LOS ANGELES COUNTY
COMMISSION ON HIV

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

Thursday, June 26, 2025
1:00PM – 3:00PM (PST)

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

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

Register Here to Join Virtually

https://lacountyboardofsupervisors.webex.com/weblink/register/r78c55acff9ecf59d94e316bb0d141133
To Join by Telephone: 1-213-306-3065
Password: EXECUTIVE Access Code: 2538 141 0956

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, June 26, 2025 | 1:00PM-3:00PM

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/r78c55acff9ecf59d94e316bb0d141133
To Join by Telephone: 1-213-306-3065
Password: EXECUTIVE Access Code: 2538 141 0956

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 (LOA) (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)
Erica Robinson (OPS Committee)			
QUORUM: 7			

AGENDA POSTED: June 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 – 1:40 PM

A. Commission (COH)/County Operational Updates
   (1) Updated 2025 COH Workplan & Meeting Schedule
   (2) PY 35 Operational Budget Updates
   (3) 2025 Annual Conference Planning

8. Co-Chair Report 1:40 PM – 1:55 PM

A. Operations Committee Leadership
   (1) Leadership Transition Discussion: Consideration to Remove Current Co-Chairs and Initiate Nomination and Election Process for New Leadership **MOTION #3**

B. July 10, 2025 COH Meeting Agenda Development
   (1) PY 35 COH Operational Budget Updates
   (2) COH Effectiveness Review & Restructuring Project Updates
   (3) Proposed Changes to Bylaws
   (4) Transitional Case Management Service Standards Public Comment Period
   (5) Assessment of the Effectiveness of the Administrative Mechanism (AEAM) Final Report
   (6) PRESENTATION: Medical Monitoring Project Presented by Dr. Ekow Sey (DHSP)
   (7) PRESENTATION: PURPOSE Study Presented by Catherine Chien, MD & Suzanne Molino, PharmD (Gilead Sciences, Inc.)

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 1:55 PM – 2:20 PM

   (1) Final COH Organization Restructure Scenarios Presentation
   (2) Proposed Changes to Bylaws and Ordinance **MOTION #4**
   (3) Process Update on Membership Renewal for Terms Ending in 2025

10. Division of HIV and STD Programs (DHSP) Report 2:20 PM – 2:30 PM

A. Fiscal, Programmatic and Procurement Updates
   (1) Ryan White Program (RWP) Part A & MAI, and CDC/Ending the HIV Epidemic (EHE)
   (2) Fiscal
   (3) Other Updates

11. Standing Committee Report 2:30 PM – 2:45 PM

A. Planning, Priorities and Allocations (PP&A) Committee
   (1) 2027-2031 Integrated HIV Plan Overview & Preparation

B. Operations Committee
   (1) Administration of the Effectiveness of the Administrative Mechanism (AEAM) Report **MOTION #5**
   (2) Membership Management
      (a) New Member Application: Leroy Blea | State Office of AIDS, Part B Representative (Seat #17) **MOTION #6**
      (b) Resignations: Bridget Gordon, Andre Molette, & Karl Halfman
      (c) Attendance Updates: Kevin Stalter, Aaron Raines & Jeremy Mitchell

(3) 2025 Training Schedule
(4) Recruitment, Retention & Engagement

C. Standards and Best Practices (SBP) Committee
(1) Transitional Case Management Service Standards | PUBLIC COMMENT PERIOD: 6/26/25-7/26/25
(2) Patient Support Services (PSS) Service Standards Review Updates
(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: 2:45 PM – 2:50 PM

A. Aging Caucus
(1) September 19, 2025 National Aging & HIV Awareness Day Event

B. Black/AA Caucus
(1) July 9, 2025 Centering Voices of the Black Transgender Community Listening Session

C. Consumer Caucus
(1) July 10, 2025 Navigating the Transition Between Ryan White and Medi-Cal Listening Session

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

V. NEXT STEPS 2:50 PM – 2:55 PM

13. Task/Assignments Recap
14. Agenda development for the next meeting

VI. ANNOUNCEMENTS 2:55 AM – 3:00 PM

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

VII. ADJOURNMENT 3:00 PM

16. Adjournment of the regular meeting on June 26, 2025

PROPOSED MOTIONS	
MOTION #1	Approve the Agenda Order as presented or revised.
MOTION #2	Approve the meeting minutes, as presented or revised.
MOTION #3	Approve removal of current Co-Chairs of the Operations Committee and direct the Committee to initiate the nomination and election process to select new Co-Chairs in accordance with the Commission's Bylaws and established procedures, as presented or revised.

MOTION #4	Approve the proposed changes to the Commission's Bylaws, as presented or revised, and open a 30-day public comment period (6/26/25 – 7/26/25). Upon conclusion of the public comment period, the proposed changes shall be forwarded to the full body for review and, if approved, submitted to the Board of Supervisors for final review and approval in accordance with established procedures.
MOTION #5	Approve the Administration of the Effectiveness of the Administrative Mechanism (AEAM) Report, as presented or revised, and forward to the full body at its July 10, 2025 meeting for final approval.
MOTION #6	Approve new membership application for Leroy Blea to occupy the State Office of AIDS, Part B Representative, Seat #17, as presented or revised, and forward to the full body for final approval.

LOS ANGELES COUNTY
COMMISSION ON HIV

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

Approved by COH 6/8/23

CODE OF CONDUCT

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

All participants and stakeholders should adhere to the following:

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

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

LOS ANGELES COUNTY COMMISSION ON HIV

2025 MEMBERSHIP ROSTER| UPDATED 6.25.25

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			***Vacant***		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	SBP	David Hardy ,MD	University of Southern California	July 1, 2023	June 30, 2025	
18	Provider representative #8	1	SBP	Martin Sattah, MD	Rand Shrader Clinic, LA County Department of Health Services	July 1, 2024	June 30, 2026	
19	Unaffiliated representative, SPA 1			***Vacant***		July 1, 2023	June 30, 2025	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	*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	1	EXC|SBP	Kevin Stalter	*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 ***(LOA)***	*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	Rita Garcia (PP&A)
32	Unaffiliated representative, at-large #1	1	PP&A	Lilieth Conolly ***(LOA)***	*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 ***(LOA)***	*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	1	OPS	Erica Robinson	Health Matters Clinic	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:	**41**						

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: 50

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 6/24/25

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

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

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

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

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

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

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

Division of HIV and STDs Contracted Community Services

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

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

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

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

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

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

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

EXECUTIVE COMMITTEE MEETING MINUTES

Thursday, May 22, 2025

COMMITTEE MEMBERS P = Present | A = Absent | EA=Excused Absence | AB2449=Virtual | Public: Virtual *Not eligible for AB2449 | LOA=LeaveofAbsence			
Danielle Campbell, MPH, PhDc, Co-Chair	P	Arlene Frames	LOA
Joseph Green, Co-Chair	P	Katja Nelson	P
Miguel Alvarez (EXEC At-Large)	P	Mario J. Perez	P
Alasdair Burton (EXEC At-Large)	P	Dechelle Richardson (EXEC At-Large)	A
Erika Davies	EA	Erica Robinson	A
Kevin Donnelly	P	Darrell Russell	P
		Justin Valero	A
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, MPIA; Lizette Martinez, MPH; Jose Rangel-Garibay, MPH; and Sonja D. Wright, DACM			

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

I. ADMINISTRATIVE MATTERS

1. **CALL TO ORDER & MEETING GUIDELINES/REMINDERS**
   Co-Chair Danielle Campbell called the meeting to order at 1:00 PM and reviewed meeting protocols and guidelines.

2. **INTRODUCTIONS, ROLL CALL, & CONFLICTS OF INTEREST STATEMENTS**
   Joseph Green initiated introductions. Cheryl Barrit, MPIA, Executive Director, led roll call.

3. **ROLL CALL (PRESENT)**: Miguel Alvarez, Alasdair Burton, Kevin Donnelly, Arburtha Franklin, Katja Nelson, Mario J. Perez, Daryl Russell, Danielle Cambpell & Joseph Green

4. **APPROVAL OF AGENDA**
   MOTION #1: Approve the Agenda Order, as presented or revised. *(MOTION #1: vApproved by Consensus.)*

5. **APPROVAL OF MEETING MINUTES**
   MOTION #2: Approve the Executive Committee minutes, as presented or revised. *(MOTION #2: √Approved by Consensus.)*

II. PUBLIC COMMENT

6. **OPPORTUNITY FOR MEMBERS OF THE PUBLIC TO ADDRESS THE COMMISSION ON ITEMS OF INTEREST THAT ARE WITHIN THE JURISDICTION OF THE COMMISSION.**
   No public comment.

III. COMMITTEE NEW BUSINESS ITEMS

7. **OPPORTUNITY FOR COMMITTEE MEMBERS TO RECOMMEND NEW BUSINESS ITEMS FOR THE FULL BODY OR A COMMITTEE LEVEL DISCUSSION ON NON-AGENDIZED MATTERS NOT POSTED ON THE AGENDA, TO BE DISCUSSED AND (IF REQUESTED) PLACED ON THE AGENDA FOR ACTION AT A FUTURE MEETING, OR MATTERS REQUIRING IMMEDIATE ACTION BECAUSE OF AN EMERGENCY, OR WHERE THE NEED TO TAKE ACTION AROSE SUBSEQUENT TO THE POSTING OF THE AGENDA.** Commissioner Daryl Russel requested that a discussion be held to exclude Commission staff from providing input in updating the Bylaws.

IV. REPORTS

8. **EXECUTIVE DIRECTOR/STAFF REPORT** Cheryl Barrit, MPIA, Executive Director, reported:
   - **A. Commission (COH)/County Operational Updates**
     - **(1) Commission (COH)/County Operational Updates**
       - **a. Updated 2025 COH Workplan & Meeting Schedule.** The updated workplan and meeting schedule were shared, including the cancellation of the June, August, and September Commission meetings. Adjustments reflect improved coordination between standing committees and caucuses, highlight upcoming listening sessions hosted by various caucuses to inform the Integrated Plan needs assessments, and provide dedicated space for ongoing restructuring discussions.
       - **b. HRSA Administrative Reverse Site Visit Updates.** HRSA is no longer requiring Ryan White Part A Planning Bodies to participate in August 6-8, 2025, reverse site visit. While the Commission will not be formally present, it remains committed to providing requested documentation in support of the visit and partnership with HRSA and DHSP.

c. PY 35 Operational Budget Updates. The Commission is currently working with the Executive Office and DHSP in negotiating its PY 35 operational budget, with more details forthcoming. It was noted that significant cuts to the operational budget are being proposed, and staff are actively working to assess and respond to the potential impacts of those reductions.

(2) Planning Council Support Staff Role, Responsibilities & Expectations

To ensure that both Commission members and staff share a mutual understanding of expectations, core responsibilities of Commission staff were shared which include but are not limited to: agenda planning and documentation, meeting facilitation support, liaising between the County and the Commission, supporting committee chairs and co-chairs, and ensuring compliance with HRSA and County mandates. Refer to *the Expectations for Planning Council Support Staff* in the meeting packet.

B. CO-CHAIR REPORT JGreen and DCampbell, Co-chairs, reported:

(1) COH Effectiveness Review & Restructuring Project

a. Review Restructure Scenarios. Consultants from Collaborative Research LLC and Next-Level Consulting Inc. facilitated a presentation outlining three proposed restructuring scenarios for the Commission. The scenarios were informed by input gathered during restructuring workgroup sessions and broader stakeholder engagement, and were designed to enhance operational efficiency, promote equity, and strengthen engagement. Due to budget constraints, the restructuring effort includes recommendations to reduce the number of standing committees and limit meeting frequency to six times per year. Additional recommendations included elevating public policy within the Executive Committee structure and integrating subject matter experts into the Commission's deliberative processes.

To guide next steps, a non-binding straw poll was conducted among Executive Committee members. Option 3 received the most support. This scenario proposes consolidating committees, increasing integration of caucus input, and emphasizing a streamlined structure focused on strategic functions. Members responded positively to its clarity, alignment with current priorities, and potential to improve participation and accountability. The consultants will incorporate the feedback into a refined proposal and return to the full Commission in July for a final vote on the restructuring model.

b. Executive At-Large Member Seats. The role and purpose of the Executive At-Large seats were revisited. Members affirmed the value of these positions in fostering leadership, representation, and engagement across the Commission. It was recommended that duty statements be revised to ensure alignment with evolving Commission goals.

c. COH & DHSP Memorandum of Understanding (MOU) Development Updates. The development of the MOU with DHSP is ongoing and aims to codify shared responsibilities, data-sharing expectations, and communication protocols between the Commission and DHSP. County Counsel and HRSA have been consulted to ensure alignment with legal and federal requirements.

(2) May 10, 2025 COH Meeting Feedback. Feedback highlighted improved engagement, clear transitions, and streamlined discussion. Members appreciated the focus on efficiency and active facilitation during the recent full Commission meeting.

(3) 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*). Members were invited to attend the upcoming "Coping with Hope" conference on June 2, 2025, which centers on healing, innovation, and the future of HIV care. Also, refer to COH training series – see training schedule HERE.

9. Division of HIV and STD Programs (DHSP) Report. Mario J. Pérez, MPH, Director, provided a detailed update on current fiscal and programmatic issues:

HRSA Part A Funding and Contract Commitments

As of May 22, 2025, DHSP had received $21 million in HRSA Part A funding, against approximately $60 million in contract commitments. In response to this funding gap, DHSP is planning to request delegated authority from the Board of Supervisors at its June 17, 2025 meeting to adjust existing contracts in alignment with available resources.

CDC HIV Surveillance Funding

There is still no update from the CDC regarding the renewal of the HIV prevention surveillance grant, which is scheduled to expire in nine days. While there has been an update to the National HIV Behavioral Surveillance (NHBS) grant, CDC staffing shortages are currently preventing DHSP from initiating activities under that award. This has created uncertainty around ongoing surveillance operations, which Mario described as a critical concern.

Prevention Contract Adjustments

On April 21, 2025, DHSP issued letters to prevention providers across 13 service categories, indicating a pause in contracts due to federal funding uncertainty. A subsequent termination letter dated April 30 notified providers that contracts would end on May 31, 2025, coinciding with the projected end of CDC funding.

However, following a meeting with the Commission's PP&A Committee and invited stakeholders, DHSP issued a rescission letter to allow contracts to continue through their original Board-approved dates of June 30, 2025, and for some providers, July 31, 2025. These contracts will receive a nominal allocation (approximately $1,000) to keep them active until alternative resources—such as ADAP rebate funds or County support—become available. Advocacy efforts are underway, including a circulating letter requesting the County to help bridge the gap.

ADAP Rebate Funds and State Advocacy

DHSP is still waiting for confirmation from the Governor's Office regarding repayment of the $5 million borrowed from ADAP rebate funds. While the Board of Supervisors' Health Deputies have been fully briefed, the status of those funds—and whether they will be divided among jurisdictions—is still unknown.

Commissioner Katja Nelson emphasized the importance of advocating for full repayment and called on the Commission and community to mobilize around upcoming opportunities, including West Hollywood Pride, to deliver a unified message to the state legislature in support of HIV funding stability.

Contingency Planning and Community Mobilization

DHSP is developing a contingency funding plan in case additional resources become available. This plan will reflect the PP&A Committee's recommended priorities and aim to preserve high-impact prevention efforts.

MPerez thanked the Commission for its role in supporting the Priority-Setting and Resource Allocation (PSRA) processes for Part A, Part B, and MAI funds.

10. <u>REPORTS</u>

7. Standing Committee Reports

A. Planning, Priorities & Allocations (PP&A) Committee PP&A Co-Chair Kevin Donnelly presented the committee's report, which included the following updates:

(1) RWP PY 35 Contingency Planning Updates. The Committee has been actively engaged in contingency planning for Program Year 35, preparing for potential funding fluctuations. This includes identifying core service categories and outlining strategies to minimize disruptions in services should reductions occur. The contingency plans were approved by the full Commission in April and May.

(**2) FY 2025 HIV Prevention Services Programming a. Recommended HIV Prevention Services Priorities** (**MOTION #3: Approve the outlined HIV prevention service priorities for Fiscal Year 2025, as presented or revised, to guide the implementation of effective and equitable HIV prevention strategies in Los Angeles County, with the understanding that, should funding be limited, the top three priorities Surveillance, HIV/STI Testing with Linkage to Care, and Biomedical Prevention (PREP/PEP/DoxyPEP) will be preserved and prioritized in implementation.)** The Committee completed its review and prioritization process for HIV prevention services. The final recommended priorities were developed based on epidemiologic data, community input, and alignment with federal and local HIV prevention goals. The top three priorities emphasized: (1) Surveillance, (2) HIV/STI Testing with Linkage to Care, and (3) Biomedical Prevention (PrEP, PEP, DoxyPEP). Other service categories were also included, but the Committee recommended that these top three priorities be preserved in the event of limited funding. KDonnelly also acknowledged the contributions of committee members and thanked DHSP staff and community participants who provided valuable feedback throughout the prioritization process.
(MOTION #3√ Passed by Roll Call Vote: MAlvarez, ABurton, KDonnelly, AFranklin, KNelson, DRussell, DCambpell & JGreen; MPerez=Abstain)

KDonelly noted that DHSPS' response and follow up on the Directives is pending.

B. Operations Committee

In the absence of the co-chairs, Commission Co-Chair JGreen reported that the committee discussed the roles and responsibilities of co-chairs and will receive formal guidance at the next meeting, where elections for new co-chairs will be discussed.

The committee reviewed the final draft of the Assessment of the Effectiveness of the Administrative Mechanism (AEAM), which is included in the meeting packet. The assessment, informed by provider surveys and DHSP input, reflects overall positive feedback on improvements to the RFP and contracting process. While some contracting

delays were noted, they were not considered systemic. Members were encouraged to review the full report and share any additional feedback with staff ahead of approval.

JGreen also issued a reminder about the 2025 Commission training schedule, encouraging members to stay current with required trainings and to refer to the schedule for upcoming sessions.

C. **Standards and Best Practices (SBP) Committee** Jose Rangel-Garibay, COH Staff, provided the report on behalf of the committee. The SBP Committee last met on May 6, 2025, where they received a presentation from Dr. Rebecca Cohen of the Division of HIV and STD Programs. Dr. Cohen provided background on the Transitional Case Management (TCM) program and addressed committee members' questions related to its structure and implementation.

D. **Public Policy Committee (PPC)** Co-Chair Katja Nelson encouraged the community to attend its next meeting June 2, 2024

8. Caucus, Task Force, and Work Group Reports

A. **Aging Caucus.** KDonnelly reported that the Aging Caucus met on May 13, 2025, and discussed plans for the upcoming Power of Aging event, scheduled for September 19, 2025, at the Vermont Corridor. The agenda for the event has been finalized, and speaker invitations are currently being extended.

B. **Black/AA Caucus.** Dawn McClendon, COH staff, reported that the Black Caucus did not meet in May and will resume meeting on June 18, 2025, at 4:00 PM virtually. The Caucus continued its community listening session series, hosting a non-Traditional HIV Provider listening session on May 13, 2025. The next session is scheduled for July 9, 2025, and will focus on engaging the Black Transgender Community – flyer forthcoming.

C. **Consumer Caucus.** Alasdair Burton, Caucus Co-Chair, reported that the Consumer Caucus will meet next on June 10, 2025, in a virtual format. The meeting will focus its discussion on stipends eligibility for unaffiliated consumer members.

D. **Transgender Caucus.** Cheryl Barrit reported that the Transgender Caucus met on May 22, 2025, and has been actively preparing for upcoming listening sessions in collaboration with the Women's Caucus and the Black Caucus, focusing on transgender individuals. Additionally, Diamond Paulk was elected as the third co-chair of the caucus.

E. **Women's Caucus.** Lizette Martinez, COH staff, reported that the Women's Caucus last met on May 19, 2025, where they discussed services available under the Ryan White Program (RWP) and reviewed allocation and contingency plans. The Caucus finalized plans for its upcoming listening session series:

- June 4 – Focused on transgender women, in collaboration with the Transgender Caucus
- June 16 – Spanish-language session at the former MCA administrative building
- June 30 – Session in South Los Angeles at Charles Drew University (CDU)

Flyers for the sessions will be distributed soon. The next Women's Caucus meeting is scheduled for July 21, 2025, from 2:00–3:00 PM, and will be held virtually.

F. Housing Taskforce (HTF). Katja Nelson reported that the Housing Task Force is scheduled to meet tomorrow morning and will be reviewing the housing survey.

V. NEXT STEPS

11. Task/Assignments Recap

- ✓ All approved motions will be elevated to the June 26, 2025 Executive Committee and July 10, 2025 Commission on HIV (COH) meetings for action, as appropriate.
- ✓ A discussion on Commission restructuring and proposed Bylaws revisions will be agendized for the June Executive Committee meeting.
- ✓ COH staff will issue a cancellation notice for the June, August, and September 2025 COH meetings.

12. Agenda development for the next meeting. *Refer to minutes.*

VI. ANNOUNCEMENTS

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

- The TransLatin@ Coalition's "HOPE" Houses are now open and have beds available, subject to a strict vetting process for eligibility.
- The Coping with Hope Conference will take place on June 2, 2025.

VII. ADJOURNMENT

A motion was made to extend the meeting 20 additional minutes. Adjournment for the regular Executive Committee meeting of May 22, 2025

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

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 - 11:20am	**Commission on HIV Restructuring and Enhanced Performance and Impact** Next Level Consulting and Collaborative Research Co-Chair, Joseph Green and Danielle Campbell
11:30am – 12:30pm	**LUNCH AND NETWORKING**
12:30pm – 1:45pm	**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: ??

1:45pm-2:45pm	**Galvanizing Effectiveness Strategies for Community Action and Policy Advocacy** NMAC? End the Epidemics Coalition, Ryan Cleary? ?
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 (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
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	TBD
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 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.

Commission on HIV Budget Overview & Ryan White Program (RWP) Program Year (PY) 35

Executive Committee

June 26, 2025

LOS ANGELES COUNTY
COMMISSION ON HIV

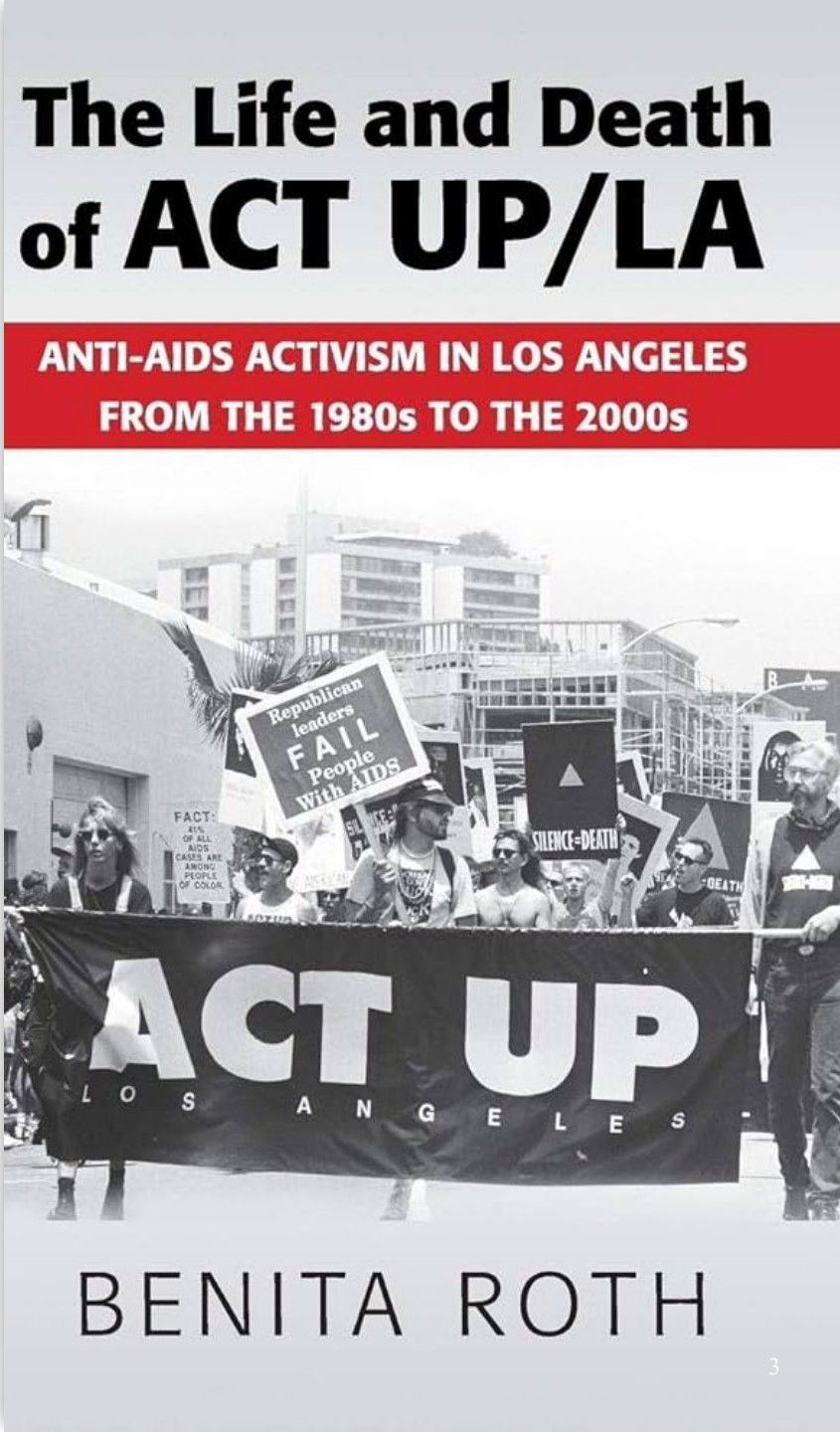
Planning Council(PC) Background

History

1989 to 1991

- LAC Board of Supervisors (BOS) established the Commission on AIDS, comprised of five community members who represented each supervisorial district
- County's Department of Public Health (DPH) created the AIDS Program Office, which was later renamed the Office of AIDS Programs and Policies (OAPP), and now known as the Division of HIV and STD Programs (DHSP).
- To coordinate federal funding for HIV/AIDS-related services awarded through the CARE Act, the BOS created the HIV Health Services Planning Council to prioritize and allocate the funding and meet the grant funding requirements. Additionally, as a mechanism to inform the BOS on policy matters related to the HIV/AIDS epidemic in Los Angeles County, the Commission on AIDS also became an advisory board.

Credits to Commissioner Alvaro Ballesteros



History (cont'd)

1997-1998

BOS dissolved both the Commission on AIDS and the HIV Health Services Planning Council and established the Commission on HIV Health Services in its place, placing the Commission under the scope and leadership of the County's CARE Act grantee, Office of AIDS Programs & Policy (OAPP), now the Division of HIV and STD Programs (DHSP).

2003

To address concerns of perception and potential conflicts of interest, the BOS amended the County Code to provide autonomy to the Commission, allow OAPP staff to serve on the Commission as non-voting members, reduce the size of the voting membership, and provide the Commission with staff independent of DHSP. Based on this milestone, the Commission was able to produce its own operational budget and work independently of its grantee, as the Commission was now and continues to be under the supervision of the BOS' Executive Office.

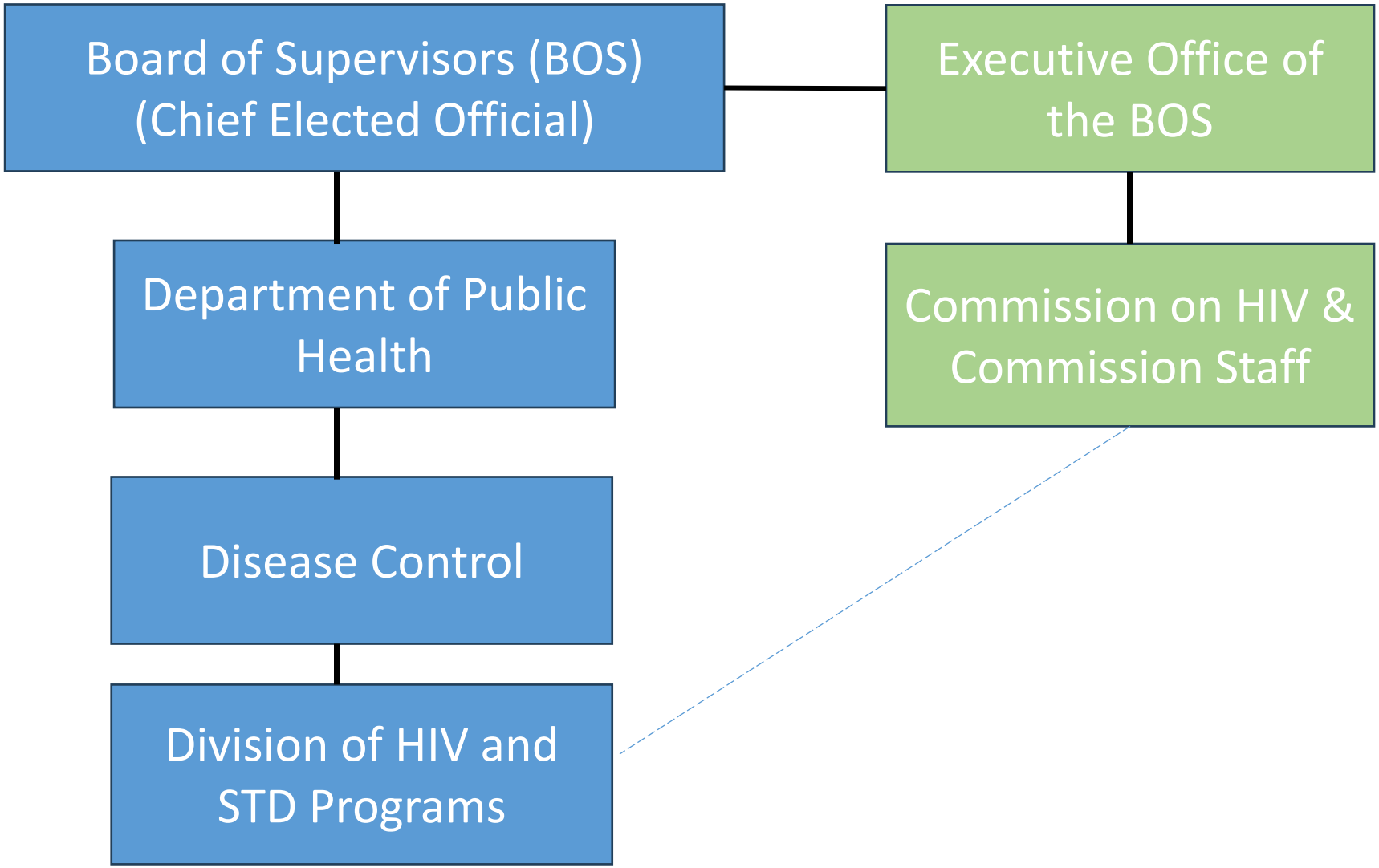
History (cont'd)

July 2013

Became an integrated and comprehensive HIV/AIDS planning body (Commission on HIV) catering to the needs of those who are living with and who are at risk of HIV/AIDS.

Evolving role within current environmental contexts, demands, and needs.

PC Organizational Structure in Relation to the Recipient (DHSP)



Ryan White CARE Act Legislation and Planning Councils

The Ryan White CARE Act (RWCA) is a federal law that provides funding and support for HIV/AIDS care and treatment, particularly for low-income individuals and those are uninsured or underinsured. The RWCA is codified in the Public Health Services (PHS) Act, which specifically states:

> "Section 2602(b)(1) of the PHS Act requires the Chief Elected Official *to establish or designate an HIV health services planning council* that shall reflect in its composition the demographics of the population of individuals with HIV/AIDS in the eligible area involved, with particular consideration given to disproportionately affected and historically underserved groups and subpopulations." Section 2609(d)(1)(A) of the PHS Act states a planning council must detail the process used to obtain community input for formulating the overall plan for priority setting and allocating funds. (See the 2023 Ryan White HIV/AIDS Program Planning Council and Planning Body Requirements and Expectations Letter.)

Ryan White CARE Act Legislation and Planning Councils

- As a condition for receiving RWCA funds, the Chief Elected Official (aka, Board of Supervisors for Los Angeles County) for the County must appoint a Planning Council. (HRSA HAB RWHAP Part A Manual, pg. 13)

- HIV Planning Councils are not advisory bodies. They are independent decision-making bodies that report to the Chief Elected Official (CEO) and work in partnership with the RWHAP Part A recipient (DPH), but not under its direction. (HRSA HAB RWHAP Part A Manual, pg. 25)

Ryan White CARE Act Legislation and Planning Councils

- Funds used for PC support are part of the 10% administrative cost cap of the RWHAP Part A award. (Section 2604(h0(3)(B) of the PHS Act; HRSA HAB RWHAP Part A Manual, pg. 36)

- The PC/PB must negotiate the size of its support budget with the recipient to carry out its legislative and programmatic responsibilities and then is responsible for developing and managing said budget within the recipient's grants management structure. PC/PB support funds may be used for such purposes as hiring staff, developing and carrying out needs assessments and estimating unmet need (sometimes with the help of consultants), conducting planning activities, holding meetings, and assuring participation of people with HIV. HRSA HAB RWHAP Part A Manual, pg. 36)

Figure 2. Roles/Duties of the Chief Elected Official, Recipient, and Planning Council/Planning Body

ROLE/DUTY	RESPONSIBILITY		
	CEO	Recipient	Planning Council/Planning Body
Establishment of PC/PB	✓		
Appointment of PC/PB Members	✓		
Needs Assessment		✓	✓
Integrated/Comprehensive Planning		✓	✓
Priority Setting			✓
Resource Allocations			✓
Directives			✓
Procurement of Services		✓	
Subrecipient Monitoring		✓	
Coordination of Services		✓	✓
Evaluation of Services: Performance, Outcomes, and Cost-Effectiveness		✓	*Optional*
Development of Service Standards		✓	✓
Clinical Quality Management		✓	*Contributes but not responsible*
Assessment of the Efficiency of the Administrative Mechanism			✓
Planning Council Operations and Support		✓	✓

Contract Budget vs Total Operational Expenses PY 30-PY 34

Ryan White Program Year (PY)	Contract Budget	Final Expenses Personnel	Final Expenses S&S	Final Indirect (15%)	Total Expenses
PY 30 (3/1/20-2/28/21)	$ 1,437,254.00	$ 958,459.00	$ 132,393.00	$ 143,769.00	$ 1,234,621.00
PY 31 (3/1/21-2/28/22)	$ 1,394,131.00	$ 997,536.00	$ 169,377.00	$ 149,645.00	$ 1,316,558.00
PY 32 (3/1/22-2/28/23)	$ 1,561,923.00	$ 941,732.00	$ 179,767.00	$ 140,692.00	$ 1,262,191.00
PY 33 (3/1/23-2/29/24)	$ 1,686,538.00	$ 1,115,401.00	$ 185,198.00	$ 167,310.00	$ 1,467,908.90
PY 34 (3/1/24-2/28/25)	$ 1,688,673.00	$ 1,229,303.00	$ 251,270.00	$ 184,395.00	$ 1,664,968.00

Contract Budget vs Total Direct Expenses - PY 30-PY 34

HIV Connect Resource Website (Sunset Date 3.13.24)					
Ryan White Program Year (PY)	**Contract Budget**	**Final Expenses Personnel**	**Final Expenses S&S**	**Final Indirect (15%)**	**Total Expenses**
PY 30 (3/1/20-2/28/21)	$ 104,647.00	$ 45,063.00	$ 30,544.00	$ 6,759.00	$ 82,366.00
PY 31 (3/1/21-2/28/22)	$ 79,600.00	$ 39,572.00	$ 25,000.00	$ 5,936.00	$ 70,508.00
PY 32 (3/1/22-2/28/23)	$ 102,447.00	$ 42,335.00	$ 6,141.00	$ 6,350.00	$ 54,826.00
PY 33 (3/1/23-2/29/24)	$ 33,000.00	$ -	$ 8,190.00	$ -	$ 8,190.00

PY 35 Budget Proposed to DHSP 6.2.24

Total Salaries and Benefits	Supplies and Services (S&S)	Total
$1,134,000	$130,060	$1,265,600

S&S Line Item	Proposed Budget Amount
Food/Revolving Fund	$15,000
Office Supplies	$2,000
Meeting Room Rentals	$14,000
Audio-visual	$18,000
Gift cards (incentives for unaffiliated consumers)	$15,000
Consultants	$50,000
Interpreters	$3,000
Photocopy/Machine rentals	$3,000
Travel/Mileage Reimbursements (for unaffiliated consumers)	$3,000
SurveyMonkey subscription	$3,600
Telecommunications (staff cell phones)	$2,000
Postage	$2,000
Total	$130,600

Program Year – Current Situation

- DHSP imposed limit/cap $500,000
- PY 2023-2024 grant billings by DHSP for COH expenses (approx.)
  - 89.73% (HRSA Part A)
  - 1.15% (CDC)
  - 6.41% (CDC EHE)
  - 2.69% (NCC)

Discussion

- Reactions and questions
- Ideas and strategies for focusing on the core duties
- What Planning Council (PC) tasks are commissioners willing and able to do to fulfill PC duties?
- Pursue negotiations, in good faith, with DPH and work on a budget that supports the COH at a reasonable and realistic level.

Expectations for Planning Council Support Staff*

Primary Responsibility of PC Support (PCS) Staff

Assist the PC/B to carry out its legislative responsibilities and to operate effectively as an independent planning body that works in partnership with the recipient.

Planning Council Support Function

The *Ryan White HIV/AIDS Program (RWHAP) Part A Manual* describes the PCS function:

"The planning council needs funding to carry out its responsibilities. HAB/DMHAP refers to these funds as 'planning council support.' Planning Council Support funds are part of the 10 percent administrative funds available to the grantee for managing the [RWHAP] Part A program. The planning council must negotiate the size of the planning council support budget with the grantee and is then responsible for developing and managing that budget within the grantee's grants management structure.

"Planning council support funds may be used for such purposes as hiring staff, developing and carrying out needs assessments and estimating unmet need, sometimes with the help of consultants, conducting planning activities, holding meetings, and assuring PLWHA participation. [p 104]

"Planning council staff may be employed through the grantee's payroll system, but measures must be taken to ensure that the planning council, not the grantee, directs the work of the planning council's staff."[p 105]

PCS Staff Responsibilities

The PCS staff can be hired through the municipal system or through a contractor but are responsible to the PC/B. PC/B leadership (usually the Chair/Co-Chairs and/or Executive Committee) sets priorities for staff, and should have a role in hiring and evaluating the performance of the PCS Manager. Other PCS staff (if any) report to the Manager.

Following is a summary of roles DMHAP expects PCS staff will play, though individual PC/Bs may establish additional or different responsibilities. In TGAs that have advisory planning bodies rather than planning councils, the recipient may play a larger role in determining planning body support staff roles and priorities.

1. *Staff committees and PC/B meetings:*
    - Attend and provide assistance at every PC/B committee meeting unless the Committee decides it does not want staff support
    - Work with Committee Chairs to ensure that committees have annual work plans with schedules, and that each meeting has an agenda, needed resource materials, and minutes documenting attendance, discussion, decisions, and recommendations to the full PC/B

* Prepared for DMHAP, April 2017, under Task Order 003111 through MSCG/Ryan White TAC

- Work with PC/B leadership to set agendas, arrange presentations, prepare meeting "packets," and otherwise plan and coordinate PC/B meetings (including logistics such as meeting space, food, and transportation)
- Ensure that all open meeting requirements (federal, state, and local) are met
- Take notes and prepare minutes of PC/B meetings, and provide draft minutes to PC/B leadership for review and for eventual adoption at the next PC/B meeting

2. *Support the PC/B in implementing legislated tasks:*
   - Facilitate and coordinate on-time completion of legislatively required and locally determined activities
   - Provide technical advice and support to specific committees in such tasks as needs assessment design, preparations for data presentations, and PSRA session planning
   - Assist in the development of PC/B policies and Standard Operating Procedures
   - Carry out direct planning activities when directed by the PC/B, such as design of needs assessment instruments, or aggregation of provider survey data for the assessment of the efficiency of the administrative mechanism (since PC/B members must not see individual provider responses)
   - Work with the PC/B to obtain external assistance where necessary to complete legislative tasks
   - Manage PC/B communications
   - Carry out other support as directed by the PC/B leadership (Chair/Co-Chairs and/or Executive Committee)
3. *Provide expert advice on Ryan White legislative requirements and HRSA/HAB regulations and expectations, and explain and interpret the PC/B's Bylaws, policies, and procedures:*
   - Have in-depth knowledge and understanding of RWHAP legislation, Policy Notices and Letters, Policy Clarification Notices (PCNs), the *RWHAP Part A Manual,* and other documents that provide guidance related to the work of PC/Bs, and be prepared to present and clarify relevant information as needed doing a meeting – to ensure that the PC/B meets requirements, and to provide guidance when members are uncertain about HRSA/HAB requirements or expectations
   - Understand and ensure that the PC/B follows municipal requirements affecting boards and commissions or planning bodies
   - Keep updated on changes in policy that may affect the work of the PC/B
4. *Oversee a training program for members*
   - Work with the assigned committee (often Membership) to ensure that new PC/B members receive a thorough orientation at the start of their service as members, including copies of key documents
   - Ensure that there is, at a minimum, annual training for members, and ideally, ongoing training to help the PC/B successfully carry out its responsibilities
   - Develop training specifically for PC/B leadership (Chairs of PC/B and committees
   - Work with PC/B leaders in designing and delivering training directly, with members, or with external training assistance

- Obtain training materials from DMAHP and other RWHAP Part A programs that can help address PC/B training needs
- Provide interactive training and facilitation that reflects sound practices and engages participants

5. *Encourage member involvement and retention, with special focus on consumers*
   - Support the open nominations process, and assist the appropriate committee in disseminating information about opportunities for membership
   - Help the PC/B identify and resolve barriers to participation, especially by consumers and other PLWH
   - Assist with outreach and other efforts to engage consumers as committee or PC/B members
   - Be available to assist individual PC/B members with problems they encounter and to ensure they receiving needed mentoring and support, especially during their first year of membership
   - Support PLWH member expense reimbursement procedures, helping to ensure that they are understood and followed and that reimbursement is provided promptly
6. *Serve as liaison with the recipient, community, and sometimes the Chief Elected Official (CEO):*
   - Help maintain a collaborative partnership between PC/B and recipient
   - Work with the recipient and PC/B to develop and/or implement an MOU between the PC/B and the recipient
   - Arrange recipient staff participation in committee meetings, to provide information and technical expertise
   - Communicate PC/B information/data and other requests for assistance to the recipient
   - Ensure that materials that should be shared with the recipient are provided promptly and the recipient is kept informed of PC/B activities and issues
   - Arrange/coordinate assistance to the recipient on behalf of the PC/B, such as preparation of PC/B sections of the annual RWHAP Part A application and provision of materials needed to meet Conditions of Grant Award related to the PC/B
   - Request recipient staff participation in training or other PC/B events as needed
   - Work with the recipient to request training and technical assistance from HRSA/HAB as needed
   - Serve as a liaison between the PC/B and the community, and support PC/B leadership outreach to the community
   - In some jurisdictions, maintain direct/official contact with the CEO and provide updates to the CEO's office on PC/B progress and concerns
7. *Help the PC manage its budget*
   - Participate in annual negotiations between the PC/B and recipient concerning the amount of administrative funding that will be provided for PC support
   - Assist the PC/B in developing its budget, to ensure that support needs are met and all proposed expenditures meet both HRSA/HAB and municipal requirements
   - Provide the PC/B budget to the recipient in the agreed-upon format

- Manage and monitor expenditure of funds for the PC/B, following municipal requirements
- Receive a monthly report on PC/B expenditures from the recipient, and work with appropriate PC/B committee to review and where needed revise it
- Work with the recipient on any necessary contracting for PC support services such as consultants, ensuring a scope of work from the PC/B and PC/B involvement in selection of contractors, consistent with municipal requirements

PCS Qualifications

DMHAP has identified the following as desired qualifications for a PCS manager:

- Strong knowledge of planning and data
- Expertise in legislative mandates of a RWHAP Part A planning body
- Understanding of HRSA expectations for the planning process
- Ability and time to work with committees
- Ability to work with People Living with HIV/AIDS and diverse stakeholders
- Ability to facilitate a partnership between planning body and recipient

In addition, the following are very helpful:

- Strong oral and written communications skills, including use of clear, concise language
- Experience in facilitation and training, especially interactive training
- Group process skills such as team building, leadership development, and problem solving
- Experience in resolving conflicts
- Commitment to community planning and consumer engagement
- Knowledge of budgeting and expenditure monitoring

COMMISSION RESTRUCTURE TRANSITION AND TIMELINE (5.05.25; 05.12.25; 06.04.25; SUBJECT TO CHANGE)

The Executive Committee (EC) will keep decisions moving in keeping with the timeline if the COH meeting is cancelled. *

Task(s)/Activities	Responsibility	Timeline/ Completion
Present restructuring report and recommendations.	Consultants	May 8, 2025 COH meeting; Updates: Timeline walk through provided at 5/8/25 meeting; full presentation at 5/22/26 EC meeting.
Present restructuring report and recommendations.	Consultants	Presentation provided at May 22, 2025 EC meeting. Straw poll result: Exhibit B and reduced membership seats.
Present updated bylaws (based on restructuring report, recommendations and feedback). Concurrent CoCo reviews of bylaws and ordinance.	Commission staff, consultants, COH Co-Chairs	June 26, 2025 Executive Committee meeting
Present updated bylaws; start 30-day public comment period on bylaws. Line up final layers of review from CoCo, EO, and prepare for BOS approval of the ordinance. Cover letter to the BOS to include timeline and start date for the members March 1, 2026; align with RW Program Year March 1-Feb. 28)	~~Commission staff~~ Consultants	July 10, 2025 COH meeting
COH approve bylaws. Submit ordinance to BOS for approval.	Commission staff Commissioners	October 9, 2025

Transitional membership application and Open Nominations Process description disseminated to all accessible stakeholder constituencies, including current Commissioners. All interested members must apply/re-apply by completing and submitting their membership applications by published deadline.	Commission staff	October - November
Newly restructured COH highlighted at the Annual Conference.		Nov. 13, 2025
Organize and verify applications for completeness and accuracy.	Commission staff	Deadline to submit application November 14, 2025
All candidates for membership must sit for membership interviews.	Proposed interview panel: • Academic partners • EO Commission Services representative • Former Co-chairs and members not applying to serve on COH. • 1-2 people from other neighboring planning councils • 1-2 consumers not applying • Collaborative Research/Next Level Consulting • COH staff • 5 to 6 members	November 17-21, 2025
Select initial cohort of candidates to recommend for membership nomination to the Commission and BOS.	Interview panel	November 21, 2025
COH approve initial cohort of members.	Commissioners	December 11, 2025
First cohort of membership nominations forwarded to the EO BOS for appointments.	Commission staff	December 11-12, 2025
BOS appointment of first cohort of new members to the new COH.	BOS	January-February 2026
First meeting of newly restructured COH.		March 12, 2026

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

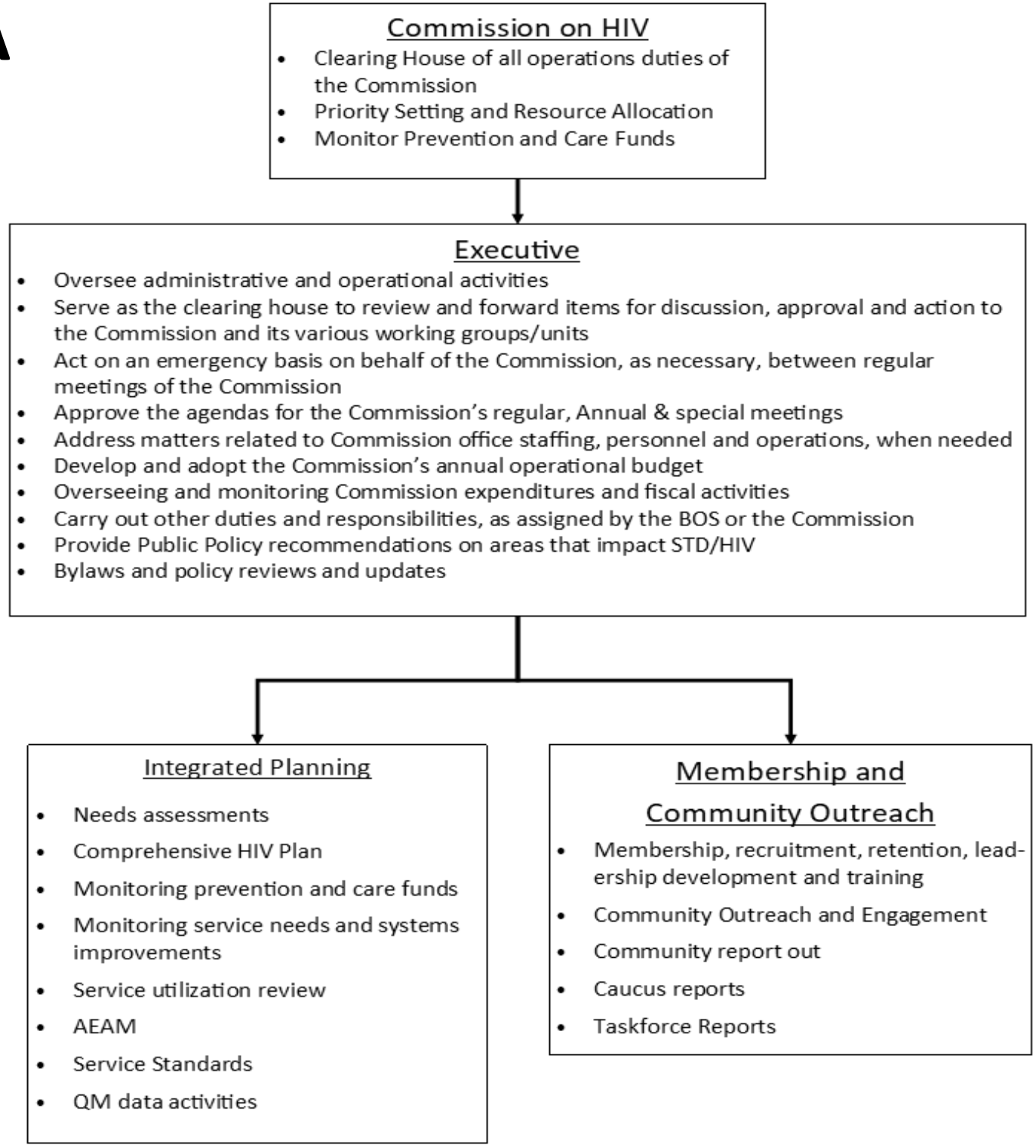
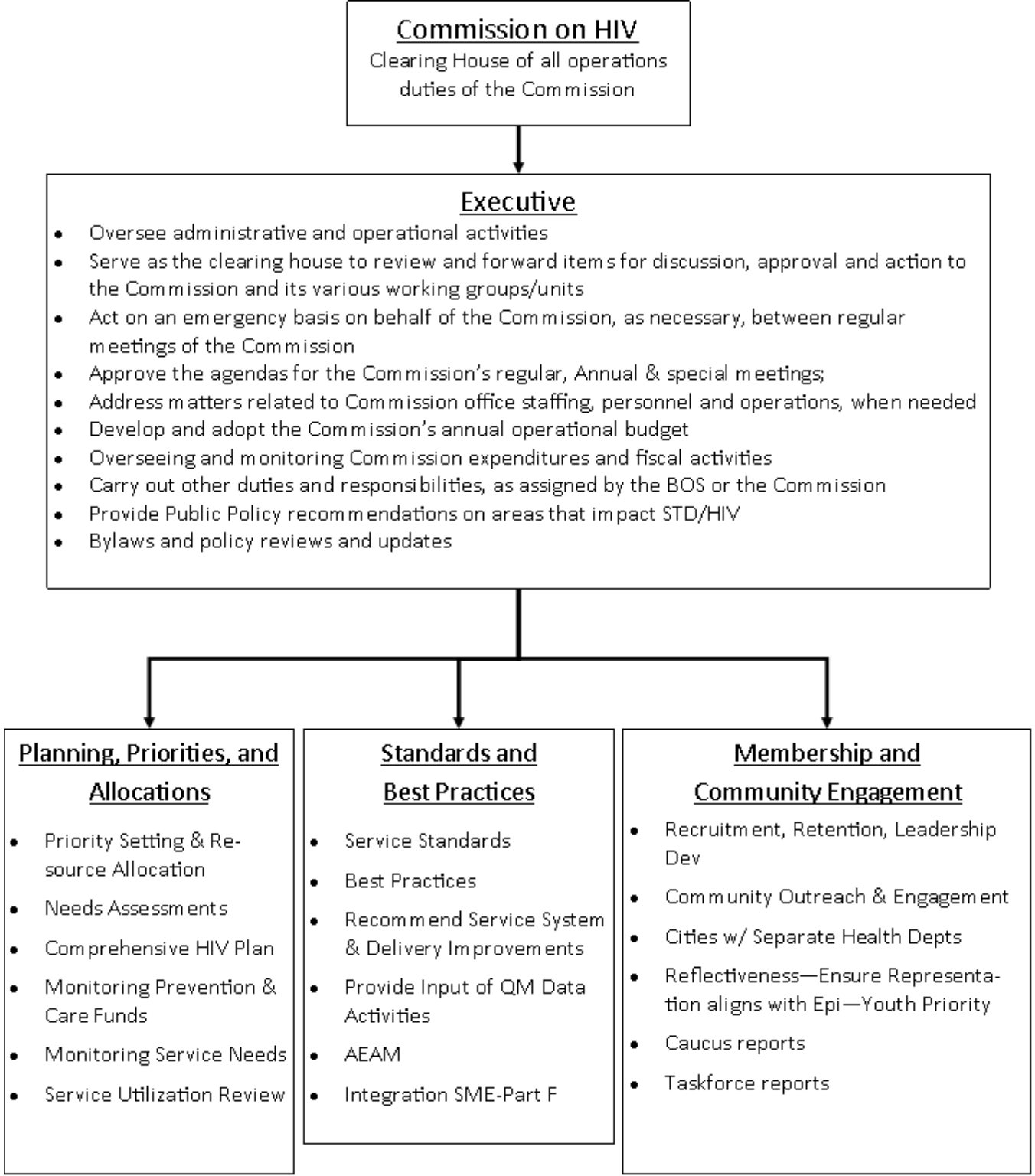

Commission on HIV
• Clearing House of all operations duties of the Commission
• Priority Setting and Resource Allocation
• Monitor Prevention and Care Funds
Executive
• Oversee administrative and operational activities
• Serve as the clearing house to review and forward items for discussion, approval 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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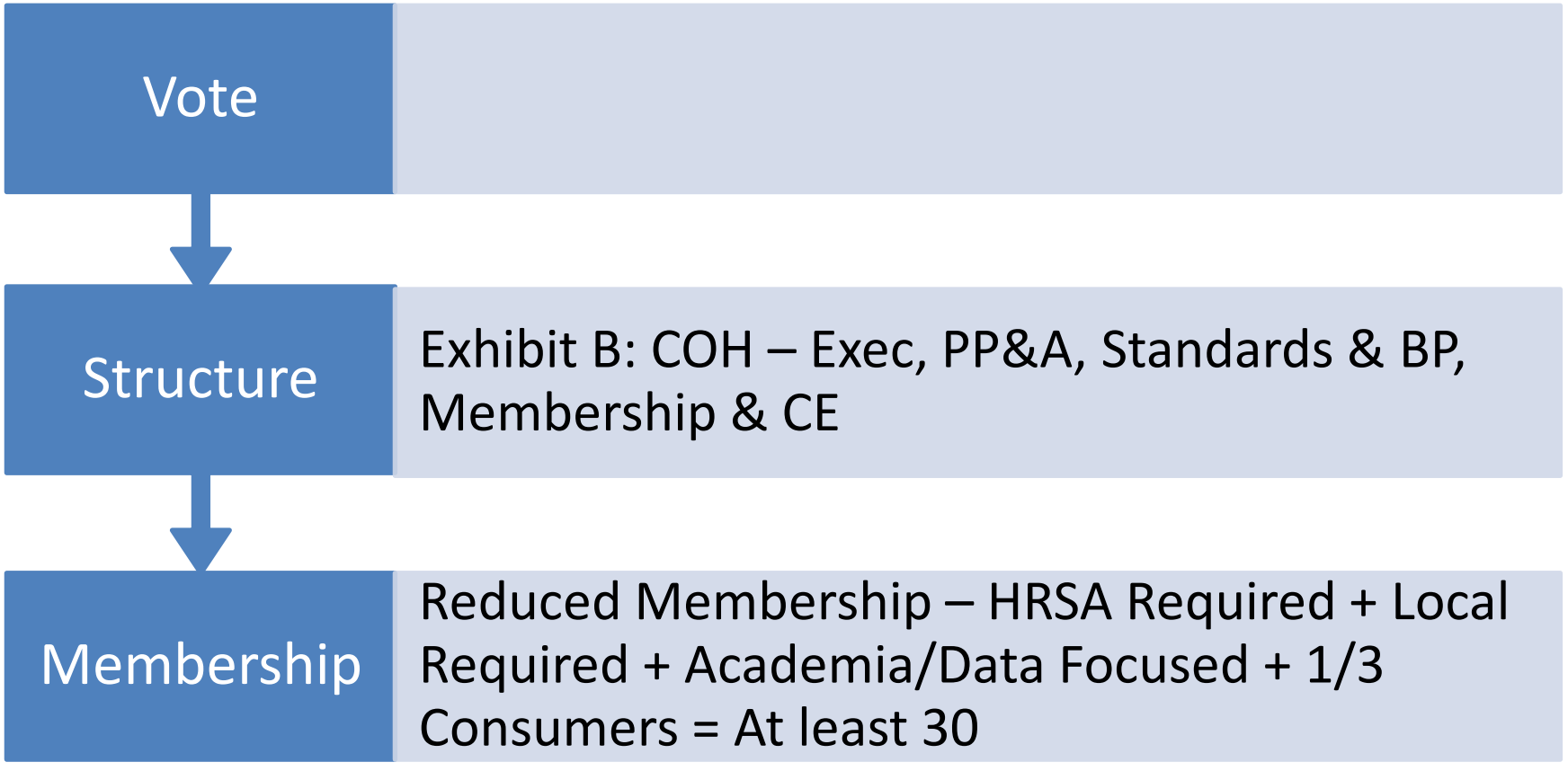
Priority Setting & Resource Allocation
Needs Assessments
Comprehensive HIV Plan
Monitoring Prevention & Care Funds
Monitoring Service Needs
Service Utilization Review
Standards and Best Practices
Service Standards
Best Practices
Recommend Service System & Delivery Improvements
Provide Input of QM Data 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.

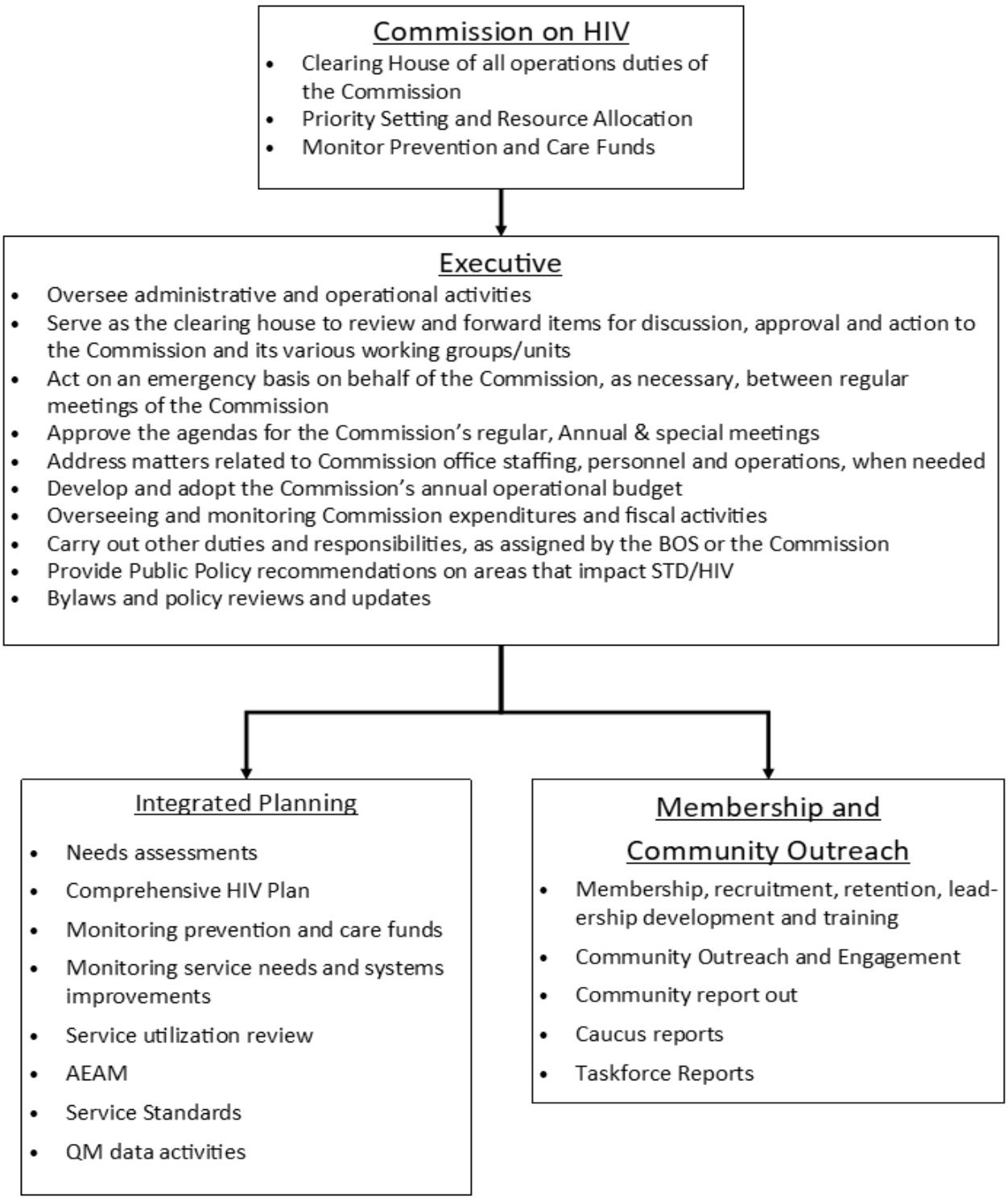


Figure 1 Exhibit A - Frequency is 6 times a year with P&R in a shorter timeframe closer together for the full Commission. Half-day planning session resulting in two separate days with one day priority ranking and one day allocation setting.

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;
- 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

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.

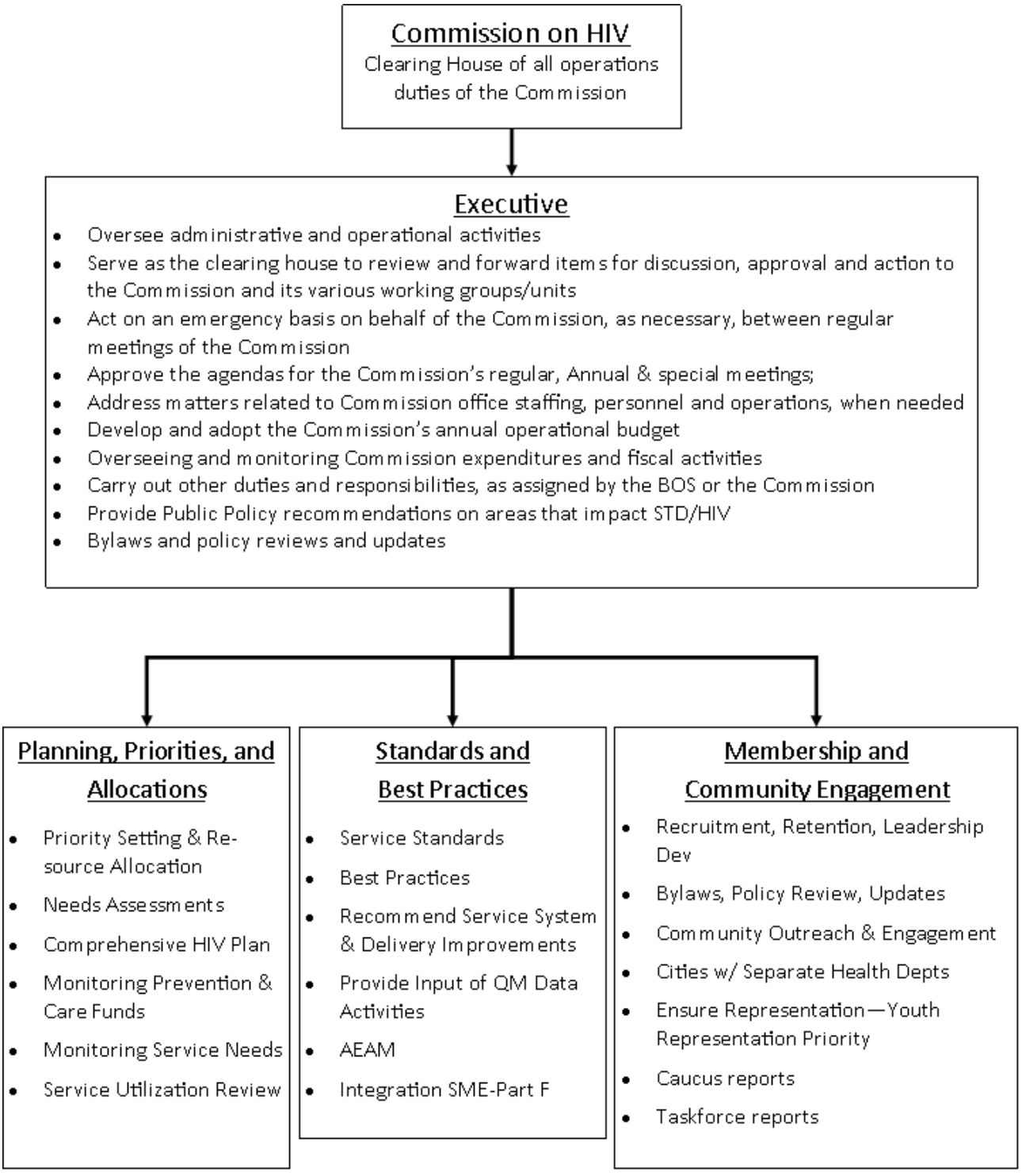


Figure 2 Exhibit B - All committees are to meet 6 times a year. Work PSRA into a multi-day longer session in the summer months, before the application is due, usually before August.

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

LOS ANGELES COUNTY COMMISSION ON HIV

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

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

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

BACKGROUND:

- **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 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 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. Consistent with the Los Angeles County Code 3.29.060 D (*Meetings and committees*), the Commission's standing committees may elect to nominate Committee-only members for 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 Operations and Executive Committees, may recommend vacating a member's seat if egregious or unresolved violations of the Code of Conduct occur, after three months of consecutive absences, if the member's term is expired, or during the term if a member has moved out of the jurisdiction and/or no longer meets the qualifications for the seat.

IV. NOMINATION PROCESS:

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

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

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

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

A. All candidates for 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, and DHSP, as a non-voting member.

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

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

A. Overseeing all Commission operational and administrative activities.

B. Serving as the clearinghouse
to review and forward items for discussion, approval and action to the Commission and its various working groups and units.

C. Acting on an emergency basis on behalf of the Commission, as necessary, between regular meetings of the Commission.

D. Approving the agendas for the Commission's regular, annual, and special meetings.

E. Determining the annual Commission work plan and functional calendar of activities, in consultation with the committees and subordinate working units.

F. Conducting strategic planning activities for the Commission.

G. Adopting a Memorandum of Understanding ("MOU") with DHSP, 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. ~~Recommending~~ Making amendments, as needed, to the Ordinance, which governs Commission operations.

J. ~~Recommending~~ 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 Operations 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.

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

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

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

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

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

Section 1. Voting Membership. The 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 and 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*

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

Proposed Revisions 06.23.25 Draft

3.29.010 Definitions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"HIV" means Human Immunodeficiency Virus.

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

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

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

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

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

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

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

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

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

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

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

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

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

CC. "Representation and Reflectiveness" are Ryan White legislative requirements for a planning council's membership to include members who represent specific interests identified in the legislation (representation), and that the planning council membership and its subset of unaffiliated consumer members reflect the ethnic, racial and gender proportions of local HIV prevalence (reflectiveness).

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

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

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

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

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

(Ord. 2013-0017 § 1, 2013: Ord. 2011-0065 § 1, 2011: Ord. 2006-0076 § 2, 2006: Ord. 2005-0044 § 1, 2005: Ord. 98-0002 § 1, 1998: Ord. 95-0010 § 2, 1995: Ord. 91-0152 § 1, 1991.)

3.29.020 Commission on HIV.

The Commission on HIV is referred to in this chapter as the "Commission."

(Ord. 2011-0065 § 2, 2011: Ord. 2005-0044 § 2, 2005: Ord. 95-0010 § 3, 1995: Ord. 91-0152 § 2, 1991.)

3.29.030 Membership.

All members of the Commission shall serve at the pleasure of the Board of Supervisors. The Commission shall consist of thirty two (32) voting members and one (1) non-voting member from DHSP nominated by the Commission and appointed by the Board of Supervisors. Consistent with the open nominations process, the following recommending entities shall forward candidates to the Commission for membership consideration:

A. 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

ody 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 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.

In all the above membership categories where not specifically required, recommending entities and the nominating body are strongly encouraged to nominate candidates living with HIV disease or members of populations disproportionately affected by the epidemic. Members are

expected to report to and represent their recommending entities and constituencies. Members may, at times, represent multiple constituencies.

In accordance with Ryan White and CDC requirements, the Commission shall ensure that its full membership and its subset of unaffiliated consumer members shall proportionately reflect the ethnic, racial and gender proportions of HIV disease prevalence in the EMA.

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

(Ord. 2013-0017 § 2, 2013: Ord. 2011-0065 § 3, 2011: Ord. 2006-0076 § 3, 2006: Ord. 2005-0044 § 3, 2005: Ord. 2003-0010 § 1, 2003: Ord. 98-0002 § 2, 1998: Ord. 95-0010 § 4, 1995: Ord. 91-0152 § 3, 1991.)

3.29.040 Alternate members.

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

(Ord. 2013-0017 § 3, 2013: Ord. 2011-0065 § 4, 2011: Ord. 2005-0044 § 4, 2005: Ord. 95-0010 § 5, 1995: Ord. 91-0152 § 4, 1991.)

3.29.045 Nominations.

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

(Ord. 2013-0017 § 4, 2013: Ord. 2011-0065 § 5, 2011: Ord. 2005-0044 § 5, 2005: Ord. 98-0002 § 3, 1998.)

3.29.046 Conflict of interest.

A. Ryan White legislation requires certain constituencies and entities to be represented on the Commission. Ryan White legislation also requires the Commission to establish priorities and allocate funds within the EMA. Therefore, Commission members, regardless of their private affiliations, may participate in the process to determine funding priorities and to allocate Ryan White Part A and B and HIV prevention funds in percentage and/or dollar amounts to various

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

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

(Ord. 2013-0017 § 5, 2013: Ord. 2011-0065 § 6, 2011: Ord. 2005-0044 § 6, 2005: Ord. 98-0002 § 4, 1998.)

3.29.050 Term of service.

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

B. At the March 2026 meeting of the HIV Commission, after this ordinance is effective, the terms of the current members of the Commission on HIV shall expire. 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 sixteen (16) members' terms will expire after one (1) year and sixteen (16) will expire after two (2) years. Thereafter, each membership term shall be two (2) years.

C. No member may serve on the Commission for more than three (3) full consecutive terms, unless such limitation is waived by the Board of Supervisors. Members may serve a maximum of three consecutive two-year terms (6 years total) and can reapply after a one-year break.

D. The Executive Committee may make an exception to the term limits in order to meet representation requirements or the need for specific expertise.

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

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

G. During the course of a year, absence from any combination of six (6) regularly scheduled Commission meetings and/or regularly scheduled meetings of the committee to which the member has been assigned may result in the Board of Supervisors removing the member from the Commission. Reinstatement or replacement may occur with subsequent nomination from the Commission and appointment by the Board of Supervisors. An alternate's attendance in a member's place is considered attendance by the member at the meeting.

(Ord. 2013-0017 § 6, 2013: Ord. 2011-0065 § 7, 2011: Ord. 2005-0044 § 7, 2005: Ord. 95-0010 § 6, 1995: Ord. 91-0152 § 5, 1991.)

3.29.060 Meetings and committees.

A. The Commission shall meet at least six (6) times a year.

B. The Commission shall establish an executive committee to set agendas for meetings, and conduct business between Commission meetings. The executive committee shall include the Director of DHSP or his/her permanent designee as a non-voting member, the co-chairs of the Commission and three
(3) at-large members elected by the Commission. For purposes of this subsection, the

authority of the executive committee to conduct business shall include acting on behalf of the

Commission in time-sensitive circumstances, which action(s) shall be ratified by the Commission at its next regularly scheduled meeting.

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

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

E. As needed by committees and appropriate for added professional expertise, as a means of further engaging community participation in the planning process, and/or as necessary to meet the requirements of the CDC HIV Planning Guidance, the Commission is empowered to appoint members who are not commission members as members of the Commission' s established standing committees. The term of each such member shall be two (2) years.

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

(Ord. 2013-0017 § 7, 2013: Ord. 2011-0065 § 8, 2011: Ord. 2005-0044 § 8, 2005: Ord. 95-0010 § 7, 1995: Ord. 91-0152 § 6, 1991.)

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. A majority of the members who have been appointed shall constitute a quorum of the Commission.

(Ord. 2011-0065 § 9, 2011: Ord. 2005-0044 § 9, 2005: Ord. 95-0010 § 8, 1995: Ord. 91-0152 § 7, 1991.)

3.29.080 Compensation.

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

Corresponding with Ryan White legislation and HRSA and CDC guidelines, members of the Commission may also be reimbursed for local travel and mileage, meals associated with Commission business, child care during Commission activities, and computer-related expenses if those costs were incurred in the performance of commission-related duties. The Commission may, in addition to reimbursing those expenses, also provide these services directly to members and/or pay monthly stipends to unaffiliated consumer members of Ryan White Part A services or HIV-negative individuals from identified high-risk or special populations who, if positive, would be eligible for Ryan White services, provided that the stipends are not paid with Ryan White funds. Eligible members must maintain a required level of participation and other performance requirements, as defined in Commission policy.

The Commission 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.

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

(Ord. 2013-0017 § 8, 2013: Ord. 2011-0065 § 10, 2011: Ord. 2005-0044 § 10, 2005: Ord. 95-0010 § 9, 1995: Ord. 91-0152 § 8, 1991.)

3.29.090 Duties.

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

A. Develop a comprehensive HIV plan, that is based on assessment of service needs and gaps and that includes a defined continuum of HIV services; monitor the implementation of that plan; assess its effectiveness; and collaborate with DHSP to update the plan on a regular basis;

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

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

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

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

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

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

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

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

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

(Ord. 2013-0017 § 9, 2013: Ord. 2011-0065 § 11, 2011: Ord. 2006-0076 § 4, 2006: Ord. 2005-0044 § 11, 2005: Ord. 95-0010 § 10, 1995: Ord. 91-0152 § 9, 1991.)

3.29.095 Grievance procedure.

The Commission shall have procedures approved by the Board of Supervisors and contained in its by-laws to address grievances with respect to Ryan White and CDC funding. The grievance procedure shall be limited as follows:

A. Providers eligible to receive Ryan White or CDC funding, consumers, consumer groups and people living with HIV coalitions, and other stakeholders and caucuses may grieve.

B. Grievances shall be limited to the Commission's, administrative agency's or grantee's failure to follow the Commission's established, written and published procedures for priority-setting, resource allocation or subsequent changes to priorities or allocations, or compliance with comprehensive care plan provisions or implementation strategies. Grievances may not involve funding allocations to individual service providers, procurement of specific services, individual patient interactions with service providers and agencies, or disagreement with the outcome of the priority- and allocation-setting process.

C. All settlements and rulings resulting from grievances shall not retroactively change priorities or allocations and shall be limited to future actions of the Commission.

D. The grievance process shall include a procedure to submit grievances that cannot be resolved through mediation to binding arbitration.

(Ord. 2013-0017 § 10, 2013: Ord. 2011-0065 § 12, 2011: Ord. 2005-0044 § 12, 2005: Ord. 98-0002 § 5, 1998.)

3.29.100 Reserved.

3.29.110 Sunset review date.

The sunset review date for the Commission is indefinite. The Commission shall continue as long as it is federally funded or upon other order of the Board of Supervisors.

(Ord. 2011-0065 § 14, 2011: Ord. 2006-0071 § 1, 2006: Ord. 2004-0070 § 1, 2004: Ord. 2001-0039 § 1, 2001: Ord. 98-0002 § 6, 1998: Ord. 95-0010 § 12, 1995.)

FOOTNOTE(S):

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Note— *Name of chapter changed by Ords. 95-0010 and Ord. 2002-004.* *(Back)*

Assessment of the Efficiency of the Administrative Mechanism (AEAM)

Ryan White Program Year 33 & 34
(March 1, 2023-February 29, 2024 and March 1, 2024- February 28, 2025)

Final for Executive Committee Approval on June 26, 2025 MOTION #5

LOS ANGELES COUNTY
COMMISSION ON HIV

Assessment of the Administrative Mechanism Ryan White Program Year 33 & 34 (March 1, 2023-February 29, 2024 and March 1, 2024-February 28, 2025)

Table of Contents

I. Introduction and Purpose of Report

As a Ryan White Part A planning council, the Los Angeles County Commission on HIV ("the Commission") is required by Health Resources and Services Administration (HRSA) to conduct an "Assessment of the Efficiency of the Administrative Mechanism" (AEAM) annually. The AEAM is meant to evaluate the speed and efficiency with which Ryan White Program funding is allocated and disbursed for HIV services in Los Angeles County. The Operations Committee of the Commission led the development, implementation, and analysis of the AEAM for Ryan White Program Years 33 (March 1, 2023-February 29, 2024) and 34 (March 1, 2024-February 28, 2025). The purpose of this report is to present the findings of this assessment.

II. Assessment Methodology

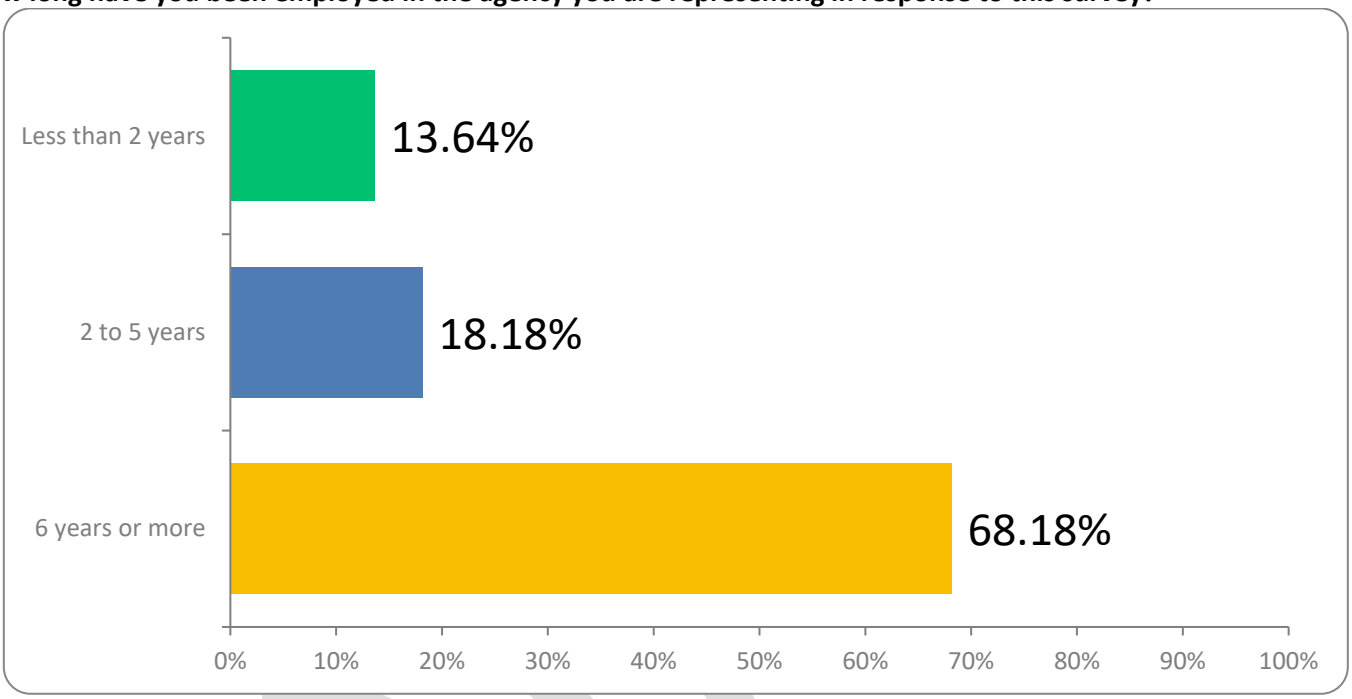
The AEAM covers 1) feedback from contracted agencies on the efficiency of Los Angeles County's administrative mechanisms (such as contracts, procurement, solicitations) to rapidly disburse funds to support HIV services in the community; and 2) survey and key informant interviews with key recipient staff to integrate their insights regarding the County's solicitations, contracting, and invoicing processes.

Online Survey for Contracted Providers:
Twenty-eight County-contracted HIV care providers were invited to participate in the AEAM survey between January 22 to February 28, 2025. Twenty agencies completed the survey. Agencies were asked to provide one response per agency. A raffle for a $100 gift card was used to incentivize provider responses.

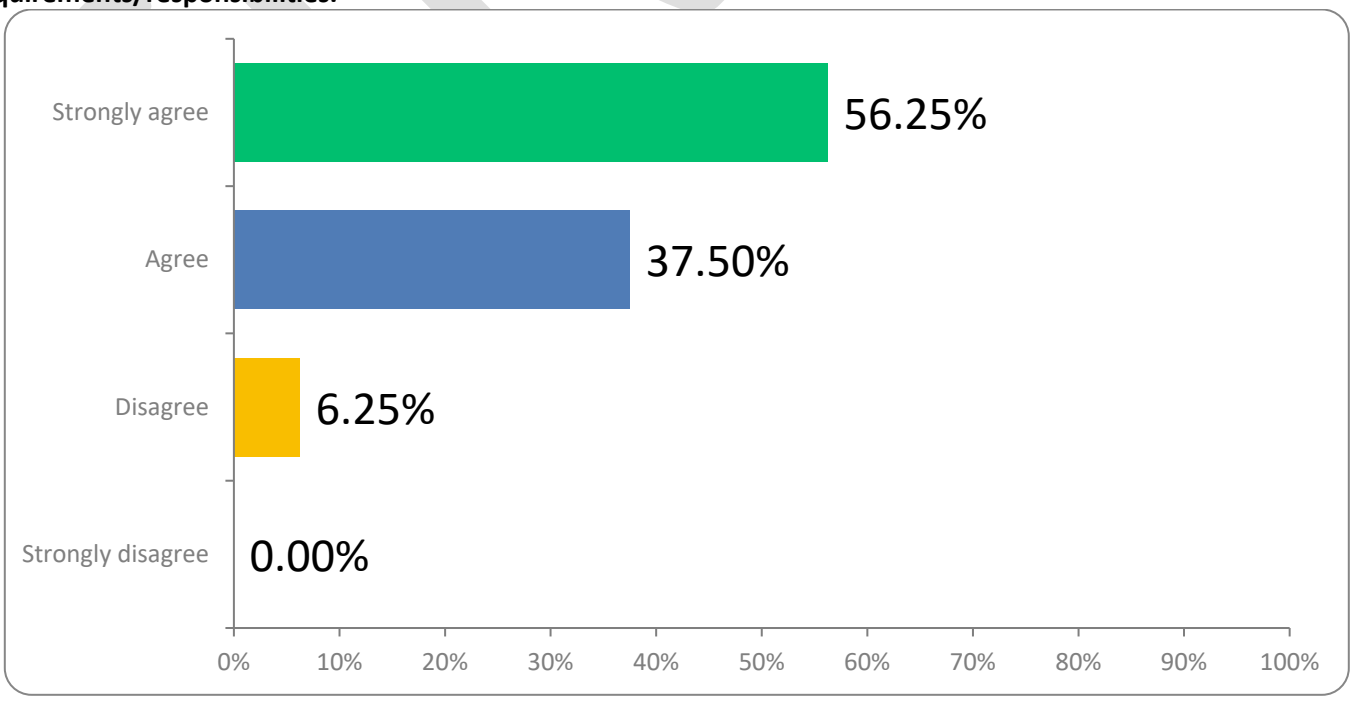
Limitations: Readers should not make broad interpretations with the results of the AEAM but rather, use the information as a record of perceptions and responses from those individuals and agencies who completed the survey.

III. Contracted Providers Responses

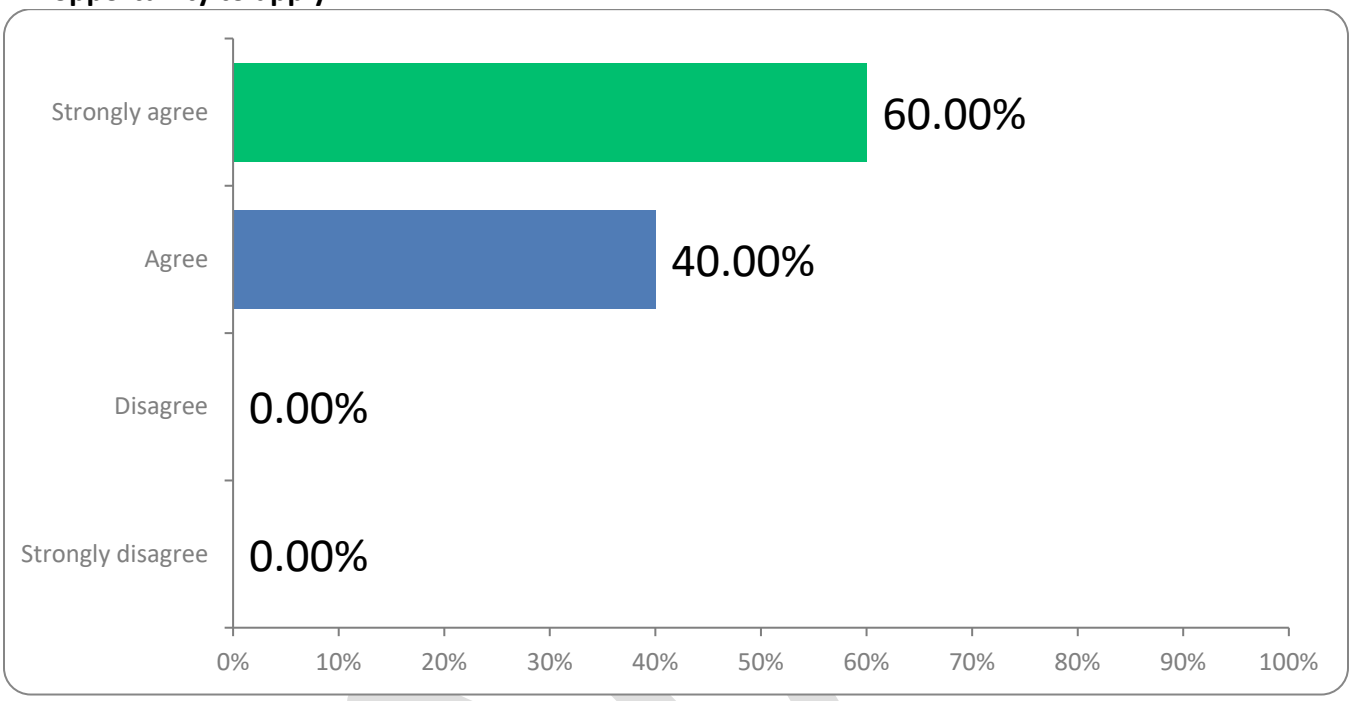
1. How long have you been employed in the agency you are representing in response to this survey?



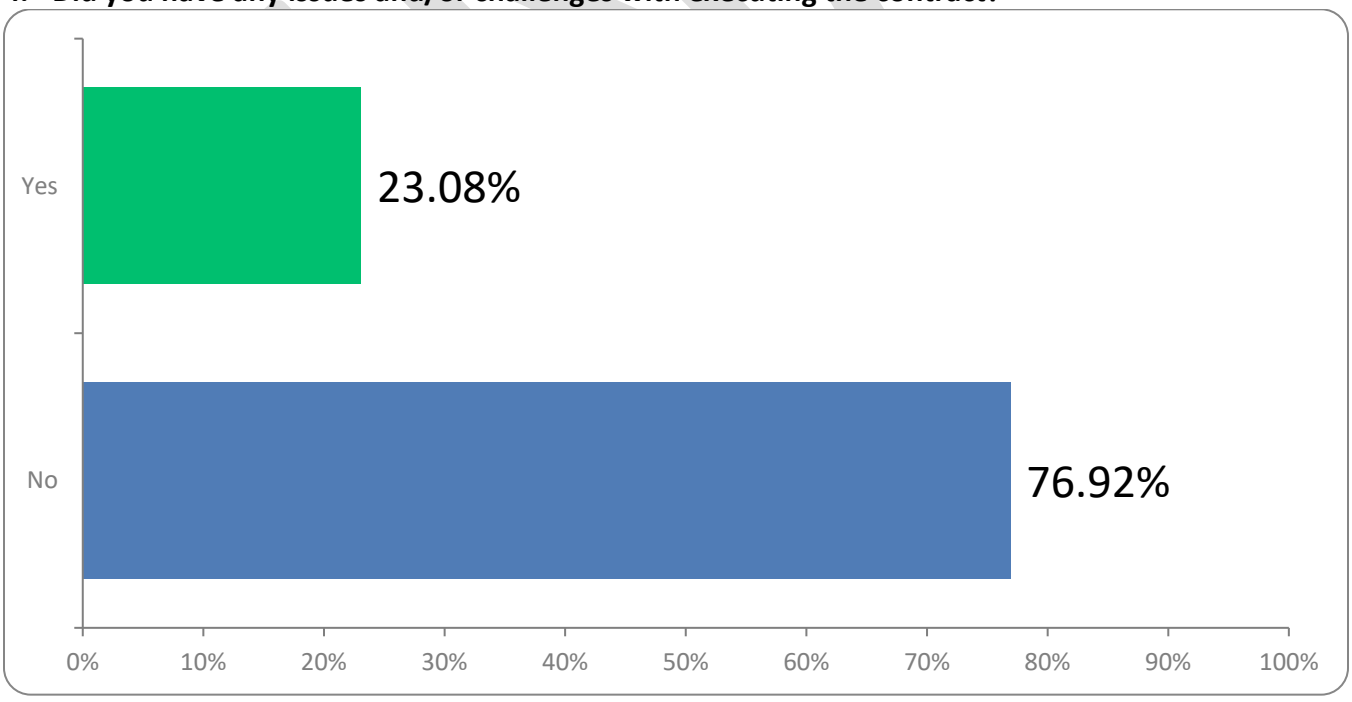
2. Please state the degree to which you agree with the following statement: The DHSP RFP provided clear instructions, outlined all policies and procedures of the procurement process, and expectations of work requirements/responsibilities.



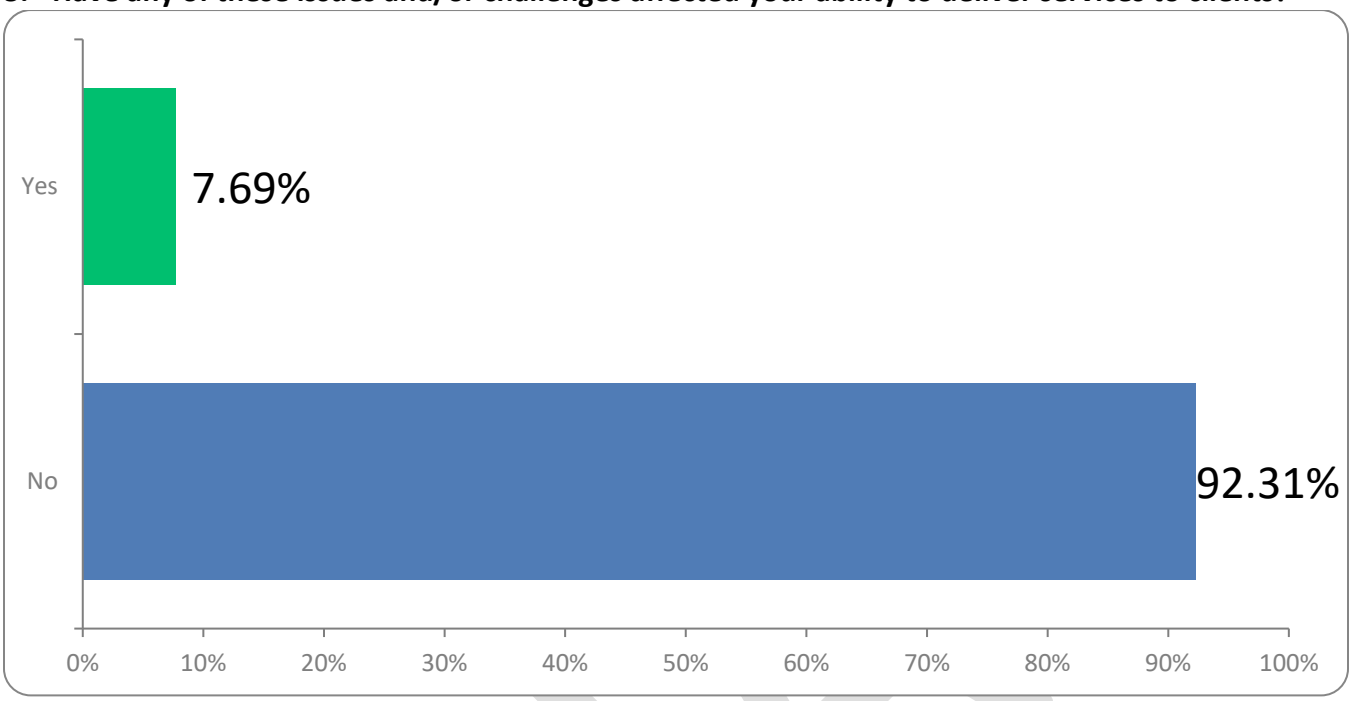
3. **Please state the degree to which you agree with the following statement: The DHSP competitive RFP procurement process is fair and all potential service providers are given a fair and equitable opportunity to apply.**



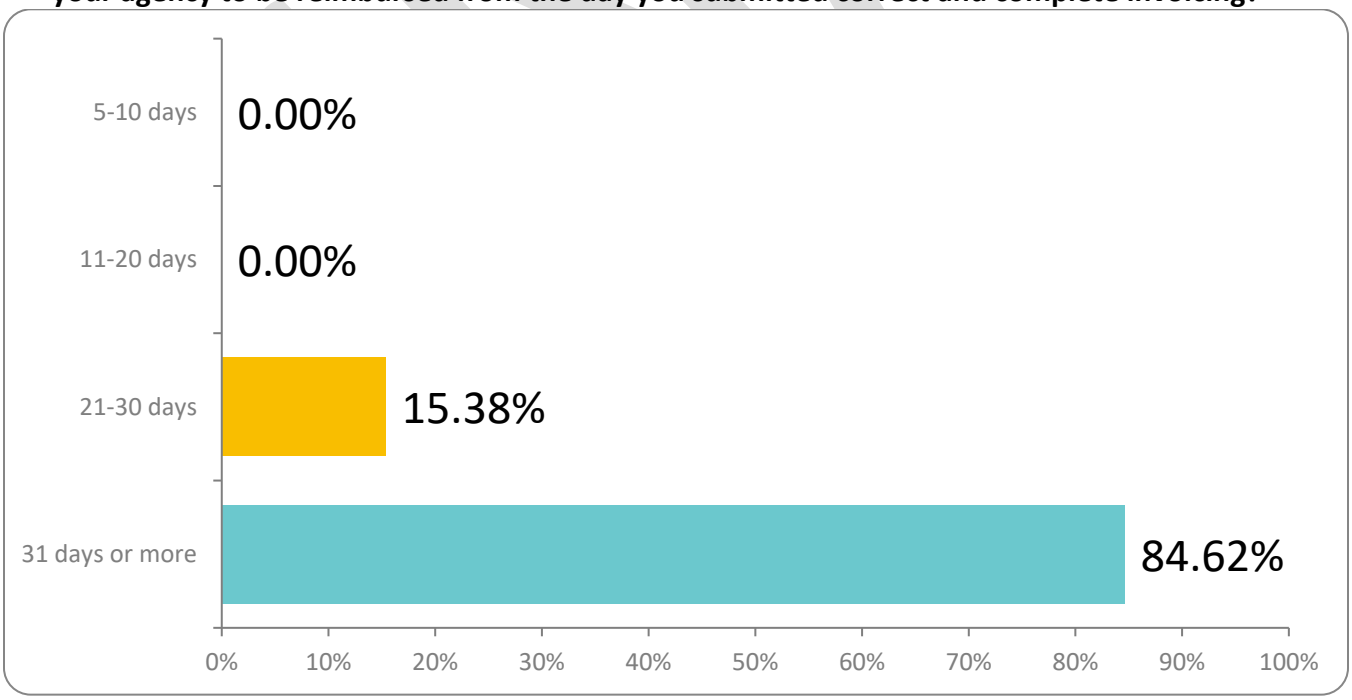
4. **Did you have any issues and/or challenges with executing the contract?**



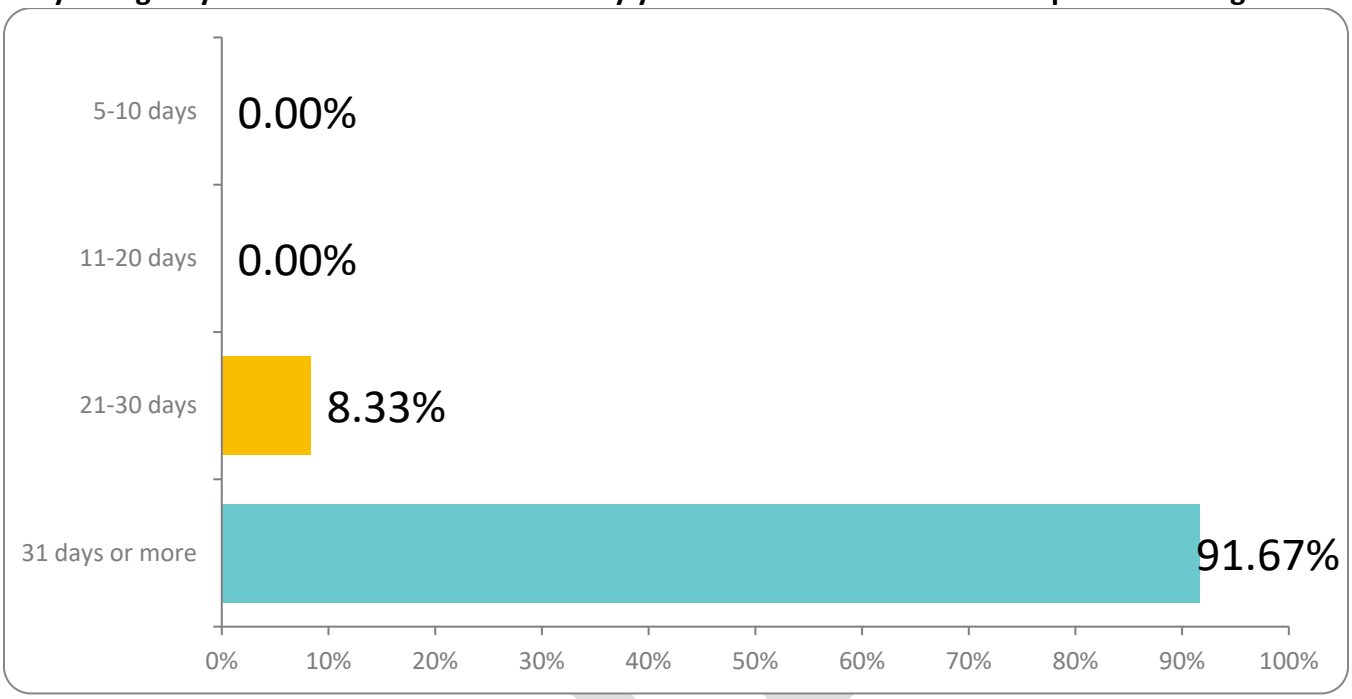
5. **Have any of these issues and/or challenges affected your ability to deliver services to clients?**



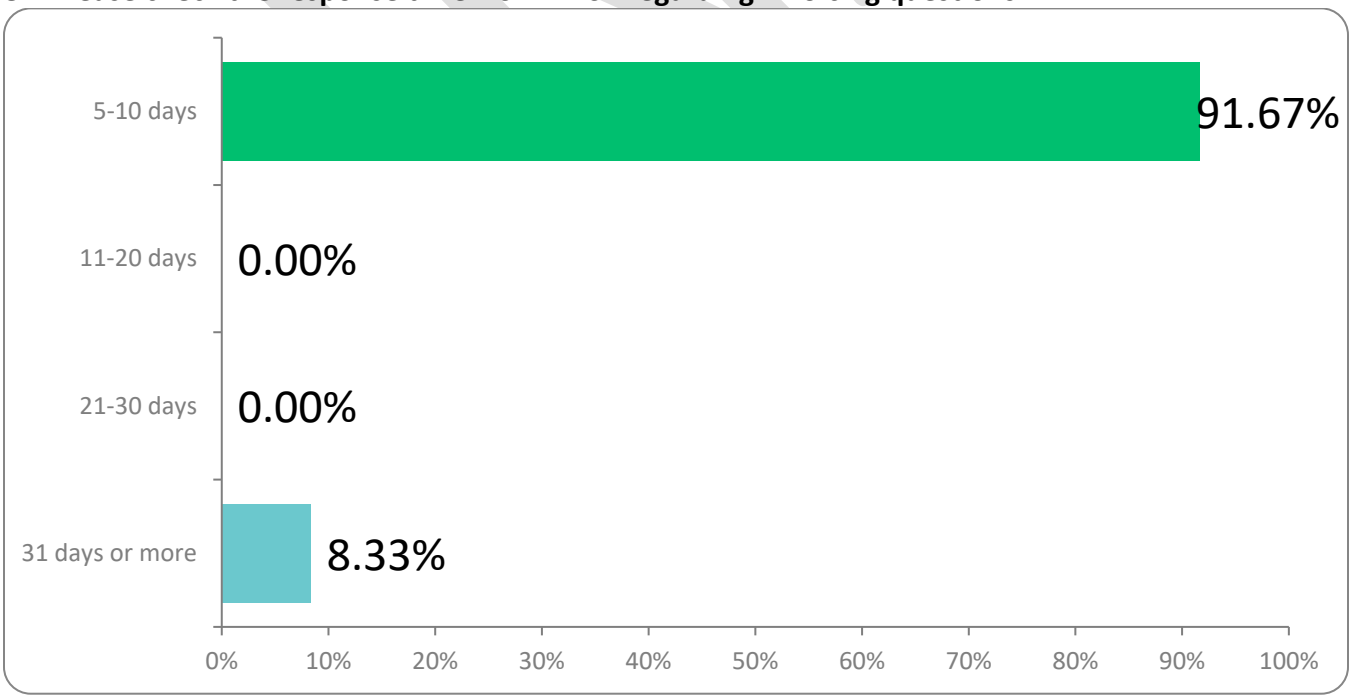
6. **During PY 33 (March 1, 2023 - February 29, 2024), how many days, on average, did it take for your agency to be reimbursed from the day you submitted correct and complete invoicing?**



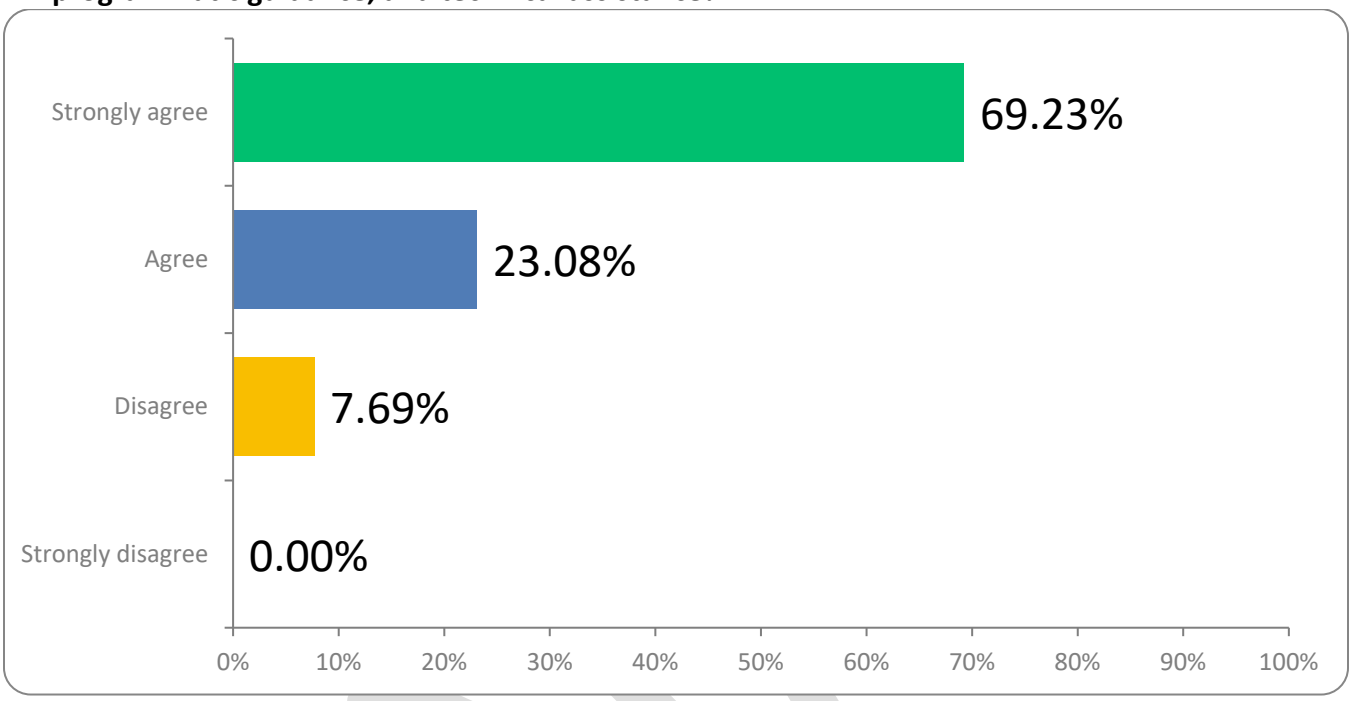
7. **During PY 34 (March 1, 2024 – February 28, 2025), how many days, on average, did it take for your agency to be reimbursed from the day you submitted correct and complete invoicing?**



8. **Please check the response time from DHSP regarding invoicing questions.**

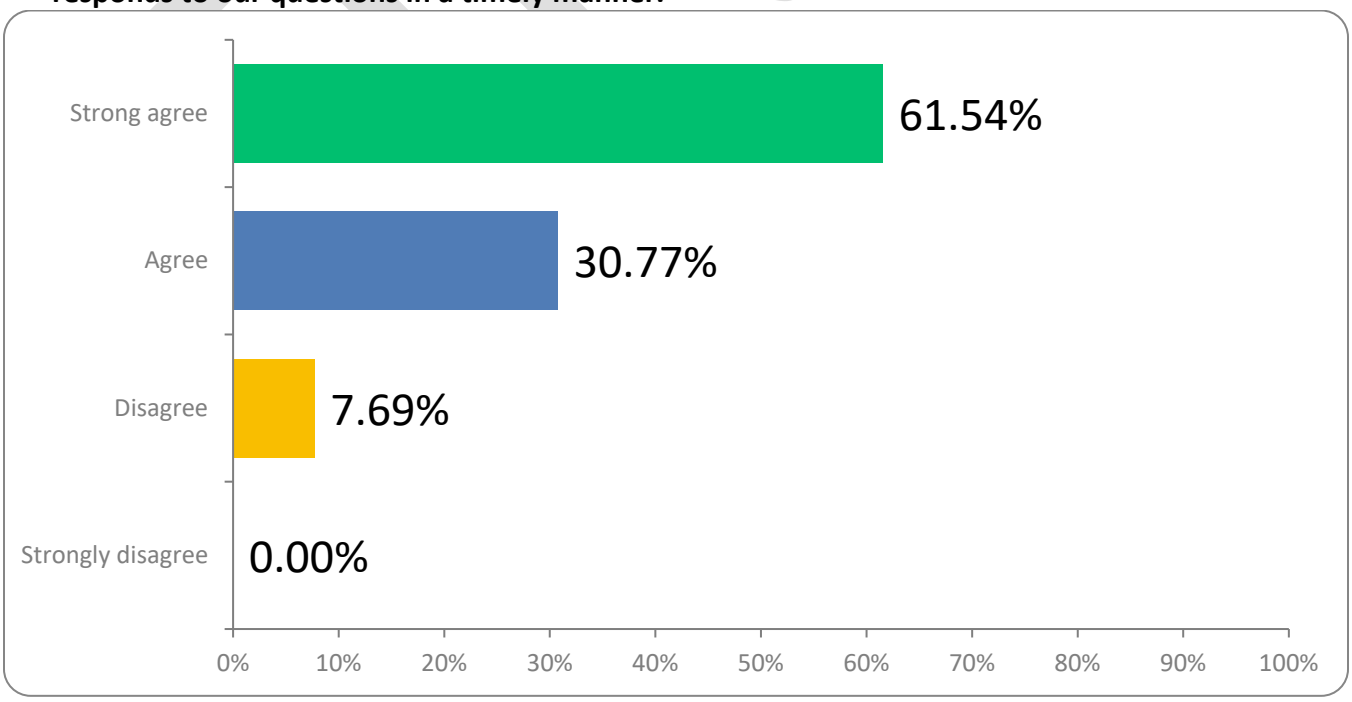


9. **Please state the degree to which you agree with the following statement: Our Contract Monitor provides clear and consistent responses to our questions and request for information, programmatic guidance, and technical assistance?**

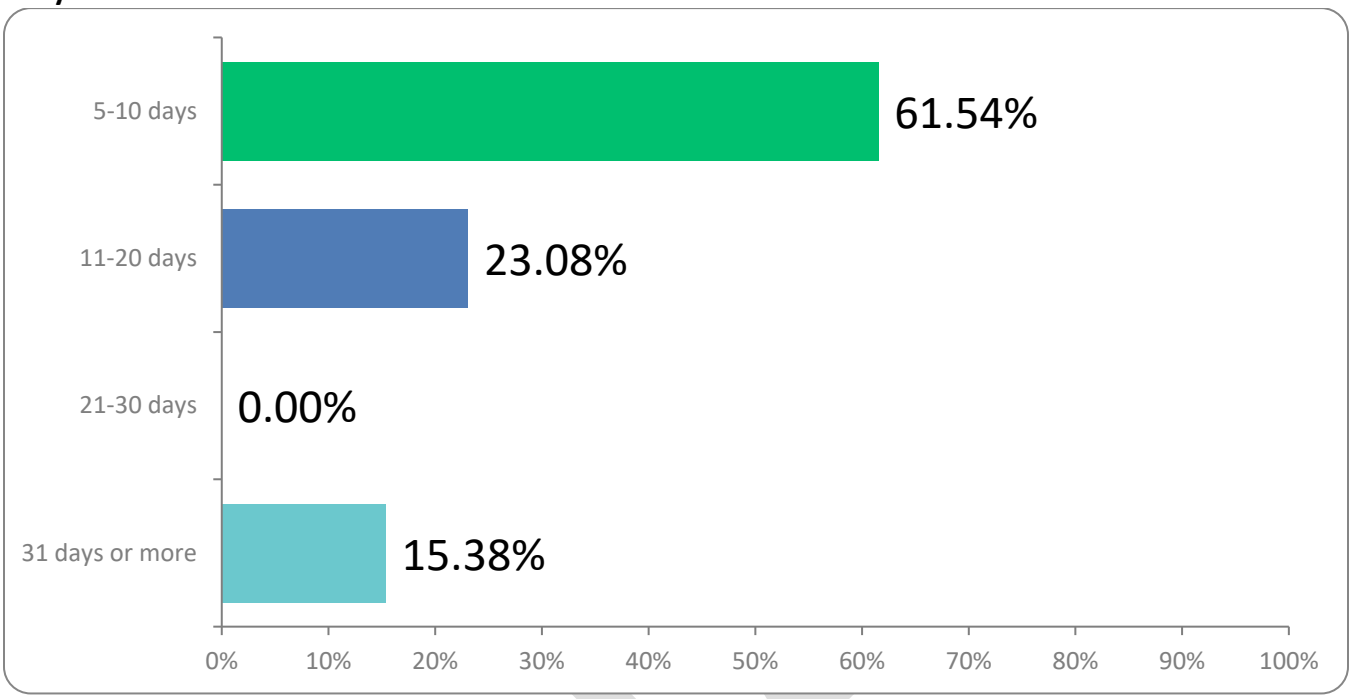


Other: Guidance is heavily dependent on the program manager.

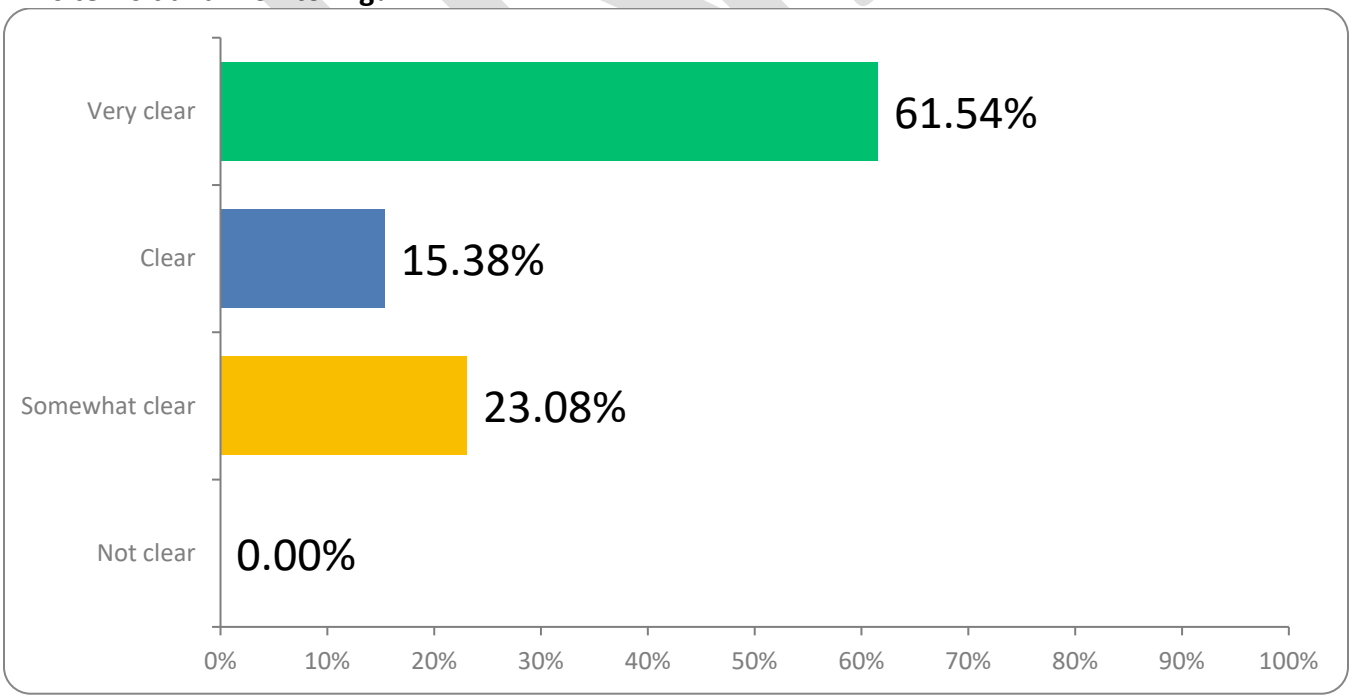
10. **Please state the degree to which you agree with the following statement: Our Contract Monitor responds to our questions in a timely manner.**



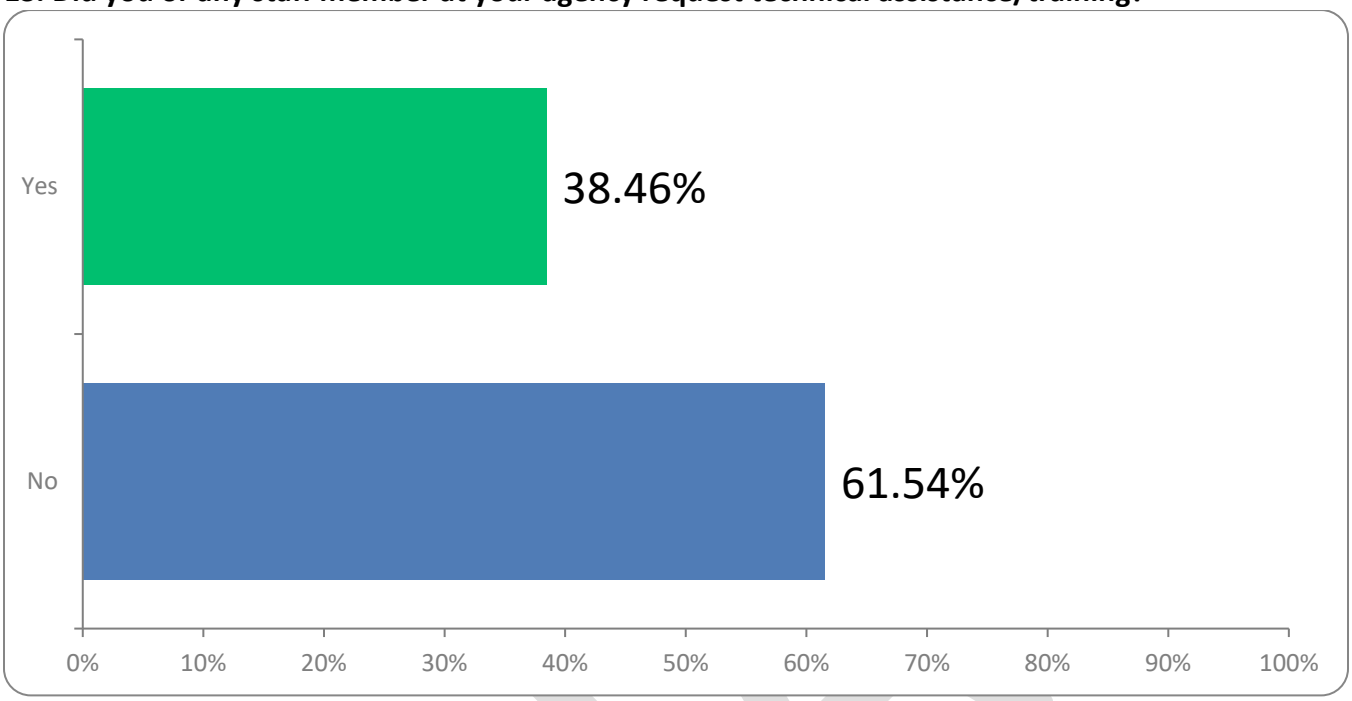
11. Please select the average response time for reprogramming/budget modifications request from your Contract Monitor.



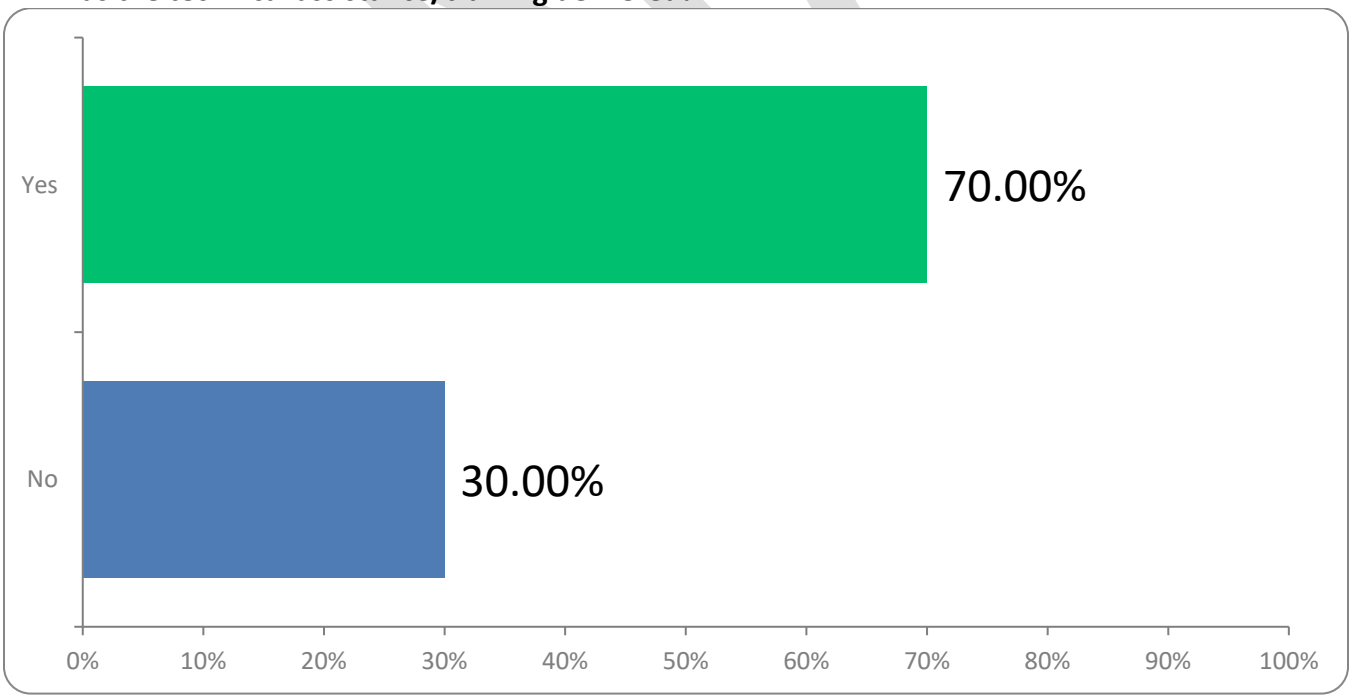
12. In terms of the process for program monitoring, are you clear on the expectations prior to the site visit and monitoring?



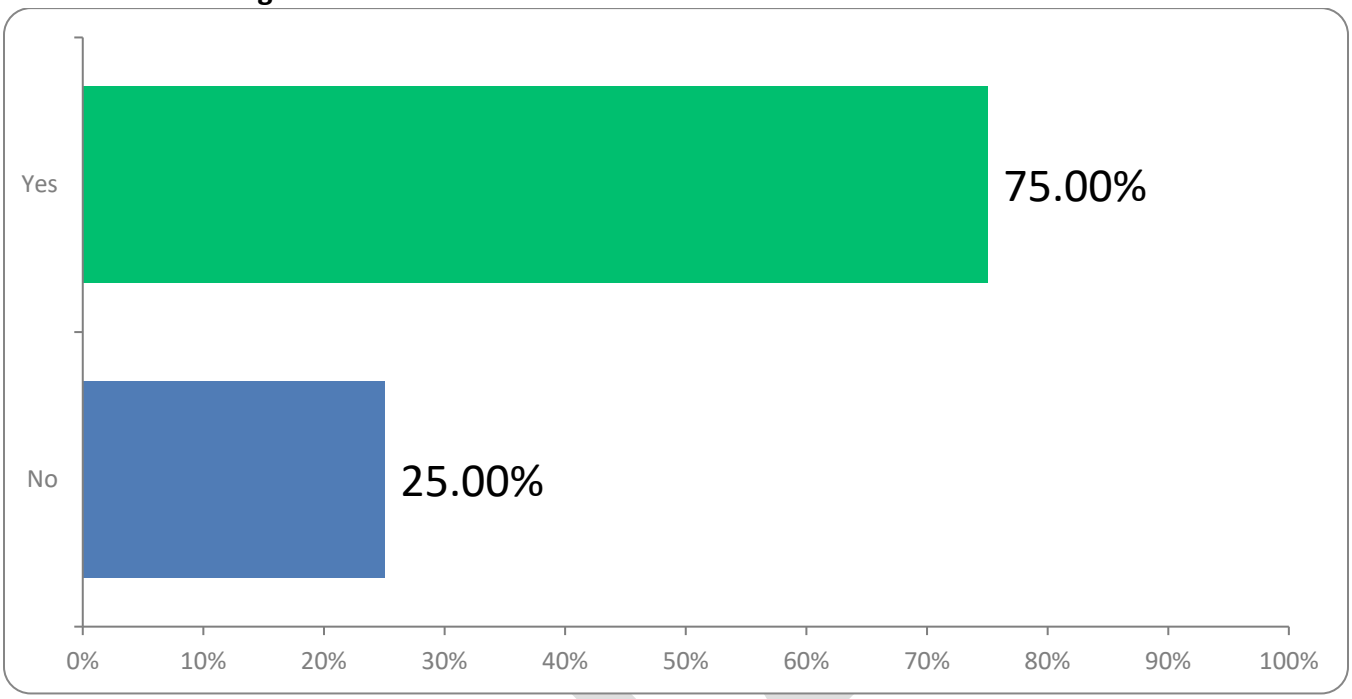
13. Did you or any staff member at your agency request technical assistance/training?



14. Was the technical assistance/training delivered?



15. Did the technical assistance/training meet your needs in helping you (or your agency) effectively address challenges?



Summary of Responses to Open-Ended Questions: *(some providers skipped the question)*

17. List the most recent Request for Proposals (RFPs) from DHSP that your agency applied for? Please specific RFP number, service category and submission date.

1. RFP NO. 2024 – 014: Comprehensive HIV and STD Prevention Services in Los Angeles County Date Submitted: 1/24/2025; Service Categories: Non-Clinic-Based Prevention Services, High Impact Prevention Programs (HIPP)
   RFP NO. 2024 – 010: Transportation Services for Eligible Ryan White Program Clients in Los Angeles County. Submitted: 10/28/2024
2. Core HIV Medical Services RFP 2024-00, Submitted 10/15/24 Comprehensive HIV and STD Prevention Services RFP 2024-014, Category 1 and Category 3, Submitted 1/27/25
3. Core HIV Medical Services for Persons Living with HIV RFP# 2024-008; applied for categories 1 (Ambulatory Outpatient Medical Services), 2 (Medical Care Coordination Services), and 3 (Patient Support Services); submitted 10/15/2024
4. Core HIV Medical Services (RFP #2024-008), Transportation Services RFA #2024-010, Comprehensive HIV AND STD Prevention Services in LA County RFP NO. 2024-014
5. Comprehensive HIV and STD Prevention Services (RFP 2024-014)
6. MCC/PSS: RFP 2024-008 due 10/15/24 HIV Testing/HIPP: RFP 2024-014 due 1/27/25
7. RFP NO. 2024-008
8. Our most recent contract is an amendment/continuation of an existing contract. The FAIN identifier is H8900016. We obtained the original contract through taking over an existing contract with a collaborative partner who was unable to provide services.

9. Core HIV Medical Services for Persons Living with HIV, RFP# 2024-008; applied for categories 1 (Ambulatory Outpatient Medical Services), 2 (Medical Care Coordination Services), and 3 (Patient Support Services); submitted 10/15/2024 Transportation Services for Eligible Ryan White Program Clients in Los Angeles County, RFA# 2024-010; submitted 10/29/2024
10. 10/15/2024 - RFP #2024-008 - Core HIV Medical Services for Persons Living with HIV 10/28/2024 - RFA #2024-010 - Transportation Services for Eligible RWP Clients in LAC
11. COMPREHENSIVE HIV AND STD PREVENTION SERVICES IN LOS ANGELES COUNTY RFP NO. 2024-014
12. None
13. 2024-008 AOM, MCC, PSS, 10/15/24 2024-014, Category 1 and 3, 1/27/25
14. Transportation Services for Eligible RW Program Clients in LA County #2024-010, 10/25/2025
15. RFP NO. 2024-008. CORE HIV MEDICAL SERVICES FOR PERSONS LIVING WITH HIV, SUBMITTED ON OCTOBER 11, 2024

18. When was your contract fully executed for PY 33 (March 1, 2023 - February 29, 2024)? *(some providers skipped the question)*

1. 03/01/2023
2. 12/28/2023
3. 04/05/2024
4. 03/01/2023
5. 03/26/2023
6. 07/19/2019
7. 07/11/2023
8. 01/16/2024
9. 05/10/2023
10. 03/08/2023
11. 04/24/2024

19. When was your contract fully executed for PY 34 (March 1, 2024 – February 28, 2025)? *(some providers skipped the question)*

1. 01/01/2024
2. 07/15/2024
3. 07/18/2024
4. 03/01/2024
5. 08/12/2024
6. 06/05/2024
7. 08/06/2024
8. 01/17/2024
9. 08/08/2024
10. 07/17/2024

20. Describe issues and/or challenges with executing the contracts, including factors within your respective agency. *(some providers skipped the question)*

1. NA
2. Different requirements needed based on the Program Manager
3. N/A
4. We are waiting for the contract. Budgets have been submitted and we are waiting on approvals.
5. The budgeting process.
6. N/A
7. There is typically a long wait time until our agency receives contracts from DHSP after budget/contract negotiations are submitted. Once a contract is received, it takes about 2-4 weeks for our agency to route for signatures, as there is a multi-layer review process internally.
8. getting the budget approved was the biggest hurdle.
9. Barriers within our agency.
10. The internal process within the city is lengthy and time consuming, as are DHSP processes.
11. NA

21. Please describe how these challenges were handled. (any issues and/or challenges with executing the contract) *(some providers skipped the question)*

1. NA
2. Different requirements needed based on the Program Manager
3. N/A
4. We are waiting for the contract. Budgets have been submitted and we are waiting on approvals.
5. The budgeting process.
6. N/A
7. There is typically a long wait time until our agency receives contracts from DHSP after budget/contract negotiations are submitted. Once a contract is received, it takes about 2-4 weeks for our agency to route for signatures, as there is a multi-layer review process internally.
8. getting the budget approved was the biggest hurdle.
9. Barriers within our agency.
10. The internal process within the city is lengthy and time consuming, as are DHSP processes.
11. NA

22. Please describe how these challenges were handled. (issues and/or challenges affected your ability to deliver services to clients?) *(some providers skipped the question)*

1. NA
2. N/A
3. We are not going to stop services because of a missing contract.
4. Hard work and communication with county program staff.
5. N/A
6. Increased communication frequency.

7. N/A

23. Please describe any factors contributing to the delay in reimbursements, including factors within your respective agency. *(some providers skipped the question)*

1. Delay in reimbursement was due to delay in contract execution.
2. We don't know why there is a delay.
3. Slow processing time
4. Our budget modification approval took more than 3 months.
5. No factors within our agency that contribute to the delay in reimbursements. Once invoices are submitted, it typically takes 30 or more days to receive reimbursements.
6. n/a
7. Agency internal issues related to delays in submission of invoicing
8. Staffing shortages and recruiting delays.
9. NONE

24. Please share any other comments you have below: *(some providers skipped the question)*

1. It is not consistent program to program. There are also discrepancies between fiscal monitoring by the county and what is allowed in the budgets.
2. For most aspects of our contract, we receive timely responses. However, the budget modification process generally takes 31 or more days, and we have to reach out repeatedly to receive a response. Regarding monitoring and site visits, we have four separate monitoring visits that could be done at once but are conducted by separate DHSP departments that do not communicate with each other. This is ultimately inefficient and more time consuming.
3. Often the monitoring report does not match the comments made during the monitoring close out.
4. DHSP program advisors are consistently responding in a timely manner.
5. DHSP DETAILED AUDIT TOOL SHOULD BE PROVIDED TO AGENCIES EVERY YEAR.
6. We developed an online portal to increase efficiency in client services. The process for DHSP to approve this portal took a significant amount of time, which interfered with our ability to serve clients in a timely manner.
7. Both HTS and Biomedical RedCap had system issues throughout 2024. HTS Prevention RedCap reporting and access for staff are still an issue. In addition, due to changes in setting up reporting functions in RedCap, our site was unable to run internal reports to enter correct data into the monthly narrative report.
8. NA

IV. Recipient Surveys Responses and Key Informant Interviews

Summary of Responses from DHSP (Recipient):

The local Recipient of Ryan White Part A funding in Los Angeles County is the Division of HIV and STD Programs (DHSP), Department of Public Health. As part of the AEAM, two senior managers in charge of managing the RFP and contracting processes from DHSP participated in the key informant interviews. In addition, the Commission developed a survey specifically for DHSP, to harness a comprehensive review and understanding of the recipient's processes regarding solicitations, contracts execution, and payments to subrecipients. The Recipient's responses are summarized below:

#	Question	Recipient Response
PART 1: REQUEST FOR PROPOSALS/SOLICITATIONS:		
1	**How many Requests for Proposals (RFPs) were released for the PY 33 Ryan White Program (March 1, 2023 to February 29, 2024)?**	2
2	**If RFPs were released in PY 33 (March 1, 2023 to February 29, 2024), select the service categories.**	Home-based Case Management Work Order Solicitation (Case management- Home Based Services via Supportive and/or Housing Services Master Agreement (SHSMA)) Childcare Services for Ryan White Program Eligible Clients in LAC (RFA)
3	**How many proposals were received for each of the service category selected in Question #2.**	Case management- Home Based – 7 proposals received. Childcare Services – 1 proposal received, but did not pass Minimum Mandatory Requirements (MMR) Review.
4	**Of the proposals received in PY 33 (March 1, 2023 to February 29, 2024), how many were new service providers?**	4 Please note that ALL 4 new service providers mentioned above in question 4 were NOT funded/awarded contracts. *These 3 providers indicated prior contracts with DHS, and regional centers, but were new to DPH/DHSP.*

5	**Of these proposals, how many service providers were awarded contracts for Ryan White program funds?**	4
6	**How many Requests for Proposals (RFPs) were released for the PY 34 (March 1, 2024 to February 28, 2025) Ryan White Program?**	4
7	**If RFPs were released in PY 34 (March 1, 2024 to February 28, 2025), select the service categories.**	Ambulatory Outpatient Medical (AOM) Medical Specialty Services Transportation Other (please specify) Patient Support Services (PSS)
8	**How many proposals were received for each of the service category selected in Question #7.**	Core HIV Medical Services comprised of AOM, MCC, and PSS. A total of 20 proposals were submitted for the Core HIV Medical Services RFP, with 18 submissions in each respective category. Ambulatory Outpatient Medical (AOM) – 18 proposals received. Medical Specialty Services (Same as Medical Care Coordination) MCC – 18 proposals received. Patient Support Services (PSS) – 18 proposals received. Transportation services – 21 applications received.

9	**Of the proposals received in PY 34 (March 1, 2024 to February 28, 2025), how many were new service providers?**	2 There were 2 new service providers to DHSP. <u>Transportation Services:</u> There were 2 new service providers who applied for Transportation services, but did not pass MMR Review.
10	**Of these proposals, how many service providers were awarded contracts for Ryan White program funds?**	39 service providers were awarded. Core HIV Medical Services – 20 (all proposals) were awarded contracts. Transportation Services – 19 out of the 21 applications received were awarded contracts.
PART II: EXECUTING CONTRACTS WITH SERVICE PROVIDERS:		
11	**How many contracts were fully executed in PY33 (March 1, 2023 to February 29, 2024)?**	A total of 64 *(renewal amendments to extend the term of the contracts with the same contract period:* *Benefits specialty services (BSS)* *Medical specialty services (MSS)* *Residential* *Medical care coordination (MCC)* *Substance use disorder transitional housing (SUDTH)* *Transitional case management (TCM)*

		Legal *Transportation*
12	**How many contracts were fully executed in PY34 (March 1, 2024 to February 28, 2025)?**	Total of 75 (renewal amendments to extend the term of contracts with same contract period (Mental health, AOM, MCC, Oral, Legal, Data mgmt., BSS, Residential SUDTH, and MSS)
13	**In general, what is the average timeframe for executing service agreements?**	46-60 days (this depends greatly upon the point determined to be the start of the process)
PART III PAYMENT: Service Provider Reporting and Invoicing Process		
14	**During PY 33 (March 1, 2023 to February 29, 2024), what was the average amount of time in days between receipt of a complete monthly report and invoice from a service provider and the issuance of a payment?**	15-30 days
15	**During PY 34 (March 1, 2024 to February 28, 2025), what has been the average amount of time in days between receipt of a complete monthly report and invoice from a service provider and the issuance of a payment?****	15-30 days It varies from agency to agency. Some agencies submit their invoices and monthly reports on time, aligning with their contract amount and approved budget. Some don't even submit their invoices in a timely manner and require extensive follow-up by finance staff and the Program Manager. However, DHSP agencies have 30 days to bill, and DHSP finance has 30 days to process once it receives the

		invoice and monthly report. It would be safe to assume that about 15 – 30 days.

KEY INFORMANT INTERVIEW RESPONSES

OVERVIEW OF THE SOLICITATIONS/REQUEST FOR PROPOSALS PROCESS AT DPH/DHSP

Based on key informant interviews with 2 DHSP senior staff and review of Request for Proposals (RFP) documents publicly available on the DPH Contracts and Grants Division, below is a summary of the key elements and process related to the solicitations and contracting procedures at the DHSP/DPH.

SOLICITATIONS PROCESS:

- The solicitations process is designed to ensure County programs do not enter into contractual agreements without a full, unbiased review and that community-based organizations (CBOs) receiving contracts meet requirements and are fully accountable to the County and federal grant requirements.
- DHSP staff begins planning and developing RFPs at least 12 months in advance to ensure continuity of care and to avoid service interruptions. There is extensive review from County Counsel to ensure that RFPs and contract documents meet the County's legal review and requirements.
- Proposal evaluation is in phases: first, to ensure they meet mandatory minimum requirements; second, and review panel convened by Contracts and Grants (C&G), DPH; third, final funding recommendations; fourth, departmental reviews; fifth, contracts go to the Board for approval. Once approved, contract negotiations occur with the CBOs, then a Board Letter is submitted for contract approval. Once approved, the CBOs sign the contracts and then they can be executed.
- DPH C&G is charged with overseeing the contracting process and solicitations for DPH overall but, for DHSP, C&G manages solicitation while DHSP manages programmatic content, contract negotiations, and contract monitoring.
- C&G's role includes responding to questions on a solicitation and releases an addendum that may clarify or change some solicitation language and answer specific questions. C&G, in collaboration with DHSP, will host a proposer's conference.
- Proposers must meet the County's minimum mandatory requirements (MMRs) as well as appear to be able to sustain services for 90 days without County funds to demonstrate financial stability. Proposers passing those tests go on to further evaluation.
- RFP reviewers are typically subject matter experts and resource partners within the County. DHSP is responsible for identifying unbiased, non-conflicted evaluators for review panels. Identifying external reviewers outside of the County is challenging due to several factors. For instance, serving on review panels requires significant time for no pay and evaluators must sign a statement of no conflict of interest so local providers are often ineligible. In addition, external reviewers may not be fully aware of the complexity of the needs and service landscape of Los Angeles County.
- Application reviewers/evaluators receive an orientation prior to receiving the proposals. The

orientation entails a review of how to use a common evaluation tool, their roles and responsibilities, the purpose and aim of the RFP. The evaluators conduct their individual reviews followed by a group discussion of their ratings and feedback. An average score for each proposal is derived from the discussions.

- Contractors are selected and funding recommendations are developed based on evaluation scores as well as funding requirements, geographic distribution of services and targeted populations defined in the solicitation, and availability of funding. Funding amount requested typically exceed available resources. Proposers may request a debriefing after the recommendations to review their proposals. They may appeal decisions.

OVERVIEW OF THE CONTRACTS EXECUTION PROCESS AT DPH/DHSP

- Once an agency has been identified as a successful bidder, they receive a letter from C&G notifying them of their selection and that a meeting with DHSP to initiate contract negotiations would be forthcoming within 2-3 days.
- DHSP provides instructions on how and where to submit budgets and scopes of work and other documents required to complete the contract. A dedicated email address is used to facilitate the submission of required contractual documents. Contractors are given at least a month to complete and submit all required documents. DHSP strives to accommodate requests for extensions from agencies which impacts the timeline for executing the contract.
- Once all contractual documents are received, DHSP reviews the documents for completeness and alignment of budgets with the scope of work and the goals and objectives of the RFP. The review process entails 3 levels of review involving the program manager, supervisor, and the Chief of Contracted Community Services (CCS). Follow-up meetings are then scheduled with the agency to secure additional documents, as needed, and discuss budget requests to ensure accuracy and optimal use of grant funds to meet service delivery requirements and standards. Agencies are given about a week to respond to questions and submit additional information as directed by DHSP.
- Once all documents are received by DHSP, their finance team will conduct additional review. The thorough programmatic and fiscal review seeks to ensure that budgets and scopes of work contain appropriate funding, staffing and service delivery mechanisms.
- The final stage of the contracting process involves securing authorized signatures from the agency and DHSP. The length of time varies depending on the agency's approval process, as some agencies may need to secure approval from their Board of Directors and City Councils. Academic institutions tend to have a longer internal approval procedures and chain of command. On average, most contracts are signed and executed within a month. Depending on if the agency requested extensions or was delayed in submitting required documentations, the process may take up to 4 months. In the case of academic institutions, the process has taken up to 1 year in the past.

Efforts by DHP to Encourage Providers to Apply for Ryan White Part A Funds

- The DPH C&G Division disseminates announcements for RFPs on behalf of the entire Department. C&G maintains a listserv of agencies registered to receive notices on funding

opportunities for DPH. In addition, funding notices are also released via the County's Internal Services Department (ISD) which maintains a database of agencies that have registered to declare their interest in doing business with the County. RFPs are posted on the DHSP website with a corresponding link to the C&G website for the full details about the RFP. Combined, these distribution listings reach a broad array of agencies and organizations of varying sizes and service areas of focus or expertise.

Key Factors that Contribute to Delays in Executing Agreements

- As described in the contract execution process earlier, delays in the process typically involve time needed by agencies to submit accurate documents and information required by the County and DHSP and the processes internal to the agencies related to securing authorized signatures for the contracts.
- The recipient noted that some agencies are able to return a signed within the same day which helps with expediting the execution of the contract.

Contract Terminations

- DHSP key informants indicated that no contracts were terminated during PY 33 and 34. One agency, a language service provider, elected to end their contract with the County due low utilization from service providers and clients.

Monthly Report Review and Invoice Payment Process

- The monthly invoicing instructions and forms are available on the DHSP website. Monthly invoices are due no later than 30 days after the end of each month. Invoices must be accompanied by all required program (narrative) reports and data in order for DHSP to process payment. DHSP staff will reach out to contractors if required forms are missing, inaccurate, or incomplete. Once DHSP receives an accurate invoice along with the monthly narrative program report, DHSP's timeframe is to pay the agency within 30 days.

Factors that may Contribute to Delays in Payments to Service Providers

- DHSP key informants noted that the common factor that affects timely payments is failure to submit accurate invoices and narrative reports on time. Agencies are instructed to correct invoices if DHSP finds discrepancies between the approved budget and allowed expenses, which affects the 30-day turnaround time for payment. Budget modification requests pending DHSP approval may also affect the timely submission of invoices to DHSP. With regard to budget modification requests, DHSP strives to approve the request within a month, however, it may take up to 3 months depending on the review and questions from DHSP.

Technical Assistance or Training Provided to Service Providers Aimed at Improving Knowledge and Skills Related to Invoicing and Monthly Reporting Requirements

- DHSP covers these areas during the successful bidders conference. DHSP provides ongoing technical assistance to agencies on an individual basis and as a collective. Additional trainings are provided when new staff are onboarded to ensure that scopes of work, approved budget and contractual requirements are understood and followed by the agency. DHSP routinely receives and responds to questions and request for guidance on how to develop a budget,

budget modification and invoicing.
- Other types of training and technical assistance provided by DHSP include how to use CaseWatch, or other systems for data collection and HIV educational and skills building.

Improvements or Successes Related to Administrative Mechanisms:

- DHSP's effort to contract with a third-party administrator (TPA) has been a significant improvement in their ability to expedite contracts for smaller grants under the Ending the HIV Epidemic initiative. The TPA model may be used for some Ryan White categories, perhaps those with smaller contractual amounts, but not for larger service categories with more complex service and contractual requirements. TPAs would be fiscally challenged to float the cost of paying RW contractors for larger service categories. DHSP is seeking to identify another qualified TPA to enhance their administrative capacity to expedite contracts.
- The County's emergency declaration to address homelessness has been useful for utilizing the sole source contracting mechanism to expedite service agreements specifically tied to the homelessness crisis.
- DHSP developed a more streamlined internal process to review contracts and invoices, decreasing the amount and frequency of back-and-forth communication between DHSP and agencies. Additionally, DHSP has established a more efficient internal communication and coordination process with the finance unit to understand programmatic requirements and minimize separate and often repetitive layers of review between finance and programmatic staff.
- The DPH C&G unit provides enhanced infrastructure and capacity support for DHSP to release and manage several RFPs in a single year.

V. Key Themes

PROVIDER PERSPECTIVES

The County's Request for Proposals (RFP) Process is Clear

Providers indicated high marks regarding DHSP's RFP process, ranging from over 93% to 100% of providers agreeing or strongly agreeing with the clarity, fairness, and competitiveness of the RFP process.

Contract Execution Timeframe is Influenced by Agency Procedures

Almost 77% of responses indicated that they did not have issues and or challenges with executing contracts. Some agencies noted that delays were due to their agency's internal approval processes adding to the overall timeframe for contract execution. Furthermore, agencies noted that the budgeting process and rounds of reviews and approvals also contribute to the delay in executing

contracts.

Average Timeframe for Payment is 31+ Days
During PY 33, respondents almost 85% indicated that on average, it took 31 or more days for their agency to be reimbursed from the day they submitted a correct and complete invoice. For PY 34, the response was almost 92%. Delays in reimbursements could be impacted by staffing shortages and submission of incorrect or incomplete invoices which must be submitted with a program narrative report.

Prompt Responses to Invoicing Questions
With regard to response time from DHSP on invoicing questions, almost 92% of respondents indicated receiving a response with 5 to 10 days. Additionally, 23% and 69% percent "agreed" or "strongly agreed" that their contract monitor provides clear and consistent responses to questions and request for information, programmatic guidance, and technical assistance.

Mixed Reactions around Communication of Expectations Prior to Site Visits and Program Monitoring
While some of the responses noted that program managers conveyed expectations clearly prior to site visits, there were also comments that alluded to the need for clearer communication of expectations for program monitoring prior to the site visit and better explanation for changes in expectations from year to year. In terms of the process for program monitoring, responses were varied: 23% somewhat clear, 15% clear, and 61% very clear.

Contractors Receive Regular Feedback on Performance and Technical Assistance (TA) on Barriers and Challenges
In general, the majority of the comments, appear to show that DHSP regularly provides feedback on contractor performance and that the feedback is helpful in improving program policies, procedures, and assisting the agencies meet their contractual goals. 75% of the respondents indicated that the TA and training they received met their needs and helped their agencies address challenges.

RECIPIENT PERSPECTIVES

The Recipient conduct broad provider outreach and information dissemination efforts to promote RFPs.

- DHSP and DPH uses a broad distribution list to disseminate RFPs and funding announcements, reaching a wide variety of agencies of diverse size, organizational capacity, and service area expertise.

The Recipient continues to enact procedures aimed at improving their review and approval process.

- DHSP continues to make positive improvements in managing solicitations, executing contracts, and processing payments to agencies through improved internal processes, communications with agencies, and ongoing general and customized training for agency staff.

The Recipient leverages the County's administrative infrastructure.

- DHSP has a well-established process, infrastructure and partnership with DPH C&G and County Counsel that help to facilitate the solicitations process.

The Recipient engages providers by seeking their input in shaping RFPs.

- DHSP seeks provider input regarding service needs and ideas for improving programs to help develop RFPs.

VI. Recommendations:

This AEAM highlighted key suggestions for improvement based on provider and recipient survey responses and interviews:

- Continue to improve payment turnaround cycles within 30 days.
- Expedite or shorten the length of time it takes to execute a contract or approve a budget modification.
- Ensure uniformity in the information communicated by program and fiscal managers to contracted agencies, particularly for site visits and audits.
- Strengthen TA and training for programmatic and fiscal staff within DHSP and for contracted providers to ensure consistency of information, particularly for agencies that face staffing challenges (i.e., recruitment, retention, turnover).

The general comments collected from this AEAM reflect the recurring themes from previous assessments such as consistency of information received from DHSP, setting clear expectations for audits/site visits; and invoice payment turnaround time.

DHSP continues to explore additional mechanisms to more quickly fund HIV services in Los Angeles County. For example, DHSP's experience with using a third-party administrator, Heluna Health, to issue HIV prevention RFPs, serves as a model for expediting some of the Ryan White service contracts. Despite the bureaucratic challenges associated with a large municipal government the size of Los Angeles County, DHSP continues to improve various administrative mechanisms to ensure that life-saving services reach people living with HIV in a timely and efficient manner.

LOS ANGELES COUNTY
COMMISSION ON HIV

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Public Comment Period for Draft Transitional Case Management: Justice Involved Individuals Service Standards

Posted: June 24, 2025

The Los Angeles County Commission on HIV (COH) announces an opportunity for the public to submit comments for the draft **Transitional Case Management (TCM): Justice-Involved Individuals** service standards revised by the Standards and Best Practices Committee. Comments from consumers, providers, HIV prevention and care stakeholders, and the public are welcome.

A draft of the document is posted to the COH website and can be found at: https://hiv.lacounty.gov/service-standards. Comments can be submitted via email to HIVCOMM@LACHIV.ORG.

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

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

Public comments are due to HIVCOMM@LACHIV.ORG by Monday July 28, 2025.

TRANSITIONAL CASE MANAGEMENT SERVICES

(Draft as of 06/18/25)

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 to prevent acquisition and transmission of HIV/STIs), and risk reduction
- 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

OUTREACH

Programs providing Transitional Case Management (TCM) for justice-involved individuals services will conduct outreach to educate potential clients, HIV and STI services providers and other supportive service organizations about the availability and benefits of transitional management services for justice-involved persons living with HIV/AIDS within the Los Angeles County Jail system. Promotion and outreach will include the provision of information sessions to incarcerated people living with HIV/AIDS that facilitate enrollment into incarcerated TCM programs. Programs will collaborate with HIV primary health care and

support services providers, as well as HIV and STI testing sites.

OUTREACH	
STANDARD	**DOCUMENTATION**
Transitional Case Management programs will conduct outreach to potential clients and providers.	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.
Transitional Case Management programs establish appointments (whenever possible) prior to release date.	Record of appointment date.

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 • Resources and referrals • Assessment of barriers to care including 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 utilizing information gathered during assessment and subsequent reassessments.

INDIVIDUAL RELEASE PLAN	
STANDARD	**DOCUMENTATION**
Individual Release Plans (IRPs) will be developed in conjunction with the client within two weeks of completing the assessment or reassessment. IRPs will be updated on an ongoing basis.	IRP 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 • 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**
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 • Provide interventions and linked referrals • Ensure coordination of care	Signed, dated progress notes on file that detail, at minimum, the following: • Description of client contacts and actions taken • Date and type of contact • Description of what occurred • Changes in the client's condition or circumstances • Progress made toward IRP goals

• 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 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.	• Barriers to IRPs 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

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 Refer to "Recommended Training Topics for Transitional Case Management Staff."	
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. Copies of diplomas on file.
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 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.

Appendix 1: 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, but not be limited to:

- 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
- Sexual identification, gender issues, and provision of trans-friendly services
- Stigma and discrimination and HIV/AIDS
- Health equity and social justice
- Motivational interviewing
- Knowledge of available housing, food, and other basic need support services

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Public Comment Period for Draft Transitional Case Management: Older Adults 50+ Service Standards

Posted: June 24, 2025

The Los Angeles County Commission on HIV (COH) announces an opportunity for the public to submit comments for the draft **Transitional Case Management (TCM): Older Adults 50+** service standards revised by the Standards and Best Practices Committee. Comments from consumers, providers, HIV prevention and care stakeholders, and the public are welcome.

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TRANSITIONAL CASE MANAGEMENT SERVICES: OLDER ADULTS 50+

(Draft as of 06/18/25)

Contents

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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

Purpose

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 to prevent acquisition and transmission of HIV/STIs), and risk reduction
- 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 Older Adults 50+

PURPOSE
Coordinate transition between systems of care for older adults 50+ living with HIV/AIDS.

SERVICE COMPONENTS

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 at a minimum 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. At a minimum, 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 at minimum 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, but not be limited to:

- 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
- Sexual identification, gender issues, and provision of trans-friendly services
- 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

510 S. Vermont Ave. Floor 14, Los Angeles, CA 90020| (213) 738-2816 | hivcomm@lachiv.org

Public Comment Period for Draft Transitional Case Management: Youth Service Standards *Posted: June 24, 2025*

The Los Angeles County Commission on HIV (COH) announces an opportunity for the public to submit comments for the draft **Transitional Case Management (TCM): Youth** service standards revised by the Standards and Best Practices Committee. Comments from consumers, providers, HIV prevention and care stakeholders, and the public are welcome.

A draft of the document is posted to the COH website and can be found at: https://hiv.lacounty.gov/service-standards. Comments can be submitted via email to HIVCOMM@LACHIV.ORG.

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

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

Public comments are due to HIVCOMM@LACHIV.ORG by Monday July 28, 2025.

TRANSITIONAL CASE MANAGEMENT SERVICES: YOUTH

(Draft as of 06/18/25)

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.

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- 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 (e.g. homelessness, substance use, and emotional distress)
- 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. Planing will be made for eventual transition to adult/non-youth specific case management at least by the client's 30th birthday.
- Eligibility for the Los Angeles County Department of Mental Health (DMH) Transition Age Youth Services, Adult Services Full-Service Partnership Program, and other DMH and Los Angeles County-funded programs to ensure continuing support while the client is in receiving TCM for youth services or once the client has completed or aged out of TCM youth services.

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: • Provide interventions and linked referrals • 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, at minimum: • 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 • 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	Signed, dated progress notes on file that detail, at minimum, the following: • Description of client contacts and actions taken • Date and type of contact • 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

• Upon transition case, communicate to client the availability of case manager for occasional support and role as a resource to maintain stability for client.	

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 Refer to Appendix 1 for additional information.	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	Resumes on file at provider agency documenting experience. Copies of diplomas on file.

• 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 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.

Appendix 1: 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, but not be limited to:

- 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).

South Los Angeles Women's Sexual Health Listening Session

LOS ANGELES COUNTY COMMISSION ON HIV

WHY ATTEND?

This listening session aims to gather insights from women living with or impacted by HIV to better understand their sexual health and HIV care needs. Your input will help shape sexual health services and resources that meet the unique needs of women.

Monday, June 30, 2025
3pm-5pm

WHAT TO EXPECT

- A safe space for open dialogue
- Connect with others who share similar experiences
- $25 gift card for participants
- **Space is limited; RSVP required**

WHERE

Drew CARES
1731 E. 120th St.
Bldg. M
Los Angeles, CA 90059

REGISTER NOW: https://tinyurl.com/yszuh5xytext

THE BLACK CAUCUS PRESENTS

CENTERING THE VOICES OF THE BLACK TRANSGENDER COMMUNITY IN LA COUNTY

The **Black Caucus of the Los Angeles County Commission on HIV**, in partnership with the **Transgender Caucus, and AMAAD Institute**, invite **Black transgender individual**s to join a dedicated ***in-person*** community listening session focused on your lived experiences, insights, and needs related to **sexual health, wellness, and healthcare access**. This is a space to speak freely, be heard, and help shape systems of care that reflect and respect your identity, truth, and brilliance.

We want to hear from you about:

- Barriers to accessing sexual and reproductive health services
- Experiences of stigma, discrimination, and resilience in care settings
- What culturally responsive and affirming care looks like
- What support, resources, and advocacy are needed

Wednesday, July 9, 2025 @ 5-7PM

South Los Angeles - exact location will be shared upon confirmed registration

Participants will receive:

✓ $50 Visa Gift Card (while supplies last) ✓ Light Refreshments
✓ Community Resources

Spaces are limited to ensure an intimate, respectful space. Capacity is capped at 25 participants. Registration is required.

REGISTER HERE: https://tinyurl.com/45emdzkb

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