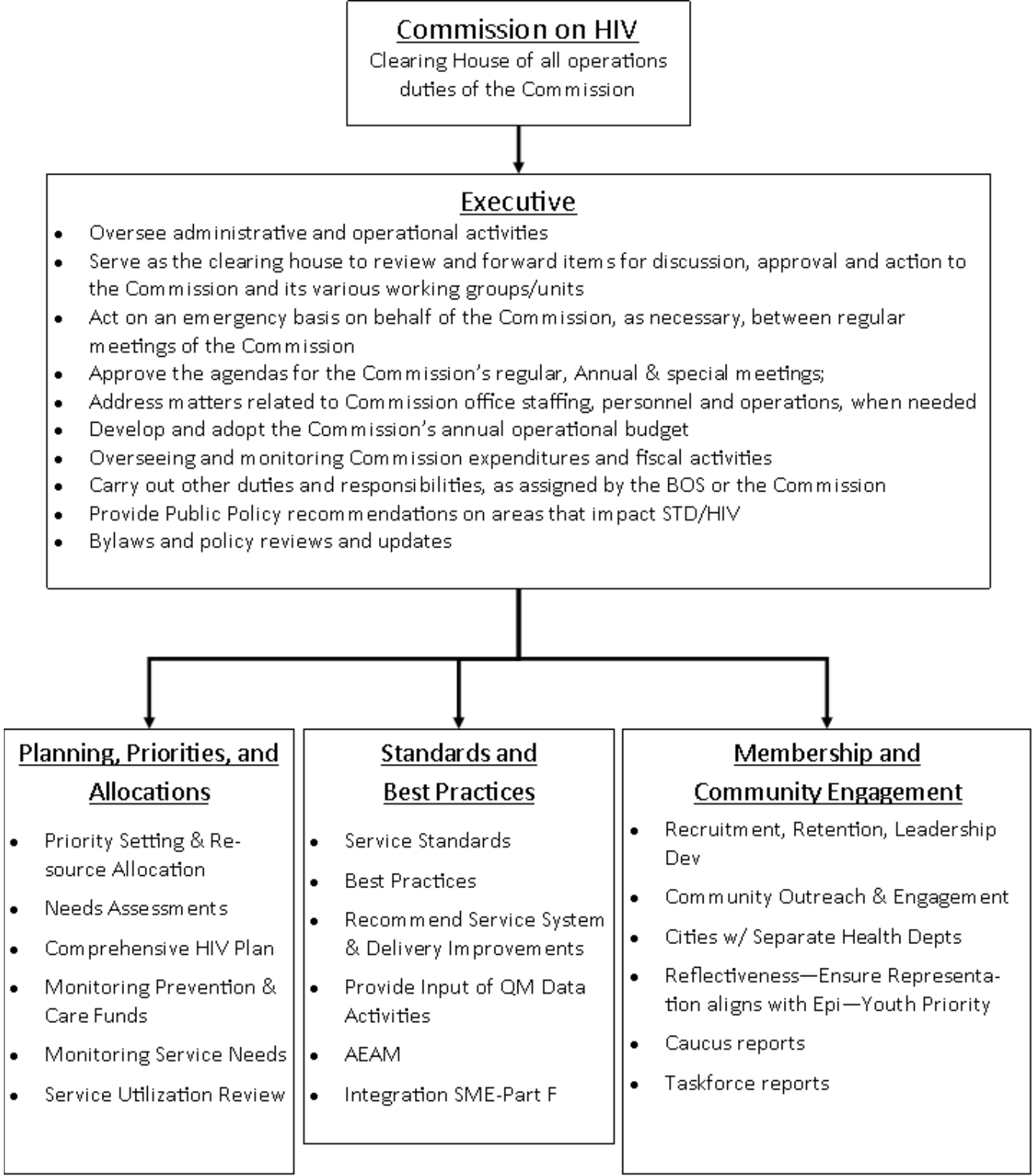
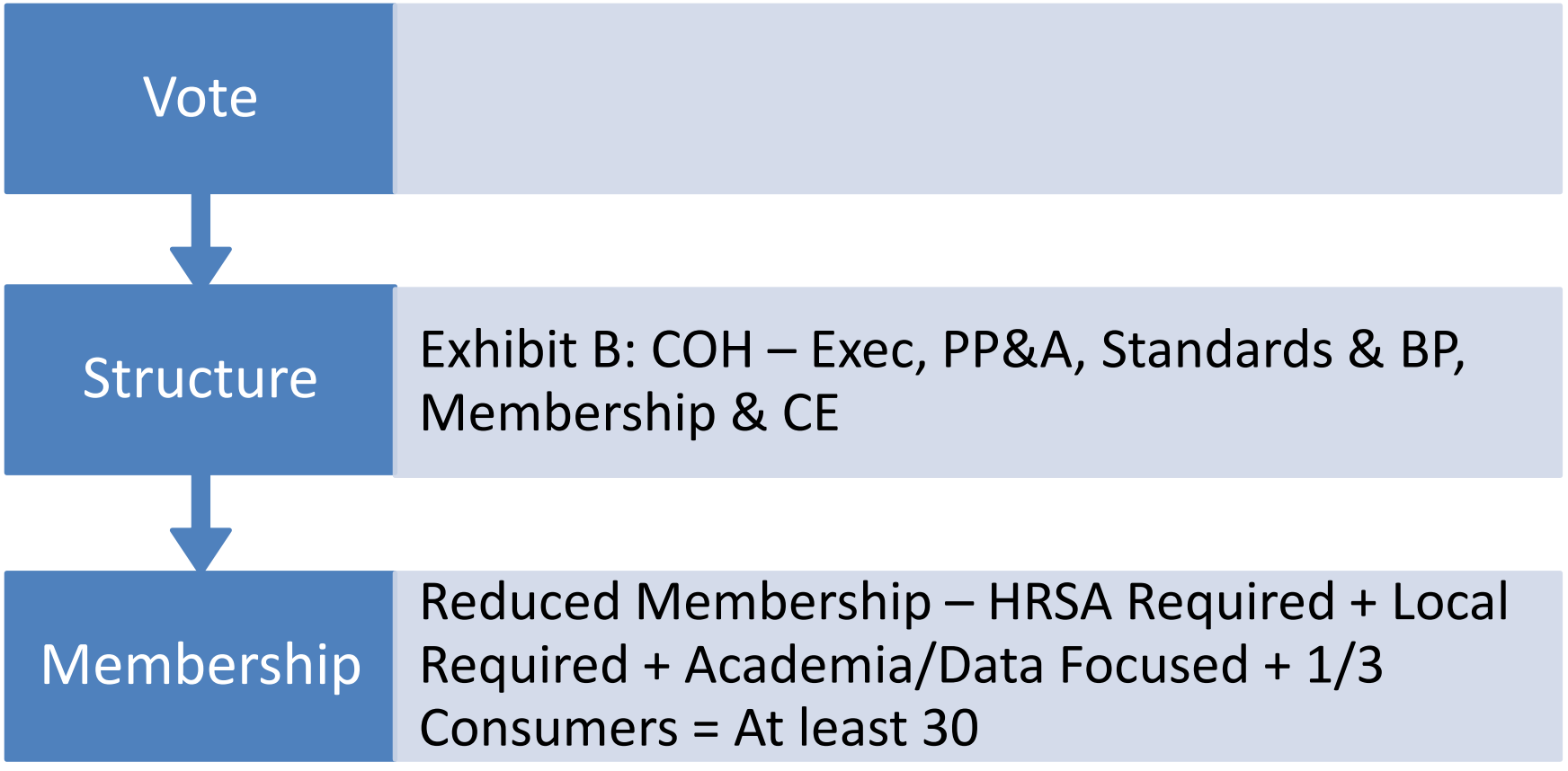

Commission on HIV
• Clearing House of all operations duties of the Commission
• Priority Setting and Resource Allocation
• Monitor Prevention and Care Funds
Executive
• Oversee administrative and operational activities
• Serve as the clearing house to review and forward items for discussion, approval and action to the Commission and its various working groups/units
• Act on an emergency basis on behalf of the Commission, as necessary, between regular meetings of the Commission
• Approve the agendas for the Commission's regular, Annual & special meetings
• Address matters related to Commission office staffing, personnel and operations, when needed
• Develop and adopt the Commission's annual operational budget
• Overseeing and monitoring Commission expenditures and fiscal activities
• Carry out other duties and responsibilities, as assigned by the BOS or the Commission
• Provide Public Policy recommendations on areas that impact STD/HIV
• Bylaws and policy reviews and updates
Integrated Planning
• Needs assessments
• Comprehensive HIV Plan
• Monitoring prevention and care funds
• Monitoring service needs and systems improvements
• Service utilization review
• AEAM
• Service Standards
• QM data activities
Membership and Community Outreach
• Membership, recruitment, retention, leadership development and training
• Community Outreach and Engagement
• Community report out
• Caucus reports
• Taskforce Reports

EXHIBIT B


Commission on HIV
Clearing House of all operations duties of the Commission
Executive
Oversee administrative and operational activities
Serve as the clearing house to review and forward items for discussion, approval and action to the Commission and its various working groups/units
Act on an emergency basis on behalf of the Commission, as necessary, between regular meetings of the Commission
Approve the agendas for the Commission's regular, Annual & special meetings;
Address matters related to Commission office staffing, personnel and operations, when needed
Develop and adopt the Commission's annual operational budget
Overseeing and monitoring Commission expenditures and fiscal activities
Carry out other duties and responsibilities, as assigned by the BOS or the Commission
Provide Public Policy recommendations on areas that impact STD/HIV
Bylaws and policy reviews and updates
Planning, Priorities, and Allocations
Priority Setting & Resource Allocation
Needs Assessments
Comprehensive HIV Plan
Monitoring Prevention & Care Funds
Monitoring Service Needs
Service Utilization Review
Standards and Best Practices
Service Standards
Best Practices
Recommend Service System & Delivery Improvements
Provide Input of QM Data Activities
AEAM
Integration SME-Part F
Membership and Community Engagement
Recruitment, Retention, Leadership Dev
Community Outreach & Engagement
Cities w/ Separate Health Depts
Reflectiveness—Ensure Representation aligns with Epi—Youth Priority
Caucus reports
Taskforce reports

COH RESTRUCTURE STRAW P



Bylaw Revisions to Reflect Vote Outcomes

- Review document

WORKGROUP OUTCOMES

LOS ANGELES COMMISSION ON HIV COMPREHENSIVE EFFECTIVENESS REVIEW AND RESTRUCTURING PROJECT

MARCH 19-21, 2025

COLLABORATIVE RESEARCH

LOS ANGELES COUNTY COMMISSION ON HIV

NL NEXT-LEVEL CONSULTING

Commission on HIV – Workgroup Report: Restructuring

Introduction

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

Directive and Overview

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

Overarching Themes and Considerations

The workgroups identified several key themes and considerations for restructuring:

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

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

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

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

Committee Restructuring Discussion

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

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

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

Membership Restructuring Discussion

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

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

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

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

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

Conclusion

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

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

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

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

*Two Virtual Listening sessions were conducted after the in-person focus group meetings to ensure all Commissioners and Community Partners could provide input. This input was incorporated into the report without any significant changes from the in-person meetings.

Exhibit A

Restructure Recommendation 1

Commission of HIV

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

Executive Committee

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

Integrated Planning

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

Membership and Community Outreach

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

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

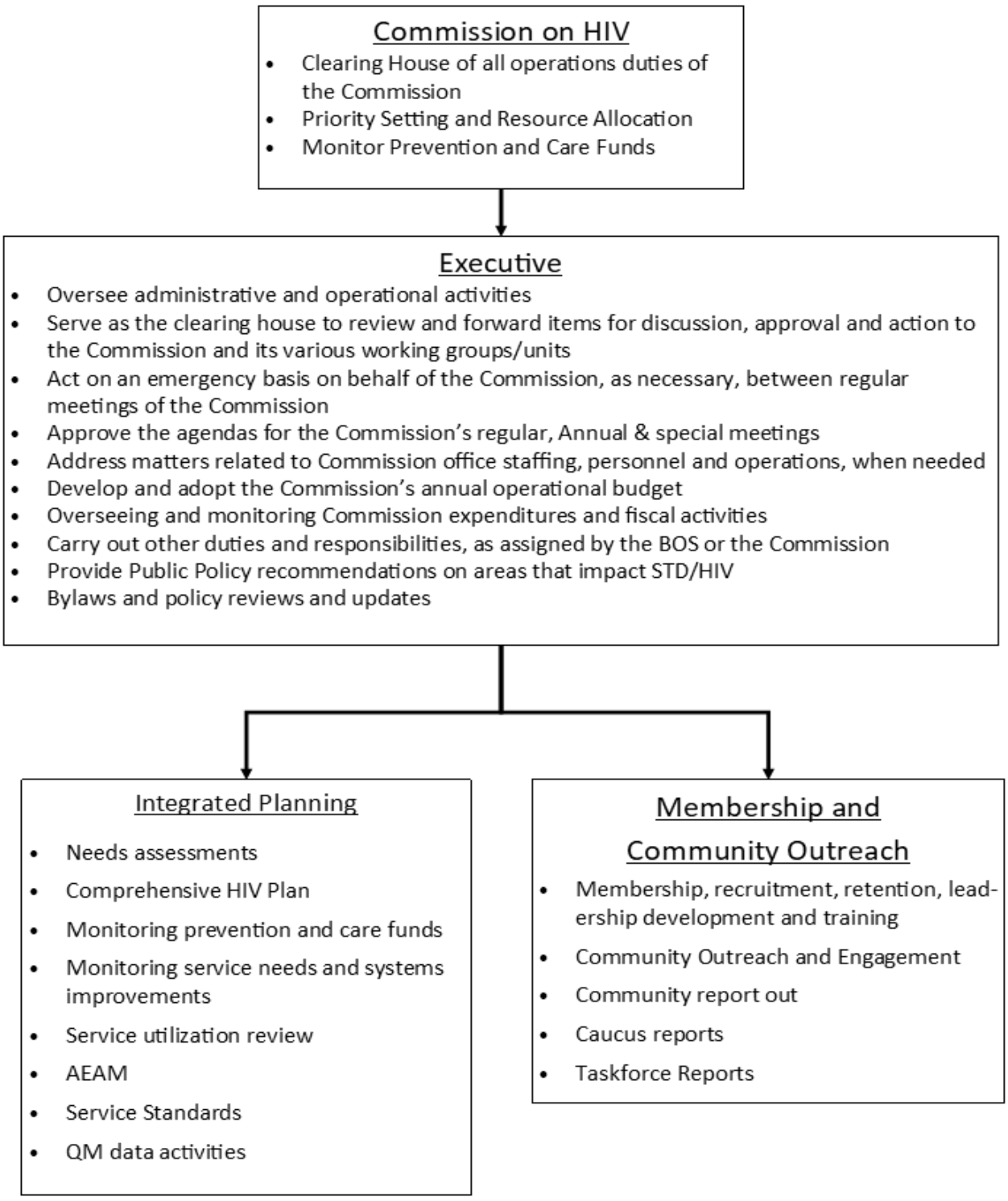


Figure 1 Exhibit A - Frequency is 6 times a year with P&R in a shorter timeframe closer together for the full Commission. Half-day planning session resulting in two separate days with one day priority ranking and one day allocation setting.

Exhibit B

Restructure Recommendation 2

Commission of HIV

- Clearing House of all operations duties of the Commission

Executive Committee

- Oversee administrative and operational activities
- Serve as the clearing house to review and forward items for discussion, approval and action to the Commission and its various working groups/units
- Act on an emergency basis on behalf of the Commission, as necessary, between regular meetings of the Commission;
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- Carry out other duties and responsibilities, as assigned by the BOS or the Commission.
- Provide Public Policy recommendations on areas that impact STD/HIV
- Bylaws and policy reviews and updates

Planning, Priorities and Allocations

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

Standards and Best Practices

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

Membership and Community Outreach

- Membership, recruitment, retention, leadership development and training
- Community Outreach and Engagement _Ensure Reflection of Epidemic - Youth
- City reports
- Caucus reports
- Taskforce Reports

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

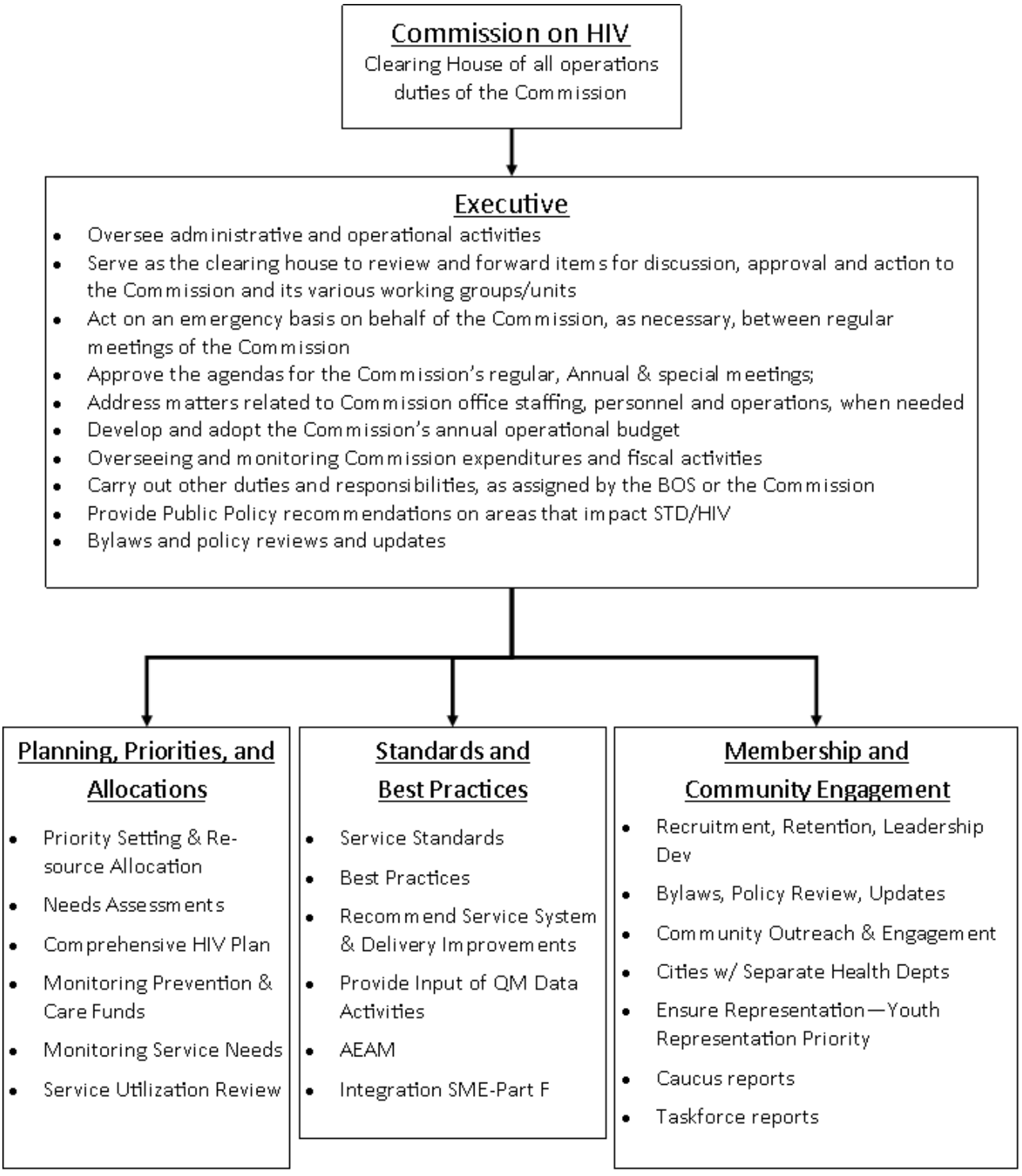

Figure 2 Exhibit B - All committees are to meet 6 times a year. Work PSRA into a multi-day longer session in the summer months, before the application is due, usually before August.

Commission on HIV Restructuring | DHSP & Community Feedback Checklist

DHSP (12/17/24 Meeting & Feb. 2025 COH Meeting)	RECOMMENDATION
1. Dramatically reduce the number of people on the Commission and focus only on RW responsibilities. If there is capacity and skills set, then expansion of roles may be considered.	• Reduce membership composition to 31-32, focusing on mandatory RW seats plus data/research expert • RW seats allows for representation of prevention experts to fulfil comprehensive HIV prevention and care planning
2. Establish regular sunset reviews of the Commission	• Incorporated in the ordinance and bylaws • Sunset reviews conducted by Commission Services/Executive Office
3. Reduce frequency of meetings	• Meet 6 times during the year for the full planning council • Meet 6 times during the year for standing committees
4. Complete critical deliverables like PSRA and Integrated Plans.	• Standing committee structure options elevates PSRA and other core functions to COH level or Executive Committee level • Reduced standing committees, absorption of policy functions under Executive Committee • Focus caucus functions on enhanced community engagement under Community Membership and Engagement Committee
5. Member Skills and Representation of Priority Populations	• Term limits and membership rotation included in updated bylaws • With the new COH structure, all seats will be up for applications and selections in 2025

2025 COMMISSION ON HIV WORKPLAN
Ongoing 12-26-24

#	DUTY/ROLE	LEAD (S)	NOTES/TIMELINE
1	Conduct ongoing needs assessments	PP&A Shared task with DHSP	• Review, analyze and hold data presentations (Feb-August COH meetings)
2	Integrated/Comprehensive Planning Comprehensive HIV Plan Development	PP&A Shared task with DHSP	• Review CDC/HRSA guidance • Develop project timeline based on CDC/HRSA guidance • CHP Due June 2026 • Plan dedicated status-neutral and/or prevention-focused planning summit in collaboration with DHSP.
3	Priority setting	PP&A	• July-September
4	Resource allocations/reallocations	PP&A	• July-September • Receive and review expenditure data – quarterly
5	Directives	PP&A	• Complete by February 2025; secure COH approval by March 2025
6	Development of service standards	SBP Shared task with DHSP	• Housing services • Transitional case management
7	Assessment of the Efficiency of the Administrative Mechanism	Operations	• PY 33 & PY 34 AEAM recipient and subrecipient surveys will be disseminated in January/February 2025. Reports completed by April 2025
8	Planning Council Operations and Support	Operations	• Membership training • Membership recruitment and retention • Fill vacancies • Mentorship program • Bylaws and policies update

9	Complete restructuring framework and key principles and align with bylaws/ordinance updates.	Executive and Operations	• January- April 2025
10	MOU with DHSP	Co-Chairs and Executive Committee	• Complete by March 2025 (awaiting DHSP feedback)
11	Ongoing community engagement and non-member involvement of PLWH	Consumer Caucus and Operations	

Engage all caucuses, committees and subgroups in all functions.

LOS ANGELES COUNTY COMMISSION ON HIV | PUBLIC COMMENTS RECEIVED ON PROPOSED CHANGES TO THE BYLAWS |
Public comment period: June 27, 2025 – July 27, 2025

#	Date Received	Name	Comments	Notes	Executive Committee Decision
1	6/29/25	Daryl Russell	Can the stipend portions always suggest a cost of living increase every two years to the stipend at least 10 percent?	Stipends for unaffiliated consumers is addressed in the ordinance. Stipends are not salaries and not subject to COLAs. For reference, Social Security COLA is 2.5% for 2024. RWHAP Part A funds cannot be used to provide cash payments such as stipends or honoraria. (HRSA HAB RWAP Part A Manual, pg. 30) Where direct	

				provision of the service is not possible or effective, store gift cards,2 vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used. (PCN 16-02)	
2	6/29/25	Daryl Russell	Where it speaks to stipends can it also say to increase unaffiliated consumers stipend to 500.00?	Stipends for unaffiliated consumers is addressed in the ordinance. Ordinance language, pending BOS approval: "*The Commission shall establish, and the Executive Director shall implement, procedures governing eligibility and utilization of reimbursements, member services,*	

				and/or stipends. Stipend amounts shall be up to, but not exceed, $500 per month, and are subject to the availability of funding as determined by the Executive Director, in accordance with Commission policy and as reported to the Board."	
3	7/7/25	Daryl Russell	I would like to suggest that the bylaws also state that the PP&A committee under the new structure have no more than 20% of those who have Ryan White and HIV prevention contracts from DHSP as committee members. Reason: This is a conflict of interest for those who receive funding from DHSP and will allow certain ones to be more reflected of the suggestion of DHSP and not the charge of the commission which is to have and reflect the interest of those living with HIV	Current COH practice is "no more than 2 people from same agency" may serve on the COH or a Committee. PSRA policy approved 7/11/24, states: *"B. Conflicts of interest are stated and followed. Commission members must state areas of conflict according to the approved*	

				Conflict of Interest Policy at the beginning of meetings. As stated in the RWHAP Part A Manual, X. Ch 8. Conflict of Interest, p. 147, Conflict of Interest can be defined as an actual or perceived interest by the member in an action that results or has the appearance of resulting in a personal, organizational, or professional gain. The definition may cover both the member and a close relative, such as a spouse, domestic partner, sibling, parent, or child. This actual or perceived bias in the decision-making process is based on the dual	

				role played by a planning council member who is affiliated with other organizations as an employee, a board member, a member, a consultant, or in some other capacity. Any funded RWHAP Part A provider must declare all funded service categories (e.g., areas of conflict of interest) at the beginning of the meeting(s). They can participate in discussions, answer questions directed by other members, and can vote on priorities and allocations presented as a slate."	
4	7/8/25	Daryl Russell	In the bylaws, it should state that the need for Caucuses as part of the Commission is a driven force that is needed because they offer ongoing insight as to what is need in the community from those who are living with	Covered in the bylaws with additional information	

			HIV. Reason: it helps the commission have ongoing need assessments and stay informed about the HIV population as whole and keep population within the HIV community. Those who receive DHSP and Prevention contracts on the PP& A committee shall not have any voting rights, only those who do not receive contracts from DHSP and Prevention shall have voting rights. Reason: It is a conflict of interest to vote on your funding source or any issues around your funding source suggestions.	covered under Policy 08.1102 Subordinate Commission Working Units: "*Caucus(es): The Commission establishes caucuses, as needed, to provide a forum for Commission members of designated "special populations" to discuss their Commission-related experiences and to strengthen that population's voice in Commission deliberations."* See Conflicts of Interest policy in #4.	
5	7/8/25	Daryl Russell	All members that receive DHSP and Prevention contracts or subcontracts having no vote rights in any COH voting items	See Conflicts of Interest policy in #4.	
6	7/10/25	Daryl Russell	I submitted a comment asking that 500-dollar stipend be	Current revised	

			stated in the bylaws all I also would like to also ask that the requires be a three-meeting attendance and no sliding scale be implemented.	policy: unaffiliated consumer members may receive $50 per eligible meeting attended—including the Commission meeting, your assigned Committee meeting, and the Consumer Caucus meeting (up to $150 per month).	
7	7/14/25	Emily Issa (County Counsel)	Make the membership number 33 (odd number) to avoid ties with votes.	Proposed bylaws show total voting membership at 32.	

LOS ANGELES COUNTY
COMMISSION ON HIV

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HIVCOMM@LACHIV.ORG • https://hiv.lacounty.gov

GUIDING QUESTIONS FOR PUBLIC COMMENTS ON THE PROPOSED CHANGES TO THE COMMISSION ON HIV BYLAWS

Background:

The Los Angeles County Commission on HIV (COH) invites public comments on the proposed changes to its bylaws to align with Health Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program Planning Council and Planning Body Requirements and Expectations letter, rectify areas of improvement and findings identified during the 2023 HRSA administrative site visit, and clarify certain sections.

For reference, the current COH bylaws is available HERE.

Please email public comments to: HIVCOMM@LACHIV.ORG

The public comment period: June 27, 2025 – July 27, 2025

When providing public comments, consider responding to the following:

1. Are there sections in the document that are confusing or unclear? Please provide specific suggestions to clarify or improve language in the proposed bylaws revisions.

2. Do you believe the COH, as defined in the proposed bylaws, is fulfilling its intended role? Why or why not? What changes in the bylaws and overall structure of the body do you suggest?

3. Provide any additional comments/recommendations not discussed above.

Thank you for your feedback.

LOS ANGELES COUNTY COMMISSION ON HIV (COH)

SUMMARY OF KEY PROPOSED BYLAWS CHANGES CHANGES

JUNE 27, 2025

LOS ANGELES COUNTY
COMMISSION ON HIV

BACKGROUND

- To align with Health Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program Planning Council and Planning Body Requirements and Expectations letter, rectify areas of improvement and findings identified during the 2023 HRSA administrative site visit, and clarify certain sections.
- The Commission on HIV (COH) discussed restructuring at standing meetings and various workshops with Commissioners and community members from January 2025 to March 2025.
- Feedback from the community was incorporated into the draft bylaws.
- The COH Effectiveness Review and Restructuring Report contains feedback from the community. Report is available HERE.
- On June 26, 2025, the COH Executive Committee reviewed the proposed changes to the bylaws and approved a public comment period to elicit feedback from the community-at-large

LOS ANGELES COUNTY
COMMISSION ON HIV

PROPOSED KEY CHANGES

Composition:

a. Change DHSP (Recipient/Part A Grantee) as non-voting member; does not count towards quorum (full Commission and DHSP staff assigned to standing Committees).
b. 32 voting members, focusing on the required seats under the Ryan White Care Act.

Term of Office (Commissioners and Alternates) :

a. 2-year staggered terms.
b. Members are limited to three consecutive terms and are eligible to reapply following a one-year break in service.

Committees:

- Reduce the number of standing committees from 5 to 4
- A more external community engagement role for the Operations Committee.
- Operations Committee name change to Membership and Community Engagement Committee
- Absorb policy and other functions into the Executive Committee or the Standards and Best Practices Committee.

PROPOSED KEY CHANGES

DHSP Role and Responsibility: "Section 12. DHSP Role & Responsibility. DHSP, despite being a non-voting member, plays a pivotal role in the Commission's work. As the RWHAP Grantee and Part A representative for the Los Angeles County EMA, DHSP provides essential epidemiological and surveillance data to guide the Commission's decision-making. DHSP plays a central role in carrying out needs assessments, conducting comprehensive planning, overseeing contracting and procurement of providers, evaluating service effectiveness, and performing quality management. Collaborating closely with DHSP, the Commission ensures effective coordination and implementation of its integrated comprehensive HIV plan. The Commission heavily relies on this partnership to ensure the optimal use of RWHAP funds and adherence to legislative and regulatory requirements, ensuring the highest standard of HIV services in Los Angeles County."

LOS ANGELES COUNTY
COMMISSION ON HIV

PROPOSED KEY CHANGES

Conflict of Interest (COI): Further, in accordance with HRSA guidance, Commission Policy #08.3108: Ryan White Conflict of Interest Requirements, dictates that all members must declare conflicts of interest involving RWHAP-funded agencies and their services, and the member is required to recuse themselves from discussion ***and/or voting*** concerning that area of conflict, or funding for those services and/or to those agencies.

Code of Conduct:

a. Applies to Commissioners and members of the public
b. Included reference to Intra-Commission Grievance and Sanctions Procedures

PUBLIC COMMENT PERIOD AND INSTRUCTIONS

- Public Comment period: June 27, 2025-July 27, 2025
- For reference, the current COH bylaws is available HERE.
- Email public comments to: HIVCOMM@LACHIV.ORG

When providing public comments, consider responding to the following:

1. Are there sections in the document that are confusing or unclear? Please provide specific suggestions to clarify or improve language in the proposed bylaws revisions.

1. Do you believe the COH, as defined in the proposed bylaws, is fulfilling its intended role? Why or why not? What changes in the bylaws and overall structure of the body do you suggest?

1. Provide any additional comments/recommendations not discussed above.

LOS ANGELES COUNTY
COMMISSION ON HIV

LOS ANGELES COUNTY COMMISSION ON HIV

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

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

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

BACKGROUND:

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

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

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

POLICY:

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

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

ARTICLES:

I. NAME AND LEGAL AUTHORITY:

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

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

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

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

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

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

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

services to individuals with HIV/AIDS; and

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

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

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

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

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

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

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

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

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

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

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

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

II. MEMBERS:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

from areas with high HIV and STD incidence and prevalence.

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

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

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

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

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

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

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

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

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

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

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

III. MEMBER REQUIREMENTS:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IV. NOMINATION PROCESS:

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

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

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

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

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

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

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

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

V. MEETINGS:

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

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

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

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

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

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

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

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

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

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

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

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

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

VI. RESOURCES:

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

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

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

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

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

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

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

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

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

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

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

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

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

VII. POLICIES AND PROCEDURES:

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

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

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

be amended from time to time, as needed.

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

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

VIII. LEADERSHIP:

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

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

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

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

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

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

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

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

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

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

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

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

IX. COMMISSION WORK STRUCTURES:

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

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

Commission.

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

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

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

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

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

X. EXECUTIVE COMMITTEE:

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

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

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

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

County's adopted legislative agendas.

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

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

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

W. Overseeing and monitoring Commission expenditures and fiscal activities.

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

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

XI. MEMBERSHIP AND COMMUNITY ENGAGEMENT COMMITTEE:

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

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

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

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

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

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

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

(job descriptions).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

XII. STANDARDS AND BEST PRACTICES (SBP) COMMITTEE:

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

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

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

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

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

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

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

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

G. Identifying and recommending solutions for service gaps.

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

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

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

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

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

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

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

XV. OFFICIAL COMMUNICATIONS AND REPRESENTATIONS:

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

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

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

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

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

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

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

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

LOS ANGELES COUNTY COMMISSION ON HIV | PUBLIC COMMENTS RECEIVED ON PROPOSED CHANGES TO THE BYLAWS |
Public comment period: June 27, 2025 – July 27, 2025

#	Date Received	Name	Comments	Notes	Executive Committee Decision
1	6/29/25	Daryl Russell	Can the stipend portions always suggest a cost of living increase every two years to the stipend at least 10 percent?	Stipends for unaffiliated consumers is addressed in the ordinance. Stipends are not salaries and not subject to COLAs. For reference, Social Security COLA is 2.5% for 2024. RWHAP Part A funds cannot be used to provide cash payments such as stipends or honoraria. (HRSA HAB RWAP Part A Manual, pg. 30) Where direct provision of the service is not possible or effective, store gift cards,2 vouchers, coupons, or tickets that can be exchanged for a specific	

				service or commodity (e.g., food or transportation) must be used. (PCN 16-02)	
2	6/29/25	Daryl Russell	Where it speaks to stipends can it also say to increase unaffiliated consumers stipend to 500.00?	Stipends for unaffiliated consumers is addressed in the ordinance. Ordinance language, pending BOS approval: "*The Commission shall establish, and the Executive Director shall implement, procedures governing eligibility and utilization of reimbursements, member services, and/or stipends. Stipend amounts shall be up to, but not exceed, $500 per month, and are subject to the availability of funding as determined by the Executive Director, in accordance with Commission policy and as reported to the Board."*	
3	7/7/25	Daryl Russell	I would like to suggest that the bylaws also state that the PP&A committee under the new structure have no more than 20% of those who have Ryan White and HIV prevention contracts from DHSP as	Current COH practice is "no more than 2 people from same agency" may serve on the COH or a	

			committee members. Reason: This is a conflict of interest for those who receive funding from DHSP and will allow certain ones to be more reflected of the suggestion of DHSP and not the charge of the commission which is to have and reflect the interest of those living with HIV	Committee. PSRA policy approved 7/11/24, states: *"B. Conflicts of interest are stated and followed. Commission members must state areas of conflict according to the approved Conflict of Interest Policy at the beginning of meetings. As stated in the RWHAP Part A Manual, X. Ch 8. Conflict of Interest, p. 147, Conflict of Interest can be defined as an actual or perceived interest by the member in an action that results or has the appearance of resulting in a personal, organizational, or professional gain. The definition may cover both the member and a close relative, such as a spouse, domestic partner, sibling, parent, or child. This actual or perceived bias in the decision-making process*	

				is based on the dual role played by a planning council member who is affiliated with other organizations as an employee, a board member, a member, a consultant, or in some other capacity. Any funded RWHAP Part A provider must declare all funded service categories (e.g., areas of conflict of interest) at the beginning of the meeting(s). They can participate in discussions, answer questions directed by other members, and can vote on priorities and allocations presented as a slate."	
4	7/8/25	Daryl Russell	In the bylaws, it should state that the need for Caucuses as part of the Commission is a driven force that is needed because they offer ongoing insight as to what is need in the community from those who are living with HIV. Reason: it helps the commission have ongoing need assessments and stay informed about the HIV population as whole and keep population within the HIV community.	Covered in the bylaws with additional information covered under Policy 08.1102 Subordinate Commission Working Units: "*Caucus(es): The Commission establishes caucuses, as needed, to provide a forum for*	

			Those who receive DHSP and Prevention contracts on the PP& A committee shall not have any voting rights, only those who do not receive contracts from DHSP and Prevention shall have voting rights. Reason: It is a conflict of interest to vote on your funding source or any issues around your funding source suggestions.	*Commission members of designated "special populations" to discuss their Commission-related experiences and to strengthen that population's voice in Commission deliberations."* See Conflicts of Interest policy in #4.	
5	7/8/25	Daryl Russell	All members that receive DHSP and Prevention contracts or subcontracts having no vote rights in any COH voting items	See Conflicts of Interest policy in #4.	
6	7/10/25	Daryl Russell	I submitted a comment asking that 500-dollar stipend be stated in the bylaws all I also would like to also ask that the requires be a three-meeting attendance and no sliding scale be implemented.	Current revised policy: unaffiliated consumer members may receive $50 per eligible meeting attended—including the Commission meeting, your assigned Committee meeting, and the Consumer Caucus meeting (up to $150 per month).	
7	7/14/25	Emily Issa (County Counsel)	Make the membership number 33 (odd number) to avoid ties with votes.	Proposed bylaws show total voting membership at 32. Recommend changing to 33/odd number.	

8	7/25/25	DHSP	1. Given the uncertainty of HRSA Part F, I recommend removing them from the membership list. Maybe they can be a non-voting member or Priorities and Allocation committee member. 2. One recommendation is to have the HRSA Part A legislatively required seats (15 currently), 2 PC co-chairs, and required 33% unaffiliated consumers comprise the voting membership. Additional seats such as academic, dental service representative, etc. can be included as non-voting participants. 3. One jurisdiction wrote into their bylaws that a maximum of 1/3 of the voting members can be a subrecipient employee or board member. 4. Given the fiscal situation, I recommend to change the meeting frequency language to at least four times a year. You can have more meetings if necessary. 5. Recommend to include language that indicates meetings will be held virtually or in different locations across the County based on epicenters of disease, and will be held in the late afternoon or evenings to foster inclusiveness/representativeness and increase access and participation.	The COH must comply with the Brown Act and cannot have exclusively virtual meetings for the full COH and standing committees. Consider additional costs for renting venues in late afternoons or evenings.	
9	7/25/25	DHSP	Only 13 HRSA Required Seats. Recommend to further reduce number of voting members	Per HRSA Part A Manual 2025 version, the State Medicaid and Part B representatives	

				are *"[considered two separate categories.]*	
10	7/25/25	DHSP	Would be helpful to know what will happen to the workgroups and taskforce and caucuses	Article IX, Section 6. Other Working Units. The Commission and its committees may create other working units such as subcommittees, ad-hoc committees, caucuses, task forces, or work groups, as they deem necessary and appropriate. Meeting with current Caucuses and task force co-chairs will be held on 8/14/25 to Walk through some of the legal considerations around standing meetings and determine a more intentional and streamlined meeting schedule moving forward.	
11	7/25/25	DHSP	Under Conflict of Interest: Employees and board members of subrecipient agencies can provide information and participate in the discussion. They cannot make a recommendation for allocation or vote on the service category of conflict.	HRSA 2023 Site Visit Finding Excerpt: "*Based on the review of*	

				the meeting minutes for the commission and its Planning, Priority and Allocations Committee, it is evident that several of these commissioners ***participated in allocations/reallocation discussions and voted on allocations including for the service categories for which their agencies are funded,*** *most recently in June 2022 on a revised FY 2023 RWHAP Part A funding allocation. Citation: Section 2602(b)(5)(C) of the PHS Act"*	
12	7/25/25	DHSP	Under "Background", first bullet: Also reference the August 2023 HRSA letter		
13	7/25/25	DHSP	Under Article I, Section 4: Item D and I are similar. I would keep I and delete item D. Refers to the comprehensive HIV plan.		
14	7/25/25	DHSP	Under Article I, Section 4, k; delete "B and CDC prevention." Establish priorities and allocations of RWHAP Part A ~~and B and CDC prevention~~ funding in percentage and/or dollar amounts to various services;,,,,"		
15	7/25/25	DHSP	Under Article I, Section 4, m: Not a HRSA RWP Part		

			A PC requirement. Refers to “Plan and develop HIV and public health services responses to address the frequency of HIV infection concurrent with STDs and other co-morbidities; plan the deployment of those best practices and innovative models in the County’s STD clinics and related health centers; and strategize mechanisms for adapting those models to non-HIV-specific platforms for an expanded STD and co-morbidity response.”		
16	7/25/25	DHSP	Under Article I, Section 4, q, r: Delete q and r. q. Act as the planning body for all HIV programs in DPH or funded by the County; and r. Make recommendations to the BOS, DHSP, and other departments concerning the allocation and expenditure of funding other than RWHAP Part A, B and CDC prevention funds expended by DHP and the County		
17	7/25/25	DHSP	Under Article I, Section 5: delete “RWHAP”. Section 5. Federal and Local Compliance: These Bylaws ensure that the Commission meets all ~~RWHAP~~, HRSA, and CDC requirements and adheres to Chapter 29 of the Los Angeles County Code.		
18	7/25/25	DHSP	Under Article II, Section 2 Composition: 32 members. Recommend to further reduce the number of voting members. There are 15 HRSA RWP Part A required seats, 2 co-chairs, and 33% UA.	Ask County Counsel if Board representatives can be eliminated.	
19	7/25/25	DHSP	Under Article II, Section 2b: (at least 11 unaffiliated consumers). Reduced number of PC members will decrease this number.		
20	7/25/25	DHSP	Under Article II, Section 2, C: Change to non-voting		

			member. C. One representative from a local academic institution with subject matter expertise in HIV research and data translation.		
21	7/25/25	DHSP	Under Article II, Section 11, DHSP Role and Responsibility. Deletions and additions. DHSP, despite being a non-voting representative, plays a pivotal role in the Commission's work. As the RWHAP Recipient and Part A representative for the Los Angeles County EMA, DHSP provides essential epidemiological data (including surveillance) and ~~surveillance data~~ fiscal information to guide the Commission's ~~decision-making~~ priority setting and resource allocation process.		
22	7/25/25	DHSP	Under Article II, Section 2, Conflict of Interest. Can we add...all members must sign a conflict of interest statement annually and the document will be retained by COH support staff...or something that refers to the HRSA legislative requirement?	Current practice now is that all COH members complete a COI form specific to HRSA annually and 1 required by the County (IRS Form 700). HRSA-specific COI form is retained in each members' electronic folder.	
23	7/25/25	DHSP	Under Article III, Member Requirements, Section 3, Conflict of Interest, C. Deletions and additions. C. Further, in accordance with HRSA Part A Manual 2023, Conflict of Interest, Page 38, dictates that all members must declare conflicts of interest required to recuse themselves from ~~discussion~~ recommending		

			an allocation amount and/or voting concerning that area of conflict. ~~Or funding for those services and/or to those agencies~~.		
24	7/25/25	DHSP	Article V, Meetings, Section 1, B "The Commission and committee meetings are subject to the Brown Act." Given the political environment, there needs to be a "safe space" for some discussions that are not recorded.	Official meeting records are the meeting minutes/summaries. Meetings are recorded to assist staff write the minutes. The Brown Act grants the public the right to record meetings, provided it doesn't cause a persistent disruption. The Act ensures transparency by requiring open meetings, public participation, and the ability for individuals to record proceedings.	
25	7/25/25	DHSP	Article V, Meetings, Section 5. Regular Meetings. Can we list fewer number of meetings as the minimum? Maybe 2? 3? 4? Add language to indicate virtual or different meeting locations based on geographic disease burden and alternate meeting times (i.e. late afternoon or evenings) to increase representativeness and inclusion.	The COH must comply with the Brown Act and cannot have exclusively virtual meetings for the full COH and standing committees. Consider additional costs for renting venues in late afternoons or evenings.	
26	7/25/25	DHSP	Article VI, Resources, Section 2. Operational Budgeting and Support. Deletions and additions.		

			"Operational support for the Commission is principally derived from the Executive Office of the Board and RWHAP Part A ~~and CDC prevention funds~~ and other funds managed by DHSP. ~~And Net County Costs ("NCC") managed by DHSP.~~ A. The total amount of each year's operational budget is negotiated annually with DHSP and the Executive Office of the Board, in accordance with County budgeting guidelines, and approved by the DHSP Director and the Commission's Executive Committee. B. Projected Commission operational expenditures are allocated from FWHAP Part A administrative funding, ~~CDC prevention, and NCC funding~~, in compliance with relevant guidance and allowable expenses ~~for each funding stream~~ per HRSA.		
27	7/25/25	DHSP	Article VI, Resources, Section 3 Other Support. Additions. Section 3. Other Support. Activities beyond the scope of RWHAP Part A planning councils and CDC HPS, as defined by HRSA and CDC guidance, are supported by other sources, including NCC and the Executive Office of the Board, as appropriate.		
28	7/25/25	DHSP	Article VII. Policies and Procedures, Section 1 Policy/Procedure Manual. Section 1. Policy/Procedure Manual. The Commission develops and adopts policies and procedures consistent with ~~RWHAP,~~ HRSA RWHAP,		

			and the CDC requirements……"		
29	7/25/25	DHSP	Article VII. Policies and Procedures, Section 3 Grievance Procedures. Section 3. Grievance Procedures. The Commission's Grievance Process is incorporated by reference into these Bylaws. The Commission's grievance procedures must comply with ~~RWHAP,~~ HRSA RWHAP and, CDC, and Los Angeles County…..		
30	7/25/25	DHSP	Article VII. Policies and Procedures, Section 5 Conflict of Interest Procedures. Section 5. Conflict of Interest Procedures. The Commission's conflict of interest procedures must comply with the HRSA RWHAP legislation, ~~HRSA guidance,~~ CDC, State of California, and Los Angeles County requirements…..		
31	7/25/25	DHSP	Article XI. Membership and Community Engagement Committee, Section 1. Voting Membership. Maybe most of these can be non-voting participants; refers to Cities of Los Angeles, Pasadena, Long Beach, and West Hollywood, representatives from the youth community; academics/behavioral scientists; members assigned by the Commission Co-Chairs; and the Commission Co-Chairs when attending.		
32	7/25/25	J. Arrington	On Page 20 of 24 - XI. MEMBERSHIP AND COMMUNITY ENGAGEMENT COMMITTEE: Section 2. Responsibilities. Letter L - Identifying, accessing, and expanding other financial resources to support the Commission's special initiatives (what		

			does this intel/mean?) and ongoing operational needs.		
33	7/25/25	J. Arrington	Page 17 of 24 - IX. COMMISSION WORK STRUCTURES: Section 5. Meetings. All committee meetings are open to the public, and the public is welcome to attend and participate. While members of the public do not have voting privileges, they play a critical role in informing discussions. If this fits this or any category on the bylaws, can we add vendors/contractors sign/or agree to COH Code of Conduct while attending meetings?		
34	7/25/25	J. Arrington	This newly drafted version of the COH Bylaws is better. I am glad to see a section from the current version be removed as follows: Section 4. Unaffiliated Consumer Membership. 1. At least one (1) unaffiliated consumer member must be co-infected with Hepatitis B or C; and 2. At least one (1) unaffiliated consumer member must be a person who was incarcerated in a Federal, state or local facility within the past three (3) years and who has a HIV diagnosis as of the date of release, or is a representative of the recently incarcerated described as such. In the current version of the Bylaws was it too much information to keep the members who are recommended descriptions? Such as: On Section 2. Composition. 1. An HIV specialty physician from an HIV medical provider, 2. A Community Health Center/Federally Qualified Health Center (“CHC”/ ”FQHC”) representative, 3. A mental health provider, 4. A substance abuse treatment provider,	See proposed changes to the bylaws. These are required by the legislation. See proposed changes to the bylaws to focus on the 15 seats required by the legislation. These seats are reflected on the membership composition.	

			5. A housing provider, etc……Will it be listed elsewhere?		
35	7/10/25	R. Archuleta	Being the Consumers and those living with HIV are the main reasons why the Ryan White Program and Planning Councils were formed, why is the Consumer Caucus only a Caucus and not a Standing Committee?		
37	7/28/25	E. Ahiati (HRSA Project Officer)	**Standards and best practices. Section 2 A.** "Working with DHSP and other bodies to develop and implement a quality management plan and its subsequent operationalization" . *PO Comment*: The development of a quality management plan is the subrecipient's responsibility. The PC contributes but is not responsible.		
38	7/28/25	E. Ahiati (HRSA Project Officer)	**Policies and procedures- section 2**- "The Division of Metropolitan HIV/AIDS Program/HIV/AIDS Bureau (DMHAP/HAB) at HRSA requires RWHAP Part A planning councils to submit their grievance and conflict of interest policies and Bylaws for review by the RWHAP Part A project officer". *PO Comment:* HRSA does not require councils to submit their grievance and conflict of interest policies and bylaws for review by the project officer. However, the recipient can share these policies with the PO for additional input and guidance. It's also helpful to the PO to become familiar with the PC's bylaws.		
39	7/28/25	E. Ahiati (HRSA Project Officer)	**Section 5. Commission member compensation**: "subsets of Commission members, may be compensated for their service on the Commission contingent upon available funding as determined by		

			the Executive Director and in compliance” PO Comment: Are the subsets of members referring to unaligned consumers?		
OTHER QUESTIONS/ITEMS TO CONSIDER					
40			Do we need to specify number of meetings per year for the Commission and Committees in the bylaws?		
41			Add California Planning Group (CPG) representative language to reflect the State’s process. **NOMINATED CPG MEMBERS** Nominated CPG members are appointed by the local planning body that they are representing. Their appointment to the CPG is confirmed by the “Letter of Nomination” that the CPG receives from each planning body. Nominated members serve as liaisons and share the work that is being done in their local community with the CPG membership, occasionally this may include additional meetings with other nominated members, and after, take the information learned from the CPG meetings and go back to their local planning body to provide detailed updates of the information shared during CPG meetings. The CPG will appoint only one nominated member per planning body to serve a full term. If a local planning body has two Co-Chairs, they must choose one to appoint to CPG. A nominated CPG membership is not a rotating position. Should the appointed member fall ill or resign, the second Co-chair can assume the position.		

QUESTIONS FROM BYLAWS REVIEW TRAINING (JULY 23, 2025)					
42			Can termed out members apply to be members of the standing committees?	Consider challenges with meeting quorum with large numbers of committee members. Having termed out Commissioners serve as voting members on a standing committee is not in alignment with the spirit and intent of member rotations. Excerpt from HRSA PC Expectations Letter: "*To ensure the PC/PB are reflective of the demographics of the population of individuals with HIV in the jurisdiction, HRSA HAB expects the PC/PB to establish term limits and membership rotations.*"	
43			Can we add the additional 4 Board members as part of Board expansion under Measure G.	This change in the BOS is not set to be implemented until 2032. Adding additional members that do not yet exist is not recommended.	
44			Can we reduce the number of pages for the bylaws	Proposed document	

			to make it easier for the consumers to read?	eliminated 4 pages and staff will use links, where appropriate, to reduce the pages.	
45			How will the staggered terms be handled?	When the updated ordinance becomes effective, the new members appointed by the Board of Supervisors will be seated. The Commission shall classify its members by lot so that 16 members' terms will expire after one (1) year and 17 will expire after two (2) years. Thereafter, each membership term shall be two (2) years.	
46			Where did the City representatives go?	See voting members of the Membership and Community Engagement Committee.	
47			Will new members for the newly restructured COH still have to go through the BOS approval?	Yes. All Commissioners serve at the pleasure of the Board and are appointed by the Board.	
48			If current members who reapply are accepted, will we automatically be assigned on the same	Not necessarily. Co-Chairs will review the	

			committee?	members' committee interest selection and reflectiveness across committees.	
49			For unaffiliated consumers applicants, will there be difference between current members who wish to reapply versus new applicants? Will new applicants get an advantage? It takes a while to learn about the COH, especially for some unaffiliated consumers. Consumers deserve the opportunity learn even if they do not have previous experience.	The Operations Committee is currently revising the membership application form and interview questions to better ascertain best candidates to serve on the COH.	
50			Consider keeping city representatives from Los Angeles, West Hollywood, Long Beach, and Pasadena as non-voting members of the full body.		
51			Consider creating an inclusive, all populations Consumer Committee instead of a Caucus.		

COUNTY OF LOS ANGELES
Public Health

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August 6, 2025

TO: Each Supervisor

FROM: Barbara Ferrer, Ph.D., M.P.H., M.Ed.
Director

SUBJECT: **ADDRESSING GAPS AND DISPARITIES TO HELP REDUCE SEXUALLY TRANSMITTED DISEASE RATES IN LOS ANGELES COUNTY (ITEM 58-A, BOARD AGENDA OF MAY 29, 2018, ITEM 8, BOARD AGENDA OF AUG 2, 2022)**

This memorandum (memo) highlights our progress in reducing Sexually Transmitted Infection (STI) rates in Los Angeles County (LAC) and reflects programmatic activity from January to May 2025 or as otherwise noted. For consistency across reporting periods, all memos have been organized into the following sections: (1) Improving the Early Identification of STD Cases, (2) Interrupting Disease Transmission Through the Treatment of Cases and Their Partners, (3) Educating Consumers and Community Providers to Raise Awareness of STDs, and (4) Local, Federal, and State Program and Funding Updates. These sections include updates tied to surveillance trends, screening and treatment services, collaboration with external partners, community awareness efforts, policy advocacy and updates, as well as the impact of recent reductions in federal funding levels.

STD Surveillance and Mpox Update

STD Surveillance

After 15 years of consistent increases, preliminary year-end data for 2024 indicate that LAC has seen a second consecutive year of decline in reported STI cases. Over 76,600 STI cases were reported to LAC Department of Public Health (Public Health) in 2024, a decrease from nearly 90,000 cases reported in 2023.

Notably, reported syphilis cases dropped by 17% from 2023 to 2024. This includes a 32% reduction in early syphilis cases -- suggesting a sustained decrease in recent infections. In addition, congenital syphilis cases also dropped, decreasing 19% from 126 cases in 2023 to 102 cases in 2024. Gonorrhea cases declined by 11%, representing the third consecutive year of reductions. Although chlamydia had shown modest year-over-year increases since the COVID-19 pandemic, 2024 saw a 16% decrease compared to 2023, keeping case numbers below pre-COVID-19 pandemic peaks.

For the first two months of 2025, preliminary data suggest continued downward trends in syphilis, gonorrhea, and chlamydia cases compared to the same period in 2024. Publicly available STI data dashboards can be accessed at:
http://publichealth.lacounty.gov/dhsp/dashboard.htm

Mpox Response and Vaccination Efforts

In the first five months of 2025, 51 mpox cases were reported in LAC -- a slight increase from 44 cases during the same period in 2024. Most cases continue to occur among men who have sex with men (MSM). Of the 51 cases, 43% were among unvaccinated persons, 53% were among fully vaccinated persons, and 4% were among partially vaccinated persons. Two individuals were hospitalized; no deaths have been reported. In 2025, Public Health launched a new mpox dashboard, updated biweekly with case and vaccination data that can be found at this link https://shorturl.at/Rt6HI. Please note that continued mpox monitoring and reporting is contingent upon funding availability and may be scaled back or discontinued if funding is no longer available.

As shared previously, Public Health assigned the Division of HIV and STD Programs (DHSP) to manage mpox surveillance and outreach, while the Vaccine Preventable Disease Control (VPDC) Program oversees vaccination efforts. During the reporting period, Public Health partnered with the California Department of Public Health and its Turnkey Teams to provide free mpox vaccines at large community Pride events through August 2025. At the West Hollywood Pride events on May 31 and June 1, 73 doses of mpox vaccines were administered. Sixty-one doses of mpox vaccine were administered at the separate LA Pride event (June 8). This team will also provide mpox vaccines at the Trans Pride LA event. Finally, DHSP continues to support providers and pharmacies in accessing mpox vaccines and offers ongoing technical assistance.

Improving the Early Identification of STD Cases

STD Screening, Diagnosis, Treatment, and Counseling Services at Public Health Centers

Public Health provides confidential STI screening, diagnosis, treatment, and counseling at no cost through its Sexual Health Clinics (SHCs) located within Public Health Centers. Visits to these clinics have steadily increased, rising from 8,912 visits in 2023 to 17,517 visits in 2024. From January through April 2025, there were 5,800 visits, placing Public Health on pace to surpass 17,000 visits again in 2025. The SHCs operate three to five days per week across various centers, and with evening hours available at some sites.

Please note that due to the closure of the North Hollywood Public Health Center, sexual health services at this location were suspended. Public Health will provide sexual health services four days per week at Glendale Health Center until the new North Hollywood Integrated Health Center opens.

The Telehealth services for HIV Pre-Exposure Prophylaxis (Tele-PrEP) program that offered counseling and medication management via phone, text, and video to individuals at elevated risk for HIV was suspended on May 31, 2025, due to resource constraints. While the telehealth option is no longer available, Public Health continues to provide in-person PrEP services at its Public Health Centers and connects clients to community providers as needed.

Public Health Mobile Vaccine and Testing (MVT) Team Collaboration

In the first three quarters of fiscal year (FY) 2024-2025, Public Health's MVT continued to provide services to people experiencing homelessness (PEH) living in sheltered and unsheltered settings throughout Los Angeles County. Services offered included screening for HIV, syphilis, gonorrhea, chlamydia, and hepatitis B and C; vaccinations; TB testing; harm reduction supplies (naloxone and fentanyl test strips); linkage to resources; and health education. Due to federal funding reductions, testing services ended April 2025, but all other services continue at this time.

Billing by Public Health of Third-Party Payors for STD Services via SHCs and MVT Team

To sustain services, Public Health continues to bill Medi-Cal, Medicare, and private insurers for eligible services and seeks reimbursement from the California Department of Public Health (CDPH) for services provided to uninsured or underinsured clients. Agreements with Medi-Cal managed care plans are under development. Though Public Health has exited the Family PACT program due to low utilization, family planning services (including emergency contraception) remain available at SHCs.

Update on Community-Based HIV/STD Prevention Contracts

Due to federal funding uncertainty and as reported to your Board, Public Health initially issued notices on April 30, 2025, to 39 agencies informing them that 83 HIV and STD prevention contracts would end effective May 31, 2025. These termination notices were subsequently rescinded, and contracts remained active with a very nominal amount of funds through their original end dates (primarily June 30 or July 31, 2025) as a strategy to preserve the contracting infrastructure and allow Public Health to quickly allocate funding onceresources became available. On June 27, 2025, Public Health belatedly received its award from the Centers for Disease Control and Prevention (CDC) to support HIV prevention and surveillance activities, with LAC receiving $19,788,675 to support services through May 31, 2026. Public Health exercised its delegated authority approved previously by the Board to extend most contracts through December 31, 2025, thereby maintaining infrastructure to support services and operations in HIV/STD surveillance; HIV/STD screening, diagnosis and linkage to care; biomedical HIV and STD prevention (HIV PEP, HIV PrEP, and DoxyPEP), vulnerable population services; and high impact prevention services (formerly termed Health

Education/Risk Reduction services).

In addition, given the ongoing federal funding uncertainty, recommendations under the HIV and STD Testing and Prevention Services Request for Proposal #2024-14 remain on hold, and future planning will be informed by stakeholder input, including feedback received from the Commission on HIV.

The disruption caused by federal funding uncertainty comes at a time when STI rates in LAC remain unacceptably high, and the loss of these essential community-based services threatens to reverse years of progress. Without adequate funding, the County's ability to provide early detection, rapid treatment, and sustained prevention will be severely compromised. The result will likely be increased STI transmission, delayed diagnoses, and worsened health outcomes -- especially in underserved communities. Without sustained funding, LAC's HIV and STI prevention infrastructure faces long-term setbacks. Public Health is proceeding with a measured approach to contracting services to ensure stability and continuity of services.

Syphilis Screening Efforts and Partnerships

- At Home HIV and Syphilis Testing

From January to March 2025, Public Health expanded its free HIV self-test kit program to include the First to Know (FTK) at-home syphilis test through the *Take Me Home* platform in partnership with NASTAD and Building Healthy Online Communities. During this period, 955 HIV self-test kits were ordered; 644 (68%) persons qualified to receive a free syphilis test. Among them, 64% were assigned male at birth, and 44% were age 30 or younger. By comparing test participants with existing STI surveillance records (surveillance matching), 56 participants (9%) were found to have syphilis. Of those, 27 had been previously diagnosed syphilis and 29 appeared to have a new infection. These results show that many people are interested in convenient, at-home options for syphilis testing -- and that this approach is helping identify both past and new infections.

- Community-Based STI Prevention Initiatives Through Third Party Administrators

Public Health continues to support community-based STI prevention efforts through partnerships with Rising Communities and Heluna Health. These efforts include distributing at-home test kits and expanding STI screening in high-impact settings. Due to recent funding reductions, Rising Communities has shifted its focus to test kit procurement, while Heluna Health continues to fund and support the expansion of routine STI screening in emergency departments across Los Angeles County.

- Enhanced Syphilis Screening Across Department of Health Services (DHS) Emergency and

Urgent Care Settings

In February 2025, routine syphilis screening expanded to all 12 DHS urgent care centers. From January to April 2025, more than 25,000 individuals of reproductive potential were screened, and 441 (2%) tested positive for syphilis. Among those who tested positive, 49% were Latinx, 14% were Black/African American and 25% were unhoused.

Plans are underway to further expand routine HIV and syphilis screening at three community (non-DHS) hospitals with implementation expected later in 2025.

Interrupt Disease Transmission through the Treatment of Cases and Their Partners

Disease Investigation and Partner Services

- Public Health-based Disease Investigation and Partner Services

Between January and May 2025, Public Health Investigators (PHIs) and Public Health Nurses (PHNs) continued to provide essential Partner Services for syphilis and HIV cases, focusing on timely treatment and notification to partners to interrupt the cycle of transmission. In 2024, PHIs and PHNs interviewed 4,670 people with syphilis, 15% had primary or secondary syphilis (early, infectious stage), 23% had early latent syphilis (infected within the past year, typically asymptomatic) and 61% had late stage syphilis or had been infected for an unknown duration (and usually not infectious), and 1% were congenital syphilis cases (infection passed from a pregnant person to their infant before birth). Over 740 sexual partners or close contacts were confidentially notified of possible exposure to syphilis, with the identity of the original client kept anonymous. Of those notified, 281 individuals were either successfully linked to treatment (after a positive diagnosis) or given preventative treatment. Untreated, syphilis can progress and eventually cause serious and permanent damage to the brain, heart, eyes, and other organs, and in some cases lead to death.

Public Health continued to serve other vulnerable populations with syphilis including incarcerated individuals and people experiencing homelessness, ensuring follow-up and linkage to care and other essential services. Ongoing resource constraints will impact the ability to reach all cases promptly.

- Community Embedded Disease Intervention Specialist (CEDIS) Program

The Community Embedded Disease Intervention Specialist (CEDIS) program supports community-based organization clinic staff to conduct disease investigation and partner services to enhance our public health reach. CEDIS investigated approximately 20% of syphilis and 15% of HIV cases countywide during this reporting period. CEDIS also achieved high treatment and patient interview rates and exceeded contact index benchmarks (identifying sexual, needle-sharing, or sexual network contacts). However, as described earlier, reductions in contract funding led to the layoff of five out of the 22 CEDIS staff and one of the two liaison positions

across the partner agencies. These staffing cuts are expected to impact LAC's disease investigation capacity, lowering partner notification rates, decreasing uptake of biomedical prevention (e.g., PrEP and DoxyPEP), and delaying early treatment for individuals exposed to HIV and STDs. As a result, County PHIs will need to either re-prioritize case follow-up or absorb a larger caseload, straining existing resources. A decline in community engagement and follow-up effectiveness is anticipated, which may undermine progress in STD prevention and response efforts.

- Specialized Investigation Team (SIT) for Persons of Reproductive Potential

Public Health's DHSP created the SIT in 2022 to reinvestigate persons of reproductive potential diagnosed with syphilis who remain untreated and unlocated in LAC. The SIT ensures that clients obtain treatment, receive partner services (both partner elicitation and partner notification services) to interrupt the cycle of re-infection. From January to May 2025, 110 cases were reopened, that led to a 54% locating rate resulting in at least 50% of clients completing adequate syphilis treatment. DHSP subject matter experts provide feedback to original investigators as a continuous quality improvement strategy.

- Housing Services for Treatment Completion: The Incentives and Enablers (I&E) Program

In 2024, Public Health expanded the Tuberculosis (TB) Control Program's I&E Program to include several additional programs, including the Vaccine Preventable Disease Control Program, the Acute Communicable Disease Control Program, and DHSP. This program was formed to support clients with reportable conditions such as HIV, mpox, or syphilis who require temporary housing to complete treatment. Depending on the condition, Public Health provides short-term housing, transportation to and from clinic appointments, and food subsidies to support clients during their stay to assist clients with completing appropriate treatment regimens. Between January and May 2025, the I&E Program housed and served 12 persons of reproductive potential diagnosed with syphilis.

- Essential Access Health Contract: Impact on Expedited Partner Therapy/Patient Delivered Partner Therapy and Youth Services

As previously shared, one of the impacted STI prevention contracts was with Essential Access Health (EAH), which played a key role in advancing sexual health education, screening, and outreach efforts. Notably, EAH maintained a website portal that provided clinicians with access to expedited partner therapy (also known as patient-delivered partner therapy, or PDPT) for the partners of individuals diagnosed with an STI. This service, which helps interrupt ongoing STI transmission, will now be reduced.

As a result of federal funding reductions, several other EAH-supported STI prevention activities will also no longer be implemented, including:

- The Spring Into Love youth conference, an annual event promoting sexual health awareness

among adolescents;
- The Teen Source mail-order condom distribution program, a resource for youth seeking confidential access to condoms;
- Training and technical assistance for LAC-based Title X providers, a statewide initiative that has also been impacted by recent federal funding cuts and freezes. Title X is the federal program dedicated to providing comprehensive family planning and related preventive health services, particularly for low-income and uninsured individuals. Essential Access Health serves as California's Title X administrator.

In addition, Planned Parenthood Los Angeles and Planned Parenthood Pasadena/San Gabriel Valley, along with other youth-focused providers, were also subcontractors of EAH or supported by EAH's PDPT portal – and these too have been impacted.

Bicillin Delivery Program

Providing no-cost Bicillin to persons diagnosed with syphilis (particularly for persons of reproductive potential) remains a priority for Public Health. Bicillin (Bic or Bicillin L-A) is a long-acting penicillin injection that treats syphilis via sustained antibiotic levels, typically requiring only one dose to treat syphilis among persons with early infection. Timely treatment with Bicillin is critical to prevent transmission, avoid serious complications (such as congenital syphilis), and reduce reinfection. From January to May 2025, Public Health provided 64 doses to LAC providers and expanded delivery to 10 Street Medicine Teams. The national shortage that began in 2023 has now been resolved.

Improved Treatment Outcomes for Women, Youth, and Incarcerated Persons

- Incarcerated Persons

Public Health continues to support syphilis screening at the Century Regional Detention Facility (CRDF). Two DHSP counselors conduct testing within the housing units during the day shift and one counselor provides testing at the Inmate Reception Center during the night shift, ensuring comprehensive coverage across key areas. Between January 1 and May 31, 2025, DHSP staff conducted 866 rapid screening tests (RSTs), identified 55 preliminary positive syphilis cases (6% positivity rate). Among the people with reactive results, CRDF Correctional Health Services (CHS) confirmed 15 new cases, with all 15 people receiving treatment in custody.

At LAC's youth detention facilities, Public Health has scaled back individual STI case follow-up and is focusing scarce resources on verifying treatment for reported syphilis cases.

- Student Wellbeing Centers

Between January and April 2025, Public Health-supported Student Wellbeing Centers (SWBCs) operated in 12 school districts and serving 45 high schools and two middle schools. During this

time SWBCs promoted sexual health and STD prevention among students, through the distribution of 8,720 condoms, the facilitation of 194 classroom-based presentations and workshops specifically on STI prevention and sexual health awareness and by engaging in 1,019 outreach activities. In total these events have reached over 14,000 students equipping them with essential knowledge and tools to practice safer behaviors and reduce STD risks.

Educate Consumers and Community Providers to Raise Awareness of STDs

Social Marketing Campaigns

Public Health recently developed three social marketing campaigns: 1) Nurse Doxy (a DoxyPEP promotion campaign), 2) HIV PrEP, and 3) Ryan White Program (RWP) promotion. However, due to the impacts to HIV/STD prevention contracts and the severe funding limitations, the release of these campaigns is on hold. Public Health's DHSP is actively collaborating with Public Health's Office of Communications and Public Affairs to identify options for releasing the campaigns. Additionally, efforts are underway to transfer all related online presence and accounts to Public Health from vendors.

Public Health and Provider Training

As part of Public Health's provider training initiative to strengthen STI prevention with clinicians, the DHSP Associate Medical Director conducted three trainings on DoxyPEP at Men's Health Foundation (West Hollywood and South Los Angeles locations) and UMMA Community Clinic. DoxyPEP is a biomedical intervention shown to reduce bacterial STIs such as syphilis, chlamydia and gonorrhea among people at elevated risk for STIs. The trainings were well received and has resulted in providers and staff highlighting increased awareness and readiness to incorporate DoxyPEP into clinical practice.

STD Awareness Among Youth

- *Don't Think Know (DTK) Program*

The DTK program continues to expand sexual health outreach among youth ages 12 to 24, with a strong presence at 34 community events this year and engagement of over 2,000 attendees. A new initiative launched in May enabled direct distribution of test kits on-site rather than by mail. This change has already increased the number of tests returned and improved youth engagement. Thirty test kits were distributed at three recent events, with more distribution events planned. The program has seen a noticeable rise in both in-person and online test kit orders.

- Pocket Guide LA

Pocket Guide LA is an online resource featuring a list of youth-friendly clinics reviewed by Public Health staff to ensure they meet youth appropriate health services standards. Staff began the process to update the guide's 198 clinic listings during this reporting period. A new survey was developed by Public Health's Office of Health Assessment and Epidemiology (OHAE) Research, Analysis, and Technical Evaluation (RATE) Unit to verify and collect information on

clinic services, hours, insurance policies, and STI testing and treatment availability to ensure the guide remains accurate and reliable. The survey is currently under review by Public Health's Institutional Review Board (IRB) to ensure ethical standards are met when engaging clinic staff. Clinics are also being re-evaluated for inclusion to confirm they meet Public Health standards for accessibility, quality, and cultural responsiveness towards youth. The Pocket Guide continues to be a critical resource used by the public and partner organizations to connect youth with trusted, up-to-date STI services across LAC.

Local, Federal and State Program and Funding Updates

Delayed Federal Funding

Recent actions by the Trump Administration have sought to eliminate or curtail existing federal public health funds, programs, staffing, and infrastructure that will substantially diminish the role of the federal government in supporting national, state, and local public health capacity to protect and preserve the public's health, including in HIV and STD prevention and treatment.

For example, DPH receives more than $19 million annually through a CDC HIV Prevention and Surveillance Cooperative Agreement, funding comprehensive HIV prevention efforts largely delivered by community-based providers. This funding is provided in annual awards that run from June 1st-May 31st. By the end of May of this year, neither DPH nor any other state or local health jurisdiction had received their FY25-funded renewal notifications necessary to maintain their contracted HIV Prevention programs. DPH worked with a coalition of HIV providers, advocacy groups, health jurisdictions from around the Country and the Chief Executive Office, Legislative Affairs and Intergovernmental Relations (CEO-LAIR) Washington, D.C. Advocates to elevate this issue to congressional leaders and the media. Thanks to this advocacy, and critical support from the Los Angeles Congressional delegation (including letters from Representatives Laura Friedman, Maxine Waters and Robert Garcia), CDC finally provided award letters for FY 25 in mid-June. DPH wants to share their sincere gratitude for all the support and advocacy from the provider community and County's Congressional delegation in pushing the CDC to provide this Congressionally approved funding.

Other relevant federal funding streams had also remained significantly delayed this year. DPH only recently in July received the final tranches of our FY25 awards from the Health Resources Services Administration for the Ryan White Program Part A, Minority AIDS Initiative Award, and the HRSA Ending the HIV Epidemic Initiative Award, totaling $53,837,739, a reduction of approximately $411,133 from the FY24 awards. DPH has worked with CEO-LAIR to keep the LA County Congressional delegation regularly updated on these delays and advocated for HRSA to make this funding available.

Proposed Federal Budget for Federal Fiscal Year (FFY) 2026

LA County is also working to advocate for STD funding in the Congressional Appropriations process. The President's FFY26 Budget, released in May, proposes significant cuts to HIV and

STD prevention and control programs. Proposed cuts include the elimination of the CDC Division of HIV/AIDS, which would cut $793.7 million from domestic HIV prevention programming, eliminating the primary source of HIV prevention funding for local health departments, and more than $19 million in annual funding for DPH. It would also Eliminate the HHS Office of Minority AIDS (from which DPH receives $3.6 million annually)

The President's Budget also proposes consolidating the CDC STD grant along with several other disease-specific grants into a larger block grant. We are concerned that this proposed consolidation would lead to a reduction in overall grant funding, and that existing grant terms will not be honored if the STD program is moved out of CDC.

Collectively, these and other proposed cuts in the President's Budget would significantly weaken LA County's ability to prevent, treat and control HIV/AIDS and STD's. It is important to note that only Congress can pass a federal budget, through the annual Appropriations process. The Board has issued pursuits of advocacy positions to reject the proposals made in the President's budget and instead expand funding for these critical sources of HIV/AIDS and STD grant funding. DPH is working with CEO-LAIR to finalize a letter outlining these funding requests for the LAC congressional delegation.

H.R.1, the One Big Beautiful Bill Act (OBBB)

On July 4th, President Trump signed H.R.1, into law. The legislation includes significant changes to Medicaid eligibility and benefits that will reduce overall enrollment and limit access to health care, substance use disorder (SUD) care, and other Medicaid-reimbursable services offered through DPH, while simultaneously increasing state and county spending on these services that will no longer be reimbursable. The Congressional Budget Office (CBO) has estimated that the Medicaid provisions under the OBBB would lead to more than 10 million people losing Medicaid coverage. Based upon LA County's percentage of national population (~2.87%), this would likely result in more than 280,000 LA County residents losing coverage. Factoring in changes to the Affordable Care Act (ACA) marketplace and the sunset of the ACA Premium Tax Credit, more than 17 million people nationally will be uninsured by 2034. Loss of health insurance coverage at this scale will substantially reduce access to STD surveillance, prevention, testing and treatment services, and place additional unfunded burdens on DPH and DHS clinics, who will need to continue serving the uninsured without reimbursement.

The bill also prohibits Medicaid funding from going to "nonprofit organizations, that are essential community providers that are primarily engaged in family planning services or reproductive services, provide for abortions other than for Hyde Amendment exceptions, and which received $1,000,000 or more (to either the provider or the provider's affiliates) in payments from Medicaid payments in FY24." This provision will largely impact funding for Planned Parenthood and similar organizations for one year, which will significantly reduce the ability of these providers to receive Medicaid reimbursement for critical care provided to LA County residents, including for STD screening and treatment.

While the majority of the cuts to Medicaid eligibility and state funding will not go into effect until December 2026 or later, the cuts to ACA marketplace subsidies and Planned Parenthood and similar organizations go into effect this year (although a federal district judge has temporarily blocked the funding provision targeting Planned Parenthood from going into effect).

Public Health continues to collaborate with CEO-LAIR and County Counsel to monitor and analyze impacts of these federal policies on the County programs and to educate Congressional members and partners about the negative effects of reductions in federal spending commitments for HIV and STI control efforts.

State Advocacy Efforts

On June 27, 2025, Governor Gavin Newsom signed into law the State Budget Act of 2025(Budget Act that includes the State budget for FY 2025-2026.

Thanks to advocacy from the End the Epidemics HIV/AIDS Coalition, public health partners and local governments, including LA County, the Budget Act allocated $75 million from the State's AIDS Drug Assistance Program (ADAP) Rebate Fund to sustain support programs experiencing loss of federal funds. This included $65 million that can be available to support HIV prevention funding cut by the Federal government, and $9 million to fund Disease Investigation Specialists at the State and Local level to work in HIV prevention. While the federal government has finally awarded HIV Prevention funding for FY 25, this allocation in the ADAP Rebate Fund might be available if there are future cuts made in the FY26 federal budget or later attempts to rescind congressionally approved funding. Historically, the ADAP Rebate Fund was created to support programs like these and has maintained a strong reserve.

In addition, thanks to the advocacy with the State legislature, the Budget Act also rejected proposals in Governor's proposed May Revision to the State Budget that would have cancelled $60 million of unspent CDPH Public Health funding, including the California Reducing Disparities Project, support for LGBTQ+ Foster Youth, LBTQ Women's Health Equity grants, Reproductive Health Justice grants, STD/Hep C prevention programs, and public health workforce programs.

Public Health and CEO-LAIR will continue to monitor and identify State budget and legislative proposals that would improve access to and efficacy of HIV and STI services in the County.

Public Health will continue to provide the Board updates on STI services in the County with our next update in January 2026. In the meantime, if you have any questions or would like additional information, please let me know.

BF:rs

c: Chief Executive Officer
County Counsel
Executive Office, Board of Supervisors

MOTION #3: Approve the Ryan White Program Year 35 Reallocations, as presented or revised and provide DHSP the authority to make adjustments of 10% greater or lesser than the approved allocations amount, as expenditure categories dictate, without returning to this body.

DIVISION OF HIV AND STD PROGRAMS (DHSP) PROPOSED REALLOCATIONS - Part A

Service Category	Service Ranking	Applied Part A Allocation Amount	Original COH Part A %	Revised Part A Allocation Amount	Revised COH Part A %	Notes
Early Intervention Services (Testing Services)	**11**	$ -	0.00%	$ 777,376	2.07%	March-June
Emergency Financial/Rental Assistance	**2**	$ 3,023,661	8.00%	$ 1,612,310	4.29%	
Home and Community-Based Services (Intensive Case Management Home Based)	**17**	$ 2,456,724	6.50%	$ 1,488,988	3.96%	
Housing: RCFCI TRCF	**1**	$ 343,941	0.91%	$ 4,414,994	11.75%	TRCF Part B
Legal Services	**23**	$ 755,915	2.00%	$ 1,006,340	2.68%	
Medical Case Management (Medical Care Coordination)	**6**	$ 10,960,770	29.00%	$ 6,027,000	16.04%	
Medical Transportation	**10**	$ 695,442	1.84%	$ 699,909	1.86%	
Mental Health Services	**3**	$ 7,559	0.02%	$ 1,367,756	3.64%	
Non-medical Case Management: Benefits Specialty Services	**5**	$ 1,492,932	3.95%	$ 1,112,845	2.96%	
Non-medical Case Management: Patient Support Services	**5**	$ -	0.00%	$ 3,606,180	9.60%	
Non-medical Case Management: Transitional Case Management-Jails	**5**	$ 597,173	1.58%	$ -	0.00%	
Nutrition Support: Food Bank/ Home Delivered Meals	**7**	$ 2,944,290	7.79%	$ 3,107,818	8.27%	
Oral Health: General/Specialty	**8**	$ 8,050,496	21.30%	$ 6,819,657	18.15%	
Outpatient Medical Health Services (Ambulatory Outpatient Medical)	**20**	$ 6,466,854	17.11%	$ 5,524,844	14.71%	
Outreach Services: Linkage Re-engagement Program (LRP)	**14**	$ -	0.00%	$ -	0.00%	HRSA EHE
Total		$ 37,795,758	100.00%	$ 37,566,017	100.00%	

DIVISION OF HIV AND STD PROGRAMS (DHSP) PROPOSED REALLOCATIONS - Minority AID Initiative (MAI)

Service Category	Service Ranking	Applied MAI Allocation Amount	Original COH MAI %	Revised MAI Allocation Amount	Revised COH MAI %
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	$ 3,470,916	100.00%	$ 3,350,148	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		$ 3,470,916	100.00%	$ 3,350,148	100.00%

LOS ANGELES COUNTY
COMMISSION ON HIV

FOR 8/28/25 OPERATIONS COMMITTEE & EXECUTIVE COMMITTEE APPROVAL
Refer to highlights for proposed revisions

POLICY/PROCEDURE #09.7201	Compensation for Unaffiliated Consumer Commission Members	Page 1 of 6

ADOPTED 4/12/12
Updated 10.8.20

SUBJECT: **Payment of compensation and reimbursements to the Commission's unaffiliated consumer members.**

PURPOSE: **To stipulate the requirements, processes and procedures for providing stipends and reimbursements to the Commission's unaffiliated consumer members.**

BACKGROUND:

- Active, full and engaged membership on the Commission requires a commitment of time, energy and resources. Ryan White legislation requires that no fewer than 33% of the members of a Ryan White Part A planning council (the Commission is Los Angeles County's Ryan White Part A planning council) must be "unaligned (unaffiliated) consumers."

- Both Ryan White legislation and guidance from the Health Resources and Services Administration (HRSA) acknowledge that planning council membership can be particularly challenging for unaffiliated consumers: "One of the greatest obstacles to PLWHA involvement in planning councils is the financial cost of participation. Costs of attending planning council meetings may involve transportation, child or partner care, and meals. Additional expenses may include sending and receiving faxes, making telephone calls, preparing materials, and accessing the Internet. These expenses can present a problem for PLWHA on disability or with very limited incomes, and for PLWHA who do not have jobs that provide them access to office equipment and supplies." (*Ryan White HIV/AIDS Program Part A Manual, VI. Planning Council Operations, 4. PLWHA/Consumer Participation, C. Ensuring PLWHA Participation, Maintenance of PLWHA Involvement, Financial Support*)

- HRSA guidance indicates that "Financial support for PLWHA involvement needs to be addressed with respect to several different categories of issues:
  - ⇨ What kinds of Ryan White or other funds are available for use in providing financial support for activities related to PLWHA involvement?
  - ⇨ What kinds of expenses can be covered for PLWHA within legislative requirements regarding 'reasonable costs?' and
  - ⇨ What allowable expenses need to be covered in order to ensure strong PLWHA participation in the planning council?" (*Ibid.*)

- HRSA guidance further stipulates that "Under Part A grants, funds are available not only for administrative costs but also for Planning Council Support. Ryan White funds can be used to cover actual expenses for PLWHA such as child care, transportation, or other meeting- related costs. Ryan White funds cannot be used to provide cash payments such as stipends or honoraria." (*Ibid.*)

- Los Angeles County Code 3.29.080 (Compensation) includes the following provisions: "Corresponding with Ryan White legislation and HRSA guidelines, members of the Commission may also be reimburse for local travel and mileage, meals associated with Commission business, child care during Commission activities, and computer-related expenses if those costs were incurred in the performance of commission-related duties. The Commission may, rather than reimburse for those expenses, make arrangements to provide services directly to members or obtain alternate funding for member stipends. . . . The Commission and the executive director will establish and implement procedures for eligibility and utilization of the foregoing described requirements."

- Section 5 (Commission Member Compensation) in Article VI (Resources) of the Commission's Bylaws (*Policy/Procedure #06.1000: Bylaws of the Los Angeles County Commission on HIV*) states "In accordance with Los Angeles County Code 3.29.080 (Compensation), Ryan White Part A planning council requirements, and/or other relevant grant restrictions, Commission members may be compensated for travel or other allowable expenses contingent upon the development policies and procedures governing Commission member compensation practices."

POLICY:

1) **Compensation**: Commission member compensation comes in two forms—stipends and reimbursements. Stipends are intended to compensate eligible members for the work they do as a member of the Los Angeles County Commission on HIV and to defray intangible costs incurred in the performance of that role. Reimbursements are intended to re-pay members for expenses they have incurred fulfilling their responsibilities as members of the Commission on HIV.

2) **Stipends**: Payment of stipends is limited to "unaffiliated" consumer members who are serving as the Commission's 17 designated unaffiliated consumer members, and their alternates, or for unaffiliated consumer members who are serving as Commission members/alternates in other membership seats/capacities by consent of the Co-Chairs and the Executive Director.
   a. Community members of the Commission are not entitled to stipends, nor are
   b. other Commission members who are not unaffiliated consumers.

3) **Stipend Requirements**: Eligible stipend recipients must meet attendance requirements, as detailed in Procedures #4 and #5, and must fulfill training requirements and member expectations, as detailed in Procedure #6. Eligible stipend recipients must complete a monthly "Stipend Claim Form," which must be subsequently approved by the Executive Director. Stipend payments are made quarterly.

4) **Reimbursements**: In accordance with Policy/Procedure #08.3303 (*Reimbursable Commission Expenses*), reimbursements are allowable re-payment of personal funds that Commission members have expended in the course of performing or fulfilling Commission responsibilities. The Commission's unaffiliated consumer members are entitled to claim all types of allowable reimbursements.

5) **Payment Sources**: Stipends and certain reimbursements are funded by Los Angeles County Net County Costs (NCC) or other non-Ryan White funds, as appropriate. Ryan White funds can be used for most reimbursements, unless not allowable by Ryan White legislation or HRSA guidance.

PROCEDURE(S):

1. **Monthly Stipends**: Eligible recipients of stipends may receive them monthly if they fulfill the respective stipend requirements as outlined in Procedures #4 - #6. Eligible stipend recipients may decline their stipends at any time for any period.

2. **Stipend Eligibility**: Commissioners and alternates who are unaffiliated consumer members are eligible to receive stipends. Commissioners and alternates who are not unaffiliated consumers and community members of the Commission are not eligible for stipends.
   a) Commissioners and alternates in the 17 designated unaffiliated consumer seats are automatically entitled to earn stipends.
   b) The Co-Chairs and the Executive Director must approve the payment of stipends to unaffiliated consumers who serve as Commission members in other membership seats that are not designated for unaffiliated consumers.

3. **Stipend Rates**: Eligible Commissioners may earn a $150.00 stipend every month that they fulfill their respective stipend requirements. Eligible Alternates may earn a $100.00 monthly stipend if they fulfill the stipend requirements. Alternates who fill a Commissioner's role and meet the requirements for any month in which the Commissioner is incapacitated, or for a seat in a month in which there is no sitting Commissioner, may earn a $150.00 monthly stipend.
   a) Unaffiliated consumer members may receive $50 per eligible meeting attended, up to $150.00 per month. This amendment allows for more flexibility and ensures that members can receive a stipend even if they're only able to attend one or two meetings in each month.[1]

[1] On July 10, 2025, the Consumer Caucus voted to amend the current stipend policy to introduce an à la carte model. Under this new model, unaffiliated consumer members will receive $50 per eligible meeting attended, up to $150.00 monthly.

4. **Commissioner Stipend Requirements**: In order to qualify for a monthly stipend, a Commissioner must attend 70% of the regularly scheduled meetings in which they are responsible for participating, including the Commission meeting, any committees to which they have been assigned, and the Consumer Caucus. Attendance for more than 75% of the meeting is necessary to qualify it as attendance.

5. **Alternate Stipend Requirements**: In order to qualify for a monthly stipend, an Alternate must attend 70% of the regularly scheduled meetings in which they are responsible for participating, including any committees in which the Alternate has taken a secondary assignment, the Consumer Caucus and any Commission/committee meetings that the Commissioner for whom they are serving as an Alternate cannot attendance. Attendance for more than 75% of the meeting is necessary to qualify it as attendance.

6. **Additional Stipend Requirements**: In addition to the attendance requirements outlined in Procedures #4 and #5, Commissioners and Alternates must fulfill all respective training requirements, and must fulfill their duties as outlined in Policies/Procedures #07.3002, #07.3003, #07.1002 (*Duty Statements for the unaffiliated seats and Alternate*) or any other respective duty statement. Commissioners and Alternates must also comply with membership requirements, as outlined in relevant Policies/Procedures #08.3000 (*Membership*).

7. **Stipend Claim Form**: All stipend recipients must complete the "Stipend Claim Form" (Attachment A) for each month in which the recipient expects to earn a stipend. Stipend Claim Forms submitted more than three months after the month(s) for which they are claimed will not be approved, unless previously authorized by the Executive Director.

8. **Executive Director Approval**: All Stipend Claim Forms must be approved by the Executive Director before the payment of the stipend. The Executive Director determines the resolution of any discrepancies between the recipient's claim and the stipend requirements.
   a) The Committee Assignment List included in the monthly Commission meeting materials is the final determinant of committee assignments, unless changes have been made and noted in the interim between Commission meetings.
   b) If a submitted Stipend Claim Form is not approved by the Executive Director, the Executive Director must indicate in writing on the form why it has not been approved, and a copy of the form is returned to the Commission member.
   c) If a form is not approved by the Executive Director for non-attendance reasons, those issues will be forwarded to the Operations Committee for follow-up review and action.

9. **Stipend Payments**: Stipends will be paid to eligible Commissioners/Alternates in aggregate quarterly amounts on calendar quarters. Stipends are paid in accordance with relevant Los Angeles County rules, requirements and procedures.
   a) Stipends can be paid in the form of currency or store vouchers, at the choice of the recipient.

11. **Reimbursements**: Reimbursements are allowable re-payment of funds expended in the course of performing or fulfilling duties as a member of the Commission. In accordance with Policy/Procedure #08.3303 (*Reimbursable Commission Expenses*), the Commission's unaffiliated consumer members are eligible for all available reimbursements.
    a) Unaffiliated consumers are eligible for all types of reimbursements without prior consent from the Executive Director, unless the procedure specifically requires prior authorization from the Executive Director.
    b) Reimbursement claims are still subject to the Executive Director's approval to ensure they were incurred in the conduct of Commission business, are necessary and are reasonable.
12. **Payment Sources**: As detailed in Policy/Procedure #08.3303 (*Reimbursable Commission Expenses*), Ryan White funds can be used for reimbursement for some allowable expenditures, but cannot be used for stipends (*"Ryan White funds cannot be used to provide cash payments such as stipends..."*). Stipends and reimbursements that are not allowed by the Ryan White Program are funded by Los Angeles County Net County Costs (NCC) or other non-Ryan White funds, as appropriate.

DEFINITIONS:

- **Approve/Approval**: in the context of this policy/procedure, when the Executive Director agrees to the payment of a reimbursement.

- **Authorize/Authorization**: in the context of this policy/procedure, the Executive Director's prior consent that an expenditure is eligible for reimbursement, provided it complies with the conditions as outlined in the foregoing procedures.

- **Bylaws:** Policy/Procedure #06.1000 (*Bylaws of the Los Angeles County Commission on HIV*), the Commission's governing operational procedures and practices.

- **Commission Members**: The term used to refer to all stakeholders formally affiliated with the Commission: Commissioners, Alternates, community representatives, approved representatives and staff. In the context of this policy, "Commission members" does not refer to staff.

- "**Eligible"**: in the context of this policy/procedure, when a Commission member qualifies for a particular type of reimbursement, or when an expenditure can be claimed for reimbursement.

- **Executive Director:** The Commission's lead staff member, who manages Commission staff and operations.

- **Health Resources and Services Administration (HRSA)**: Health Resources and Services Administration, the federal agency that administers and governs the Ryan White Program nationally.
- **Los Angeles County Code (3.29)**: the legal provisions establishing the Commission and governing its operations.

- **Net County Costs (NCC)**: Los Angeles County general funds, not federally supported.
- **Planning Council**: In Ryan White Part A-funded jurisdictions, the planning council is responsible for various planning and evaluation functions of the local Ryan White Part A system of care; the Commission on HIV is the local Ryan White Part A planning council for Los Angeles County.
- **"PLWHA"**: People Living with HIV/AIDS.
- **Unaffiliated Consumers**: same as "unaligned consumer"; see below.
- **Unaligned Consumers**: by HRSA definition and consistent with Commission Policy/Procedure #08.3107 (*Consumer Definitions and Related Rules and Requirements*), a Commission member is unaligned if he/she receives services from a Part A-funded provider and is not affiliated as an "officer, employee or consultant" of any Part A-funded agency.

NOTED AND APPROVED: Craig A. Vincent-Jones **EFFECTIVE DATE:** April 12, 2012

Original Approval: 4/12/2012 *Revision(s): Updated 10.8.20*

Service Standard Development

LOS ANGELES COUNTY COMMISSION ON HIV

KEYWORDS AND ACRONYMS

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

WHAT ARE SERVICE STANDARDS?

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

WHAT ARE SERVICE CATEGORIES?

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

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

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

HRSA/HAB GUIDANCE FOR SERVICE STANDARDS

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

COH SERVICE STANDARDS

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

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

REMINDER

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

DEVELOPING SERVICE STANDARDS

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

SERVICE STANDARD DEVELOPMENT PROCESS

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

together.

WE CAN END HIV IN OUR COMMUNITY ONCE AND FOR ALL

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

TRANSITIONAL CASE MANAGEMENT SERVICES: JUSTICE-INVOLVED INDIVIDUALS

SERVICE STANDARDS FOR RYAN WHITE HIV/AIDS PROGRAM CARE AND TREATMENT SERVICES

Los Angeles County Commission on HIV
510 S. Vermont Ave. 14th Floor, Los Angeles, CA 90020
(213) 738-2816 | hivcomm@lachiv.org
REVISED: 08/05/25 | APPROVED BY COH: PENDING

Contents

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

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

HRSA HAB Policy Clarification Notice (PCN) # 18-02: The use of Ryan White HIV/AIDS Program Funds for Core Medical Services and Support Services for People Living with HIV Who Are Incarcerated and Justice Involved

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

Service Standards: Ryan White HIV/AIDS Programs

Introduction

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

Service Description

Transitional Case Management (TCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services for special populations living with HIV/AIDS to mitigate and eliminate barriers to HIV care services.

- Intake and assessment of available resources and needs
- Periodic reassessments of status and needs
- Development and implementation of Individual Release Plans
- Appropriate linked referrals to housing, community case management, medical/physical healthcare, mental health, dental health, and substance use disorder treatment
- Coordination of services that facilitate retention in care, achieve viral suppression, and maintain overall health and wellness

- Access to HIV and STI information, education, partner services, and behavioral and biomedical interventions such as Pre-Exposure Prophylaxis (PrEP) and Doxycycline Post-Exposure Prophylaxis (Doxy PEP) to prevent acquisition and transmission of HIV/STIs
- Active, ongoing monitoring and follow-up
- Ongoing assessment of the client's needs and personal support systems

HRSA Guidance for Non-Medical Case Management

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

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

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

General Eligibility Requirements for Ryan White Services

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

Given the barriers with attaining documentation, contractors are expected to follow the Los Angeles County, Department of Public Health, Division of HIV and STD Programs (DHSP) guidance for using self-attestation forms for documentation eligibility for Ryan White services.

Transitional Case Management for Justice-Involved Individuals

The goal of TCM for Justice-Involved individuals is to improve HIV health outcomes among justice-involved people living with HIV/AIDS by supporting post-release linkage and engagement in HIV care. The objectives of TCM for Justice-Involved individuals include:

- Identify and address barriers to care
- Assist with health and social service system navigation
- Provide health education and risk reduction counseling
- Refer and link to culturally competent HIV medical providers
- Support reentry through community or jail-based resources

SERVICE STANDARDS

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

IN-REACH AND OUTREACH

Programs providing TCM services for justice-involved individuals will conduct in-reach and outreach activities to educate clients, and HIV/AIDS primary health care and support services providers about the availability and benefits of TCM services. In-reach refers to pre-release services including promotion and initiation of services to justice-involved individuals. Outreach refers to post-release services including promotion, initiation or continuation of services to people who have been released from incarceration, as well as promotion to service providers in the community.

IN-REACH AND OUTREACH	
STANDARD	DOCUMENTATION
Transitional Case Management programs will conduct in-reach and outreach activities to clients and providers.	In-reach/Outreach plan on file at provider agency
Transitional Case Management programs will provide information sessions to incarcerated people living with HIV/AIDS.	Record of information sessions at provider agency. Copies of flyers and materials used. Record of referrals provided to clients.

COMPREHENSIVE ASSESSMENT

Comprehensive assessment/reassessment is completed in a cooperative, interactive, face-to-face interview process. Assessment/reassessment identifies and evaluates a client's medical, physical, psychosocial, environmental and financial strengths, needs and resources.

Comprehensive assessment is conducted to determine the:

- Client's needs for treatment and support services
- Client's current capacity to meet those needs
- Ability of the client's social support network to help meet client need(s)
- Extent to which other agencies are involved in client's care
- Areas in which the client requires assistance in securing services
- Client's medical home post-release and linkage to Medical Care Coordination (MCC) program prior to release to ensure continuity of care

COMPREHENSIVE ASSESSMENT	
STANDARD	DOCUMENTATION
Completed and enter comprehensive assessments into DHSP's data management system within 15 days of the initiation of services. Perform reassessments at least once per year or when a client's needs change or they have re-entered a case management program.	Comprehensive assessment or reassessment on file in client chart to include: • Date • Signature and title of staff person Client strengths, needs and available resources in: • Medical/physical healthcare • Medications and Adherence issues • Housing and living situation • Benefits and resources available • Potential barriers to care • Gender affirming care • Lega issues/incarceration history • Social support system

INDIVIDUAL RELEASE PLAN (IRP)

An Individual Release Plan (IRP) determines the case management goals for a client and is developed in conjunction with the client and case manager within two weeks of the conclusion of the comprehensive assessment or reassessment. An IRP is a tool that enables the case manager to assist the client in systematically addressing barriers to HIV medical care by developing a concrete strategy to improve access and engagement in medical and other support services. All goals shall be determined by using information gathered during assessment and reassessments.

INDIVIDUAL RELEASE PLAN	
STANDARD	DOCUMENTATION
Individual Release Plans (IRPs) will be developed in conjunction with the client within	IRP on file in client chart to include: • Name of client and case manager

two weeks of completing the assessment or reassessment. IRPs will be updated on an ongoing basis.	• Date and signature of case manager; notation of verbal consent from client • Date and description of client goals and desired outcomes • Action steps to be taken by client, case manager and others • Customized services offered to client to facilitate success in meeting goals, such as referrals to peer navigators and other social or health services • Goal timeframes • Disposition of each goal as it is met, changed, or determined to be unattainable

IMPLEMENTATION, MONITORING, AND FOLLOW-UP OF IRP

Implementation, monitoring, and follow-up involved ongoing contract and interventions with (or on behalf of) the client to ensure that IRP goals are addressed, and that the client is linked to and appropriately accesses and maintains primary health care and community-based supportive services identified on the IRP. These activities ensure that referrals are completed, and services are obtained in a timely, coordinated fashion.

IMPLEMENTATION, MONITORING, AND FOLLOW-UP OF IRP	
STANDARD	DOCUMENTATION
Transitional Case Management programs establish appointments (whenever possible) prior to release date.	Record of appointment date.
Case managers will: • Provide referrals, advocacy, and interventions based on the intake, assessment, and IRP • Monitor changes in the client's condition • Update/revise the IRP • Ensure coordination of care • Help clients submit applications and obtain health benefits and care • Conduct monitoring and follow-up to confirm completion of referrals and service utilization	Signed, dated progress notes on file that detail the following: • Date and type of action taken (client contact, advocacy, follow-up on referral, etc.) • Description of what occurred • Update on the client's condition or circumstances • Progress made toward IRP goals • Barriers to IRP goals and actions taken to resolved them • Status of referrals and interventions • Barriers to referrals and interventions and actions taken to resolve them

• Advocate on behalf of clients with other service providers • Empower clients to use independent living strategies • Help clients resolve barriers • Follow-up on IRP goals • Maintain/attempt contact at minimum of once every two weeks and at least one face-to-face contact monthly • Follow-up missed appointments by the end of the next business day • Collaborate with the client's community-based case manager for coordination and follow-up when appropriate • Transition clients out of TCM services at six month's post-release.	• Time spent with, or on behalf of, client • Case manager's signature and title

STAFFING REQUIREMENTS AND QUALIFICATIONS

At minimum, all TCM staff will be able to provide linguistically and culturally appropriate care to people living with HIV/AIDS and complete documentation as required by their positions. Case management staff will complete an agency-based orientation and be trained and oriented regarding client confidentiality and HIPAA regulations before providing services. See "Personnel and Cultural Linguistic Competence" section on the Universal Service Standards.

STAFFING REQUIREMENTS AND QUALIFICATIONS	
STANDARD	DOCUMENTATION
Case managers will have: • Knowledge of HIV/STIs and related issues • Knowledge of and sensitivity to incarceration and correctional settings and populations • Knowledge of and sensitivity to lesbian, gay, bisexual, and transgender persons • Effective Motivational Interviewing and assessment skills • Ability to appropriately interact and collaborate with others • Effective written/verbal communication skills	Resume, training certificates, interview assessment notes, reference checks, and annual performance reviews on file.

• Ability to work independently • Effective problem-solving skills • Ability to respond appropriately in crisis situations • Effective organizational skills • Prioritize caseload • Patience • Multitasking skills	
Case managers will meet one of the following educational requirement criteria: • A bachelor's degree in a Health or Human Services field and have completed a minimum of eight hours of course work on the basics of HIV/AIDS prior to providing services to clients • An associate degree plus one-year direct case management experience in health or human services • A high school diploma or GED and a minimum of three years of experience providing direct social services to patients/clients within a medical setting or in the field of HIV. Prior experience providing services to justice-involved individuals is preferred. Personal life experience is highly valued and should be considered when making hiring decisions.	Resumes on file at provider agency documenting experience.
All staff will be given orientation prior to providing services.	Record of orientation in employee file at provider agency.
Case managers and other staff will participate in training as recommended by DHSP.	Documentation of training maintained in employee files to include: • Date, time, and location of function • Function type • Staff members attending • Sponsor or provider of function • Training outline, handouts, or materials • Meeting agenda and/or minutes
Case management staff will receive a minimum of four hours of client care-related	All client care-related supervision will be documented as follows: • Date of client care-related supervision

supervision per month from a master's level mental health professional.	• Supervision format • Name and title of participants • Issues and concerns identified • Guidance provided and follow-up plan • Verification that guidance and plan have been implemented • Client care supervisor's name, title, and signature.
Clinical supervisor will provide general clinical guidance and follow-up plans for case management staff.	Documentation of client care related supervision for individual clients will be maintained in the client's individual file.

Recommended Training Topics

Transitional Case Management staff should complete ongoing training related to the provision of TCM services. Staff development and enhancement activities should include:

- HIV/AIDS Medical and Treatment Updates
- Risk Behavior and Harm Reduction Interventions
- Addiction and Substance Use Treatment
- HIV Disclosure and Partner Services
- Trauma-informed Care
- Person First Language
- Mental health and HIV/AIDS
- Legal Issues, including Jails/Corrections Services
- Alternatives to Incarceration Training
- Integrated HIV/STI prevention and care services including Hepatitis C screening and treatment
- Gender and sexuality
- Stigma and discrimination and HIV/AIDS
- Health equity and social justice
- Motivational interviewing
- Knowledge of available housing, food, and other basic need support services

LOS ANGELES COUNTY
COMMISSION ON HIV

TRANSITIONAL CASE MANAGEMENT SERVICES: OLDER ADULTS 50+

SERVICE STANDARDS FOR RYAN WHITE HIV/AIDS PROGRAM CARE AND TREATMENT SERVICES

Los Angeles County Commission on HIV
510 S. Vermont Ave. 14th Floor, Los Angeles CA 90020

REVISED: 08/05/25 | APPROVED BY COH: PENDING

Contents

IMPORTANT: The service standards for Transitional Case Management: Older Adults 50+ Services adhere to requirements and restrictions from the federal agency, Health Resources and Services Administration (HRSA). The key documents used in developing standards are as follows:

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- Intake and assessment of available resources and needs
- Periodic reassessments of status and needs
- Appropriate linked referrals to housing, community case management, medical/physical healthcare, mental health, dental health, and substance use disorder treatment
- Coordination of services that facilitate retention in care, achieve viral suppression, and maintain overall health and wellness

- Access to HIV and STI information, education, partner services, and behavioral and biomedical interventions such as Pre-Exposure Prophylaxis (PrEP) and Doxycycline Post-Exposure Prophylaxis (Doxy PEP) to prevent acquisition and transmission of HIV/STIs.
- Active, ongoing monitoring and follow-up
- Ongoing assessment of the client's needs and personal support systems

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

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

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

General Eligibility Requirements for Ryan White Services

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

Given the barriers with attaining documentation, contractors are expected to follow the Los Angeles County, Department of Public Health, Division of HIV and STD Programs (DHSP) guidance for using self-attestation forms for documentation eligibility for Ryan White services.

TCM for Older Adults 50+: Service Compoments

Purpose: coordinate transition between systems of care for older adults 50+ living with HIV/AIDS.

Comprehensive Assessment: identifies and reevaluates a client's medical, physical, psychosocial, environmental and other health and social service needs. To ensure optimal transitional care plans for older adults living with HIV who may be eligible for other payor sources outside of or in tandem with Ryan White-funded services, comprehensive assessments and screenings should be performed when the client approaches their 50th birthday.

Assessments may include: (assessments conducted under other RW medical services such as AOM or MCC may be used as a base to avoid duplicative assessments and burden on the client and provider).

1. Comprehensive benefits analysis and financial security
2. Clients 55 years and older should be assessed for eligibility for Program of All-Inclusive Care for the Elderly (PACE)
3. Mental health
4. Hearing
5. Neurocognitive disorders/cognitive function
6. Functional status
7. Frailty/falls and gait
8. Social support and levels of interactions, including access to care giving support and related services.
9. Vision
10. Dental
11. Hearing
12. Osteoporosis/bone density
13. Cancers
14. Muscle loss and atrophy
15. Nutritional needs
16. Housing status
17. Immunizations
18. Polypharmacy/drug interactions
19. HIV-specific routine tests
20. Cardiovascular disease
21. Smoking-related complications
22. Renal disease
23. Coinfections
24. Hormone deficiency
25. Peripherical neuropathology
26. Sexual health
27. Advance care planning
28. Occupational and physical therapy

**these assessments and screenings are derived from the Aging Task Force Recommendations.*

Care Planning

Once the comprehensive assessment is completed, a standing care plan should be developed in collaboration with the client that the patient may use to communicate their care needs to

providers who may be operating under different healthcare systems. Care plans should include the client's health goals, medication adherence and continuity, eligibility for services, and an HIV care provider contact to assist with communicating care needs during periods of transitions into another health system (such as Medi-Cal, Medicare), or non-HIV specialist providers.

Resource Navigation

Resource navigation seeks to assist clients with understanding and accessing information about resources available to them and their caregivers. Case managers should:

1. Work with the client and show them what benefits they may be eligible for using Benefitscheckup.org.
2. Connect them to a Benefits Specialty Services (BSS) to access and enroll in public and/or private health and disability programs.
3. Educate and assist client in navigating enrollment and application processes.

Follow-up Support: Ongoing contact and intervention with (or on behalf of) the client to ensure that care plan goals and resource needs are addressed, and that the client is linked to and appropriately accesses and maintains primary health care and community-based supportive services identifies on the care plan.

TCM Older Adults Service Components	
STANDARD	DOCUMENTATION
Comprehensive Assessment and Screening	Recommended assessment and screenings are completed around the client's 50th birthday.
Care Planning	Results of the assessments/screenings are used to develop a care plan that contains the client's health goals, medication adherence and continuity, eligibility for services, and an HIV care provider contact to assist with communicating care needs during periods of transitions into another health system (such as Medi-Cal, Medicare), or non-HIV specialist providers.
Resource Navigation	Documentation of joint effort with client to identify programs they may be eligible for via Benefitscheckup.org, BSS, and assistance with enrollment/application process.
Follow-up Support	Documentation of contact with and offers of support for clients regarding the status of their care plan and enrollment in other services at 3-month intervals up to a year.

Recommended Training Topics for Transitional Case Management Staff

Transitional Case Management staff should complete ongoing training related to the provision of TCM services. Staff development and enhancement activities should include:

- HIV/AIDS Medical and Treatment Updates
- Risk Behavior and Harm Reduction Interventions
- Addiction and Substance Use Treatment
- HIV Disclosure and Partner Services
- Trauma-informed Care
- Person First Language
- Mental health and HIV/AIDS
- Legal Issues
- Alternatives to Incarceration Training
- Integrated HIV/STI prevention and care services including Hepatitis C screening and treatment
- Gender and sexuality
- Stigma and discrimination and HIV/AIDS
- Health equity and social justice
- Motivational interviewing
- Knowledge of available housing, food, and other basic need support services

LOS ANGELES COUNTY
COMMISSION ON HIV

TRANSITIONAL CASE MANAGEMENT SERVICES: YOUTH

SERVICE STANDARDS FOR RYAN WHITE HIV/AIDS PROGRAM CARE AND TREATMENT SERVICES

Los Angeles County Commission on HIV
510 S. Vermont Ave. 14th Floor, Los Angeles, CA 90020
(213) 738-2816 | hivcomm@lachiv.org
REVISED: 08/05/25 | APPROVED BY COH: PENDING

Contents

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

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

HRSA HAB Policy Clarification Notice (PCN) # 18-02: The use of Ryan White HIV/AIDS Program Funds for Core Medical Services and Support Services for People Living with HIV Who Are Incarcerated and Justice Involved

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

Service Standards: Ryan White HIV/AIDS Programs

Introduction

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

Service Description

Transitional Case Management (TCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services for special populations living with HIV/AIDS to mitigate and eliminate barriers to HIV care services.

- Intake and assessment of available resources and needs
- Periodic reassessments of status and needs
- Appropriate linked referrals to housing, community case management, medical/physical healthcare, mental health, dental health, and substance use disorder treatment
- Coordination of services that facilitate retention in care, achieve viral suppression, and maintain overall health and wellness
- Access to HIV and STI information, education, partner services, and behavioral and biomedical interventions such as Pre-Exposure Prophylaxis (PrEP) and Doxycycline Post-Exposure Prophylaxis (Doxy PEP) to prevent acquisition and transmission of HIV/STIs.
- Active, ongoing monitoring and follow-up

- Ongoing assessment of the client's needs and personal support systems

HRSA Guidance for Non-Medical Case Management

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

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

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

General Eligibility Requirements for Ryan White Services

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

Given the barriers with attaining documentation, contractors are expected to follow the Los Angeles County, Department of Public Health, Division of HIV and STD Programs (DHSP) guidance for using self-attestation forms for documentation eligibility for Ryan White services.

Transitional Case Management for Youth

For the purposes of these standards, "youth" is defined as adolescents and young adults aged 13-29 years old living with HIV/AIDS, including homeless, runaways, and emancipating/emancipated youth at risk for HIV/STIs. Transitional Case Management (TCM) for youth is a client-centered

activity that coordinates services designed to promote access to and utilization of HIV care by identifying and linking youth living with HIV/AIDS to HIV medical and supportive services. The objectives of TCM for youth living with HIV/AIDS include:

- Locating youth not engaged in HIV care
- Identifying and addressing client barriers to care
- Reducing homelessness
- Reducing substance use
- Improving the health status of transitional youth
- Easing a youth's transition from living on the streets or in foster care to community care
- Increasing access to education
- Increasing self-efficacy and self-sufficiency
- Facilitating access and adherence to primary health care
- Ensuring access to appropriate services and to the continuum of care
- Increasing access to HIV information and education
- Developing resources and increasing coordination between providers

SERVICE STANDARDS

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

OUTREACH

Outreach activities are defined as targeted activities designed to bring youth living with HIV/AIDS into HIV medical treatment services. This includes effective and culturally relevant methods to located, engage, and motivate youth living with HIV/AIDS in HIV medical services.

OUTREACH	
STANDARD	DOCUMENTATION
Transitional case management programs will outreach to potential clients and providers.	Outreach plan on file at provider agency.

COMPREHENSIVE ASSESSMENT AND REASSESSMENT

Comprehensive assessment and reassessment is completed in a cooperative, interactive, face-to-face interview process. Youth-friendly assessment(s) should consider the length of the questionnaire. See appendix 1 for additional information.

Assessment/reassessment identifies and evaluates a client's medical, physical, psychosocial, environmental and financial strengths, needs, and resources.

Comprehensive assessment is conducted to determine the following:

- Client's needs for engaging in HIV medical care and treatment, and supportive services
- Client's current capacity to meet those needs
- Ability of the client's social support network to help client gain access to, engage in, and maintain adherence to HIV care and treatment
- Extent to which other agencies are involved in client's care
- Areas in which the client requires assistance in securing services
- Readiness for transition to adult/mainstream case management services. Youth may remain in TCM for youth services until age 29. Appropriateness of continued transitional case management services will be assessed annually, and clients shall be transitioned into non-youth specific HIV care as appropriate but not later than age 30.

COMPREHENSIVE ASSESSMENT AND REASSESSMENT	
STANDARD	DOCUMENTATION
Complete and enter comprehensive assessments into DHSP's data management system within 30 days of the initiation of services. Perform reassessments at least once per year or as needed.	Comprehensive assessment or reassessment on file in client chart to include: • Date • Signature and title of staff person Client strengths, needs and available resources in: • Medical/physical healthcare • Medications and Adherence issues • Mental Health • Substance use and substance use treatment • Nutrition/Food • Housing and living situation • Family and dependent care issues • Access to gender-affirming care • DCFS and other agency involvement • Transportation • Language/Literacy skills • Religious/Spiritual support • Social support system • Relationship history

	• Domestic violence/Intimate Partner Violence (IPV) • History of physical or emotional trauma • Financial resources • Employment and Education • Legal issues/incarceration history • Risk behaviors • HIV/STI prevention issues • Harm reduction services and support • Environmental factors • Resources and referrals • Assessment of readiness for transition to adult services.

INDVIDUAL SERVICE PLAN (ISP)

An Individual Service Plan (ISP) determines the case management goals for a client and is developed in conjunction with the client and case manager within two weeks of the completion of the comprehensive assessment or reassessment. A service plan is a tool that enables the case manager to assist the client in systematically addressing barriers to HIV medical care by developing a concrete strategy to improve access and engagement to needed medical and other support services. All goals shall be determined by utilizing information gathered during assessment and subsequent reassessments.

INDIVIDUAL SERVICE PLAN	
STANDARD	DOCUMENTATION
ISPs will be developed in conjunction with the client within two weeks of completing the assessment or reassessment.	ISP on file in client chart to include: • Name of client and case manager • Date and signature of case manager and client • Date and description of client goals and desired outcomes • Action steps to be taken by client, case manager and others • Goal timeframes • Disposition of each goal as it is met, changed or determined to be unattainable

BRIEF INTERVENTIONS

Brief intervention sessions actively facilitate a client's entry into HIV medical care through the resolution of barriers to primary HIV-specific healthcare. The interventions focus on specific

barriers identified through a client assessment and assist the client in successfully addressing those barriers to HIV care. Case managers must prepare clients for the transition into non-youth specific HIV medical services and a lifetime of managing HIV/AIDS. This includes empowering youth with information and skills necessary to increase their readiness to engage in non-youth specific HIV medical care.

BRIEF INTERVENTIONS	
STANDARD	DOCUMENTATION
Case managers will: • Risk Reduction Counseling: Provide risk reduction/harm reduction sessions for clients that are actively engaging in behaviors that put them at risk for transmitting HIV and acquiring other STIs. • Linkage to HIV Medical Care: To assist the client with access to and engagement in primary HIV-specific health care by linking them to an HIV medical clinic • Disclosure and Partner Notification: Addressing disclosure and partner notification for clients who have not disclosed their HIV status to partner(s) or family member(s). • Help clients resolve barriers	Signed, dated progress notes on file that detail: • Description of client contracts and actions taken • Date and type of contact • Description of what occurred • Changes in the client's condition or circumstances • Progress made toward goals • Barriers to ISPs and actions taken to resolve them • Linked referrals and interventions and status/results • Barriers to referrals and interventions/actions taken • Time spent with, or on behalf of, client • Case manager's signature and title • Detailed transition plan to adult services with specific linkage to health, medical, and social services.

IMPLEMENTATION, MONITORING, AND FOLLOW-UP OF ISP

Implementation, Monitoring, and Follow-up of Isp involve ongoing contact and interventions with (or on behalf of) the client to ensure that ISP goals are addressed, and that the client is linked to and appropriately accesses and maintains primary healthcare and community-based supportive services identified on the ISP. These activities ensure that referrals are completed, and services are obtained in a timely, coordinated fashion.

IMPLEMENTATION, MONITORING, AND FOLLOW-UP OF ISP	
STANDARD	DOCUMENTATION
Case managers will: • Provide referrals, advocacy, and interventions based on the intake, assessment, and ISP	Signed, dated progress notes on file that detail: • Description of client contacts and actions taken • Date and type of contact

• Monitor changes in the client's condition • Update/revise the ISP • Provide interventions and linked referrals • Ensure coordination of care • Help clients submit applications and obtain health benefits and care • Conduct monitoring and follow-up to confirm completion of referrals and service utilization • Advocate on behalf of clients with other service providers • Empower clients to use independent living strategies • Help clients resolve barriers • Follow-up on ISP goals • Maintain/attempt contact at minimum of once every two weeks and at least one face-to-face contact monthly • Follow-up missed appointments by the end of the next business day • Collaborate with the client's community-based case manager for coordination and follow-up when appropriate • Transition clients out of TCM when appropriate • Develop a transition plan to adult services such as Medical Care Coordination (MCC), job placement, permanent supportive housing, or other appropriate services at least 6 months prior to formal date of release from TCM for youth program • Upon transition case, communicate to client the availability of case manager for occasional support and role as a resource to maintain stability for client.	• Description of what occurred • Changes in the client's condition or circumstances • Progress made toward ISP goals • Barriers to ISPs and actions taken to resolve them • Linked referrals and interventions and status/results • Barriers to referrals and interventions • Time spent with, or on behalf of, client • Case manager's signature and title • Detailed transition plan to adult services, with specific linkage to health, medical, and social services • Documentation of expedited linkage to MCC for eligible clients

STAFFING REQUIREMENTS AND QUALIFICATIONS

At minimum, all TCM staff will be able to provide linguistically and culturally appropriate care to clients and complete documentation as required by their positions. Case management staff will complete an agency-based orientation and be trained and oriented regarding client confidentiality and HIPAA regulations before providing services. See "Personnel and Cultural Linguistic Competence" section on the Universal Service Standards.

STAFFING REQUIREMENTS AND QUALIFICATIONS	
STANDARD	DOCUMENTATION
Case managers will have: • Knowledge of HIV/STIs and related issues • Knowledge of and sensitivity to run away, homeless or emancipating/emancipated youth • Effective Motivational Interviewing and assessment skills • Knowledge of adolescent development • Knowledge of, and sensitivity to, lesbian, gay, bisexual, and transgender persons • Ability to appropriately interact and collaborate with others • Effective written/verbal communication skills • Ability to work independently • Effective problem-solving skills • Ability to respond appropriately in crisis situations • Effective organizational skills	Resume, training certificates, interview assessment notes, reference checks, and annual performance reviews on file.
Case managers will meet one of the following educational requirement criteria: • A bachelor's degree in a Health or Human Services field and have completed a minimum of eight hours of course work on the basics of HIV/AIDS prior to providing services to clients • An associate degree plus one-year direct case management experience in health or human services	Resumes on file at provider agency documenting experience. Copies of diplomas on file.

• A high school diploma or GED and a minimum of three years of experience providing direct social services to patients/clients within a medical setting or in the field of HIV. Prior experience providing services to run away, homeless, emancipated or emancipating youth is preferred. Personal life experience with relevant issues is highly valued and should be considered when making hiring decisions.	
All staff will be given orientation prior to providing services.	Record of orientation in employee file at provider agency.
Case management staff will complete DHSP's required case management certifications/training within three months of being hired.	Documentation of certification completion maintained in employee file.
Case managers and other staff will participate in recertification as required by DHSP.	Documentation of training maintained in employee files to include: • Date, time, and location of function • Function type • Staff members attending • Sponsor or provider of function • Training outline, handouts, or materials • Meeting agenda and/or minutes
Case management staff will receive a minimum of four hours of client care-related supervision per month from a master's level mental health professional.	All client care-related supervision will be documented as follows, at minimum: • Date of client care-related supervision • Supervision format • Name and title of participants • Issues and concerns identified • Guidance provided and follow-up plan • Verification that guidance and plan have been implemented • Client care supervisor's name, title, and signature.
Clinical supervisor will provide general clinical guidance, and follow-up plans for case management staff.	Documentation of client care related supervision for individual clients will be maintained in the client's individual file.

Recommended Training Topics and Additional Resources

Transitional Case Management staff should complete ongoing training related to the provision of TCM services. Staff development and enhancement activities should include:

- Integrated HIV/STI prevention and care services
- The role of substances in HIV and STI prevention and progression
- Substance use harm reduction models and strategies
- Sexual identification, gender issues, and provision of trans-friendly services
- Cultural competence
- Correctional issues
- Youth development issues
- Risk reduction and partner notification
- Current medical treatment and updates
- Mental health issues for people living with HIV
- Confidentiality and disclosure
- Behavior change strategies
- Stigma and discrimination
- Community resources including public/private benefits
- Grief and loss

Providers for TCM: Youth services should refer to the "Best Practices for Youth-Friendly Clinical Services," developed by Advocates for Youth, a national organization that advocates for policies and champions programs that recognize young people's rights to honest sexual health information.

Providers are highly encouraged to use or adapt youth-friendly assessment tools such as the HEADSS assessment for adolescents (Home and Environment; Education and Employment; Activities; Drugs; Sexuality; Suicide; Depression).

SERVICE STANDARDS REVISION DATE TRACKER FOR PLANNING PURPOSES

Last.updated¿6❸-96-8❶

KEYWORDS AND ACRONYMS	
HRSA: Health Resources and Services Administration	COH: Commission on HIV
RWHAP: Ryan White HIV/AIDS Program	DHSP: Division on HIV and STD Programs
HAB PCN 16-02: HIV/AIDS Bureau Policy Clarification Notice 16-02 RWHAP: Eligible Individuals & Allowable Uses of Funds	SBP Committee: Standards and Best Practices Committee
	PLWH: People Living With HIV

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HRSA Service Category	COH Standard Title	DHSP Service	Description	Notes
N/A	AIDS Drug Assistance Program (ADAP) Enrollment	N/A	State program that provides medications that prolong quality of life and delay health deterioration to people living with HIV who cannot afford them.	ADAP contracts directly with agencies. Administered by the California Department of Public Health, Office of AIDS.
Child Care Services	Child Care Services	Child Care Services	Childcare services for the children of clients living with HIV, provided intermittently, only while the client attends in person, telehealth, or other appointments and/or RWHAP related meetings, groups, or training sessions.	Last approved by COH: 7/8/2021
Early Intervention Services	Early Intervention Program (EIS) Services	Testing Services	Targeted testing to identify HIV+ individuals.	Last approved by COH: 5/2/217
Emergency Financial Assistance	Emergency Financial Assistance (EFA)	Emergency Financial Assistance	Pay assistance for rent, utilities, and food and transportation for PLWH experiencing emergency circumstances.	Last approved by COH: 2/13/2025
Food Bank/Home Delivered Meals	Nutrition Support Services	Nutrition Support Services	Home-delivered meals and food bank/pantry services programs.	Last approved by COH: 8/10/2023
N/A	HIV/STI Prevention Services	Prevention Services	Services used alone or in combination to prevent the transmission of HIV and STIs.	Last approved by COH: 4/11/2024 Not.a.program_.Standards.apply.to. prevention.services¡

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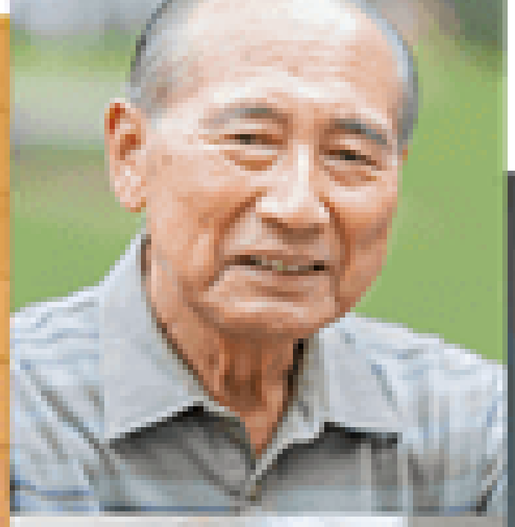
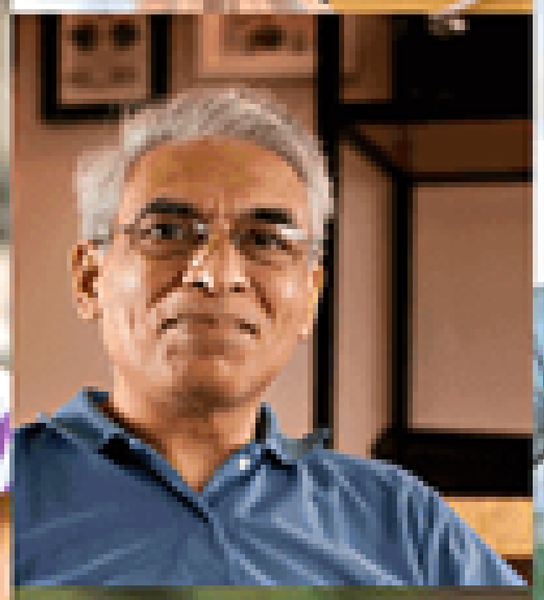
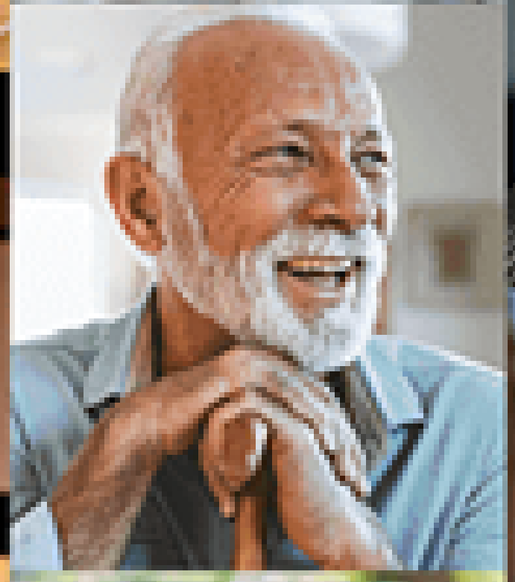
HRSA Service Category	COH Standard Title	DHSP Service	Description	Notes
Home and Community-Based Health Services	Home-Based Case Management	Home-Based Case Management	Specialized home care for homebound clients.	Last approved by COH: 9/9/2022
Hospice	Hospice Services	Hospice Services	Helping terminally ill clients approach death with dignity and comfort.	Last approved by COH: 5/2/2017
Housing	Housing Services: Permanent Supportive	Housing For Health	Supportive housing rental subsidy program of LA County Department of Health Services.	Last approved by COH: 4/10/2025
Housing	Housing Services: Residential Care Facility for Chronically Ill (RCFCI) and Transitional Residential Care Facility (TRCF)	Housing Services RCFCI/TRCF	RCFCI: Home-like housing that provides 24-hour care. TRCF: Short-term housing that provides 24-hour assistance to clients with independent living skills.	Last approved by COH: 4/10/2025
Legal Services	Legal Services	Legal Services	Legal information, representation, advice, and services.	Last approved by COH: 7/12/2018
Linguistic Services	Language Interpretation Services	Language Services	Interpretation (oral and written) and translation assistance to assist communication between clients and their healthcare providers.	Last approved by COH: 5/2/2017
Medical Case Management	Medical Care Coordination (MCC)	Medical Care Coordination	HIV care coordination through a team of health providers to improve quality of life.	Last approved by COH: 1/11/2024
	Treatment Education Services	Treatment Education Services	Provide ongoing education and support to ensure compliance with a client's prescribed treatment regimen and help identify and overcome barriers to adherence.	Last approved by COH: 5/2/2017
Medical Nutrition Therapy	Medical Nutrition Therapy Services	Medical Nutrition Therapy	Nutrition assessment and screening, and appropriate inventions and treatments to maintain and optimize nutrition	Last approved by COH: 5/2/2017

HRSA Service Category	COH Standard Title	DHSP Service	Description	Notes
			status and self-management skills to help treat HIV disease.	
Medical Transportation	Transportation Services	Medical Transportation	Ride services to medical and social services appointments.	Last approved by COH: 2/13/2025
Mental Health Services	Mental Health Services	Mental Health Services	Psychiatry, psychotherapy, and counseling services.	Last approved by COH: 5/2/2017 SBP.will.begin.review.in.August.868❶.
Non-Medical Case Management	Benefits Specialty Services (BSS)	Benefits Specialty Services	Assistance navigating public and/or private benefits and programs.	Last approved by COH: 9/8/2022
	Patient Support Services (PSS)	Patient Support Services	Provide interventions that target behavioral, emotional, social, or environmental factors that negatively affect health outcomes with the aim of improving an individual's health functioning and overall well-being.	New service standard currently under development..SBP.will.continue.review.on.❹❶~~8~~68❶
	Transitional Case Management: Justice-Involved Individuals	Transitional Case Management- Jails	Support for post-release linkage and engagement in HIV care.	Last approved by COH: 12/8/2022 Currently under review¡.SBP.will.continue.review.on.❹❶~~8~~68❶
	Transitional Case Management: Youth	Transitional Case Management- Youth	Coordinates services designed to promote access to and utilization of HIV care by identifying and linking youth living with HIV/AIDS to HIV medical and supportive services.	Last approved by COH: 12/8/2022 Currently under review¡.SBP.will.continue.review.on.❹❶~~8~~68❶
	Transitional Case Management: Older Adults 50+	N/A	Coordinate transition between systems of care for older adults 50+ living with HIV/AIDS.	SBP.will.continue.review.on.❹❶~~8~~8❶
Oral Health Care	Oral Health Care Services	Oral Health Services	General and specialty dental care services.	Last approved by COH: 4/13/2023
Outpatient/Ambulatory Health Services	Ambulatory Outpatient Medical (AOM)	Ambulatory Outpatient Medical	HIV medical care accessed through a medical provider.	Last approved by COH: 2/13/2025
Outreach Services	Outreach Services	Linkage and Retention Program	Promote access to and engagement in appropriate services for people newly diagnosed or identified as	Last approved by COH: 5/2/2017

HRSA Service Category	COH Standard Title	DHSP Service	Description	Notes
			living with HIV and those lost or returning to treatment.	
Permanency Planning	Permanency Planning	Permanency Planning	Provision of legal counsel and assistance regarding the preparation of custody options for legal dependents or minor children or PLWH including guardianship, joint custody, joint guardianship and adoption.	Last approved by COH: 5/2/2017
Psychosocial Support Services	Psychosocial Support Services	Psychosocial Support Services	Help PLWH cope with their diagnosis and any other psychosocial stressors they may be experiencing through counseling services and mental health support.	Last approved by COH: 9/10/2020
Referral for Health Care and Support Services	Referral Services	Referral	Developing referral directories and coordinating public awareness about referral directories and available referral services.	Last approved by COH: 5/2/2017
Substance Abuse Services (residential) Substance Abuse Outpatient Care	Substance Use Disorder and Residential Treatment Services	Substance Use Disorder Transitional Housing	Temporary residential housing that includes screening, assessment, diagnosis, and treatment of drug or alcohol use disorders.	Last approved by COH: 1/13/2022
N/A	Universal Standards and Client Bill of Rights and Responsibilities	N/A	Establishes the minimum standards of care necessary to achieve optimal health among PLWH, regardless of where services are received in the County. These standards apply to all services.	Last approved by COH: 1/11/2024 Not.a.program– SBP.committee. will.review.this.document.on.a.bi_ annual.basis.or.as.necessary.per. community.stakeholder? contracted.agency?or.COH. request¡




THE POWER OF AGING:

NAVIGATING SERVICES IN TIMES OF UNCERTAINTIES

September 19, 2025 | 9:30am - 3:00pm

Lunch will be provided.

Vermont Corridor

510 S. Vermont Ave 9th Floor, Los Angeles, CA 90020

VALIDATED PARKING: 523 SHATTO PL, LA 90020

Scan QR code to RSVP.

Questions? Email hivcomm@lachiv.org or call 213-738-2816

LOS ANGELES COUNTY COMMISSION ON HIV

We're Listening

share your concerns with us.

HIV + STD Services Customer Support Line

(800) 260-8787

Why should I call?

The Customer Support Line can assist you with accessing HIV or STD services and addressing concerns about the quality of services you have received.

Will I be denied services for reporting a problem?

No. You will not be denied services. Your name and personal information can be kept confidential.

Can I call anonymously?

Yes.

Can I contact you through other ways?

Yes.

By Email:
dhspsupport@ph.lacounty.gov

On the web:
http://publichealth.lacounty.gov/dhsp/QuestionServices.htm

County of Los Angeles Public Health
Division of HIV and STD Programs

Estamos Escuchando

Comparta sus inquietudes con nosotros.

Servicios de VIH + ETS
Línea de Atención al Cliente

(800) 260-8787

¿Por qué debería llamar?

La Línea de Atención al Cliente puede ayudarlo a acceder a los servicios de VIH o ETS y abordar las inquietudes sobre la calidad de los servicios que ha recibido.

¿Se me negarán los servicios por informar de un problema?

No. No se le negarán los servicios. Su nombre e información personal pueden mantenerse confidenciales.

¿Puedo llamar de forma anónima?

Si.

¿Puedo ponerme en contacto con usted a través de otras formas?

Si.

Por correo electronico:
dhspsupport@ph.lacounty.gov

En el sitio web:
http://publichealth.lacounty.gov/dhsp/QuestionServices.htm

County of Los Angeles
Public Health
Division of HIV and STD Programs