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

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EXECUTIVE COMMITTEE MEETING

Thursday, December 12, 2024
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/r5bd6054377766a4a65b4a7963adb2cc3

To Join by Telephone: 1-213-306-3065
Password: EXECUTIVE   Access Code: 2539 929 6105

Public Comments

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

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

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

Accommodations

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

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

together.

WE CAN END HIV IN OUR COMMUNITIES ONCE & FOR ALL

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

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

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

EXECUTIVE COMMITTEE

Thursday, December 12, 2024 | 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:
To Join by Telephone: 1-213-306-3065
https://lacountyboardofsupervisors.webex.com/weblink/register/r5bd6054377766a4a65b4a7963adb2cc3
Password: EXECUTIVE Access Code: 2539 929 6105

EXECUTIVE COMMITTEE MEMBERS			
Danielle Campbell, PhDc, MPH, Co-Chair	*Joseph Green, Co-Chair*	Miguel Alvarez	Alasdair Burton (Executive At-Large)
Erika Davies	Kevin Donnelly	Felipé Gonzalez	Bridget Gordon (Executive At-Large)
Lee Kochems, MA (LOA)	Katja Nelson, MPP	Mario J. Peréz, MPH	Dechelle Richardson (Executive At-Large)
Kevin Stalter	Justin Valero, MPA		
QUORUM: 7			

AGENDA POSTED: December 6, 2024

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.

7. Standing Committee Report 1:15 PM – 1:45 PM

A. Planning, Priorities and Allocations (PP&A) Committee
  (1) Paradigm and Operating Values | **MOTION #3**
  (2) Ryan White Program (RWP) Years 35-37 Directives | IN DEVELOPMENT
  (3) October 28, 2024 Antelope Valley Listening Session | FOLLOW UP & FEEDBACK

B. Operations Committee
  (1) Membership Management
    a. New Membership Applications Hold Due to Vacancy Limitations and Proposed Restructuring | REMINDER
    b. 2025 Conflict of Interest Form and Parity, Inclusion & Reflectiveness (PIR) Survey | REMINDER
  (2) Assessment of the Effectiveness of the Administrative Mechanism (AEAM) |SURVEY REVIEW
  (3) 2025 Proposed Training Topics & Schedule
  (4) Recruitment, Retention & Engagement

D. Standards and Best Practices (SBP) Committee
  (1) Emergency Financial Assistance (EFA) Service Standards | **MOTION #4**
  (2) Ambulatory Outpatient Medical (AOM) Service Standards | **MOTION #5**
  (3) Housing Service Standards | REVIEW IN PROCESS
  (4) Service Standards Schedule

E. Public Policy Committee (PPC)
  (1) Federal, State, County Policy & Budget
    a. 2024 Legislative Docket | UPDATES
    b. 2024 Policy Priorities | UPDATES
  (2) The Wall Las Memorias "Act Now Against Meth" Campaign | UPDATES

8. Caucus, Task Force, and Work Group Reports: 1:45 PM – 2:00 PM

A. Aging Caucus
B. Black/AA Caucus
C. Consumer Caucus
  - December 17, 2024 "Hybrid" Retreat | FLYER
  - February 13, 2025 Consumer Resource Event | FLYER
D. Transgender Caucus
E. Women's Caucus
F. Housing Task Force

IV. REPORTS

9. Executive Director/Staff Report 2:00 PM – 2:15 PM

A. Commission (COH)/County Operational Updates
  (1) November 14, 2024 Annual Conference Evaluation | REVIEW & FEEDBACK
  (2) 2026-2030 National HIV/AIDS Strategy and the National Strategy Plans for Sexually Transmitted Infections, Vaccines, and Viral Hepatitis Public Comment Submission
  (3) HRSA 2024 Technical Assistance Site Visit | FINDINGS & NEXT STEPS
  (4) 2025 Draft COH Workplan & Meeting Schedule | REVIEW & DISCUSSION
    a. COH Organizational Assessment & Restructure

10. Co-Chair Report 2:15 PM – 2:35 PM

A. 2024 At-A-Glance | REVIEW & REFLECTIONS
B. 2025 COH & Committee Co-Chair Open Nominations & Elections | REMINDER
C. 2024 BOS Executive Office Commissioner Forum | FEEDBACK
D. Member Vacancies & Recruitment
E. 2024 Meeting Schedule

11. Division of HIV and STD Programs (DHSP) Report 2:35 PM – 2:50 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) Mpox | UPDATES

V. NEXT STEPS 2:50 PM – 2:55 PM

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

VI. ANNOUNCEMENTS 2:55 AM – 3:00 PM

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

VII. ADJOURNMENT 3:00 PM

15. Adjournment for the special meeting of December 12, 2024.

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 PP&A Committee's Paradigms and Operations Values, as presented or revised, and forward to full body for final approval.
MOTION #4	Approve the Emergency Financial Assistance (EFA) Service Standards, as presented or revised, and forward to the full body for final approval.
MOTION #5	Approve the Ambulatory Outpatient Medical (AOM) Service Standards, 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.)

HYBRID MEETING GUIDELINES, ETTIQUETTE & REMINDERS

(Updated 7.15.24)

☐ This meeting is a **Brown-Act meeting** and is being recorded.

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

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

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

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

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

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

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

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

2024 MEMBERSHIP ROSTER| UPDATED 11.12.24

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			***Vacant***	Long Beach Health & Human Services	July 1, 2023	June 30, 2025	
4	City of Los Angeles representative	1	SBP	Dahlia Ale-Ferlito	AIDS Coordinator's Office, City of Los Angeles	July 1, 2024	June 30, 2026	
5	City of West Hollywood representative	1	PP&A	Dee Saunders	City of West Hollywood	July 1, 2023	June 30, 2025	
6	Director, DHSP *Non Voting*	1	EXC	Mario Pérez, MPH	DHSP, LA County Department of Public Health	July 1, 2024	June 30, 2026	
7	Part B representative	1	PP&A	Karl Halfman, MA	California Department of Public Health, Office of AIDS	July 1, 2024	June 30, 2026	
8	Part C representative	1	OPS	Leon Maultsby, 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	1	SBP	Andre Molette ***(LOA)***	Men's Health Foundation	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	1	EXC|OPS	Dechelle Richardson	AMAAD Institute	July 1, 2024	June 30, 2026	
17	Provider representative #7			***Vacant***		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	
22	Unaffiliated representative, SPA 4			***Vacant***		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	
27	Unaffiliated representative, Supervisorial District 1	1	PP	Leonardo Martinez-Real	*Unaffiliated representative*	July 1, 2023	June 30, 2025	Arburtha Franklin (PPC)
28	Unaffiliated representative, Supervisorial District 2	1	EXC|OPS	Bridget Gordon	*Unaffiliated representative*	July 1, 2024	June 30, 2026	
29	Unaffiliated representative, Supervisorial District 3	1	SBP	Arlene Frames	*Unaffiliated representative*	July 1, 2023	June 30, 2025	
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	*Unaffiliated representative*	July 1, 2024	June 30, 2026	
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	PP&A	Daryl Russell, M.Ed	*Unaffiliated representative*	July 1, 2024	June 30, 2026	David Hardy (SBP)
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	EXC|OPS	Justin Valero, MA	No affiliation	July 1, 2023	June 30, 2025	
40	Representative, Board Office 5	1	PP&A	Jonathan Weedman	ViaCare Community Health	July 1, 2024	June 30, 2026	
41	Representative, HOPWA	1	PP&A	Matthew Muhonen ***(LOA)***	City of Los Angeles, HOPWA	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 | PP	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	Ronnie Osorio	Center for Health Justice (CHJ)	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	SBP	Felipe Findley, PA-C, MPAS, AAHIVS	Watts Healthcare Corp	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:	43						

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: 47

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 12/11/24

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
			Health Education/Risk Reduction (HERR)
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation 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)
			Transportation Services
CIELO	**Mikhaela**	Los Angeles General Hospital	No Ryan White or prevention contracts
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	Biomedical HIV Prevention/EHE

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DONNELLY	**Kevin**	Unaffiliated representative	No Ryan White or prevention contracts
FERGUSON	**Kerry**	ViiV Healthcare	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	Case Management, Home-Based
			Benefits Specialty
			Nutrition Support
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			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
			Data to Care Services
GONZALEZ	**Felipe**	Unaffiliated representative	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated representative	No Ryan White or prevention contracts
GREEN	**Joseph**	Unaffiliated representative	No Ryan White or prevention contracts
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
HARDY	**David**	LAC-USC Rand Schrader Clinic	No Ryan White or prevention contracts
HERRERA	**Ismael "Ish"**	Unaffiliated representative	No Ryan White or prevention contracts
JONES	**Terrance**	Unaffiliated representative	No Ryan White or prevention contracts
KOCHEMS	**Lee**	Unaffiliated representative	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
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 Affiliation)	No Ryan White or prevention contracts
MOLETTE	**Andre**	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
MUHONEN	**Matthew**	HOPWA-City of Los Angeles	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
NELSON	**Katja**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			Nutrition Support
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			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
			Data to Care Services
OSORIO	**Ronnie**	Center For Health Justice (CHJ)	Transitional Case Management - Jails
			Promoting Healthcare Engagement Among Vulnerable Populations
PATEL	**Byron**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			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
RICHARDSON	**Dechelle**	AMAAD Institute	Community Engagement/EHE
ROBINSON	**Erica**	Health Matters Clinic	No Ryan White or prevention contracts
RUSSEL	**Daryl**	Unaffiliated representative	No Ryan White or prevention contracts
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SAN AGUSTIN	**Harold**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation 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 Affiliation)	No Ryan White or prevention contracts
VALERO	**Justin**	No Affiliation	No Ryan White or prevention contracts
WEEDMAN	**Jonathan**	ViaCare Community Health	Biomedical HIV Prevention
YBARRA	**Russell**	Capitol Drugs	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SAN AGUSTIN	**Harold**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation 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 Affiliation)	No Ryan White or prevention contracts
VALERO	**Justin**	No Affiliation	No Ryan White or prevention contracts
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	

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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, October 24, 2024

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	Bridget Gordon	A
Joseph Green, Co-Chair	P	Lee Kochems	LOA
Miguel Alvarez (EXEC At-Large)	P	Katja Nelson	P
Alasdair Burton (EXEC At-Large)	AB2449	Mario J. Pérez	P
Erika Davies	EA	Dechelle Richardson	P
Kevin Donnelly	P	Kevin Stalter	A
Felipe Gonzalez	P	Justin Valero	P
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, MPIA; Lizette Martinez, MPH; Dawn Mc Clendon; and Jose Rangel-Garibay, MPH			

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

I. ADMINISTRATIVE MATTERS

1. CALL TO ORDER & MEETING GUIDELINES/REMINDERS

Commissioner Joseph Green, COH Co-Chair, commenced the Executive Committee meeting at around 1:02PM and provided an overview of the meeting guidelines.

2. INTRODUCTIONS, ROLL CALL, & CONFLICTS OF INTEREST STATEMENTS

J. Green initiated introductions and requested that Committee members their state conflicts of interest. Cheryl Barrit, MPIA, Executive Director, led roll call.

ROLL CALL (PRESENT): Miguel Alvarez, Kevin Donnelly, Dechelle Richardson, Justin Valero, Danielle Campbell, and Joseph Green.

3. **APPROVAL OF AGENDA**
MOTION #2: Approve the Agenda Order, as presented or revised. *(Approved; passed by consensus)*

4. **APPROVAL OF MEETING MINUTES**
MOTION #3: Approve the Executive Committee minutes, as presented or revised. *(Approved; passed by consensus.)*

II. PUBLIC COMMENT

5. **OPPORTUNITY FOR MEMBERS OF THE PUBLIC TO ADDRESS THE COMMISSION ON ITEMS OF INTEREST THAT ARE WITHIN THE JURISDICTION OF THE COMMISSION.**
Sabel Samone-Loreca announced upcoming holiday-inspired events and a Trans Visibility Day event hosted by the Minority AIDS Program (MAP). For more information, please contact S. Samone-Loreca at ladymocha2009@gmail.com.

III. COMMITTEE NEW BUSINESS ITEMS

6. **OPPORTUNITY FOR COMMITTEE MEMBERS TO RECOMMEND NEW BUSINESS ITEMS FOR THE FULL BODY OR A COMMITTEE LEVEL DISCUSSION ON NON-AGENDIZED MATTERS NOT POSTED ON THE AGENDA, TO BE DISCUSSED AND (IF REQUESTED) PLACED ON THE AGENDA FOR ACTION AT A FUTURE MEETING, OR MATTERS REQUIRING IMMEDIATE ACTION BECAUSE OF AN EMERGENCY, OR WHERE THE NEED TO TAKE ACTION AROSE SUBSEQUENT TO THE POSTING OF THE AGENDA.**
No new business.

IV. REPORTS

7. **Standing Committee Reports**
   A. **Planning, Priorities & Allocations (PP&A) Committee** Kevin Donnelly, PP&A Co-Chair, reported the committee last met on October 15, 2024, and did not meet quorum.
      (1) **Paradigm and Operating Values (P&OV) Updates.** The Committee discussed updates to the P&OV. The final approved version will be presented at an upcoming Executive Committee.
      (2) **October 28, 204 Antelope Valley Sexual Health Listening Sessions** The Committee was reminded of the upcoming listening session; see flyer for information.
      (3) **Directives**. The Committee is continuing to develop the program directives and is seeking additional recommendations from the Women's Caucus. Feedback from the October 28th AV listening session will also be incorporated into the directives.

B. Operations Committee Justin Valero, Committee Co-Chair, reported:

(1) Membership Management

a. **New Membership Applications Hold Due to Vacancy Limitations and Proposed Restructuring.** Effective immediately, all incoming membership applications are on hold, except for those eligible for vacant seats. Beginning January 2025, the Commission will initiate discussions and activities aimed at potentially restructuring membership, informed by HRSA's findings. This process will be led by consultants Collaborative Research and Next Level Consulting. Members also noted that additional considerations around reorganization may arise should the Board of Supervisors expand as per the ballot initiative.

b. **Seat Vacate: Ronnie Osorio MOTION #3** (Passed by Roll Call Vote√: MAlvarez, ABallesteros, KDonnelly, FGonzalez, KNelson, DRichardson, JValero, JGreen and DCambpell; Abstain: MPérez)

c. **Seat Change: Arburtha Franklin, Alternate, to HIV Stakeholder Representative #4 MOTION #4** (Passed by Roll Call Vote√: MAlvarez, ABallesteros, KDonnelly, FGonzalez, KNelson, DRichardson, JValero, JGreen and DCambpell; Abstain: MPérez)

d. **New Member Applications**
   - **Sabel Samone-Loreca | Alternate (Seat #29) MOTION #5** S. Samone-Loreca shared comments in support of her application.
     (Passed by Roll Call Vote√: MAlvarez, ABallesteros, KDonnelly, FGonzalez, KNelson, DRichardson, JValero, JGreen and DCambpell; Abstain: MPérez)
   - **Joaquin Gutierrez | Alternate (Seat #21) MOTION #6** J. Gutierrez shared comments in support of his application.
     (Passed by Roll Call Vote√: MAlvarez, ABallesteros, KDonnelly, FGonzalez, KNelson, DRichardson, JValero, JGreen and DCambpell; Abstain: MPérez)

e. **Committee-Only Member Applications**
   - **Caitlyn Dolan | Standards & Best Practices (SBP) Committee MOTION #7**
     (Passed by Roll Call Vote√: MAlvarez, ABallesteros, KDonnelly, FGonzalez, KNelson, DRichardson, JValero, JGreen and DCambpell; Abstain: MPérez)
   - **OM Davis | Public Policy Committee (PPC) MOTION #8** OM D. shared comments in support of their application.
     (Passed by Roll Call Vote√: MAlvarez, ABallesteros, KDonnelly, FGonzalez, KNelson, DRichardson, JValero, JGreen and DCambpell; Abstain: MPérez)

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(2) Assessment of the Effectiveness of the Administrative Mechanism (AEAM) PY 32 Report | REVIEW & NEXT STEPS
Based on HRSA's Technical Assistance Site Visit findings, the next AEAM must be more focused and narrower in scope, eliminating non-essential information. The Committee will address Ryan White Program (RWP) Years 33 and 34 to align with the current RWP year and use the same surveys to draw comparisons over time.

(3) 2024 Training Schedule. The 2024 training series is complete. The Committee, in collaboration with staff, will develop the 2025 training schedule and invite suggestions for training ideas from the Committee.

(4) Recruitment, Retention & Engagement
Outreach Team. The Outreach Team is actively participating in capacity-building exercises, such as practicing an Elevator Pitch, in preparation for upcoming outreach and engagement activities.

C. Public Policy Committee (PPC) Katja Nelson, PPC Co-Chair, reported that updates are pending the November 6, 2024, election results. Additionally, due to the elections, the Committee has rescheduled its November meeting to November 18, 2024, from 1:30 PM to 3:30 PM at the Vermont Corridor. The meeting will include a presentation from The Wall Las Memorias on the "Act Now Against Meth" initiative.

D. Standards and Best Practices (SBP) Committee Erika Davies, SBP Co-Chair, reported:

(1) Transportation Service Standards | MOTION #9 (Passed by Roll Call Vote√: MAlvarez, ABallesteros, KDonnelly, FGonzalez, KNelson, DRichardson, JValero, JGreen and DCambpell; Abstain: MPérez)

(2) Emergency Financial Assistance (EFA) Service Standards | REVIEW
The EFA service standards are out for public comment until November 1, 2024.

(3) Service Standards Schedule
The Committee will be its review of the Temporary Housing service standard at its November meeting.

The next SBP Committee meeting will be November 12, 2024, 1:30-3:30PM, at the Vermont Corridor.

8. Caucus, Task Force, and Work Group Reports

A. Aging Caucus. C. Barrit reported:

- The Caucus in collaboration with the Women's Caucus held a Loneliness and Isolation community event on September 23, 2024, and the event was well attended. The presentation slides are available on the COH website's Events page.

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- The Caucus leadership held a call with Dr. Gary Tsai from LA County Substance Prevention and Control (SAPC) to identify activities for collaboration.
- The Caucus will continue to work on its 2025 workplan and has canceled its December meeting.

B. Black/AA Caucus. Danielle Campbell, Caucus Co-Chair, reported:

- The Caucus hosted a booth at the October 19 Taste of Soul in partnership with Dr. William King and AMAAD, engaging over 500 people with HIV education and awareness, and referring attendees to HIV testing.
- The October 22 listening session for Black women at Dollarhide Community Center gathered 19 participants who provided valuable feedback on improving services for Black women. An executive summary will follow.
- As a reminder, the World AIDS Day community event, in partnership with D2 and Charles R. Drew University (CDU), will be held on December 6, 2024, at 10 AM at CDU, followed by a resource fair. See FLYER for details.
- Nominations for 2025 co-chairs are open. Interested individuals should contact staff.

C. Consumer Caucus. Damone Thomas, Co-Chair, reported:

- On October 14, 2024, the Caucus Co-Chairs held a leadership planning luncheon for the inaugural consumer resource fair on February 13, 2025, at The California Endowment. The fair will follow the Commission meeting, with coordination support from the Executive Committee. See Save the Date flyer.
- The Caucus will hold a meeting in December, with the date, time, and scope to be determined. Nominations for co-chairs will open at that time.

D. Transgender Caucus. José Rangel-Garibay, COH staff, reported:

- The Caucus last met on September 24, 2024, to review their meeting schedule for the remainder of the year.
- Co-Chair Jada Ali stepped down from leadership, and Mallery Jenna Robinson and Arburtha Franklin were nominated as potential Co-Chairs.
- Given holidays and lack of leadership, all remaining meetings for 2024 are canceled and the Caucus will reconvene in January 2025 at which time co-chair elections will be held. In the interim, COH staff will meet with co-chair nominees to provide an overview of the co-chair roles and responsibilities.

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E. **Women's Caucus.** Lizette Martinez, COH staff, reported:
- The Caucus last convened on October 21, 2024, where they discussed feedback from the Loneliness and Isolation event panel discussion as well as held a discussion soliciting recommendations to include in the PP&A directives.
- During the meeting, co-chair nominations were reopened, and Dr. Mikhaela Cielo and Shary Alonzo were both renominated.
- Concerns were raised about a recent decline in interest and participation, and discussions are underway to explore strategies for reengaging the community.
- The Caucus is scheduled to reconvene in January 2025, at which time they will address meeting frequency, scheduling, and revisit childcare services.

F. **Housing Taskforce (HTF).** C. Barrit reported:
- The HTF last met on September 27, 2024, to review their workplan and hold a panel with DHSP-funded housing and legal services agencies. The goal is to understand client needs and develop programmatic ideas to use these services as a pathway to prevent homelessness among PLWH.
- Next steps for the HTF are to draft public comments to the National HIV/AIDS Strategy Request for Information (RFI) around funding, systemic, administrative burden, and policy issues, and to reach out again to other agencies who were not able to join today's meeting.
- The October meeting is cancelled. HTF meetings occur on the last Friday of each month from 9-10 am.

G. **Annual Conference Workgroup**. C. Barrit reported:
The workgroup will finalize the Annual Conference program and confirm the speakers. The next meeting will include staff and the COH co-chairs to continue refining the remaining details. The event flyer is available HERE.

V. **REPORTS**

9. **EXECUTIVE DIRECTOR/STAFF REPORT** Cheryl Barrit, MPIA, Executive Director, reported:

A. **Commission (COH)/County Operational Updates**

(1) **Annual Conference.** *Refer to Annual Conference Workgroup report.*

(2) **HRSA TA Site Visit Findings Report.** Staff met with the HRSA TA team to review their findings. We are currently awaiting the hard copy of the findings report and will share it with the Committee upon receipt for further discussion.

(3) **COH Organizational Assessment & Restructure Proposal.** As part of the bylaws update process, staff has engaged consultants Collaborative Research and Next Level Consulting to lead a series of discussions and activities aimed at informing an

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organizational restructuring, in response to HRSA's site visit findings and our bylaws review. Please refer to the Scope of Work included in the meeting packet.

A kick-off discussion with the full body is scheduled for the January 9, 2025, COH meeting. In preparation, a Community Review workshop will be held during the Annual Conference break-out session to gather community feedback on the Commission.

10. **CO-CHAIR REPORT** J. Green and Danielle Campbell, Co-chairs, reported:
   A. **2025-2027 COH Co-Chair Open Nominations & Elections.** Co-chair nominations are open, with elections taking place at the January 9, 2025 COH meeting. Nominations for eligible candidates will be accepted up until the start of elections.
   B. **2024 Meeting Calendar Reminder** *No updates*
      (1) **November 14, 2024 Annual Conference |MLK BHC**
      (2) **December 12, 2024 COH Meeting | Canceled**
      (3) **November & December Executive & Operations Committee Meetings | December 12, 2024**
   C. **Conferences, Meetings & Trainings**
   D. **Role & Responsibility of Commission Representatives at Conferences | REVISIT.** A reminder was issued to members who receive sponsorships to attend approved conferences, meetings, and/or trainings on behalf of the Commission. As part of the sponsorship agreement, members are expected to submit a comprehensive report following their participation. This report should include an overview of their experiences, key takeaways, and any insights or strategies that could help inform and improve future Commission planning and initiatives. The goal is to ensure that the knowledge gained from these events is effectively shared and applied to the Commission's ongoing work.
   E. **Member Vacancies & Recruitment Member Vacancies & Recruitment**
   Refer to the Operations Committee report.

11. **Division of HIV and STD Programs (DHSP) Report.** Mario J. Pérez, MPH, Director, reported the following:
   A. **Fiscal, Programmatic and Procurement Updates**
      - A presentation to the COH on DHSP's prevention and care programs and services portfolio is anticipated for February 2025.
      - The RWP and MAI grant application has been successfully submitted; an award notification is expected on or around March 2025.

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- DHSP staff is working to maximize RWP funding from November 2024 to March 1, 2025, as a significant portion remains unspent. Many agencies face challenges in utilizing resources due to staffing issues, limited workforce capacity, and underperformance. DHSP is collaborating with agencies to address these issues and ensure funds are allocated and spent efficiently before the end of the grant period.
- The future of the Ending the HIV Epidemic (EHE) initiative is uncertain, pending the final version of the federal spending bill. While the Senate supports preserving the EHE, the House has proposed cuts.
- DHSP is relying on Tobacco Settlement funds to offset CDC funding cuts to its STI programs, although the exact amount for the upcoming fiscal year remains uncertain. The Tobacco Settlement funds were awarded to providers in two phases: initially as seed grants to kick-start programs and services, followed by additional funding towards the end of Phase 1 to sustain and support ongoing services and programs.
- To support the Prevention Services request for proposal, a request for $10 million has been submitted to help bridge the funding gap and sustain critical STI prevention efforts. Recommendations have been made not to fund certain underperforming agencies. Finally, a set of contracts is set to expire on June 30, 2025, and DHSP is currently deliberating on which contracts should be extended.
- DHSP reported that over 1,200 participants have been successfully enrolled in the newly launched FLEX program for acute HIV clients, which is funded through the Ending the HIV Epidemic (EHE) initiative. This program has seen strong demand, highlighting its importance in addressing the needs of those living with acute HIV. However, due to ongoing budgetary uncertainty, it remains unclear whether the program will receive continued funding beyond February 2025. Despite this uncertainty, the high demand for the program underscores its value, and DHSP is actively working to explore funding options to ensure its sustainability.
- The Board of Supervisors (BOS) has approved a new case watch replacement system, with an implementation date set for March 1, 2026.
- DHSP staff member Jaime Cervantes has accepted a job offer in Washington, D.C., and congratulations are in order. DHSP is now seeking a policy analyst to fill the vacancy. M. Pérez noted that while DHSP has successfully filled 344 budgeted positions, there are still critical vacancies that remain unfunded. The upcoming workforce summit will provide an opportunity to recruit staff.
- DHSP shared that six (6) mpox cases were reported last week, bringing the aggregate total of cases to over 2,500.

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V. NEXT STEPS

11. Task/Assignments Recap

A. All motions will be elevated for approval at the January 9, 2025, COH meeting.
B. Submission of NHAS Public Comments
C. The December 12, 2025, COH meeting has been canceled.
D. Co-Chair elections and a community discussion on bylaws and COH structure are scheduled for the January 9, 2025, COH meeting.
E. The November and December Executive Committee meetings will be combined and held on December 12, 2024, from 1:00-3:00 PM; the Operations Committee meeting schedule will follow.
F. Reminder for the Annual Conference on November 14, 2024, from 9:00 AM-4:00 PM at MLK BHC.

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.

- Minority AIDS Program (MAP) upcoming holiday events and Trans Visibility Day event reminder – see S. Samone-Loreca for more information.
- 12/7/24 AMAAD HIV.E Capstone Event "Summit of our Tribes" – see Dechelle Richardson for more information
- 11/8/24 Aging & HIV: Shared Experiences, Unique Challenges Webinar

VII. ADJOURNMENT

Adjournment for the meeting of October 24, 204

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PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE PARADIGMS AND OPERATING VALUES

(Approved - PP&A 11/19/2024)

PARADIGMS (Decision-Making)

- **Equity:** Allocate resources in a manner that address avoidable or curable differences among groups of people, whether those groups are defined by ethnicity, socially, economically, demographically, or geographically.
- **Compassion:** Response to suffering of others that motivates a desire to help.
- ~~**Retributive Justice:** Making up for past inequities.~~
- **Restorative Justice**: correction of past inequities[1].

OPERATING VALUES

- **Efficiency**: Accomplishing the desired operational outcomes with the least use of resources.
- **Quality**: The highest level of competence in the decision-making process.
- **Advocacy**: Addressing the asymmetrical power relationships of stakeholders in the process.
- **Representation**: Ensuring that all relevant stakeholders/constituencies are adequately represented in the decision-making process.
- **Humility**: Acknowledging that we do not know everything and willingness to listen carefully to others.
- **Access**: Assuring access to the process for all stakeholders and/or constituencies.

1. *Restorative justice seeks to examine the harmful impact of a crime and then determines what can be done to repair that harm while holding the person who caused it accountable for his or her actions. Accountability for the offender means accepting responsibility and acting to repair the harm done.*

Suggestions for Multi-Year (PY 35-37) Program Directives

For Discussion Purposes Only*

1. Patient Navigation and Support – to support consumers as they navigate the various services available to them (whether RWP related or not); needs to go beyond referral by providing assistance in making calls, attending appointments, encouragement during difficult periods, etc.
2. Increase workforce capacity by providing ongoing training for frontline staff to reduce stigma and improve cultural competency/sensitivity and create more welcoming physical environments that celebrate all populations (waiting rooms). Incorporate methods to ensure client confidentiality and desire for privacy.
3. Increase use of long-acting injectable (LAI) antiretroviral therapy (ART) and injectable PrEP to address issues with medication adherence (forgetting or pill fatigue), inability to store medications due to being unhoused, active substance use, etc.
4. Increase awareness of available services throughout the County and from various providers. Increase partnerships with non-traditional partners to expand messaging and awareness and explore the feasibility of offering testing with non-traditional providers.
5. The recipient must create marketing and social awareness campaigns using print materials and digital media, including social media to raise awareness of HIV risk and available services.
    - The recipient must develop measurable, culturally responsive print and digital marketing campaigns specifically tailored to the Black community.
6. Increase access to appointments outside of traditional business hours (evenings and weekends). May need to increase service availability in a specific geographic area(s).
7. Address the unique needs of people who use substances.
8. Core medical and support service providers must Increase opportunities to hire individuals with lived experience (within various capacities) that reflect the populations being served particularly women, people of a trans experience, Black/AA MSM, Latine/x MSM, formerly incarcerated, former substance users.
9. Increase training and ensure staff are periodically screening clients for Medi-Cal eligibility, including dental providers. Counsel clients with undocumented status, or mixed status families, to dispel Public Charge inaccuracies and encourage enrollment in Medi-Cal.
10. Recipient to formally report the status of all directives issued by the Planning Council

Transgender Caucus Recommendations:

11. Housing service providers must have policies in place that protect the rights of Transgender, Gender Non-Confirming, and Intersex (TGI) People Living with HIV (PLWH).

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

For Discussion

12. Housing service providers must have staff trained in Trauma-Informed Care strategies.
13. Core Medical and Support service providers must have staff qualified to provide gender-affirming/ appropriate services to Transgender, Gender non-conforming, and Intersex people.

Women's Caucus Recommendations:

- Recipient to work with the Women's Caucus to develop services that meet the needs of women including, women who are pregnant or have children. Services will be developed in collaboration with the Women's Caucus and the recipient and must be approved by both parties. At least 2 funded core medical providers must offer women's-centered services.

Aging Caucus Recommendations:

- Benefits Specialty services must be available to PLWH within each Service Planning Area (SPA). Benefits Specialty services must also expand to include services available for aging populations (50+) within Los Angeles County. The recipient must work with the local Area on Aging to identify services.

Black Caucus Recommendations:

- Develop pilot community engagement activities, e.g., incentivized coalition-building and ambassador programs that engage trusted influencers from diverse Black subpopulations, including transgender individuals, MSM, women, and youth. These initiatives will aim to foster connection, build trust, and raise HIV awareness by promoting available services and encouraging community-driven advocacy and support beyond traditional providers and spaces.

For Discussion

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

ANTELOPE VALLEY LISTENING SESSION: EVENT SUMMARY

EVENT DATE: OCTOBER 28, 2024

PURPOSE

- Gather feedback from the Antelope Valley community on opportunities, challenges, and community needs related to sexual health and wellness.
- Identify solutions to inform planning efforts to improve services, address challenges and increase service utilization within the Antelope Valley.

CHALLENGES

Challenges identified include:

- Limited resources (including staff) and services
- Despite availability, providers and clients lack knowledge of existing services/resources in the area
- Fear of stigma due to a prevalent conservative culture
- Lack of staff knowledge/training around LGTBQ and trans issues
- Provider discomfort discussing sexual health history
- Providers lack knowledge of Prep/PEP/DoxyPEP

COMMUNITY NEEDS

Participants noted the following community needs for engagement:

- Welcoming spaces celebrating all identities
- Other supportive services (housing, mental health, etc.)
- Service availability in outlying areas
- Evening and weekend hours
- Education on HIV/STIs
- Knowledge of how to find needed services (central info hub)
- Constant follow up
- Incentives

RECOMMENDATIONS

- Ongoing collaboration and regular convening of providers to increase knowledge of existing resources and build strong partnerships within the Antelope Valley.
- Offer weekend and evening hours to accommodate all clients.
- Provide ongoing staff training on HIV/STI care and prevention and people first care (trauma-informed care, stigma, reproductive justice, gender-affirming care, etc.).
- Increase resources to scale up education, outreach, and staffing.
- Use a variety of methods to promote services and provide education using simple, culturally-appropriate language.
- Increase efforts to educate seniors, youth, Spanish-only speakers and sex workers.

Assessment of the Efficiency of the Administrative Mechanism
Ryan White Program Year (PY) 33 and 34
Provider Survey -DRAFT

Please complete the survey below.

Purpose: The Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87) mandates the Los Angeles County Commission on HIV (COH) to conduct an annual Assessment of the Efficiency of the Administrative Mechanism (AEAM). This assessment is a review of how quickly and well the Ryan White HIV/AIDS Program Part A recipient, the Division of HIV and STD Programs (DHSP), Department of Public Health, carries out the process to contract with and pay providers in a timely manner for delivering HIV-related services so that the needs of people living with HIV (PLWH) throughout our Eligible Metropolitan Area (EMA) are met. Your responses will be kept private and confidential. All responses will be summarized in aggregate; no individual responses will be reported to DHSP. Therefore, please be open and honest in your responses. The completion of the survey is a federal mandate and your cooperation is greatly appreciated.

Instructions: Please complete all sections and provide responses based on Program Year 33 (PY33) (March 1, 2023 - February 28, 2024) and PY 34 (March 1, 2024 – February 28, 2025). It should take 15-20 minutes to complete. If you have any questions, please contact Cheryl Barrit, Executive Director, Commission on HIV, at 213-618-6164 or cbarrit@lachiv.org.
We would like to receive your completed survey by February 14, 2025. Thank you!

Q1. First and Last Name

Q2. Name of Provider Agency

Q3. Position in Agency

RFP Process and Selection of Service Providers

Q4. Which response best describes the amount of time provided by the sponsor for your agency to prepare and submit your most recent Ryan White Part A application?

1. Not enough time/too little time
2. Enough time
3. Plenty of time

DRAFT

Q4a. When was your most recent grant proposal to DHSP and for what service category (ies)?

Notice of Grant Award from Recipient & Placement of Service Agreement with Service Provider

Q5. Please select the program year your agency has received Ryan White Part A funding during the past 2 years. __ PY 33 ___PY34

Q6. Please list the Ryan White Part A service categories that your agency received funding for in PY 33.

Q7. Please list the Ryan White Part A service categories that your agency received funding for in PY 34.

Q8. When was your service agreement/contract fully executed for PY 33? (March 1, 2023 - February 28, 2024)

Q9. When was your service agreement/contract fully executed for PY 34 (March 1, 2024 – February 2025)

Q8. Did you have any issues and/or challenges with executing the Service Agreement and/or receiving funds? ___YES ___NO

Q9. Describe issues and/or challenges with executing the Service Agreement and/or receiving funds.

Q10. Have any of these issues and/or challenges affected your ability to deliver of services to clients?
___YES ___NO

Q11. Please describe how these challenges were handled.

Q12. How did you communicate these challenges to clients, if at all?

Service Provider Reimbursement

Q13. During PY 33, what is the average time between approval of an invoice submission and the receipt of a reimbursement check?

1. 5-10 days
2. 10-20 days
3. 20-30 days
4. More than 30days

Q14. During PY 34, what is the average time between approval of an invoice submission and the receipt of a reimbursement check?

1. 5-10 days
2. 10-20 days
3. 20-30 days

DRAFT

4. More than 30days

Q15. Please describe any factors contributing to the delay in reimbursements.

Financing Process

Q16. Please check the response time for purchase order/invoicing questions from your Grants Management Specialist/Contract Monitor from DHSP.

1. 5-10 days
2. 10-20 days
3. 20-30 days
4. More than 30days

Q17. Please rate the response of your Contract Monitor to your questions and request for information/guidance.

1 . Excellent
2. Good
3. Fair
4. Poor

Q18. Please select the response time for programmatic questions (design/implementation/monitoring) from your Contract Monitor.

1. 1-4 days
2. 5 -10 days
3. 10-20 days
4. 20-30 days
5. More than 30 days

Q19. Please select the response time for reprogramming/budget modifications request from your Contract Monitor.

1. 5-10 days
2. 10-20 days
3. 20-30 days
4. More than 30days

Additional Comments:

Q21. Please provide any comments overall on the procurement, contracting and reimbursement process areas that were not addressed in previous questions.

DRAFT

Assessment of the Efficiency of the Administrative Mechanism Recipient Survey
Ryan White Program Year (PY) 33 and PY 34
PY 33 = March 1, 2023 to February 28, 2024
PY 34 = March 1, 2024 to February 28, 2025
(Draft 11.01.24)

REQUEST FOR PROPOSALS:

1. How many Requests for Proposals (RFPs) were released for the PY 33 Ryan White Program?

2. If RFPs were released in PY 33, list the service categories and the number of proposals received per service category.

3. Of the proposals received in PY 33, how many were new service providers?

4. Of these proposals, how many service providers were awarded contracts for Ryan White program funds?

5. How many Requests for Proposals (RFPs) were released for the PY 34 Ryan White Program?

6. If RFPs were released in PY 34, list the service categories and the number of proposals received per service category.

7. Of the proposals received in PY 34, how many were new service providers?

8. Of these proposals, how many service providers were awarded contracts for Ryan White program funds?

9. Please describe the process used to review proposals for PY 33.

10. Please describe the composition of the external review panel (number of reviewers, demographics of reviewers - age, race/ethnicity, gender identity, geography, professional background, HIV status).

11. During PY 33 and PY 34, what work was undertaken by the Recipient to encourage new providers to apply for Ryan White Part A funds; such as outreach to potential new service providers.

DRAFT

EXECUTING SERVICE AGREEMENTS WITH SERVICE PROVIDERS:

1. How many service agreements were fully executed in PY33?
2. How many service agreements were fully executed in PY34?
3. Describe key factors that contribute to delays in executing agreements with service providers?
4. In general what is the average timeframe for executing service agreements?

REIMBURSEMENT: Service Provider Reporting and Invoicing Process

1. Please describe the monthly reporting and invoicing process.
2. Did the Recipient change reimbursement/payment systems?
3. How did these changes impact the reimbursement for services?
4. During PY 33, what was the average amount of time in days between receipt of a complete monthly report and accurate invoice from a service provider and the issuance of a reimbursement payment?
5. During PY 34, what has been the average amount of time in days between receipt of a complete monthly report and accurate invoice from a service provider and the issuance of a reimbursement payment?
6. List/describe any factors contributing to the delay in reimbursements to service providers.

DRAFT

Assessment of the Efficiency of the Administrative Mechanism Document Review

(To be conducted by staff by reviewing meeting minutes and other relevant documentation)

Ryan White Program Year (PY) 33 and PY 34

USE OF FUNDS: Priorities, Resource Allocations, Directives and Reprogramming

1. Describe the COH's PSRA process as defined in policies and procedures.

2. Did the COH follow its PSRA process, policies and procedures?

3. List data, fiscal, and programmatic reports received from the Recipient to help inform the PSRA process:

Type of Data /Information Received from Recipient	Date Received by the COH	Date presented to the COH or PP&A

4. List PP&A and COH meeting dates and approval dates for PY 33 allocations, reallocations, and directives.

5. List PP&A and COH meeting dates and approval dates for PY 34 allocations, reallocations, and directives.

DRAFT

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COMMISSION ON HIV

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

EMERGENCY FINANCIAL ASSISTANCE SERVICE STANDARDS

***Note:** Items highlighted in yellow are additions. Items in ~~red~~ are deletions.*

INTRODUCTION

Service standards for the Ryan White HIV/AIDS Part A Program outline the elements and expectations a service provider should follow when implementing a specific service category. The standards are written for providers and provide guidance on what services may be offered when developing their Ryan White Part A programs. The standards set the minimum level of care Ryan White funded agencies should offer to clients, however, providers are encouraged to exceed these standards.

The Los Angeles County Commission on HIV developed the Emergency Financial Assistance Service Standards to ensure people living with HIV (PLWH) can apply for **short-term or one-time** financial assistance to assist with emergency expenses. Short-term is defined as 3 months or less. The development of the Standards includes guidance from service providers, consumers, the Los Angeles County Department of Public Health - Division of HIV and STD Programs (DHSP), as well as members of the Los Angeles County Commission on HIV, Standards & Best Practices (SBP) Committee. All contractors must meet the Universal Standards of Care in addition to the following Emergency Financial Assistance Service Standards.[1]

EMERGENCY FINANCIAL ASSISTANCE OVERVIEW

Emergency Financial Assistance (EFA) provides limited one-time or short-term payments to assist a Ryan White Part A client with an urgent need for essential items or services due to hardship. Short-term is defined as 3 months or less. The purpose of emergency financial assistance is to ensure clients can pay for critical services that play a role on whether a client is able to stay engaged in medical care and/or adhere to treatment. EFA is a needs-based assistance program, not a government entitlement, subject to the availability of funding. Emergency financial assistance must occur as a direct payment to an agency (i.e. organization, landlord, vendor) or through a voucher program. Direct cash payments to clients are not permitted.

EFA is not meant to be a continuous means of support; rather, it is meant to be provided with limited frequency and for limited periods of time and is based on the availability of funds.

Emergency financial assistance should only be provided for an urgent or emergency need for essential items or services necessary to improve health outcomes. Agencies are responsible for referring clients to the appropriate Ryan White service category related to the need for continuous

[1] Universal Service Standards and Client Bill of Rights and Responsibilities can be accessed at https://hiv.lacounty.gov/service-standards

provision of services and non-emergency situations.
An emergency is defined as:

- Unexpected event that hinders ability to meet housing, utility, food, medication need; and/or
- Unexpected loss of income; and/or
- Experiencing a crisis situation that hinders ability to meet housing, utility, food, or medication need
- Public health emergencies, such as the COVID-19 pandemic, that severely disrupt national systems of care, employment, and safety net. Contracted agencies must follow DHSP and Health Resources and Services Administration (HRSA) guidelines on special use of EFA in times of public health emergencies.

Emergency Financial Assistance may not be used for:

- Ongoing or annual payments for any services or goods for clients
- Direct cash payments to clients
- Activities that can be paid for under another Ryan White service category

Based on capacity and contract guidance from DHSP, an agency may provide emergency financial assistance if the client presents with an emergency need that cannot first be met through the appropriate Ryan White Service Category. Support to clients should be offered while the client's application is under review/processing and whether they qualify of not, they should always be linked back to case management or benefits specialty services for continuity of support.

Table 1. Categories for Determining Emergency Needs and Ryan White Services

Emergency Need	Ryan White Service Category
Short term rental assistance	Housing Services
Move-in assistance	
Essential utility assistance	
Emergency food assistance	Nutrition Services
Transportation	Transportation
Medication assistance to avoid lapses in medication	Ambulatory Outpatient Medical

KEY COMPONENTS
Emergency Financial Assistance (EFA) services provide people living with HIV with limited one-time or short-term financial assistance due to hardship. Short term is defined as 3 months or less. Agencies will establish program services based on agency capacity and Division of HIV & STD Programs contract requirements. EFA is decided on a case-by-case basis by a case manager or social worker and is subject

to the availability of funding. Financial assistance is never paid directly to clients but issued via checks or vouchers to specific vendors or agencies.

Agencies and staff will make every effort to reduce the amount of documentation necessary, while staying within funding and contract requirements, for a client in need of emergency financial assistance. A signed affidavit declaring homelessness should be kept on file for clients without an address.

~~EFA services are capped annually per client at $5,000 per 12-month period. With consultation with the SBP Committee, DHSP may increase the $5,000 annual cap for cost of living adjustments.~~

Although these standards include information for all EFA categories, some categories may be prioritized in response to need and funding availability. Additionally, to ensure equitable access, caps may be put into place for the maximum funding amount that may be requested per application and/or the number of requests an individual may make.

ELIGIBILITY CRITERIA

Agencies coordinating EFA will follow eligibility requirements for potential clients based on DHSP guidance and the type of financial assistance the client is seeking. Clients may enter EFA services through self-referral or referral by a case management or another provider. Each client requesting EFA will be subject to eligibility determination that confirms the need for services. Programs coordinating EFA are responsible to determine such eligibility. Eligibility documentation should be appropriate to the requested financial assistance and completed annually, at minimum, or for every instance a client seeks emergency financial assistance.

Eligibility criteria includes:

- Los Angeles County resident
- Verification of HIV positive status
- Current proof of income
- EFA application based on the type of assistance the client is requesting.

In addition to the general Ryan White eligibility criteria, priority should be given to individuals who present an emergency need with the appropriate documentation that qualifies as an emergency, subject to payor of last resort requirements. When accessing Emergency Financial Assistance funds, clients must work with case managers or other service providers to develop a plan to avoid similar emergencies in the future. Case managers should make efforts to transition clients to more permanent and/or long-term services.

REFERRALS

All service providers must work in partnership with the client, their internal care coordination team and external providers, both Ryan White funded and non-Ryan White funded sites, to ensure appropriate and timely service referrals are made according to client's needs.

In addition, agencies and staff are responsible for linking clients to care if they are not in care as well as addressing the conditions that led to the emergency need to ensure accessing EFA is a one-time need or rare occurrence. For clients accessing EFA services, staff is responsible for referring clients to a program with a case manager or Medical Care Coordination provider if they are not linked already.

Table 1. Emergency Financial Assistance Standards of Care

SERVICE COMPONENT	STANDARD	DOCUMENTATION
Staff Requirement and Qualifications	Agencies will hire staff with experience in case management in an area of social services or experience working with people living with HIV. Bachelor's degree in a related field preferred.	Staff resumes on file.
	Staff are required to seek other sources of financial assistance, discounts, and/or subsidies for clients requesting EFA services to demonstrate Ryan White funding is the payor of last resort. (See Appendix A for a list of additional non-Ryan White resources).	Lists of other financial sources, discounts, and/or subsidies for which the staff applied for the client on file. See *Appendix A* as a reference starting point.
	Staff are required to connect clients to or provide referrals for: • A Case manager for a needed service or for Medical Care Coordination • Wraparound services to empower clients and prevent future use of Emergency Financial Assistance services • Opportunities for trainings such as job or workforce trainings	Lists of referrals the staff provided to the client. Name of case manager(s) client connects with in client file.
Eligibility	Agency will determine client eligibility for EFA at minimum annually, or for every instance a client requests EFA. Eligible uses may include: • Short term housing rental assistance • Essential utility assistance • Emergency food assistance • Transportation • Medication assistance to avoid lapses in medication • Mortgage Assistance • Rental Security deposits	Documentation of emergency need and eligible use in client file. Documentation of Ryan White eligibility requirements in client file.

	*Continuous provision of service or non-emergency needs should fall under the appropriate Ryan White service category and not under EFA.	
Housing Assistance	Eligible clients must provide evidence they are a named tenant under a valid lease or legal resident of the premises. If rental assistance is needed beyond an emergency, please refer to our *Housing Standards, Temporary Housing Services - Income Based Rental Subsidies (page 15).*	Documentation in client file that demonstrates emergency need and type of assistance received. Application for Housing Assistance includes: • Notice from landlord stating past due rent or, in the case of new tenancy, amount of rent and security deposit being charged
Utility Assistance	Eligible clients must provide evidence they have an account in their name with the utility company or proof or responsibility to make utility payments. Limited to past due bills for gas, electric, or water service. Staff is responsible for checking client eligibility for SoCal Edison assistance program	Documentation in client file that demonstrates emergency need and type of assistance received. Application for Utility Assistance includes: • Copy of the most recent bill in client name or a signed affidavit with the name of the individual that is responsible for paying the bill. • Copy of the lease that matches the address from the bill • Proof of inability to pay
Food Assistance	Limited to gift card distribution to eligible clients by medical case managers or social workers at their discretion and based on need. Staff is responsible for referring clients to a food pantry and/or CalFresh.	Documentation in client file that demonstrates emergency need and type of assistance received.
Transportation Assistance	Eligible clients must provide evidence they need transportation to/from appointments related to core medical and support services.	Documentation in client file that demonstrates emergency need and type of assistance received.
Medication Assistance	Eligible clients must provide evidence they are need of medication assistance to avoid a lapse in medication.	Documentation in client file that demonstrates emergency need and type of assistance received.

APPENDIX A

EMERGENCY ASSISTANCE RESOURCES

The list below is intended to provide agency staff with starting point of additional resources to assist clients with emergency needs. Please note it is not a comprehensive list of available resources in Los Angeles County and staff are encouraged to seek other resources for client care.

211 Los Angeles
https://www.211la.org/
Phone: Dial 2-1-1

Los Angeles Housing + Community Investment Department, City of Los Angeles (HCIDLA)
Housing Opportunities for Persons with HIV/AIDS (HOPWA)
https://hcidla.lacity.org/people-with-aids

Comprehensive Housing Information & Referrals for People Living with HIV/AIDS (CHIRP LA)
http://www.chirpla.org/

Los Angeles Housing Services Authority
https://www.lahsa.org/get-help

Department of Public Social Services, Los Angeles County
http://dpss.lacounty.gov/wps/portal/dpss/main/programs-and-services/homeless-services/

CalWorks - Monthly financial assistance for low-income families who have children under 18 years old
https://yourbenefits.laclrs.org

Los Angeles Regional Food Bank – Free and low-cost food
www.lafoodbank.org/get-help/pantrylocator

Project Angel Food
https://www.angelfood.org/

Los Angeles Department of Water and Power (LADWP) – Low Income Discount Program or Lifeline Discount Program for Utility Bill Assistance
Phone: (213) 481-5411

Low-Income Home Energy Assistance Program (HEAP) – Utility Bill Assistance
http://www.csd.ca.gov/Services/FindServicesinYourArea.aspx
Phone: (866) 675-6623

Women, Infants, and Children (WIC)
https://www.phfewic.org/

Veterans of Foreign Wars – Unmet Needs Program
https://www.vfw.org/assistance/financial-grants

City of West Hollywood HIV/AIDS Resources
https://www.weho.org/services/social-services/hiv-aids-resources

The People's Guide to Welfare, Health & Services
https://www.hungeractionla.org/peoplesguide

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AMBULATORY OUTPATIENT MEDICAL (AOM) SERVICE STANDARDS

IMPORTANT: Service standards must 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:

- Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18)
- HIV/AIDS Bureau, Division of Metropolitan HIV/AIDS Programs National Monitoring Standards for Ryan White Part A Grantees: Program – Part A

INTRODUCTION

Service standards for the Ryan White HIV/AIDS Part A Program (RWHAP) outline the elements and expectations a service provider should follow when implementing a specific service category. The purpose of the standards is to ensure that all RWHAP service providers offer the same fundamental components of the given service category. Additionally, the standards set the minimum level of care Ryan White-funded service providers may offer clients, however, service providers are encouraged to exceed these standards.

The Los Angeles County Commission on HIV (COH) developed the Ambulatory Outpatient Medical (AOM) service standards to establish the minimum service necessary to provide HIV specialty medical care to people living with HIV. The developed of the standards included review of current clinical guidelines, as well as feedback from service providers, people living with HIV, members of the COH's Standards and Best Practices (SBP) Committee, COH caucuses, and the public-at-large. All service standards approved by the COH align with the Universal Service Standards and Client Bill of Rights and Responsibilities (Universal Standards) approved by the COH on January 11, 2024. AOM providers must also follow the Universal Standards in addition to the standards described in this document.

AMBULATORY OUTPATIENT MEDICAL (AOM) OVERVIEW

AOM Services are evidence-based preventive, diagnostic and therapeutic medical services provided through outpatient medical visits by California-licensed health care professionals. Clinics shall offer a full-range of health services to HIV-positive RWP eligible clients with the objective of helping them cope with their HIV diagnosis, adhere to treatment, prevent HIV transmission, and identify and address co-morbidities.

Ambulatory Outpatient Medical (AOM) services include, but are not limited to:

- Medical evaluation and clinical care including sexual history taking
- AIDS Drug Assistance Program (ADAP) enrollment services

- Laboratory testing including disease monitoring, STI testing, viral hepatitis testing, and other clinically indicated tests
- Linkage and referrals to medical subspecialty care, oral health, Medical Care Coordination, mental health care, substance use disorder services, and other service providers
- Secondary HIV prevention in the ambulatory outpatient setting
- Retention of clients in medical care.

The goals of AOM services include:

- Provide patients with high-quality care and medication even if they do not have health insurance and connect patients to additional care and support services as applicable.
- Help patients achieve low or suppressed viral load to improve their health and prevent HIV transmission (Undetectable=Untransmittable)
- Prevent and treat opportunistic infections
- Provide education and support with risk reduction strategies

SERVICE COMPONENTS

HIV/AIDS AOM services form the foundation for the Los Angeles County HIV/AIDS continuum of care. AOM services are responsible for assuring that the full spectrum of primary and HIV specialty medical care needs for patients are met either by the program directly or by referral to other health care agencies. Services will be provided to individuals living with HIV who are residents of Los Angeles County and meet Ryan White eligibility requirements.

AOM services will be patient-centered, respecting the inherent dignity of the patient. Programs must ensure that patients are given the opportunity to ask questions and receive accurate answers regarding services provided by AOM service providers and other professionals to whom they are referred. Such patient-practitioner discussions are relationship building and serve to develop trust and confidence. Patients must be seen as active partners in decisions about their personal health care regimen.

AOM services must be provided consistent with the following treatment guidelines:

- Clinical Practice Guidance for Persson with Immunodeficiency Virus: 2020
- American Academy of HIV Medicine HIV Treatment Guidelines
- Guidelines for the Use of Antiretrovirals Agents in Adults and Adolescents with HIV

The core of the AOM services standard is medical evaluation and clinical care that includes:

- Initial assessment and reassessment
- Follow-up treatment visits
- Additional assessments
- Laboratory assessment and diagnostic screening (including drug resistance testing)
- Medication service
- Antiretroviral (ART) therapy
- Treatment adherence counseling
- Health maintenance

- Clinical trials
- Primary HIV nursing care
- Medical specialty services
- Nutrition screening and referral
- Referrals to other Ryan White Program services and other publicly funded healthcare and social services programs.

MEDICAL EVALUATION AND CLINICAL CARE

AOM programs must confirm the presence of HIV infection and provide tests to diagnose the extent of immunologic deficiency in the immune system. Additionally, programs must provide diagnostic and therapeutic measures for preventing and treating the deterioration of the immune system and related conditions that conform to the most recent clinical protocols. At minimum, these services include regular medical evaluations; appropriate treatment of HIV infection; and prophylactic and treatment interventions for complications of HIV infection, including opportunistic infections, opportunistic malignancies and other AIDS defining conditions.

The following core services must be provided onsite or through referral to another facility offering the required service(s). Qualified health care professionals for these services include physicians, Nurse Practitioners (NPs) and/or Physician Assistants (PAs). Except where indicated, licensed nurses may provide primary HIV nursing care services and linkage to other Ryan White Services as needed.

STANDARD	DOCUMENTATION
AOM medical visits/evaluation and treatment should be scheduled based on acuity and viral suppression goals. Once a patient has demonstrated long-term durability of viral suppression, the patient should have at minimum 1 medical visit per year and have labs done 2 times per year. The patient’s other comorbidities may require additional medical visits and should consult with provider for treatment plan adjustments.	Medical record review to confirm.
AOM core services will be provided by physicians, NPs, and/or PAs. Licensed nurses will provide primary HIV nursing care services and linkage to other Ryan White services as needed.	Policies and procedures manual and medical chart review to confirm.

INITIAL ASSESSMENT AND REASSESSMENT

Every effort should be made to accommodate timely medical appointments for patients newly diagnosed with HIV or newly re-engaging in HIV medical care. Clinics may receive requests for appointments from patients directly, from HIV test counselors, or from “linkage” staff such as patient navigators and/or peer navigators, whose role is to refer and actively engage patients back in medical

care. If possible, patients should see their medical provider on their first visit to the clinic to help improve their success in truly engaging in their medical care.

The initial assessment of HIV-infected individuals must be comprehensive in its scope, including physical, sociocultural, and emotional assessments and may require two to three outpatient visits to complete. Unless indicated more frequently by a patient's changing health condition, a comprehensive reassessment should be completed on an annual basis. The AOM practitioners (physician, NP, PA, or licensed nurse) responsible for completing the initial assessment and reassessments will use assessment tools based on established HIV practice guidelines. While taking steps to ensure a patient's confidentiality, the results of these assessments will be shared with Medical Care Coordination staff to help identify and intervene on patient needs. An initial assessment and annual reassessment for HIV-infected patient should include a general medical history; a comprehensive HIV-related history, including a psychosocial history; sexual health history, mental health, and substance abuse histories; and a comprehensive physical examination. When obtaining the patient's history, the practitioner should use vocabulary that the patient can understand, regardless of education level. AOM providers must follow and use the most current clinical guidelines and assessment tools for general medical and comprehensive HIV medical histories.

STANDARD	DOCUMENTATION
Comprehensive baseline assessment will be completed by physician, NP, PA, or licensed nurse and updated, as necessary.	Medical record review to confirm.

FOLLOW-UP TREATMENT VISITS

Patients should have follow-up visits scheduled following established clinical guidelines. If the patient is clinically unstable or poorly adherent, a more frequent follow-up should be considered. Visits should be scheduled more frequently at entry to care, when starting or changing ART regimens, or for management of acute problems. Due to the complex nature of HIV treatment, ongoing AOM visits must be flexible in duration and scope, requiring that programs develop practitioner clinic schedules allowing for this complexity. Follow-up should be conducted as recommended by the specialist or clinical judgment.

STANDARD	DOCUMENTATION
Patients should have follow-up visits scheduled following established clinical guidelines.	Patient medical chart to confirm frequency.

OTHER ASSESSMENTS – OLDER ADULTS WITH HIV

According to the Health Resources and Service Administration (HRSA), the RWHAP client population is aging. Of the more than half a million clients served by RWHAP, 46.1 percent are aged 50 years and older and this continues to grow. While Ryan White clients in Los Angeles County show higher engagement and retention in care, and viral suppression rates, within the 50+ population there exists disparities by racial/ethnic, socioeconomic, geographic, and age groups stratification.

AOM providers must at minimum assess patients 50 years and older for mental health, neurocognitive disorders/cognitive function, functional status, frailty/falls and gait, social support and levels of interactions, vision, dental, and hearing. Additional recommended assessments and screenings for older adults living with HIV can be found on page 6 of the Aging Task Force Recommendations.

Other specialized assessments leading to more specific services may be indicated for patients receiving AOM services. AOM programs must designate a member of the treatment team (physician, NP, PA, or licensed nurse) to make these assessments in the clinic setting.

STANDARD	DOCUMENTATION
Other assessments based on patient needs will be performed.	Assessments and updates noted documented in patient's medical record.

LABORATORY ASSESSMENT AND DIAGNOSTIC SCREENING (INCLUDING DRUG RESISTANCE SCREENING)

AOM programs must have access to all laboratory services required to comply fully with established practice guidelines for HIV prevention and risk reduction and for the clinical management of HIV disease. Programs must assure timely, quality lab results, readily available for review in medical encounters.

DRUG RESISTANCE TESTING

When appropriate, AOM practitioners may order drug resistance testing to measure a patient's pattern of resistance of HIV to antiretroviral medications. Genotypic testing looks for viral mutations, and is expected for all naïve patients, and phenotypic testing measures the amount of drug needed to suppress replication of HIV. By using resistance testing, practitioners can determine if the virus is likely to be suppressed by each antiretroviral drug. This information is used to guide practitioners in prescribing the most effective drug combinations for treatment.

Counseling and education about drug resistance testing must be provided by the patient's medical practitioner, RN and/or other appropriate licensed health care provider (if designated by the practitioner). Patients must be fully educated about their medical needs and treatment options according to standards of medical care. Patients must be given an opportunity to ask questions about their immune system, antiretroviral therapies, and drug resistance testing. All patient education efforts will be documented in the patient record.

STANDARD	DOCUMENTATION
Baseline lab tests based on current clinical guidelines.	Record of tests and results on file in patient medical chart.
Ongoing lab tests based on clinical guidelines and provider's clinical judgement.	Record of tests and results on file in patient medical chart.
Appropriate health care provider will provide drug resistance testing as indicated.	Record of drug resistance testing on file in patient medical chart.
Drug resistance testing providers must follow most recent, established resistance testing	Program review and monitoring to confirm.

guidelines, including genotypic testing on all naïve patients.	

MEDICATION SERVICES

Medications should be provided to interrupt or delay the progression of HIV-disease, prevent, and treat opportunistic infections, and promote optimal health. Patients should be referred to an approved AIDS Drug Assistance Program (ADAP) enrollment site and, as indicated, to Medical Care Coordination programs for additional assistance with public benefit concerns. Patients eligible for ADAP will be referred to a participating pharmacy for prescriptions on the ADAP formulary. If the patient requires medications that are not listed on the ADAP formulary or that can be reimbursed through other local pharmacy assistance resources, the AOM program is responsible for making every effort possible to link them to medications and exercise due diligence for that effort consistent with their ethical responsibilities.

STANDARD	DOCUMENTATION
Patients requiring medications will be referred to ADAP enrollment site.	ADAP referral documented in patient medical chart.
AOM programs must exercise every effort and due diligence consistent with their ethical responsibilities to ensure that patients can get necessary medications not on the ADAP and local formularies.	Documentation in patient's medical chart.

ANTIRETROVIRAL THERAPY (ART)

Antiretroviral therapy will be prescribed in accordance with the established guidelines based upon the DHHS Guidelines for the Use of Antiretroviral Agents in HIV-infected Adults and Adolescents Decisions to begin ART treatment must be collaborative between patient and AOM practitioner.

STANDARD	DOCUMENTATION
ART will be prescribed in accordance with DHHS Guidelines for the Use of Antiretroviral Agents in HIV-infected Adults and Adolescents.	Program monitoring to confirm.
Patients will be part of treatment decision-making process.	Documentation of communication in patient medical chart.

MEDICATION ADHERENCE ASSESSMENT

Medication adherence assessment should be performed for patients at every medical visit. Providers should refer patients challenged by maintaining treatment adherence to Medical Care Coordination (MCC) services and other Ryan White services as needed.

STANDARD	DOCUMENTATION

Medical providers or treatment adherence counselors will provide direct treatment adherence counseling or refreshers to all patients.	Notes in medical file indicating that counseling was provided, by whom and relevant outcomes.
Medical providers or treatment adherence counselors will develop treatment adherence assessments of patients where need is indicated.	Assessment on file in patient chart signed and dated by medical staff or treatment adherence counselor responsible, indicating, at a minimum, any follow-up intended.
Medical providers will refer patients with more acute treatment adherence needs to specialized treatment adherence or treatment education programs.	Referral(s) noted in assessment and/or patient chart, as applicable.

PATIENT EDUCATION AND SUPPORT

Medical providers and treatment adherence counselors will provide patient education and support to make information about HIV disease and its treatments available, as necessary.

STANDARD	DOCUMENTATION
Medical providers and/or Treatment Adherence Counselors may provide patient education and support. Support can include: • Accompanying patients to medical visits and clinical trials visits and/or providing transportation support • Helping patients understand HIV disease and treatment options • Helping patients with adherence issues • Providing emotional support	Progress notes on file in patient chart to include (at minimum): • Date, time spent, type of contact • What occurred during the contact • Signature and title of the person providing the contact • Referrals provided, and interventions made (as appropriate) • Results of referrals, interventions and progress made toward goals in the individual service plan (as appropriate)

STANDARD HEALTH MAINTENANCE

AOM practitioners will discuss general preventive health care and health maintenance with all patients routinely, and at a minimum, annually. AOM programs will strive to provide preventive health services consistent with the most current recommendations of the U.S. Preventive Health Services Task Force . AOM practitioners will work in conjunction with other Ryan White service providers to ensure that a patient's standard health maintenance needs are being met.

STANDARD	DOCUMENTATION
Practitioners will discuss health maintenance with patients annually (at minimum), including: • Cancer screening (cervical, breast, rectal — per American Cancer Society guidelines) • Vaccines • Pap screening	Annual health maintenance discussions will be documented in patient medical chart.

• Hepatitis screening, vaccination • TB screening • Family planning • Counseling on sexual health options and STI screening including discussions about Pre-Exposure Prophylaxis (PrEP), Post-Exposure Prophylaxis (PEP), and Doxy PEP • Counseling on food and water safety • Counseling on nutrition, exercise, and diet • Harm reduction for alcohol and drug use • Smoking cessation • Mental health and wellness including substance use disorder support and social isolation resources	

COMPLEMENTARY, ALTERNATIVE AND EXPERIMENTAL THERAPIES

AOM practitioners must be aware if their patients are accessing complementary, alternative, and experimental therapies. Providers are encouraged to discuss at regular intervals complementary, alternative, and experimental therapies with patients, discussing frankly and accurately both their potential benefits and potential harm. Practitioners may consult the National Institutes of Health (NIH) National Center for Complementary and Alternative Medicine (http://nccam.nih.gov) for more information.

STANDARD	DOCUMENTATION
Practitioners must know if their patients are using complementary and alternative therapies and are encouraged to discuss these therapies with their patients regularly.	Record of therapy use and/or discussion on file in patient medical record.

PRIMARY HIV NURSING CARE

AOM programs will provide primary HIV nursing care performed by a licensed nurse and/or appropriate licensed health care provider. If available, services will be coordinated with Medical Care Coordination programs to ensure the seamless, non-duplicative, and most appropriate delivery of service.

STANDARD	DOCUMENTATION
Licensed nurses and/or other appropriate licensed health care providers in AOM programs will provide primary HIV nursing care to include (at minimum): • Nursing assessment, evaluation, and follow-up • Triage	Documentation of primary HIV nursing care service provision on file in patient medical chart.

• Consultation/communication with primary practitioner • Patient counseling • Patient/family education • Services requiring specialized nursing skill • Preventive nursing procedures • Service coordination in conjunction with Medical Care Coordination	

MEDICAL SPECIALTY SERVICES HIV/AIDS AND REFERRALS

AOM service programs are required to provide access to specialty and subspecialty care to fully comply with the DHHS Guidelines.

HIV-related specialty or subspecialty care include (but are not limited to):

- Cardiology
- Dermatology
- Ear, nose, and throat (ENT)
- Gastroenterology
- Gender affirming care
- General surgery
- Gerontology
- Gynecology
- Infusion therapy
- Mental Health
- Nephrology
- Neurology
- Nutrition Therapy
- Obstetrics
- Oncology
- Ophthalmology
- Oral health
- Orthopedics
- Podiatry
- Proctology
- Pulmonary medicine
- Substance Use Disorder Treatment
- Urology

Referrals to medical specialists are made as complications occur that are beyond the scope of practice of primary HIV medical and nursing care. Such complications require referral to specialty and subspecialty physicians for consultation, diagnosis, and therapeutic services. In some cases, the AOM practitioner may need only to consult verbally with a medical specialist for clarification and confirmation on an approach to HIV clinical management. In other cases, the physician may need to refer a patient to a medical specialist for diagnostic and therapeutic services. Medical specialty services are considered consultative; patients will be referred back to the original AOM clinic for ongoing primary HIV medical care.

AOM programs must develop written policies and procedures that facilitate referral to medical specialists. All referrals must be tracked and monitored. The results of the referrals must be documented in the patient's medical record.

STANDARD	DOCUMENTATION
AOM programs must develop policies and procedures for referral to all medical specialists.	Referral policies and procedures on file at provider agency.

All referrals will be tracked and monitored.	Record of linked referrals and results on file in patient medical record.
In referrals for medical specialists, medical outpatient specialty practitioners are responsible for: • Assessing a patient's need for specialty care • Providing pertinent background clinical information to medical specialist • Making a referral appointment • Communicating all referral appointment information • Tracking and monitoring referrals and results • Assuring the patient returns to the AOM program of origin	Record of referral activities on file in patient medical record.

COORDINATION OF SPECIALTY CARE

It is imperative that AOM programs and medical specialists coordinate their care to ensure integration of specialty treatment with primary HIV medical care. As noted above, AOM programs must provide pertinent background clinical information in their referrals to medical specialists. In turn, specialists within the County-contracted system must provide to AOM programs a written report of their findings within two weeks of seeing a referred patient. Medical specialists within the County-contracted system must contact the referring medical provider within one business day in the event that urgent matters arise, to follow up on unusual findings or to plan a required hospitalization.

STANDARD	DOCUMENTATION
Specialists within the County-contracted system must provide written reports within two weeks of seeing a referred patient.	Specialty report on file at provider agency
Specialists within the County-contracted system must contact AOM programs within one business day: • When urgent matters arise • To follow up on unusual findings • To plan required hospitalization	Documentation of communication in patient file at provider agency.

NUTRITION SCREENING AND REFERRAL

Nutrition is a component of the Public Health Service standards of care in order to guard against malnutrition and wasting. The physician, NP, PA, RN, or RD should screen all patients for nutrition concerns and provide a written prescription for all at-risk patients for medical nutrition therapy within six months of an individual becoming an active patient in the AOM program.

AOM programs may provide medical nutrition therapy onsite or may refer patients in need of these services to specialized providers offsite. All programs providing nutrition therapy (including AOM services sites) must adhere to the American Academy of Nutrition and Dietetics guidance Evidence-Based Nutrition Practice Guidelines (eatrightpro.org)

STANDARD	DOCUMENTATION
AOM service providers should screen all patients for nutrition-related concerns for all at-risk patients.	Record of screening for nutrition related problems noted in patient's medical chart.
AOM service providers will provide a written prescription for all at-risk patients for medical nutrition therapy within six months of an individual becoming an active patient.	Record of screening for nutrition related problems noted in patient's medical chart.
When indicated, patients will also be referred to nutrition therapy for: • Physical changes/weight concerns • Oral/GI symptoms • Metabolic complications and other medical conditions • Barriers to nutrition • Behavioral concerns or unusual eating behaviors • Changes in diagnosis	Record of linked referral on file in patient medical chart.
Referral to medical nutrition therapy must include: • Written prescription, diagnosis, and desired nutrition outcome • Signed copy of patient's consent to release medical information • Results from nutrition-related lab assessments	Record of linked referral on file in patient medical chart.

MEDICAL CARE COORDINATION (MCC) SERVICES

To best address the complex needs of their patients, AOM providers are expected to either partner with Medical Care Coordination (MCC) team located at their clinics or refer to an MCC team at another agency. For additional details, please see the Medical Care Coordination Standard of Care, Los Angeles Commission on HIV, 2024.

HIV PREVENTION IN AMBULATORY/OUTPATIENT MEDICAL SETTINGS

HIV prevention is a critical component to ongoing care for people living with HIV. Prevention services provided in AOM clinics may include HIV counseling, testing and referral; partner counseling; prevention and medical care; and referral for intensive services. For additional details see the HIV Prevention Service Standards Los Angeles, Commission on HIV, 2024.

2024 ANNUAL CONFERENCE EVALUATION REPORT

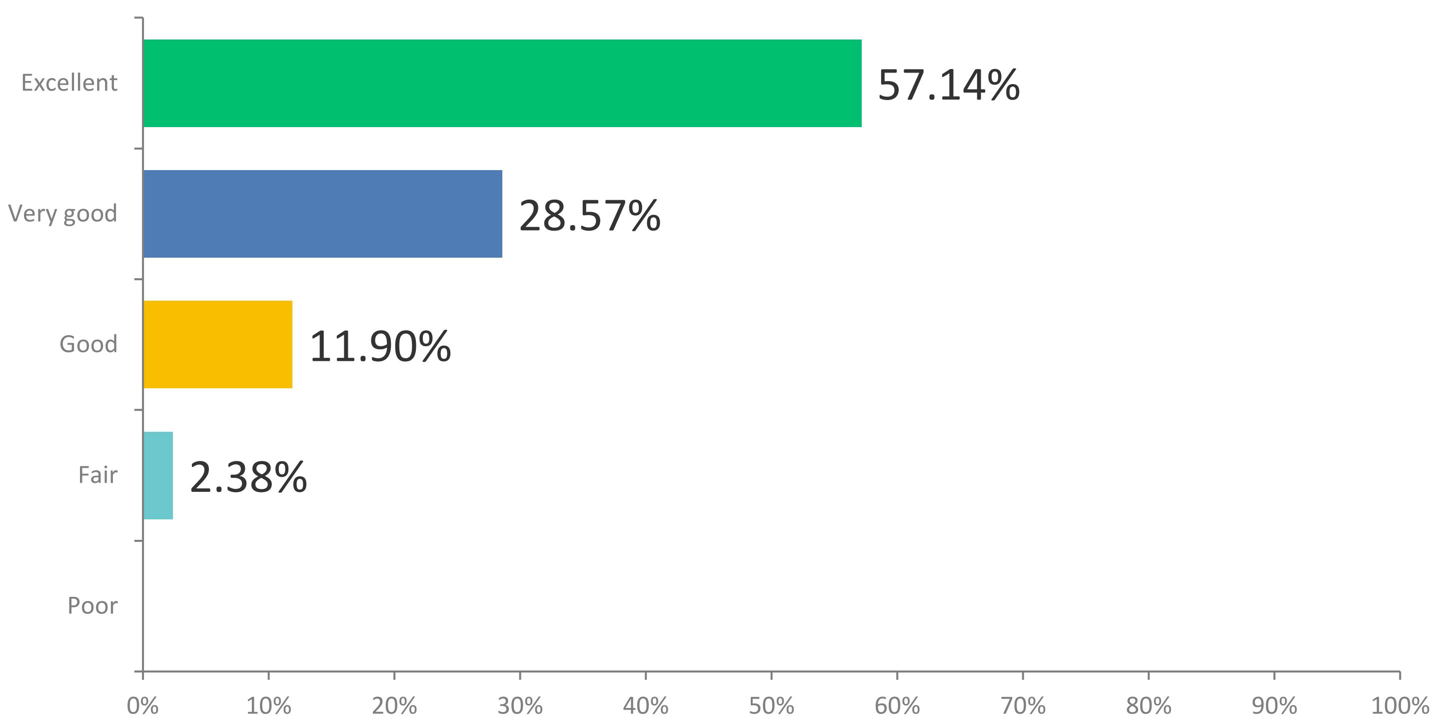
December 12, 2024
Executive Committee

BACKGROUND

- Held on November 14, 2024 at the MLK Behavioral Center
- Theme: Bold Transformation to Confront and End HIV
- Led by a planning workgroup and elicited feedback from the Executive Committee and full council; Planning started in June
- Issued a call for abstracts to highlight local best practices; Received 10 abstracts
- 10 student volunteers from Charles Drew University and the University of Southern California
- 146 attendees

Q1: Overall, how would you rate the event?

Answered: 42 Skipped: 0



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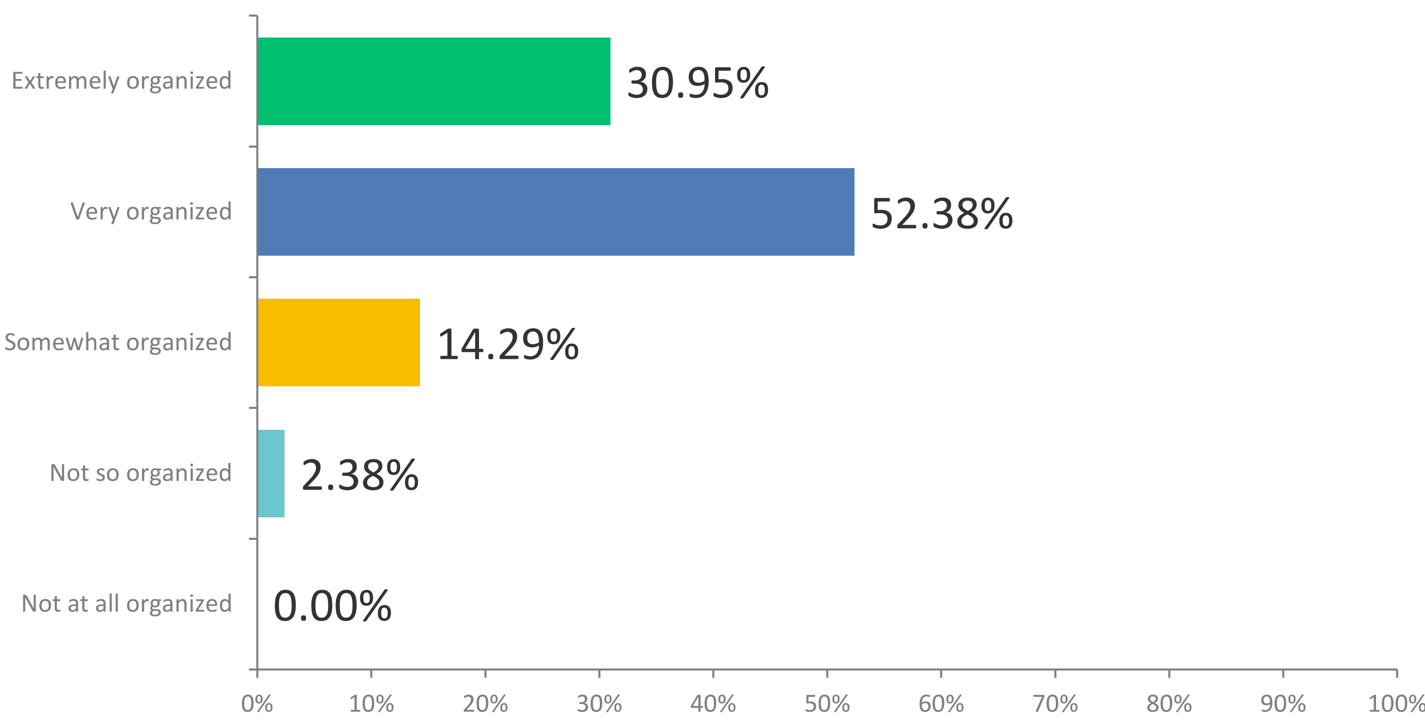
Q4: How organized was the event?

Answered: 42 Skipped: 0



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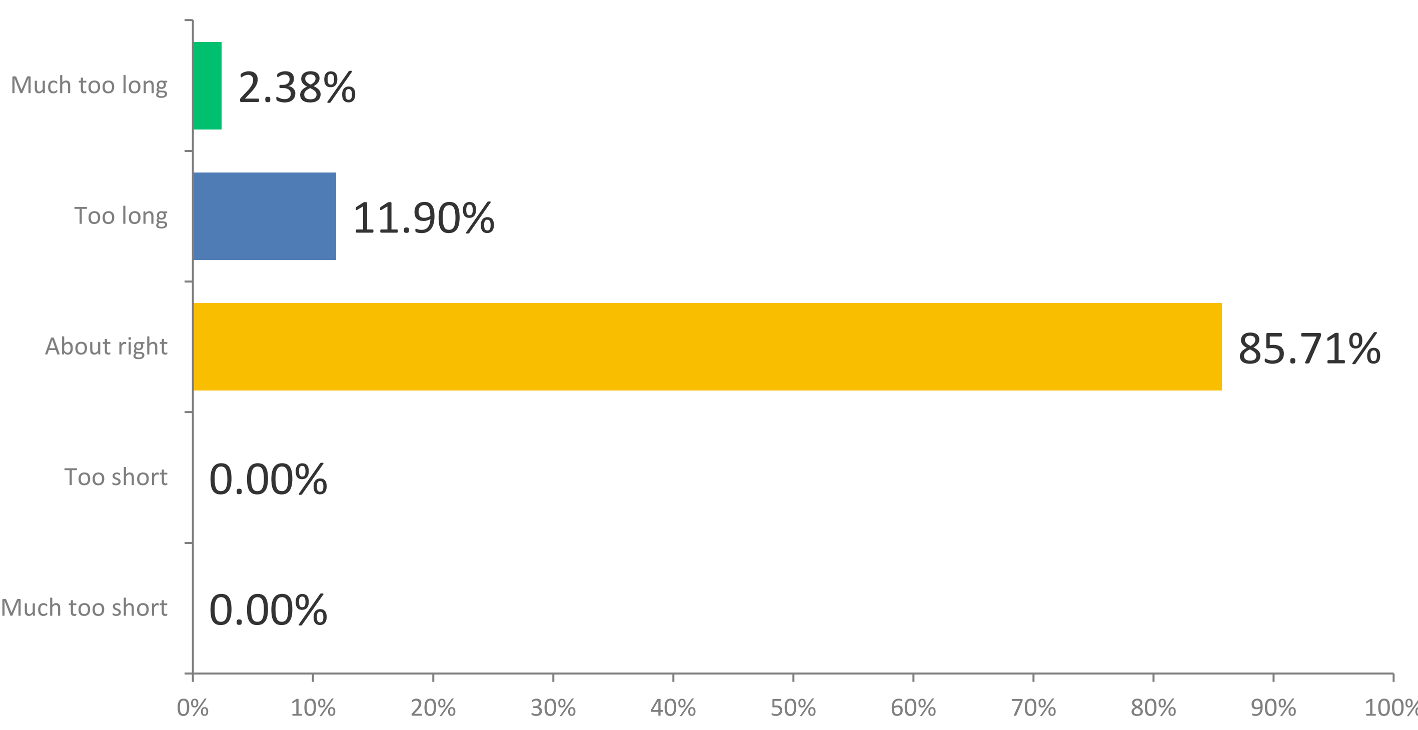
Q5: Was the event length too long, too short or about right?

Answered: 42 Skipped: 0



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Q6: Using a star rating (5 stars being excellent), please rate the Division of HIV and STD Progams (DHSP) keynote presentation.

Answered: 39 Skipped: 3

Q7: Using a star rating (5 stars being excellent), please rate the panel discussion on guaranteed income.

Answered: 40 Skipped: 2

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Q8: Using a star rating (5 stars being excellent) please rate the keynote and panel discussion on HIV cure.

Answered: 40 Skipped: 2

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Q9: Using a star rating (5 stars being excellent) please rate the closing performance by Pickle, West Hollywood Drag Laureate.

Answered: 37 Skipped: 5

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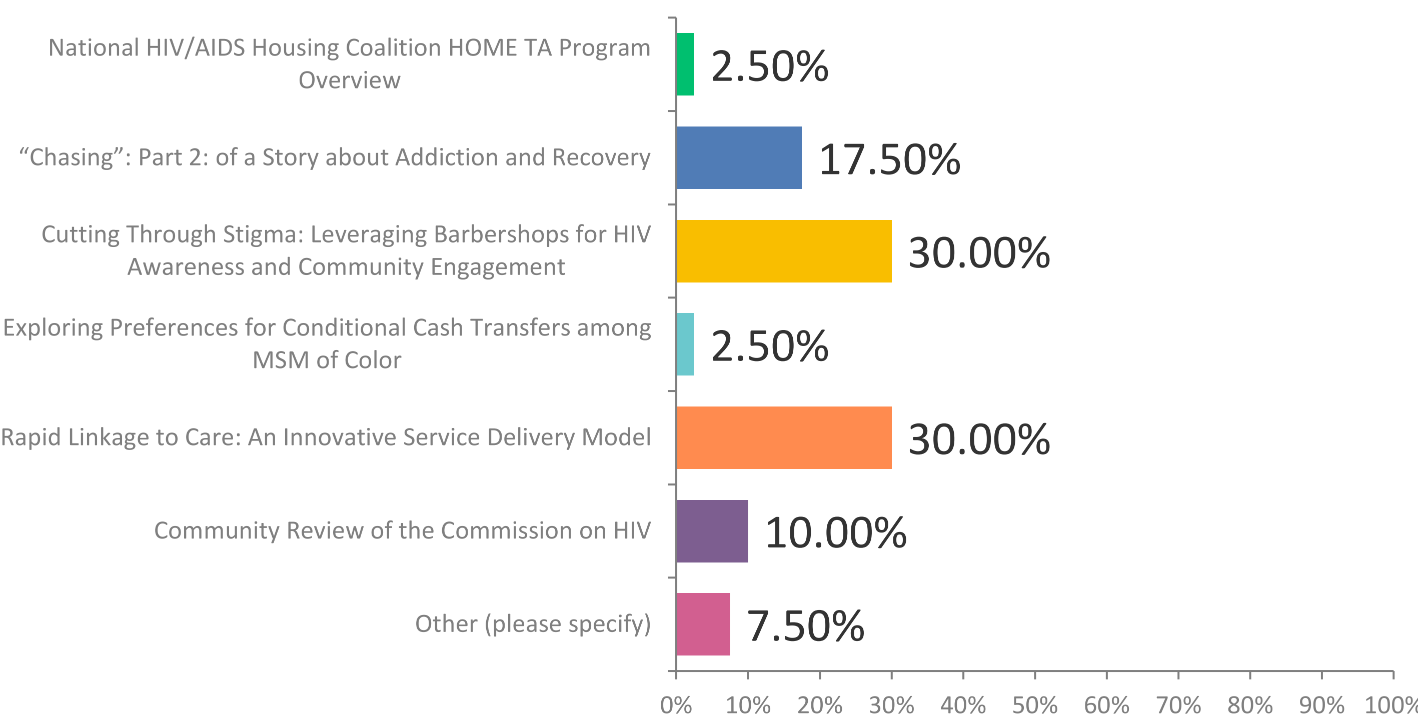
Q10: Please check which first afternoon breakout session you attended.

Answered: 40 Skipped: 2



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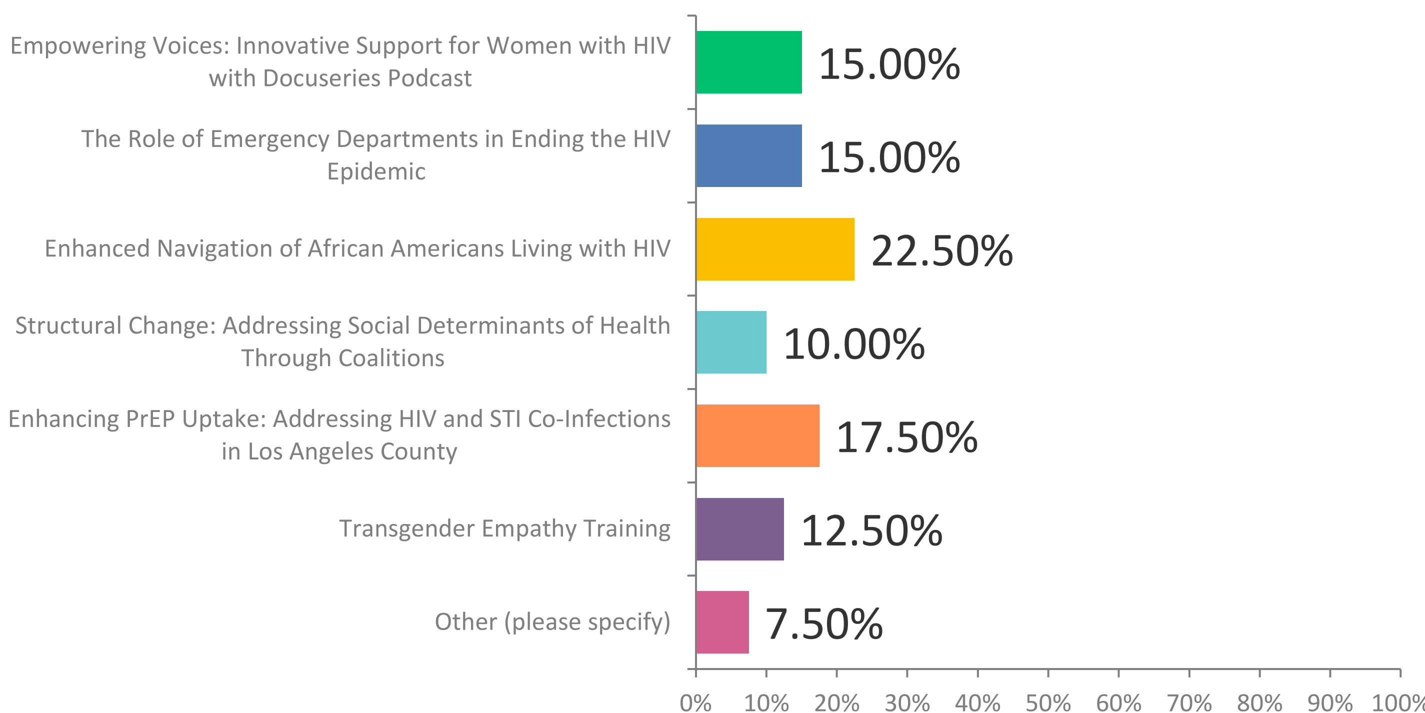
Q11: Using a star rating (5 being excellent), how would you rate the quality of the first session you attended?

Answered: 39 Skipped: 3

Q12: Please check which second afternoon breakout session you attended.

Answered: 40 Skipped: 2



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Q13: Using a star rating (5 being excellent), how would you rate the quality of the second afternoon session you attended?

Answered: 38   Skipped: 4

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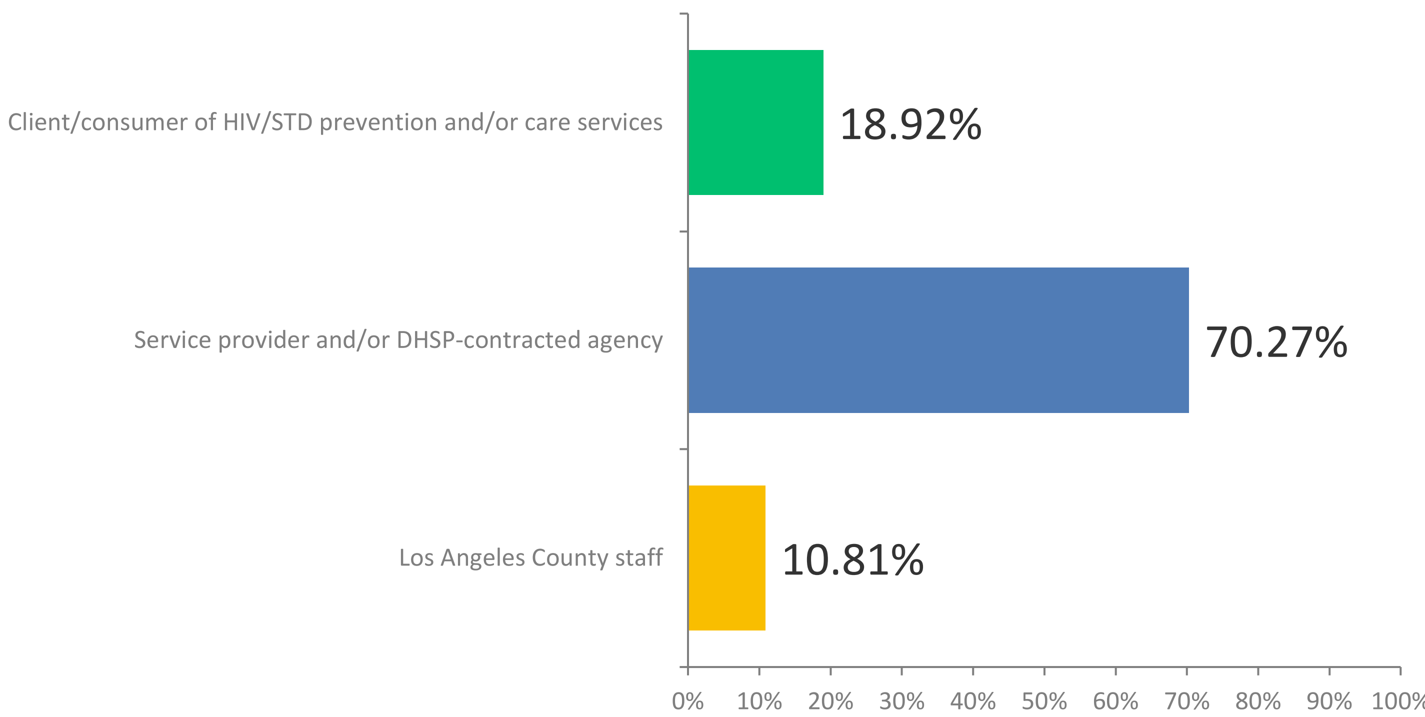
Q15: Which of the following categories best describes you. Please select one.

Answered: 37 Skipped: 5



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SEE SEPARATE DOCUMENT FOR COMMENTS

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

2024 ANNUAL CONFERENCE COMMENTS
BOLD TRANSFORMATION TO CONFRONT AND END HIV

WHAT DID YOU LIKE ABOUT THE EVENT?

1. Break out group
2. I love the organization and engagement
3. Excellent speakers. Well organized. Enjoyed the sessions on guaranteed income, and Dr. Montaner.
4. Bringing people together who are on the COH
5. All the informative information in the workshops
6. Overall everything, but the breakout sessions, were very informative.
7. The content! In comparison to other HIV-related conferences, the content was both informative, but also provided a lot of hope for the future.
8. The breakout groups were wonderful, I wish I could've attended all of them. It was great that people had various options for presentations/education opportunities through these groups.
9. Breakout sessions
10. Breakout sessions
11. new information that it was provided
12. The various topics for the breakout sessions were amazing, as well as the speakers.
13. I appreciated the breakout sessions and provided lunch.
14. I loved the guaranteed income (GI) panel!
15. The morning sessions that discussed what the current rates of HIV are in LA County, what programs are available and the session with the London patient. And Pickle the Drag Queen was amazing!
16. I enjoyed the opening panel discussions. I thought the virtual panel went better than expected
17. Topic in the breakout groups.
18. I appreciated that participants had the opportunity to choose from different afternoon breakout sessions.
19. Break Away Time
20. The breakout sessions, Cutting through stigma: leveraging Barbershop…. Also Enhanced Navigation of African Americans Living with HIV
21. I like the presentation the podcast the one for the barbers and the comedy
22. I enjoyed the breakout rooms, it allowed me to stop and view sessions that really caught my attention.
23. I liked that I could share my story and hopefully inspire your attendees.
24. Networking opportunities
25. I was taught more about HIV community. From the two sessions I was scheduled for, I learned more about how HIV could be caught earlier in the Emergency Room and I learned about the

program FLEX card that helps patients of HIV with monthly payments to help with bills or anything they need help with.

26. Cure panel
27. the transparency about the results of the programs
28. Sharing of information.
29. The information was full and dynamic. The organization was excellent!!
30. The information and resources that were provided during the conference. I enjoyed the presenters being open-minded, addressing questions from the audience effectively. I thought the conference was well-structured, the pacing was just right.
31. the breakout sessions
32. Networking; break out sessions; the cure plenary
33. i liked the presentation on research to find a cure for HIV
34. Variety of topics
35. The order of presentation
36. Networking, speakers, drag queen.
37. The Togetherness and fresh ideas
38. the breakout session with Drew Care and Dr. Spencer

WHAT DID YOU DISLIKE ABOUT THE EVENT?

1. I enjoyed the whole event.
2. N/A
3. Location - parking was difficult and difficult to see speakers (column blocking view).
4. Wish there could be even more people there
5. nothing
6. N/A
7. Only two breakout sessions.
8. NA
9. Non sound proofing of breakout rooms, and being distracted by other session happening next time the ones I attended.
10. Food
11. food wasn't ready
12. Nothing. Everything was great.
13. Was slightly disorganized in regards to the parking situation. Would recommend putting signage where guest are allowed to park
14. There was no where to sit for lunch and there were no breaks (or very small ones) in between sessions.
15. I think the lunch layout was a little lacking. It would have been nice to secure tables for folks to sit down and eat, since food isn't allowed inside of MLK Behavioral Center.
16. Parking was difficult
17. I didn't appreciate the breakfast was not ready by the stated time (8:15 am) and lunch was not ready by when participants were let out for lunch (12 pm)
18. N/A
19. N/A
20. Nothing
21. Nothing
22. That I couldn’t get signed on to WebEx.

23. N/A
24. I think it would have been easier to get to the event if there was a sign at the gate we went through.
25. I would like to hear more about upcoming events while they are still accepting applications
26. lack of parking and drag show.
27. N/A
28. I wish there was more areas where people could enjoy their lunches/breaks.
29. Pickle could've been more coherent
30. parking was challenging.
31. Morning sessions combined was too much time sitting for my old backside. No sessions (except for the commission specific one) gave an opportunity for interaction.
32. Nothing
33. I did not like the section about the cure. It seemed less relevant at this conference.
34. Not being able to ask all the panelist questions
35. Guaranteed Income presentation they never give hope or said if they would help the HIV community. It was very disappointing and then to not allow audience questions was horrible

Other Comments:

- Too much scientific data not understandable
- More time should have been allowed for the panel discussion. It felt rushed toward the end.
- No specific details on how the HIV community could benefit and no audience question
- One presenter was a little difficult to hear
- Hard to hear discussion through zoom due to technical difficulties
- Poor connection, hard to hear both patient speakers. Cure not accessible in near future so less relevant to this conference.
- I enjoyed myself oh so much thank you for having me my beautiful community.
- I was unable to attend.
- overall the conference was very nice
- The panel discussions topics were great, and the speakers shared valuable information. I liked that each are from different professional backgrounds.
- This was an excellent event, look forward to the next time we all come together to educate and uplift each other.
- Everything was amazing thank you for letting me be a part
- I'm be proud be part of this!!
- Food was ok and limited options for breakfast.
- These two breakout session were cut edge on ways to improve outreach and patient care. All CBO need to take notes and follow
- Thank you for the invitation. It was a beautiful conference and very educational.
- I just wanted to send a big thank you follow up note for making the space for me to attend yesterday's conference - I apologize that we did not connect in person on-site. I really enjoyed the opportunity to network with so many people working in the HIV treatment and prevention space, many of which I had not had the pleasure of meeting before. I thought overall the conference went very well and the programming was great.

HIV/AIDS Bureau
5600 Fishers Lane
Rockville, MD 20857

October 9, 2024

Mario J. Perez
Director, Division of HIV and STD Programs (DHSP)
Los Angeles County Department of Public Health
600 S. Commonwealth Avenue, Fl. 9
Los Angeles, CA 90005
mjperez@ph.lacounty.gov

Re: Grant # H89HA00016

Dear Mario Perez,

Thank you, your participating recipient/administrative agency staff, the Planning Council Support staff, and the participating Planning Council members/leadership for a successful Planning Council/Planning Body (PC/PB) Technical Assistance Site Visit (TASV) conducted May 21 - May 23, 2024.

The TASV provided the site visit team an opportunity to provide resources to the **Los Angeles County Commission on HIV (COH)** to ensure compliance with all statutory and programmatic requirements and to strengthen the Planning Council's capacity to plan for and coordinate the delivery of HIV services in the jurisdiction. The visit also allowed the team to focus on areas for operational and administrative performance improvement including recruitment, membership, and workplan development. During this visit, we identified and discussed exemplary components of your Planning Council operations, findings that require a corrective action, as well as areas for improvement.

Enclosed is a copy of the final *TA After Action Report (TAAR)*. This report provides an overview of the TA session(s), related content areas, and the objectives addressed by the session(s). The objectives section on the report outlines the activities conducted, a situational analysis, findings, areas for improvement, and recommendations.

The TAAR includes two types of findings that will require a formal response in the *Technical Assistance Action Plan (TAAP)*:

1. Legislative Findings: issues that are based on a legislative requirement.
2. Programmatic Findings: issues tied to HRSA HAB – DMHAP program requirements and expectations.

Each finding is followed by a recommendation that is intended to help you improve or correct each finding. You will be required to complete and submit the Technical Assistance Action Plan

(TAAP), attached as Appendix A, addressing the findings and recommendations. This TAAP is due within 30 calendar days of receipt of the enclosed report.

As shared above, areas for improvement are also identified within the TAAR. Each improvement area is followed by an improvement recommendation that relates to best practices and is offered as a suggestion to enhance Planning Council operations and increase efficiency and/or effectiveness. Improvement recommendations do not require a formal response but may be discussed during monitoring.

The TAAR and TAAP will be officially shared with you through the Electronic Handbook (EHB), but your response will be required via email. I will schedule a post-site visit conference call within the next two weeks to discuss any questions you have about the report, as well as the procedure for submitting your TAAP. Going forward, I will monitor your progress for implementing the corrective actions during scheduled monitoring calls.

Thank you again for your assistance during the TASV. I commend you and the LA County Commission on HIV (COH) for your continued efforts to plan for a system of care that provides quality services to people with HIV in your area. Please contact me at 301-945-5220, or at KHilton@hrsa.gov if you have any questions.

Sincerely,

Krystal M. Hilton

Krystal Hilton, MPH
Project Officer - Western Branch
Division of Metropolitan HIV/AIDS Programs (DMHAP)

cc: Chrissy Abrahms Woodland, Director, DMHAP
Monique Hitch, Deputy Director, DMHAP
Karen Gooden, Chief - Western Branch, DMHAP
Veronyca Washington, Senior Project Officer PCs/PBs, DMHAP
Ka'leef Stanton Morse, Senior Project Officer PCs/PBs, DMHAP
Dr. Michael Green, Chief – Planning Division
Cheryl Barrit, Executive Director – LA COH

Attachment: Appendix A – Technical Assistance Action Plan (TAAP)

DIVISION OF METROPOLITAN HIV/AIDS PROGRAMS

Veronyca Washington & Ka'leef Stanton Morse — *Senior Project Officers, Planning Councils & Planning Bodies (PC/PB)*

PLANNING COUNCIL/PLANNING BODY (PC/PB) TECHNICAL ASSISTANCE (TA) PROJECT

PART A TA AFTER ACTION REPORT (TAAR)

v3 – 7/17/24

PROJECT OFFICER INFO					
Full Name:	Krystal Hilton	**Email:**	KHilton@hrsa.gov		
DMHAP Branch:	Western	**Branch Chief:**	Karen Gooden	**Email:**	KGooden@hrsa.gov

JURISDICTION INFO					
EMA/TGA Name:	Los Angeles County EMA	**EHE Jurisdiction?:**	YES	**Grant #:**	H89HA00016
PC or PB?: PC	**PC/PB Name:**	Los Angeles County Commission on HIV		**Website:**	Commission on HIV (lacounty.gov)

LOGISTICS OVERVIEW			
TA Name:	**PC/PB TA Site Visit**	**Total Unique Participants:**	**16**
Start Date/Time:	Tuesday May 21, 2024 @ 9:00 am PST	**End Date/Time:**	Thursday May 23, 2024 @ 12pm PST
Delivery Method:	☐ **In-Person during a Comprehensive Site Visit (CSV)** ☒ **In-Person Technical Assistance Site Visit (TASV)** ☐ **Other w/description:**	☐ **Webinar** ☐ **Teams/Zoom Meeting**	
Scope of TA Delivery:			
2.5 day on site tailored training broken down into 5 sessions. Days 1-2 was scheduled from 9am to 4pm and Day 3 was scheduled from 9am to 12pm.			
Points of Contact:			
Cheryl Barrit, Executive Director, CBarrit@lachiv.org Dawn McClendon, Assistant Director, DMclendon@lachiv.org			
INSERT LINKS TO THE FOLLOWING FILES *(as applicable):*			
Recording:		**Chat History:**	
Polls:		**Q & A:**	
Transcript:			

RECENT COMPREHENSIVE SITE VISIT (CSV) FINDINGS			
Does this jurisdiction have any outstanding PC/PB related findings from their most recent CSV? *(If NO, move to the Executive Summary Section)*	☒ **YES** ☐ **NO**		
If YES, does this jurisdiction have a Corrective Action Plan (CAP)?	☒ **YES** ☐ **NO**		
Dates of Visit:	February 13-17, 2023	**Project Officer During Visit:**	Babak Yaghmaei

PLEASE INSERT FINDINGS AND STATUS UPDATES BELOW:

Finding #1 Type:	Legislative	**Description:**	Lack of compliance with the requirement for consumer/stakeholder recruitment and/or involvement.
Finding Description:	Lack of compliance with the requirement to ensure separation of Planning Council and recipient roles.	**Citation:**	Section 2602 (7)(a) of the PHS Act
	The Director of DHSP, who also functions as a CEO designee for the jurisdiction, is a voting member of the LA Commission on HIV and a voting member of the Executive Committee.		
Recommendation:	The recipient must ensure separation of Planning Council and recipient roles to avoid any actual and/or perceived conflict of interest. Per Section 2602 (7)(a) of the PHS Act, a separation of Planning Body and the recipient is necessary to avoid a conflict of interest. A recipient's representative, whose positions are funded by RWHAP funds, provides in-kind services, or has significant involvement in the HIV award, shall not occupy a seat on the Planning Council, nor have a vote in the deliberation of the Planning Council. For additional guidance, the recipient should review HRSA's Ryan White HIV/AIDS Program Planning Council and Planning Body Requirements and Expectation Letter which clarifies HRSA expectation on the required community input process for RWHAP Part A awards, specific to the separation of Planning Council and recipient roles.		
UPDATE:	The recipient (DHSP) has not submitted an update yet.		

Finding #2 Type:	Legislative	**Description:**	Lack of compliance with the requirement for Planning Council membership to comply with representation and reflectiveness.
Finding Description:		**Citation:**	Section 2602(b)(5)(C) of the PHS Act
	Los Angeles (LA) Commission on HIV currently has three vacancies for the following legislatively mandated categories: a) RWHAP Part C Provider, b) Hospital Planning Agency or Health Care Planning Agency, and c) Representatives of Individuals who Formerly were Incarcerated.		
Recommendation:	LA Commission on HIV must ensure that its operations committee prioritizes and expedites its efforts to recruit, review, and nominate qualified candidates for the currently vacant legislatively mandated categories for subsequent submission for Chief Elected Official (CEO)'s review and appointment. The CEO should prioritize their review, consideration, and timely appointment of commissioners to ensure smooth and uninterrupted operations of the HIV Planning Council.		
UPDATE:	The recipient (DHSP) has not submitted an update yet.		

Finding #3 Type:	Legislative	**Description:**	Lack of compliance with the requirement for Planning Council membership to comply with representation and reflectiveness.
Finding Description:		**Citation:**	Section 2602(b)(5)(C) of the PHS Act
	LA Commission on HIV currently has 37 CEO-appointed members, including seven (7) unaffiliated client representatives. This represents 19 percent, which is below the 33 percent unaligned client representation requirement for planning bodies, as stated in Section 2602(b)(5)(C) of the PHS Act.		
Recommendation:	The LA Commission on HIV, through its Operations Committee, should review, revise, prioritize, and expedite its efforts to recruit and nominate unaffiliated clients for subsequent submission for CEO review and appointment to ensure consistent compliance with the unaligned client participation requirement. To that effect: 1. Operations Committee should proactively and consistently solicit input and assistance from the established Commission on HIV Caucuses, specifically, its Consumer Caucus, Black/African American Caucus, Transgender Caucus, Women's Caucus and Aging Caucus. This will allow the Planning Council to increase the pool of potential eligible/qualified applicants from diverse backgrounds to improve overall representation and reflectiveness of the Commission. 2. Recipient and the Planning Council should engage its provider network in a deeper, more proactive, and consistent recruitment effort that may include a) conducting designated trainings for providers on the importance of recruitment, b) having hard-copy membership applications (in English and Spanish) available at funded agencies, c) conducting Planning Council recruitment "Meet and Greet" events at providers' agency support groups and other client meeting, etc. 3. Establish a "Bring a Friend" Day, when unaffiliated commissioners can bring their friends to PC meetings to get a better understanding of the PC and be able to apply for membership on the spot, if interested. 4. Establish a Commission on HIV Community Recruitment Annual Schedule that will ensure the Commission on HIV's prominent presence and participation in the most important community events, such as during Pride Events, World AIDS Day Events, (December), National HIV Black Awareness Events, (February), National Latino HIV Awareness Events (October), National Women's Awareness Events, (March), etc.		
UPDATE:	The recipient (DHSP) has not submitted an update yet.		

Finding #4 Type:	Legislative	**Description:**	Lack of compliance with the requirement for consumer/stakeholder recruitment and/or involvement.
Finding Description:		**Citation:**	Section 2602(b)(5)(C) of the PHS Act
	Currently, there is one commissioner listed on the membership roster, (Mr. Stalter), whose membership term expired in July 2022. There is no documentation the commissioner was timely reappointed for any additional membership terms. This commissioner is a co-chair of the Standards and Best Practices Committee and a member of the Executive Committee.		

	There is another commissioner listed on the membership roster, (Mr. Moreno), whose membership term expired in July 2022. There is no documentation the commissioner was timely reappointed for any additional membership terms. This commissioner represents the legislatively mandated category of Health Care Providers and is a member of the Operations Committees.
Recommendation:	Steps recommended for compliance: 1. Recipient and the commission should review and consistently follow the nominating process outlined in the currently approved LA Commission on HIV Bylaws in Article 4: Nomination Process, p. 9, and LA Commission on HIV Policy and Procedure #09.4205, Commission Membership Evaluation and Nominations Process (approved in May 2018). 2. Recipient and the commission support staff should review HRSA's Ryan White HIV/AIDS Program Planning Council and Planning Body Requirements and Expectation Letter, which provides clarification on HRSA's expectation on the required community input process for RWHAP Part A awards, specific to PC term limits and membership rotation. 3. The commissioner nomination and re-appointment process should begin early to allow the CEO ample time to review, consider and make approval decisions on member applications. 4. The CEO should prioritize its review, consideration, and reappointment of commissioners whose term is expiring to avoid prolonged vacancies and to ensure smooth and uninterrupted operations of the commission.
UPDATE:	The recipient (DHSP) has not submitted an update yet.

Finding #5 Type:	Legislative	**Description:**	Lack of compliance with the requirement for consumer/stakeholder recruitment and/or involvement.
Finding Description:		**Citation:**	Section 2602(b)(5)(C) of the PHS Act
	Lack of compliance with the conflict-of-interest requirement for PC members. The LA Commission on HIV currently has 37 duly appointed PC members. There is no documentation of current, completed, and signed Conflict of Interest (COI) declaration for any of the appointed commissioners. Most of the COI declarations are outdated, going back to 2018 and 2019. The most recent COI declaration is dated June 2021. In addition, several commissioners who are affiliated with currently funded providers declared "No Conflict" on their COI declarations. Based on the review of the meeting minutes for the commission and its Planning, Priority and Allocations Committee, it is evident that several of these commissioners participated in allocations/reallocation discussions and voted on allocations including for the service categories for which their agencies are funded, most recently in June 2022 on a revised FY 2023 RWHAP Part A funding allocation.		
Recommendation:	As stated in the RWHAP Part A Manual, X. Ch 8. Conflict of Interest, p. 147, Conflict of Interest can be defined as an actual or perceived interest by the member in an action that results or has the appearance of resulting in a personal, organizational, or professional gain. The definition may cover both the member and a close relative, such as a spouse, domestic partner, sibling, parent, or child. This actual or perceived bias in the decision-making process is based on the dual role played by a planning council member who is affiliated with other		

	organizations as an employee, a board member, a member, a consultant, or in some other capacity. Recommended steps of action: 1. LA Commission on HIV support staff members must ensure that all commissioners have a current, completed, and signed COI declaration. 2. LA Commission on HIV support staff members should review the Conflict-of-Interest requirements for Planning Councils, as outlined in the RWHAP Part A Manual, Section X, Chapter 8, pp. 143-152. 3. LA Commission of HIV support staff should review the Los Angeles County Conflict of Interest Policy #12.0001, approved in June 2008, specifically item 2 under the Procedures section on p. 4. 4. LA Commission of HIV support staff should conduct a COI refresher training for all commissioners to ensure uniform understanding with participation documentation on file. 5. The recipient and PC support staff members must maintain up-to-date documentation of all members' terms, appointments, representation categories, and agency affiliations.
UPDATE:	The recipient (DHSP) has not submitted an update yet.

EXECUTIVE SUMMARY	
Overview of TA session(s):	This TASV was geared to support and equip the Los Angeles County Commission on HIV (COH) with knowledge and tools to mitigate challenges faced with legislative and programmatic compliance. Via regular meetings with the LA COH leadership and HRSA Project Officer, a collaboratively tailored agenda and content was developed to support PC improvements.
TA Session(s) Content Area(s):	Session 1: Review the Annual Planning Cycle Session 2: Membership: Term limits, Rotations, and Succession Planning Session 3: Assessment of the Efficiency of the Administrative Mechanism Session 4: Empowering Communities (Conversations around meaningful community input and engagement) Session 5: Membership Considerations: Recruitment, Engagement, Retention, and Meeting Logistics
Objectives addressed by session(s):	1. To strengthen the PC's knowledge of the planning requirements for the RWHAP as they prioritize their work plan as a syndemic planning council. 2. To strengthen the PC's ability to identify partnerships, capacity and resources needed to support work plan implementation. 3. To enhance the PC's ability to conduct membership recruitment, engagement, retention, and innovation.
Major strengths identified during session(s):	1. The LA COH Support Office is sufficiently staffed by 5 FTEs, led by an Executive Director, supporting multiple committees, workgroups and caucuses. 2. The LA COH Support Office highly organizes their documentation as found during the document submission and review.

	3. The LA COH has a visually appealing website, https://hiv.lacounty.gov/ , that provides comprehensive information on the LA COH's purpose, membership & staff roster, committee meeting information, membership resources including the application, and training resources.
Findings:	1. Administrative, Programmatic, Other: Lack of compliance with requirement for member term limits and rotations. 2. Administrative, Governance and Constituent Involvement, Legislative: Lack of compliance with the requirement for planning council membership to comply with representation and reflectiveness.

OBJECTIVE #1: To strengthen the PC's knowledge of the planning requirements for the RWHAP as they prioritize their work plan as a syndemic planning council.	**SUMMARY OF OBSERVATION**
Activity:	TA Session 1 "The Annual RWHAP Part A Planning Cycle" provided an overview of the tasks of the Planning Cycle, suggestions on how to successfully complete annual planning, and how the PC and recipient collaborate in annual planning. TA Session 3 "Assessment of the Efficiency of the Administrative Mechanism "provided an in-depth overview of the AEAM with supportive suggestions.
Analysis:	The LA COH identified the need to provide additional information on PSRA, rapid reallocation, needs assessment, directives, and workplan processes. LA COH completed the most recent AEAM several years behind, March 2023 to review the 2020-2021 grant year, with additional items asked in its scope. The Commission started the legislatively required activities of the GY'20 AEAM in the third quarter of 2022 between August and September. The Commission includes an assessment of commission members' understanding of the priority setting and resource allocation process in the AEAM.
Areas for Improvement:	1. The design, development, and implementation of the AEAM
Improvement Recommendations:	1. Narrow the scope of the AEAM to the legislative requirements and conduct it during the grant year (after the first quarter preferably) vs years after. The Commission includes an assessment of members' understanding of the priority setting and resource allocation process in the AEAM. Although this determination may interest LA COH, it is beyond the scope of the AEAM. It does not support the Commission in determining the administrative agency's ability to quickly disperse RWHAP Part A funds into the community. LA COH should remove this assessment from the AEAM activities and report. The AEAM must be conducted annually and timely to support LA COH in determining how quickly and well the administrative agency contracts and pays providers for delivering HIV-related services to ensure Part A funds meet the needs of PWH, with an emphasis on those with the greatest need for RWHAP services. Delays in the assessment may negatively impact the reliability and accuracy of data collected and the local system of care supporting PWH with achieving positive health outcomes. Potential corrective action(s) addressing contracting and provider payment may be delayed in implementation or acknowledgment.
Finding 1:	Administrative, Administrative Other, Legislative

Description:	Other
Finding Description:	LA COH completed the most recent AEAM several years behind, March 2023 to review the 2020-2021 grant year, with additional items asked in its scope.
Citation(s):	Section 2602(b)(4)(E) of the PHS Act Quick Reference Handout 7.2: Assessment of the Administrative Mechanism (targethiv.org) Part A Manual 2024 (hrsa.gov) Page 36
Finding Recommendation:	A PC/PB must conduct an annual assessment of the administrative mechanism to ensure that services are being funded as indicated by PC/PB priorities, that funds are contracted in a timely and transparent process, and subrecipient providers are reimbursed in a timely manner. This should be done for the most recent grant year as the assessment looks at whether contracting and expenditure of Part A funds are consistent with allocations made by the PC and the proportion of formula and supplemental Part A funds are expended by the end of the program year. The PC needs this information for the Letter of Assurance that must be included each year in the Part A application. All requirements that are not being met in an EMA/TGA should be documented, and a corrective action plan (CAP) should be implemented. The PC/PB signs an assurance that is submitted with the competitive application and NCC that the assessment of grant recipient activities ensured timely allocation/contracting of funds and payments to subrecipient providers. For example, the assessment done in March 2023 should be assessing the administrative mechanism that was in place from March 2022 to February 2023.

OBJECTIVE #2: To strengthen the PC's ability to identify partnerships, capacity and resources needed to support work plan implementation.	**SUMMARY OF OBSERVATION**
Activity:	Session 4: Empowering Communities (Conversations around meaningful community input and engagement)
Analysis:	The LA COH has attempted to establish a collaborative relationship with the State Medicaid office (MediCal) to garner an applicant for membership as well as information sharing, as the MediCal expansion impacts the design and funding of the services for the Ryan White System of Care (Service Standards and resource allocation). The LA COH is an integrated HIV Prevention and Care Planning Council, guided by a syndemic approach to planning. This syndemic approach has been challenging, as Ryan White is the only prescriptive funding source related to how planning is to be conducted. As such, there are challenges in establishing clarity on the scope of the LA COH's planning duties and sphere of influence related to non-Ryan White funding. These challenges are exacerbated by periodically conflicting priorities of the DHSP and the LA COH.
Areas for Improvement:	1. The LA COH's priorities related to syndemic planning. 2. The relationship between LA COH and the DHSP, especially related to roles and responsibilities.
Improvement Recommendations:	1. Determine what areas of syndemic planning are feasible, relevant, and appropriate in relation to the mandated activities of the funding sources.

	2. Establish a Memorandum of Understanding (MOU) between the PC and the LA County Department of Public Health's Division of HIV and STD Programs (DHSP).
Finding 2:	n/a
Description:	
Finding Description:	
Citation(s):	
Recommendations:	

OBJECTIVE #3: To enhance the PC's ability to conduct membership recruitment, engagement, retention, and innovation.	**SUMMARY OF OBSERVATION**
Activity:	TA Session 2 "Membership: Term limits, Rotations, and Succession Planning" included a review of the August 29, 2023, Dear Colleague Letter, "Ryan White HIV/AIDS Program Planning Council and Planning Body Requirements and Expectations Letter" clarification regarding the requirement for PC/PB membership term limits and rotations, sound practices for term limit implementation, and succession planning techniques. TA Session 4 "Empowering Communities" provided an overview of HRSA HAB's recognition of the value of people with lived experience and the ways their input and expertise contribute to the delivery of services that are tailored to the needs of people with HIV. During this session, we reviewed the February 28, 2023 dear colleague letter on "Supporting Community Engagement' and the December 6, 2022 dear colleague letter on "Supporting People with Lived Experience". After the overview, a discussion was held around how to get meaningful community input and engagement in the LA COH, especially with the priority population-focused caucuses. TA Session 5 "Membership Considerations: Recruitment, Engagement, Retention & Meetings" was held during the Operations Committee Meeting. This session provided the Ops Committee members with an overview of the recruitment and selection process, including the legislative mandate and HRSA HAB minimum standards for open nominations, representation, and reflectiveness including a discussion of challenges to meeting those standards and suggestions on how to recruit to meet those standards. This session also discussed participation vs engagement, the importance of supporting member participation, engagement and retention, and how to encourage attendance and engagement by making meetings member friendly.
Analysis:	The LA COH allows for 50 voting members and one non-voting member. Members are nominated by the Commission and appointed by the LA Board of Supervisors (BOS) as stated in the 4.9.24 version of their bylaws. Due to the size of the jurisdiction and its syndemic approach, the LA COH includes membership categories beyond the 13 legislatively required membership categories for planning council/planning bodies. Commission members can serve a maximum of three consecutive two-year terms and requires a one-year break before applying again.

	The LA COH continues to have challenges in recruitment to fill vacant legislatively mandated seats. The LA COH also has challenges with marketing/promoting their existence. The LA COH's current structure only allows commissioners to be members of the standing committees, significantly limiting the pool of potential members and increasing the burden of commissioners to complete tasks.
Areas for Improvement:	1.Access to meetings 2. Consistent meeting participation from non-commissioners. 3. Membership structure for standing committees.
Improvement Recommendations:	1. Encourage PC to review agenda items to reduce the length of meetings. 2. Encourage PC to consider changing meeting times to allow for more people to engage. 3. Encourage the PC to open committee membership to non-commissioners.
Finding:	Administrative, Governance and Constituent Involvement, Legislative
Description:	Lack of compliance with the requirement for planning council membership to comply with representation and reflectiveness.
Finding Description:	Currently, the LA COH has 8 vacancies; 1 MediCal (Medicaid) rep, 1 Long Beach city rep, 1 provider rep, 4 unaffiliated consumers, and 1 local health/hospital planning agency rep.
Citation(s):	Reflectiveness [§2602(b)(1) of the PHS Act] Representation [§2602(b)(2) of the PHS Act]
Recommendations:	Open committee membership to non-commissioners to allow for a broader recruitment pool. Continue recruitment efforts to fill those vacancies. Consider meeting logistics to engage more people.
Finding:	Administrative, Programmatic
Description:	Other: Lack of compliance with requirement for member term limits and rotation.
Finding Description:	Section 3 of the Commission's Bylaws states members can serve a maximum of three consecutive two-year terms and can reapply for membership following a one-year break. The FY'21 Part A Planning Council/Planning Body Membership Roster submitted includes nine members who have served longer terms, including A. Ballesteros, B. Gordon, J. Green, L. Kochems, D. Murray, M. Perez, R. Rosales, L. Spencer, and K. Stalter. Although commendable to see continued engagement and involvement of longstanding members, LA COH must adhere to its established term limits and implement the one-year break described in their bylaws to allow new membership and compliance with established term limits.
Citation(s):	HRSA HAB Ryan White HIV/AIDS Program Planning Council and Planning Body Requirements and Expectations Letter Program Letter, dated August 29, 2023
Recommendations:	Implementation of established term limits and rotations Maintain and monitor membership terms and rotations documentation and develop appropriate succession planning strategies that support PC operations and continuity.

APPENDIX A: ACTION PLAN TEMPLATE

APPENDIX A

TA ACTION PLAN (TAAP)

v2 – 10/8/24 (COH 10.31.24)

JURISDICTION INFO

EMA/TGA Name:	Los Angeles County EMA	**HRSA Grant #:**	H89HA00016	**Project Officer (PO):**	Krystal Hilton	**PO's Email:**	KHilton@hrsa.gov	**TASV Dates:**	Tuesday May 21, 2024 to Thursday May 23, 2024
Recipient Name & Title:	Mario J. Perez, Director - Division of HIV and STD Programs (DHSP)						**Email:**	MJPerez@ph.lacounty.gov	
PC or PB?:	PC	**PC/PB Name:**	Los Angeles County Commission on HIV (LACOH)	**PC/PB Contact & Title:**	Cheryl Barrit, Executive Director		**Contact Email:**	CBarrit@lachiv.org	

TA Finding Description	Action Steps	Status	Due date	Responsible Party	Goal/Desired Outcome/Deliverable
1. Administrative, Legislative: LA COH completed the most recent AEAM several years behind, March 2023 to review the 2020-2021 grant year, with additional items asked in its scope.	The LACOH will narrow the scope of its AEAM and focus strictly on what is legislatively required and will use the same survey instruments in order to establish comparisons overtime. The LACOH completed the PY 32 AEAM in August 2024. The Operations Committee will review the AEAM survey questionnaires for PY 33 and PY 34 at its October 24 meeting with a target date of disseminating the survey in January/February 2025. Two program years will be covered in order to catch up with the RW grant year cycles. The AEAM surveys for PY 35 will be disseminated to providers in March 2025 and annually during the month of March thereafter. This will ensure completion of annual AEAM reports by June-July of each year.	PY 32 AEAM - completed on August 2024 PY 33 and 34 -in progress; started	PY 33 & PY 34 AEAM recipient and subrecipient surveys will be disseminated in January/February 2025. Reports completed by April 2025.	LACOH support staff and Operations Committee	• Narrow scope of the AEAM to strictly focus on legislatively required components. • Utilize, with minor changes, the same AEAM survey instruments to establish comparisons overtime. • Catch-up with AEAMs cycles to ensure that the study is conducted during the first quarter of the grant year. • AEAM reports completed in June and July of each year, beginning with the PY 35 AEAM report.

TA Finding Description	Action Steps	Status	Due date	Responsible Party	Goal/Desired Outcome/Deliverable
2. Administrative, Governance and Constituent Involvement, Legislative: Lack of compliance with the requirement for planning council membership to comply with representation and reflectiveness.	**PC Vacancies:** The LACOH will continue to conduct targeted recruitment for vacancies and leverage the various caucuses to elicit membership applications among consumers. PC support staff will continue direct appeals to the State Med-Cal office for a Medicaid representative. **Committee-only membership:** The current COH bylaws *allows* community members/individuals to serve as Committee-only members. The Planning, Priorities and Allocations and Standards and Best Practices Committees both have committee-only members. Two more committee-only membership applications are scheduled for full COH approval at their January 2025 meetings.	**State Medicaid**: continue to email Dr. Karen Mark to seek a State Medicaid representative to the LACOH. Follow-up emails are sent a quarterly basis. **City of Long Beach (CLB):** Membership application was approved by the Operations and Executive Committees on 9/26/24; pending approval from full PC and Board of Supervisors. 1 Provider Representative: **1 Local health/hospital planning agency:** A membership application was received from Anthem Blue Cross but was rescinded because the applicant could not commit to attending the full PC meetings on a consistent basis. Outreach calls are made to LACare, HealthNet, Kaiser Permanent on a quarterly basis.	**State Medicaid:** Follow-up recruitment emails to Dr. Mark on February, June and October 2025. **City of Long Beach (CLB):** Secure full PC and Board approval by the end of January 2025. The November COH meeting is dedicated to the annual conference and the December meeting has been cancelled. **1 Local health/hospital planning agency:** Continue to make outreach calls to local health plans on a quarterly basis to elicit applications. Secure a hospital representative application by the end April 2025. **Vacant provider seats**: 2 alternates are in the process of moving to the vacant provider seats; appropriate approvals are in progress. Secure PC and Board approval by the	LACOH PC support staff Operations Committee	**State Medicaid:** Secure State Medicaid representative to the LACOH. Keep educating the State about the importance of this representative on the local HIV planning process. **City of Long Beach (CLB):** Onboard CLB representative by the end of January 2025. The applicant completed new membership orientation on 101/24. **1 Local health/hospital planning agency:** Reinforce the importance of this seat to the local health plans and continue quarterly calls/pressure to secure membership. **4 unaffiliated consumers (UC):** Continue to use the caucuses to recruit UCs and prepare them for leadership roles on the PC. Promote vacancies at health fairs and meetings with providers and community advisory boards. Move alternates in good standing to UC seats, if they meet the HRSA definition of an unaffiliated consumer. **Vacant provider seats**: Continue membership recruitment and move alternates in good standing to vacant provider seats (if any).

TA Finding Description	Action Steps	Status	Due date	Responsible Party	Goal/Desired Outcome/Deliverable
		4 unaffiliated consumers (UC): As of 10/21/24, there are three vacant UC seats. **Vacant provider seats:** An alternate was approved by the Operations and Executive Committees to fill one of the provider seats on 8/22/24. The COH did not achieve quorum at its September meeting, hence, their application will be approved by the full PC and the Board during the month of January 2025. Another alternate is set to move in a vacant provider seat and is on the Operations and Executive Committees agenda for approval on 10/24/24. The October full PC meeting was cancelled; November is dedicated to the annual conference, and the December full PC meeting has	end of January 2025. **Vacant unaffiliated consumer seats:** Secure at least 3 UC applications from caucuses and local community advisory boards by April 2025.		

TA Finding Description	Action Steps	Status	Due date	Responsible Party	Goal/Desired Outcome/Deliverable
		also been cancelled.			

TA Finding Description	Action Steps	Status	Due date	Responsible Party	Goal/Desired Outcome/Deliverable
3. Administrative, Programmatic: Lack of compliance with requirement for member term limits and rotation.	**Implementation of established term limits and rotations:** The COH is still in the process of updating its bylaws. The version reviewed by the HRSA TA team contains *proposed* changes to the bylaws that will establish term limits and rotations. The Board of Supervisors waives term limits for County Commissions to ensure continuity and community input. Members cited in the TA After Action Report are in good standing and were approved by the Board for continued service on the COH. Derek Murphy (West Hollywood representative) has resigned from the COH and has been replaced by another West Hollywood representative. The full PC will focus on the bylaws and restructure of the PC during the first few meetings of 2025 and secure approval for the bylaws by April 2025.	Bylaws are slated for additional vetting the full PC and the community in early 2025, with anticipated approval by April 2025.	By the end of April 2025.	PC staff, COH, Executive Office of the Board, County Counsel	Complete a comprehensive review & update of the COH bylaws to address 2023 HRSA site visit findings, 2024 HRSA TA site visit after action report findings, and legislative requirements. The comprehensive bylaws update is more than just a document update exercise, but also serves an opportunity to critically examine the form, function, and effectiveness of the COH as an integrated prevention and care planning body.
4. Determine what areas of syndemic planning are feasible, relevant, and appropriate in relation to the mandated activities of the funding sources.	As part of the COH comprehensive bylaws change and planning council restructuring, the PC will discuss and determine appropriate activities related to syndemic planning.	Bylaws and PC structure are slated for additional vetting the full PC and the community in early 2025, with anticipated approval by April 2025.	By the end of April 2025.	PC staff, COH, DHSP	Complete a comprehensive review & update of the COH bylaws to address 2023 HRSA site visit findings, 2024 HRSA TA site visit after action report findings, and legislative requirements. The comprehensive bylaws update is more than just a document update exercise, but also serves an opportunity to critically examine the form, function, and effectiveness of the COH as an integrated prevention and care planning body. This process will include examining the scope the COH's domain, including determining what aspects of syndemic planning is appropriate for the COH to undertake.
5. Establish an MOU between the PC and DHSP.	Finalize updated MOU once feedback from DHSP is received.	The updated MOU has been drafted and was sent to DHSP on August 19, 2024 for feedback. The COH is awaiting feedback from DHSP. COH staff will refine/edit the MOU as needed and secure approvals when the document is finalized.	Finalize updated MOU and secure approvals by March 2025.	PC staff, COH Co-Chairs, DHSP	Develop a multi-year updated and signed MOU by March 2025.

TA Finding Description	Action Steps	Status	Due date	Responsible Party	Goal/Desired Outcome/Deliverable

Thank you for submitting your entry. A copy is included below for your records.

Request for Information (RFI): To Inform the Development of the 2026 – 2030 National HIV/AIDS Strategy and the National Strategic Plans for Sexually Transmitted Infections, Vaccines, and Viral Hepatitis

Organization	Los Angeles Commission on HIV
Location (City, State)	Los Angeles
Nature of Comments	Organization
Addressing Syndemics	• Provide additional flexibility in use of funds/resources to help people meet their basic needs such as housing, food, employment, allowing people to focus on meeting their health needs. • Eliminate administrative burden associated with delivering services, accessing services, and collecting data for evaluating services. Service providers and clients experience undue stress and lengthy bureaucratic processes that impact health outcomes for HIV, STIs, and viral hepatitis. Addressing mistrust in government and healthcare providers is needed to overcome challenges reaching priority populations. Expand efforts to improve health literacy and combat misinformation and disinformation. • Coordinate resources to implement service delivery systems in nontraditional settings including schools, community-based organizations, faith-based organizations, and other nonclinical settings where members of priority populations may frequent or congregate. • Align HIV, STI, and viral hepatitis prevention and treatment efforts with substance use and mental health services. • Provide incentives to service providers implementing syndemic approaches.
Organizational Use	• In 2021, the Commission on HIV developed their “Integrated HIV Plan” which aligns with the 2021-2025 National HIV Strategic Plan. The document was product of partner collaboration, needs assessments, community listening sessions, and review of HIV surveillance and care continuum data which align the goals of the National HIV Strategic Plan. • Increased data collection to track progress on goals, objectives, and strategies outlined in the strategic plan. Increased transparency such as

	interactive dashboards in a format that is accessible to all and easy to navigate.
Communicating Progress	• Biannual reports highlighting progress and areas for improvement to maintain momentum towards achieving the goals of the strategic plan. Reports should be tailored to a variety of audiences such as service providers, researchers, and the public in a various formats including infographics, video formats, executive summaries, factsheets, etc. • Incorporating opportunities for feedback from all stakeholders during and post implementation of strategies.
Additional Comments	
NHAS Priorities	Components from the National STI Strategic Plan that should be maintained and highlighted are: • Commitment to reducing HIV-related health outcome disparities among people living with HIV and people who experience risk for HIV among priority populations. • Research and implementation of emerging interventions for HIV prevention and care to prevent new HIV infections and improve the quality of life for people living with HIV. • Cross-sector collaborative approaches to meet the goals and effectively implement strategies to prevent new HIV infections and improve the quality of life for people living with HIV. The following areas of the STI National Strategic Plan should be modified: o Expand/scale up goal 3.5, strategy 3.5.2 -> train and expand a diverse HIV workforce. o Expand indicators focused on quality of life among people with HIV. o The NHAS should increase efforts to collaborate with federal partners to lower the cost of emerging HIV prevention and care treatments to improve scaling efforts. o Increase frequency of reporting on progress to meet NHAS goals; provide more data on indicators.
NHAS Strategies and Objectives	The following objectives and strategies should be prioritized: • Objective 1.1; Strategy 1.2.3 • Objective 2.1; Strategies 2.1.1, 2.1.2 • Objective 2.5; Strategy 2.5.2 • Objective 3.1; Strategies 3.1.1 • Objective 3.5
HIV-Related Health Equity	The following objectives and strategies should be prioritized: • People living with or who experience risk for HIV within priority populations face barriers to accessing emerging HIV prevention methods such as Long-Acting Injectable (LAI) PrEP. Reducing barriers to access for priority populations can accelerate HIV-related health equity in prevention. Examples include hosting workshops at local HIV prevention and care service providers to educate community on the effectiveness, availability,

	and process for obtaining LAI PrEP for themselves or someone they know could benefit from LAI PrEP. • National HIV/AIDS Strategy goals, objectives, and strategies associated with improving HIV-related health equity must address social determinants of health, such as housing and employment instability, language barriers, and lack of trust in health care providers, which may impact a person's capacity to access HIV prevention and care services. For example, integrating approaches focused on building partnerships to establish guaranteed income programs at the local level can enable economic self-sufficiency among priority populations and improve health outcomes.
Additional Comments (NHAS)	
STI Plan Priorities	Components from the National STI Strategic Plan that should be maintained and highlighted are: • Accelerating progress in STI research, technology and innovation particularly focusing on advancements in preventive strategies, such as vaccines, and therapeutic agents for the treatment of STI's. This is particularly important for both syphilis and gonorrhea. • The commitment to reduce STI-related health disparities and health inequities as STIs continue to disproportionally impact specific communities and populations. Continued efforts to provide culturally competent and linguistically appropriate prevention and care services and diverse strategies that address the social determinants of health and co-occurring conditions are essential to combating STIs. • The use of primary prevention to halt the spread of STIs, namely by raising awareness and education for both providers and the public. Comprehensive sexual health education is imperative and should happen throughout the lifespan. Additionally, all health care providers must be properly trained to discuss sexual health with their patients regularly. The following areas of the STI National Strategic Plan should be modified: o Expansion of Goal 1, Objectives 1.1 and 1.2 -> Increase awareness of STIs and sexual health and expand implementation of quality, comprehensive STI primary prevention activities. Youth are not receiving the sexual health education and there needs to be some measure of accountability. Additionally, education efforts need to expand beyond youth to adults. o Messaging of risk, prevention and testing should not be focused on specific populations but rather of any person engaging in sexual behaviors. For example, focusing messaging or testing strategies on MSM excludes populations that engage in male-to-male sexual contact but may not identify as such. o Efforts to reduce financial barriers and access to testing and care should also be highlighted. o Expansion of efforts to accelerate STI innovation including prioritizing the development and assessment of appropriate data to support approval of STI prevention tools such as vaccines, diagnostics, therapeutics, and

	microbicides. This is particularly important for syphilis, antibiotic resistant gonorrhea, and Herpes Simplex Virus (HSV). Greater support is needed to advance research and investments in STI vaccines and treatments. o Efforts to integrate programs that address STIs, HIV, viral hepatitis and substance use disorder should be expanded, including funding opportunities that address one or more of the other components of the syndemic and elimination of administrative barriers to effectively implement innovative strategies. o Increase frequency of reporting on progress to meet National STI Strategic Plan goals; provide more data on indicators.
STI Plan Strategies and Objectives	The following objectives and strategies should be prioritized: o Objective 1.1 o Strategies 1.1.1 and 1.1.2 o Objective 1.2 o Strategies 1.2.1 and 1.2.2 o Objective 2.1 o Strategies 2.1.1, 2.1.3, 2.1.4 and 2.1.5 o Objective 2.2 o Strategies 2.2.1, 2.2.3, and 2.2.4 o Objective 3.1 o Strategies 3.1.1 and 3.1.4 o Objective 3.2 o Strategy 3.2.2 o Objective 3.3 o Strategy 3.3.1 o Objective 3.4 o Strategies 3.4.1 and 3.4.2 o Objective 4.1 o Strategies 4.1.1, 4.1.2, and 4.1.4 o Objective 4.2 o Objective 4.3 o Strategies 4.3.1 and 4.3.2 o Objective 5.1 o Strategy 5.1.2 o Objective 5.2 o Strategies 5.2.1, 5.2.3, 5.2.4, 5.2.5, and 5.2.7
Syphilis and Health Equity	The following objectives and strategies should be prioritized: o Objective 1.1 o Strategies 1.1.1, 1.1.2, 1.1.4 and 1.1.5 o Objective 1.2 o Strategies 1.2.1, 1.2.2, 1.2.3, 1.2.4 o Objective 1.4 o Strategies 1.4.1, 1.4.2 and 1.4.4 o Objective 2.1 o Strategies 2.1.1, 2.1.3, 2.1.4 and 2.1.5 o Objective 2.2

	o Strategies 2.2.1, and 2.2.3 o Objective 3.4 o Strategies 3.4.1 and 3.4.2 o Objective 4.1 o Strategies 4.1.1, 4.1.2, and 4.1.4 o Objective 4.2 o Objective 4.3 o Strategies 4.3.1 and 4.3.2 o Objective 5.1 o Strategy 5.1.1 and 5.1.2 o Objective 5.2 o Strategies 5.2.2, 5.2.3, 5.2.4, 5.2.5, and 5.2.7
Additional Comments (STIs)	
Vaccine Plan Priorities	Components from the National Vaccine Plan that should be maintained and highlighted are: • Accelerating progress in the development of innovative, safe, and effective vaccines that prevent infectious diseases. Including the support of public-private partnerships that enable flexible vaccine manufacturing processes and ensure safe and efficient vaccine storage and distribution for routine and emergency use. • Reducing financial and systems barriers for providers to deliver and for the public to access routine vaccinations are key in increasing vaccination rates. Additionally, vaccinations should be made available in a variety of settings to help meet people where they are at and reduce in access. The following components of the Vaccines National Strategic Plan should be expanded: o Countering vaccine mis- and disinformation to increase public support for the individual and societal benefit of vaccination. Vaccination hesitancy is at an all-time high and greater efforts are needed to educate the public on the safety and effectiveness of vaccines. Additionally, healthcare providers should not be opposing messaging around safety and efficacy. o The goal of reducing disparities and inequities in vaccine confidence and acceptance. Increased efforts to reach populations that continue to lack access to vaccines or continue to demonstrate vaccine hesitancy are needed. Collaborating with trusted community members and organizations is needed to counter decades of medical mistrust and increased mistrust in government.
Vaccine Plan Strategies and Objectives	Recognizing limited resources and the need to direct resources to settings and populations disproportionately impacted, the following objectives and strategies should be prioritized: o Objective 1.1 o Strategies 1.1.2, 1.1.3 and 1.1.4 o Objective 1.2

	o Strategies 1.2.1 and 1.2.4 o Objective 2.1 o Strategies 2.1.1 o Objective 2.2 o Strategies 2.2.1 and 2.2.4 o Objective 2.3 (all strategies) o Objective 3.1 o Strategies 3.1.2, 3.1.3, 3.1.4 and 3.1.6 o Objective 3.2 o Strategy 3.2.1 and 3.2.4 o Objective 3.3 o Strategy 3.3.1 o Objective 3.4 o Strategies 3.4.1, 3.4.2, 3.4.4 and 3.4.5 o Objective 4.1 (all strategies) o Objective 4.2 o Strategy 4.2.3 o Objective 4.3 o Strategies 4.3.1, 4.3.2, 4.3.3 o Objective 4.4 o Strategies 4.4.1, 4.4.3, and 4.4.5 o Objective 4.5 (all strategies) o Objective 5.1 o Strategies 5.1.1, 5.1.2 and 5.1.3 o Objective 5.3 o Strategies 5.3.1, 5.3.2, and 5.3.4
Lessons Learned from COVID-19	The following goals and strategies should be prioritized in the next iteration of the National Vaccine Strategic Plan: o Accelerative vaccine research and development. o Expanding domestic manufacturing capacity as well as ensuring a flexible and resilient vaccine supply chain. o Enhancing regulatory flexibility and approval processes. o Prioritizing research and funding into vaccine platforms that can be rapidly adapted to new pathogens. o Strengthening vaccine distribution and equity by ensuring equitable distribution of vaccines, expanding access across multiple channels, and developing strong community engagement/outreach efforts. o Build and main public trust in vaccine through robust education campaigns, combating misinformation through media literacy, and engaging trusted voices ins public health campaigns that are culturally appropriate, language-accessible, and have clear messaging. o Strengthen preparedness and response coordination across federal, state, and local levels as well as global vaccine coordination.
Additional Comments (Vaccines)	

Viral Hepatitis Plan Priorities	Components from the National STI Strategic Plan that should be maintained and highlighted are: • Commitment to reduce health disparities and health inequities among communities and populations disproportionally impacted by viral hepatitis. Continued efforts to provide culturally competent and linguistically appropriate prevention and care services and diverse strategies that address the social determinants of health and co-occurring conditions are essential to combating viral hepatitis. • Continued research and implementation of syndemic approaches that work and engage priority populations in settings where they commonly receive services for viral hepatitis, HIV, and other STIs. Examples of these settings include SUD treatment programs, SSPs, correctional institutions, homeless services providers, crisis centers, HIV clinics, STI clinics, and Federally Qualifies Health Centers/Community Health Centers. • Support objectives and strategies addressing social determinants of health to minimize disparities in the number of infections, morbidity, and mortality among at risk groups. Focus on efforts to ameliorate negative interactions with health care or social services systems to improve the likelihood of care-seeking behaviors. The following areas of the STI National Strategic Plan should be modified: • Expand Goal 3, Objective 3.24 "Provide hepatitis prevention education, hepatitis treatment, and substance use disorder treatment for people in correctional settings, particularly for those who may use drugs. • Expand Goal 4, Objective 4.1.2 "Facilitate viral hepatitis care reporting to state, local, tribal, and territorial public health departments by aligning with efforts to report other infectious disease and using electronic case reporting and interoperable health information technology." • Expand Goal 5, Objective 5.1 "Integrate programs to address the syndemic of viral hepatitis, HIV, STIs, and substance use disorders" and Objective 5.4 "Improve mechanisms to measure, monitor, evaluate, report, and disseminate progress toward achieving organizational, local, and national goals. • Expand efforts to reduce financial barriers and access to testing and care.
Viral Hepatitis Strategies and Objectives	The following objectives and strategies should be prioritized: • Objective 1.1; strategies 1.1.1, 1.1.3, 1.1.4 • Objective 1.2; strategies 1.2.1, 1.2.2, 1.2.3, 1.2.4 • Objective 1.3; strategies 1.3.1, 1.3.3 • Objective 1.4; strategies 1.4.2, 1.4.3, 1.4.4 • Objective 1.5; strategies 1.5.2, 1.5.4 • Objective 2.1; strategies 2.1.1, 2.1.2, 2.1.3, 2.1.4 • Objective 2.2; strategies 2.2.2, 2.2.3, 2.2.5 • Objective 2.3; strategies 2.3.2, 2.3.4 • Objective 2.4; strategies 2.4.2, 2.4.7, 2.4.8 • Objective 3.1; strategies 3.1.1, 3.1.4 • Objective 3.2; strategies 3.2.1, 3.2.4 • Objective 3.3; strategies 3.3.1, 3.3.2

	• Objective 3.4; strategies 3.4.1, 3.4.2 • Objective 4.1; strategies 4.1.1 • Objective 4.2; strategies 4.2.1 • Objective 4.3; strategies 4.3.1 • Objective 5.1; strategies 5.1.1, 5.1.3 • Objective 5.2; strategies 5.2.1, 5.2.3, 5.2.5 • Objective 5.3; strategies 5.3.1, 5.3.2 • Objective 5.4; strategies 5.4.1, 5.4.3
Acute Hepatitis C and Hepatitis B-Related Deaths	The following objectives and strategies should be prioritized: • Objective 1.1; strategies 1.1.1, 1.1.3, 1.1.4 • Objective 1.2; strategies 1.2.1, 1.2.2, 1.2.3, 1.2.4 • Objective 1.3; strategies 1.3.1, 1.3.3 • Objective 1.4; strategies 1.4.2, 1.4.3, 1.4.4 • Objective 1.5; strategies 1.5.2, 1.5.4 • Objective 2.1; strategies 2.1.1, 2.1.2, 2.1.3, 2.1.4 • Objective 2.2; strategies 2.2.2, 2.2.3, 2.2.5 • Objective 2.3; strategies 2.3.2, 2.3.4 • Objective 2.4; strategies 2.4.2, 2.4.7, 2.4.8 • Objective 4.1; strategies 4.1.1 • Objective 4.2; strategies 4.2.1 • Objective 4.3; strategies 4.3.1 • Objective 5.1; strategies 5.1.1, 5.1.3 • Objective 5.2; strategies 5.2.1, 5.2.3, 5.2.5 • Objective 5.3; strategies 5.3.1, 5.3.2 • Objective 5.4; strategies 5.4.1, 5.4.3
Additional Comments (Viral Hepatitis)	

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

FOR DISCUSSION /PLANNING PURPOSES ONLY
12.04.24

- **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	Commission on HIV Restructure ****facilitated by Next Level Consulting and Collaborative Research****
2/13/25 @ The California Endowment *Consumer Resource Fair will be held from 12 noon to 5pm	Unmet Needs Presentation (DHSP/Sona Oksuzyan, PhD, MD, MPH)
3/13/25 @ The California Endowment	Year 33 Utilization Report for All RWP Services Presentation (DHSP/Sona Oksuzyan, PhD, MD, MPH)
4/10/25 @ Location TBD	Year 33 Utilization Report for RW Core Services Presentation (DHSP/Sona Oksuzyan, PhD, MD, MPH)
5/8/25 @ Location TBD	Year 33 Utilization Report for RW Support Services Presentation (DHSP/Sona Oksuzyan, PhD, MD, MPH)
6/12/25 @ Location TBD	PURPOSE Study (Requested by Suzanne Molino, PharmD, Gilead Sciences, Inc.) *Anchor presentation as part of prevention-focused conversation and planning
7/10/25 @ Location TBD	Medical Monitoring Project (Dr. Ekow Sey, DHSP)

8/14/25 @ Location TBD	America's HIV Epidemic Analysis Dashboard (AHEAD)
9/11/25 @ Location TBD	
11/14/24 @ Location TBD	ANNUAL CONFERENCE
12/12/24 @ Location TBD	

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

2025 COMMISSION ON HIV WORKPLAN
Draft/Proposed 12.5.24

#	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

DRAFT

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.

Get Ready for Co-Chair Open Nominations & Elections: Your Questions Answered!

Greetings! It's that time of year again—election season is upon us, not just for general elections, but also for our Commission, Committee and Caucus Co-Chairs. The nomination and election process for COH, Committee, and Caucus Co-Chairs is underway. Below is a quick FAQ to help you prepare and make an informed decision about becoming a Co-Chair.

Am I Eligible?

****Per COH Bylaws, Policies #08.1102 and #08.1104***

Commission Co-Chairs (Nominations remain open until the January 9, 2025, COH meeting)

(2) Commission Co-Chairs have two-year staggered terms – one co-chair seat is up for election which will serve the Jan 2025-Dec 2026 term.

- Only voting Commissioners can serve as Commission Co-Chairs.
- Candidates must have at least one year of service on the Commission to ensure leadership diversity and representation.
- At least one Co-Chair must be HIV-positive, and at least one must be a person of color. It is also preferred that at least one Co-Chair is female.

Committee Co-Chairs (Nominations will open by December, with elections in January 2025)

(2) Committee Co-Chairs serve one-year terms – all co-chair seats are up for election which will serve the Jan-Dec 2025 term.

- The Commission does not impose specific requirements, though one year of experience on the Committee is strongly encouraged.
- Nominees must be primary members of the Committee, not serving in alternate or secondary roles.
- Only Commissioners can serve as Co-Chairs.

Caucus Co-Chairs (Nominations will open by December, with elections in January 2025)

Caucuses typically have two Co-Chairs serving one-year terms, except the Consumer Caucus, which has three seats, including a prevention representative. All co-chair seats are up for election which will serve the Jan-Dec 2025 term.

- One Co-Chair must be a Commissioner to ensure that the Caucus activities are aligned with the COH's scope, goals and objectives
- Note: Caucuses are not subject to Brown Act requirements but work with COH consent to set their own leadership structure, guidelines, membership, and activities.

****All Co-Chair candidates will be asked to provide a brief statement before the election.***

What Are the Co-Chair Roles & Responsibilities?

- Lead COH/committee/caucus activities and meetings.

- Set agendas for meetings in collaboration with staff.
- Develop work plans with the Executive Director and staff.
- Facilitate meetings, guiding discussion and ensuring effective workflow.
- Summarize discussions and assist in developing work products.
- Act on behalf of the group and communicate with stakeholders.

How Should I Prepare?

- Honestly assess your accessibility, bandwidth, and time to ensure you are able to show up fully and prepared. *Co-Chair roles require at least 10-12 commitment hours per month.*
- Review the COH Co-Chair training slides to understand the role's expectations
- Familiarize yourself with the:
  - Ryan White Program Part A Planning Council Primer,
  - COH bylaws,
  - COH Co-Chair Duty Statement (if applicable),
  - Committee Co-Chair Duty Statement (if applicable)
  - Required Commissioner trainings.

Ready to take on a leadership role? Nominate yourself or a colleague and help guide our collective work toward meaningful community impact! If you have questions, please reach out to your respective staff lead.

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov

POLICY/PROCEDURE #08.1104	Commission and Committee Co-Chair Elections and Terms	

SUBJECT: **The process and scheduling for Commission and Committee Co-Chair elections.**

PURPOSE: **To outline the steps and timing for the Commission's and standing committees' Co-Chair elections.**

BACKGROUND:

- Federal Ryan White legislation mandates that all Part A jurisdictions establish local HIV planning councils to develop a comprehensive HIV plan, rank priorities and determine allocations, create standards of care, and to carry out a number of other responsibilities. The Los Angeles County Commission on HIV serves as the local Ryan White Part A HIV planning council for the Los Angeles County.

- In accordance with Ryan White rules and Ordinance 3.29 of the Los Angeles County Charter, the Commission on HIV comprises 51 voting members, meets monthly, and fulfills its various responsibilities through an open, transparent meeting process. The meetings comply with appropriate provisions of California's Ralph M. Brown Act, and are run according to Robert's Rules of Order.

- Elected leadership is necessary to represent the planning council, facilitate the meetings, and oversee planning council work, among other responsibilities. The Health Resources and Services Administration (HRSA), the federal agency responsible for administering the Ryan White Program, recommends that planning councils elect Co-Chairs for these functions. The Commission on HIV has adopted HRSA's guidance with two Co-Chairs elected by the membership.

- The Commission on HIV relies on a strong committee structure to discharge its work responsibilities. Consistent with the Commission's By-Laws, the Commission organizational structure comprises five standing committees: Executive, Public Policy (PP), Operations, Priorities, Planning, and Allocations (PP&A), and Standards and Best Practices (SBP). Except for the Executive Committee (where the Commission Co-Chairs serve as the Committee Co-Chairs), the standing committees are led by two Co-Chairs elected by the Committee membership.

- The Commission Co-Chairs' duties, responsibilities, rights and expectations are detailed in *Duty Statement, Commission Co-Chair*). The Committee Co-Chairs' duties, responsibilities, rights and expectations are detailed in *Duty Statement, Committee Co-Chair*.

POLICY:

1. The Commission Co-Chairs are elected to two-year terms, and each Co-Chair seat expires in December of alternate years. Except for the Executive Committee, each of the standing committees annually elects two Committee Co-Chairs to one-year terms that expire in February. There are no limits to the number of terms to which a Commission or committee Co-Chair can be re-elected. Co-Chairs elected to fill mid-term vacancies are elected for the remaining duration of the term, until it expires.

2. The Commission Co-Chairs are considered members of all committees, and also serve as Executive Committee Co-Chairs. Committee Co-Chairs cannot serve as Co-Chair to more than one committee at a time.

3. Nominations for the vacant Commission Co-Chair seat are normally opened in August, unless unexpected circumstances arise (meeting cancellations, absence of quorum, etc.) prevent it. Nominations for the Committee Co-Chair seats are usually opened in January, following election of the Commission Co-Chairs and final committee assignments, unless otherwise delayed. Members can nominate themselves or can be nominated by other stakeholders throughout the period in which the nominations are open.

4. Except for immediate vacancies in both Co-Chair seats, nominations must be open at the monthly meeting prior to the Co-Chair elections. Unless delayed or postponed, the Co-Chair elections are held at following month's regular meeting.

5. Commission Co-Chair candidates must have at least a year's service on the Commission. At least one of them must be HIV-positive and at least one of them must be a person of color. Only Commissioners can serve as the Co-Chairs. Only Commissioners serving in their primary committee assignment may serve as Committee Co-Chairs, but at least one of the Committee Co-Chair seats must be filled by a Commissioner. Unaffiliated HIV-positive consumers are highly encouraged to seek leadership roles and run for a Commission or Committee Co-Chair seat whenever possible.

6. Co-Chairs are elected through a sequential voting process until there are only one or two candidates remaining, as need dictates. The Commission/committee must approve the final candidate(s) through a consent vote of approval or through individual roll call votes. All Co-Chairs must be elected by a majority of the voting membership. A Co-Chair candidate's failure to earn a majority vote disqualifies that member as a Co-Chair candidate for that term, closes the election for that meeting, extends the nominations period, and postpones the election to the subsequent meeting.

7. Commission and Committee Co-Chair terms are allowed to be extended to accommodate delayed meeting schedules, lack of suitable candidates, or when the body cannot determine definitive, final Co-Chair candidates. A single Co-Chair may also continue to serve, when needed, until a second Co-Chair candidate is identified and elected.

PROCEDURE(S):

1. **Terms of Office**: The Commission Co-Chairs are elected to office for staggered two-year terms. Aside from the Executive Committee, standing committee Co-Chairs are elected for two-year terms.
   a. Commission Co-Chair terms expire in alternate years to ensure leadership continuity. The Commission Co-Chairs also serve as Co-Chairs of the Executive Committee, and serve in those roles for the duration of their tenure as Commission Co-Chairs.
   b. The four, remaining standing committees [Public Policy (PP), Operations, Priorities Planning and Allocations (PP&A) and Standards and Best Practices (SBP)] elect their Co-Chairs for one-year terms that expire concurrently.
   c. Commission Co-Chair terms expire in December of the calendar year, unless the November and/or December monthly Commission meeting(s) are cancelled, quorum is not achieved at the meeting at which the Co-Chair is scheduled to be elected, or by majority vote of the Commission to accommodate an extension of the Co-Chair election process.
   d. Committee Co-Chair terms expire in February of the calendar year, but may be extended, if needed, until new Co-Chairs are elected to fill the leadership positions.
   e. In the case of a mid-term vacancy in one of the Commission Co-Chair seats, the Commission Co-Chair is subsequently elected to fill the unfinished term resulting from the vacancy. Likewise, committee Co-Chairs elected to fill mid-term vacancies are elected for the respective unfinished terms.
   f. Commission Co-Chairs are considered voting members of all Committees and subcommittees, but are not counted towards quorum unless present.
2. **Commission Co-Chair Election Process**: Normally—unless adjusted for unexpected circumstances—the Commission Co-Chair elections proceed according to the following schedule:
   a. 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**, after nominations periods opened at the prior regularly scheduled meeting.
   b. 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.
   c. The Co-Chairs delegate facilitation of the Co-Chair election to the Parliamentarian, Executive Director or other designated staff.

d. Commission members who have been nominated, meet the qualifications, and who accept their nominations are presented for Commission vote.

e. The Parliamentarian (or Executive Director/staff) leads Commission voting to elect the new Commission Co-Chair.

g. Following the new Co-Chair's election, the Commission Co-Chairs and the Executive Director must determine Commission members' final committee assignments by the end of December in order to open committee Co-Chair nominations the following month.

3. **Committee Co-Chair Election Process**: Normally—unless adjusted for unexpected circumstances—the committee Co-Chair elections proceed according to the following schedule:
   a. Aside from the Executive Committee (the Commission Co-Chairs serve as the Executive Committee Co-Chairs), the standing committees open candidate nominations for both Co-Chair seats at their January meetings (following final committee assignments).

   b. Nominations are closed the following month when Committee Co-Chair elections are opened under the Co-Chair reports.

   c. The current Co-Chairs delegate facilitation of the Co-Chair election to the Executive Director or another assigned staff representative.

   d. Committee members who have been nominated, meet the qualifications, and who accept their nominations are presented for Committee vote.

   e. The Executive Director (or other designated staff) leads Committee voting to elect the new Co-Chairs.

   f. The newly elected Co-Chairs begin service at the following committee meeting.

   As per Robert's Rules of Order, The Commission Co-Chairs should maintain a position of neutrality and not vote in Committee co-chair elections unless there is a tie vote for a position, then they may (but are not required to) vote to break the tie.

4. **Co-Chair Qualifications/Eligibility**: Only voting Commissioners may serve as Commission Co-Chairs. In order to ensure leadership diversity and representation, eligible Commission Co-Chair candidates must have at least one year of service and experience on the Commission. Among the two Commission Co-Chairs, at least one of the Co-Chairs must be HIV-positive, and at least one of them must be a person of color. Additionally, it is strongly preferred that at least one of the two Co-Chairs is female.

The Commission does not impose eligibility or qualification requirements for Committee Co-Chairs, although it is strongly encouraged that nominees acquire at least one year's experience with the Committee before standing as a Co-Chair candidate.

a. Any Committee member nominated as a Co-Chair candidate must be serving on that Committee in his/her primary Committee assignment.
b. Only Commissioners may serve as Co-Chairs.
b. Alternates, members serving on the committee in secondary Committee assignments, and BOS-appointed non-Commission committee members may not serve as Co-Chairs.

5. **Co-Chair Nominations**: Outside the rare possibility of immediate vacancies in both Commission Co-Chair seats, all Commission and Committee Co-Chair elections must follow a nominations period opened at the respective body's prior regular meeting. The nominations period is designed to give potential candidates the opportunity to consider standing for election and the responsibility of assuming a leadership position. Candidates may nominate themselves or participants may nominate other members. Any stakeholder may nominate Co-Chair candidates.

   Candidates can be nominated in public when the nominations are opened or any time prior to the closure of the nominations—including just prior to when the Co-Chair elections are opened at the subsequent meeting—or by contacting the Executive Director through phone, email and/or in writing at any time during the period in which nominations are open. Nominations are formally closed when the eligible candidates begin making their statements.

   All Commission Co-Chair candidates nominated prior to the meeting of the Co-Chair election are given the opportunity to provide a brief (single paragraph, single page) statement about their candidacy. All Co-Chair candidates should be given the opportunity to make a short oral statement about their candidacy prior to the election.

6. **Co-Chair Election Voting Procedures**: Co-Chairs are elected by a majority vote:
   a. Roll call voting for elections requires each voting member to state the name of the candidate for whom he/she is voting, or to abstain, in each round of votes.
   b. If there are more than two candidates nominated for Commission Co-Chair, voting will proceed in sequential roll calls until a final candidate earns a majority of votes and is elected by a consent or roll call vote. If no candidates earn a majority of votes in a single round, the candidate earning the least number of votes will be eliminated from the subsequent round of roll call voting. The process continues until there is a majority vote for one candidate, or only one candidate remains and the others have been eliminated. Once the final candidate has been selected, the Commission must approve that candidate for the Co-Chair seat in a consent or roll call vote.

c. When there is only one Commission Co-Chair candidate, the vote serves as approval or rejection of the nominated candidate.
   1) A consent vote may be used to approve the final candidate(s) for the Co-Chair seat(s). A roll call vote is <u>not</u> necessary for a final candidate unless there are objections to the election of the candidate.

d. If there are two Commission Co-Chair vacancies to fill, voting adheres to the process outlined above except that the final two candidates are identified as the final Co-Chair candidates. A consent vote may be used to approve both final candidates, but a subsequent roll call vote is necessary to identify which candidate will fill the longer term; the candidate earning more votes fills the seat with the longer term.
   1) A roll call vote to approve both candidates to fill the Co-Chair seats is <u>not</u> necessary unless there are objections to the election of one or both of the candidates.
   2) When there are objections to the election of one or both of the candidates, each candidate must be approved by a majority through an individual roll call vote.

e. If there are three or more candidates nominated for the two Committee Co-Chair seats, the same process described for Commission Co-Chair election voting (Procedure #4a) is followed. If there are only two Committee Co-Chair candidates, the Committee is entitled to unanimously accept the “slate of Co-Chair nominees”; otherwise an individual roll call vote is necessary to approve the election of each candidate to a Co-Chair seat.

f. In the case of a tie during the final vote, the body can re-cast its vote to accommodate changes in voting. If the body cannot resolve the tie after a new vote, the current Co-Chair(s) remain in office, voting is closed, nominations remain open until the subsequent meeting, and a new election is resumed at that meeting. The process will repeat monthly until a clear majority vote-earner is identified.

g. If a majority of the voting members oppose a final candidate’s/final candidates’ nominations, the current Co-Chair(s) retain their seat until the subsequent meeting, nominations remain open, and a new election is held at the next meeting. The final candidates’ whose nominations were opposed are no longer eligible to fill the seat in the current term. The process will repeat monthly until the body finds majority support for a final candidate(s).

7. **Co-Chair Election Contingencies**: A number of factors may impede the normal Co-Chair election timelines outlined in Procedures #2, #3 and #6. Following are potential challenges that can result in process delays, and how those challenges should be resolved:

   a. Inadequate Number of Qualified Co-Chair Candidates: The Co-Chair whose term has expired may continue in the seat with the term extended until a new Co-Chair is elected. If the Co-Chair does not choose to continue, or has resigned, a Commission or Committee Co-Chair may temporarily serve as a single Co-Chair until a second Co-Chair can be identified and elected. Co-Chair nominations will remain open indefinitely until qualified candidate(s) are identified and elected.

b. **Cancelled Meeting(s) or Quorum(s) Not Realized**: Nominations can be opened at a subsequent meeting and/or extended to accommodate the cancelled meeting(s) or absence of quorum(s). If the meeting for which the election is scheduled is cancelled or a quorum is not present, nominations remain open an additional month and the election proceeds the following month.

NOTED AND APPROVED:	[signature]	**EFFECTIVE DATE:**	September 12, 2019
Original Approval:		*Revision(s):10/19/16; 7/24/17; 9/12/19*	

ALL CONSUMERS OF HIV & HIV PREVENTION SERVICES ARE INVITED TO

2024 CONSUMER CAUCUS "HYBRID" RETREAT

TUESDAY, DECEMBER 17, 2024
12:30-3:30PM

510 S. VERMONT AVE, 9TH FL (CR TK02), LA 90020
*VALIDATED PARKING @ 523 SHATTO PL, LA 90020

(PLEASE INFORM PARKING & BUILDING SECURITY STAFF YOU ARE ATTENDING A COMMISSION ON HIV-SPONSORED MEETING)

LUNCH * 2024 REFLECTIONS * 2025 PLANNING * 2025 CO-CHAIR NOMINATIONS * RAFFLE PRIZES

Scan QR code or click HERE to join virtual option

SAVE THE DATE

CONSUMER RESOURCE FAIR 2025

LOVE BEGINS WITH ME

Empowering Wellness, Advocacy, and Community Beyond HIV

Thursday, February 13, 2025

12:00PM - 5:00PM

The California Endowment

Join us for the 2025 Consumer Resource Fair, a holistic event focused on supporting the whole person beyond HIV.

Interested in participating as a vendor or service provider, hosting a workshop, tabling, or giving a presentation?

CLICK HERE TO SIGN-UP

LOS ANGELES COUNTY
COMMISSION ON HIV

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

INSIDE:

- Awareness
- Updates
- Strategic Plan
- Health Access for All
- Racial Equity
- Mental Health and Substance Use

STAFF HIGHLIGHT

Please join us in congratulating **Lauren Granillo** on her promotion to Chief of the ADAP Evaluation & Monitoring Section. Lauren joined OA in 2021, working in the Surveillance, Research & Prevention (SuPER) Branch as the data manager for the California Medical Monitoring Project, then as a research scientist in the Care Evaluation and Monitoring section of the ADAP & CARE Evaluation & Informatics (ACEI) Branch.

Lauren

Lauren earned her master's degree in public health from UC Irvine and a PhD in Epidemiology from UC Davis. While completing her PhD, Lauren worked on a variety of research projects focused on environmental and developmental epidemiology. Prior to joining the OA family, Lauren worked with California Department of Developmental Services as a graduate student assistant and then as a research data analyst working on risk mitigation and adverse event prevention.

Outside of work, Lauren enjoys getting outdoors and volunteering, doing park clean-ups on the weekends, coaching Special Olympics with Team Davis, and walking along the Davis Arboretum!

Congratulations on your promotion Lauren!

COMMUNITY PARTNER SPOTLIGHT

TruEvolution

On November 21st, **TruEvolution** hosted a site-visit of their **Project Legacy** for members of the California Planning Group (CPG), OA, and the Sexually Transmitted Diseases Control Branch (STDCB). TruEvolution, a non-profit serving the Inland Empire, has a mission to fight for health equity and racial justice to advance the quality of life and human dignity of LGBTQ+ people.

Project Legacy is a public/private partnership between the Housing Authority of the County of Riverside and TruEvolution. Funded in part by Project Homekey, Project Legacy provides 49 beds of transitional supportive housing, a fitness center, career center, and wrap around services, all available on one campus.

Gabriel Maldonado, TruEvolution CEO, and his team walked CPG members and OA/STDCB staff, including Dr. Marisa Ramos and Dr. Kathleen Jacobson, through a night tour of Project Legacy's grounds and gave the group an overview of the key aspects of developing and running housing programs serving LGBTQ+ people who have experienced homelessness.

"Housing First" is one of the six Social Determinants of Health that our *Ending the Epidemics Strategic Plan* is based on. This site-visit was an opportunity to see that in action. Thank you to TruEvolution, and to the residents of Project Legacy who welcomed us to your home!

HIV AWARENESS

On **World AIDS Day, December 1st**, CDPH remembered those who have died from AIDS-related illness and bring awareness about HIV/AIDS, an epidemic that continues to impact millions. We amplify our continued commitment to fighting against discrimination and stigma for those living with HIV. Through our work with community members and partners to include Peregrine Media and TakeMeHome, we promote HIV testing and prevention, education, and provide various resources to help End the HIV Epidemic. To learn more please see the following links:

- *Ending the Epidemics Integrated Statewide Strategic Plan*
- Office of AIDS - HIV Prevention Branch
- *Real Talk: Embracing Sexual Health & Empowerment*
- TakeMeHome - Home Testing Program

GENERAL UPDATES

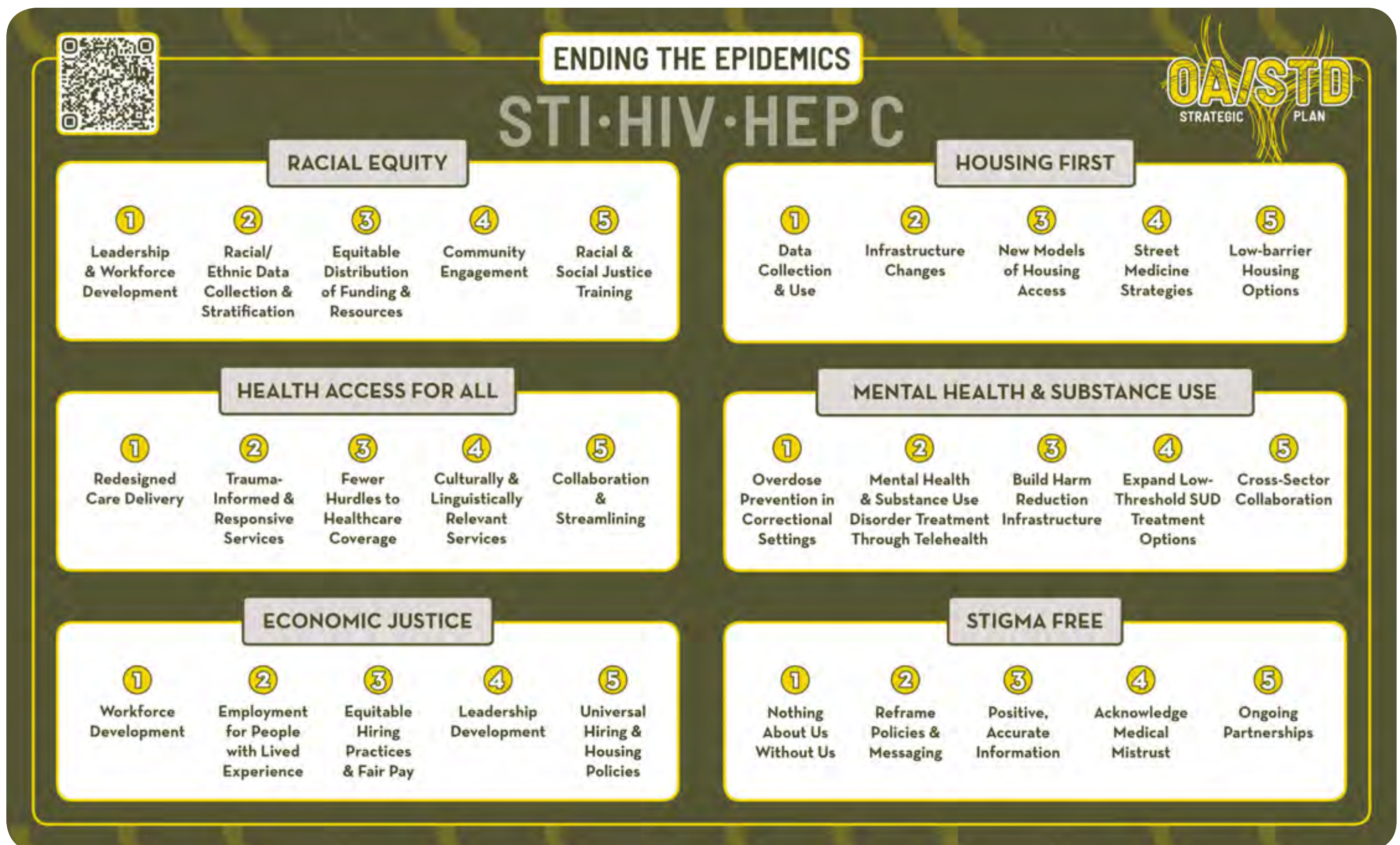
Mpox

OA is committed to providing updated information related to mpox. We have partnered with the Division of Communicable Disease Control (DCDC), a program within the Center of Infectious Diseases and have disseminated a number of documents in an effort to keep our clients and stakeholders informed. Please refer to the DCDC website to stay informed.

Digital assets are available for LHJs and CBOs on DCDC's Campaign Toolkits website.

HIV/STD/HCV Integration

We are re-initiating our integration discussions



and moving forward with the necessary steps to integrate our HIV, STI, and HCV programs into a single new Division. We will continue to keep you apprised on our journey!

ENDING THE EPIDEMICS STRATEGIC PLAN OA/STD

The visual at the top of this page is a high-level summary of our *Strategic Plan* that organizes 30 Strategies across six Social Determinants of Health (SDoH).

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

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

HEALTH ACCESS FOR ALL

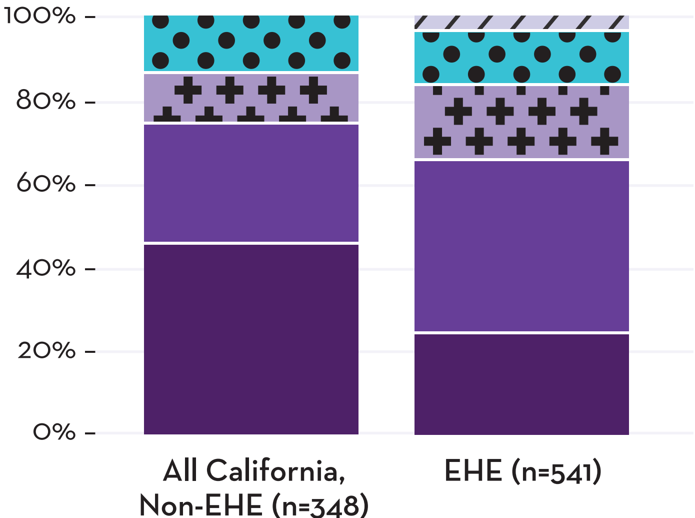
> Strategy 1: Redesigned Care Delivery

OA continues to implement its **Building Healthy Online Communities (BHOC)** self-testing program to allow for rapid OraQuick test orders in all jurisdictions in California. The program, **TakeMeHome**, is advertised on gay dating apps, where users see an ad for home testing and are offered a free HIV-home test kit.

In October, 348 individuals in 43 counties ordered self-test kits, with 281 (80.8%) individuals ordering 2 tests. Additionally, OA's existing TakeMeHome Program continues in the six California Consortium Phase I Ending the HIV Epidemic in America counties. Between the program's initiation in September 1, 2020,

and October 31, 2024, 14,046 tests have been distributed. This month, mail-in lab tests (including dried blood spot tests for HIV, syphilis, and Hepatitis C, as well as 3-site tests for gonorrhea and chlamydia) accounted for 193 (65.7%) of the 541 total tests distributed in EHE counties. Of those ordering rapid tests, 254 (73.0%) ordered 2 tests.

HIV Test History Among Individuals Who Ordered TakeMeHome Kits, Oct. 2024



Additional Key Characteristics	EHE	All California, Non-EHE
Of those sharing their gender, were cisgender men	57.3%	64.3%
Of those sharing their race or ethnicity, identify as Hispanic or Latinx	32.9%	43.0%
Were 17-29 years old	39.7%	47.4%
Of those sharing their number of sex partners, reported 3 or more in the past year	46.1%	48.0%

TAKEMEHOME

Since September 2020, 1,538 test kit recipients have completed the anonymous follow up survey from EHE counties; there have been 635 responses from the California expansion since January 2023.

Survey Highlights	EHE	All California, Non-EHE
Would recommend TakeMeHome to a friend	94.2%	94.4%
Identify as a man who has sex with other men	50.2%	53.3%
Reported having been diagnosed with an STI in the past year	8.3%	10.4%

> Strategy 3: Fewer Hurdles to Healthcare Coverage

As of December 2, 2024, there are 278 PrEP-AP enrollment sites and 229 clinical provider sites that currently make up the PrEP-AP Provider network.

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

As of December 2, 2024, the number of ADAP clients enrolled in each respective ADAP Insurance Assistance Program are shown in the chart at the top of page six.

Active PrEP-AP Clients by Age and Insurance Coverage:

Current Age	PrEP-AP Only		PrEP-AP With Medi-Cal		PrEP-AP With Medicare		PrEP-AP With Private Insurance		TOTAL	
	N	%	N	%	N	%	N	%	N	%
18 - 24	379	11%	---	---	---	---	25	1%	404	12%
25 - 34	1,138	34%	---	---	---	---	168	5%	1,306	39%
35 - 44	754	23%	---	---	2	0%	133	4%	889	27%
45 - 64	404	12%	---	---	11	0%	102	3%	517	16%
65+	26	1%	---	---	181	5%	4	0%	211	6%
TOTAL	**2,701**	**81%**	**0**	**0%**	**194**	**6%**	**432**	**13%**	**3,327**	**100%**

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

Current Age	Latinx		American Indian or Alaskan Native		Asian		Black or African American		Native Hawaiian/ Pacific Islander		White		More Than One Race Reported		Decline to Provide		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
18 - 24	212	6%	3	0%	56	2%	16	0%	1	0%	70	2%	2	0%	44	1%	404	12%
25 - 34	725	22%	3	0%	129	4%	87	3%	7	0%	255	8%	12	0%	88	3%	1,306	39%
35 - 44	491	15%	4	0%	82	2%	50	2%	4	0%	195	6%	6	0%	57	2%	889	27%
45 - 64	267	8%	---	---	50	2%	19	1%	1	0%	139	4%	---	---	41	1%	517	16%
65+	20	1%	---	---	3	0%	5	0%	---	---	172	5%	---	---	11	0%	211	6%
TOTAL	**1,715**	**52%**	**10**	**0%**	**320**	**10%**	**177**	**5%**	**13**	**0%**	**831**	**25%**	**20**	**1%**	**241**	**7%**	**3,327**	**100%**

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

Gender	Latinx		American Indian or Alaskan Native		Asian		Black or African American		Native Hawaiian/ Pacific Islander		White		More Than One Race Reported		Decline to Provide		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Female	51	2%	---	---	5	0%	9	0%	1	0%	12	0%	---	---	8	0%	86	3%
Male	1,550	47%	9	0%	294	9%	164	5%	12	0%	790	24%	19	1%	210	6%	3,048	92%
Trans	92	3%	---	---	14	0%	4	0%	---	---	14	0%	1	0%	6	0%	131	4%
Unknown	22	1%	1	0%	7	0%	---	---	---	---	15	0%	---	---	17	1%	62	2%
TOTAL	**1,715**	**52%**	**10**	**0%**	**320**	**10%**	**177**	**5%**	**13**	**0%**	**831**	**25%**	**20**	**1%**	**241**	**7%**	**3,327**	**100%**

All PrEP-AP charts prepared by: ADAP Fiscal Forecasting Evaluation and Monitoring (AFFEM) Section, ADAP and Care Evaluation and Informatics Branch, Office of AIDS. Client was eligible for PrEP-AP as of run date: 11/30/2024 at 12:01:44 AM Data source: ADAP Enrollment System. Site assignments are based on the site that submitted the most recent application.

ADAP Insurance Assistance Program	Number of Clients Enrolled	Percentage Change from October
Employer Based Health Insurance Premium Payment (EB-HIPP) Program	551	- 0.54%
Office of AIDS Health Insurance Premium Payment (OA-HIPP) Program	5,366	- 0.70%
Medicare Premium Payment Program (MPPP)	2,148	- 2.54%
Total	**8,025**	**- 1.68%**

Source: ADAP Enrollment System

RACIAL EQUITY

> Strategy 4: Community Engagement

Fall 2024 In-Person Meeting Thank Yous

The 2024 Fall In-Person CPG Meeting was a great success! Thank you to all CPG members who provided feedback in the spring meeting survey that was used to plan this meeting. We want to extend a heartfelt thank you for attending the meeting and for ALL the time, dedication and work you have put into helping to cultivate and foster a positive and intentional planning body.

We appreciate your engagement, personal perspectives, insights, and help in creating a safe space for sharing and listening! If you were able to attend, we hope you found the meeting informative to our CPG and collective work. If you were unable to attend, we look forward to seeing you at the Spring in-person meeting. Huge thank you to all Steering Committee members who helped to plan the meeting, support the CPG members, and helped with setting up, running mics, cleaning up, and so much more! Also, thank you to the OA Liaisons and STDCB Liaisons who continuously support CPG members throughout the monthly committee meetings leading up to and during this event.

Thank you to the CPG Host Committee for their stellar planning and facilitation and OA Director, Dr. Marisa Ramos, for taking time out of her busy schedule to attend and provide her candid open forum updates. Also, much appreciation to the OA and STDCB Management Teams for attending the meeting and supporting CPG members. We also want to express a huge thanks to Community Co-Chairs Yara Tapia and John Paul Soto for their ongoing work and support in helping to plan for this meeting!

And lastly, another huge thank you to Rachel Kallett and CSUS for taking care of all our travel and hotel logistics!

Fall 2024 In-Person Meeting Highlights

On **Day 1**, we hosted a two-part Leadership Academy focused on increasing the skills and capacity around self-care for CPG members. The first session was a training presentation on burnout and self-care facilitated by Sam Shapiro from Sam Shapiro Coaching. This presentation included an interactive talk bridging both individual and system-level solutions to the

challenges faced by our public health workforce as well as breakout discussions and activities to integrate the learning, foster dialogue and connection, and create actionable plans. This session was followed by an artistic self-care activity facilitated by Art Magic, where CPG members practiced self-care while creating resin ocean art on acacia boards.

Notably, CPG observed International Transgender Day of Remembrance and Resilience (TDOR), which is globally recognized on November 20 to honor those who lost their lives as a result of transphobia and anti-trans hatred. This day is meant to draw attention to the continued acts of violence endured by trans people and to remember trans community members lost, uplift them, and honor their memory and their lives. We recognized TDOR with a community altar in the meeting room. CPG members and staff brought pictures of trans people we are remembering and items to decorate the altar. We also wrote names, memories, and messages on notecards. We deeply appreciate all CPG members, staff, and guests for sharing and honoring the trans community in this space.

On **Day 2** we had presentations by Natalie Sanchez, Elia Silveyra, Veronica Nava, and Jen Lothridge on storytelling and the Confessions Podcast; Jena Adams and Dr. Kathleen Jacobson to the Women's Committee on doxycycline post-exposure prophylaxis (doxyPEP); and Yara Tapia and John Paul Soto, Community Co-Chairs, on CPG committee accomplishments.

On **Day 3**, we had a community-led presentation by A. K. Parker on a program overview of Rainbow Pride Youth Alliance. We also featured presentations by CPG members including updates on HIV and aging by Jax Kelly and the amazing harm reduction work at Face to Face by Lorie Violette.

Much appreciation to all presenters for sharing their time, effort, and expertise with CPG!

CPG Community Member Recruitment Announcement

Again, we wanted to announce that the CPG is looking for community members to join their committees. CPG is a statewide planning body that advises and partners with OA and STDCB to develop comprehensive plans and implement special projects to address community needs related to the HIV/STD/HCV syndemic. CPG has four committees and information about their transformative work is detailed below. If you are interested in being a part of a committee, please email cpg@cdph.ca.gov for more information.

- **CPG Women's Committee:**

The Women's Committee's mission is to address disparities in women, especially women of color, related to harm reduction, HIV, HCV, and STDs through education, representation, and advocacy. In March 2024, the committee hosted a 3-part webinar series on HIV prevention and care among women in the Central Valley. This series included topics such as an overview of the HIV epidemiologic and healthcare landscape of the Central Valley, key prevention strategies, and how to create responsive and compassionate HIV care systems for women. It uplifted the stories of women with lived experience and created impactful change in around HIV prevention in the Central Valley.

The committee also uplifted the voices of women living with HIV by coordinating a presentation in recognition of National Women and Girls HIV/AIDS Awareness Day on March 10. The presentation included an overview of HIV and women in California and featured a presentation on the Dynamic Divas Program from Children's Hospital Oakland.

Currently, the Women's Committee is working on the creation of a client-focused and provider-focused infographic that highlights PrEP utilization among women. Additionally, their current advocacy efforts are focused on including cisgender women in doxyPEP guidance.

- **CPG Youth Committee:**

The Youth Committee's mission is to address disparities in HIV/STD/HCV prevention and care for adolescents and young adults up to 29 years of age, especially those who are often overlooked and marginalized. They believe in education, representation, and most importantly, taking action! In 2024, the committee hosted a webinar in recognition of National Youth HIV/AIDS Awareness Day on April 10 featuring a training by Children's Hospital Los Angeles to unpack adultism and how we can disrupt it through multigenerational partnerships.

Currently, they are planning to recruit young people into their committee with the goal of uplifting their voices and equipping them with the tools to make informed choices about their health.

- **CPG HIV & Aging Committee:**

The HIV & Aging Committee's mission is to reduce disparities and improve health outcomes and quality of life for the aging community (aged 50 and more), those living with HIV, those who are HIV possible, and long-term survivors. In 2023, the committee published an infographic to education local health departments, service providers, and the community on the impact HIV has on people with HIV aged 50 or more (HIV & Aging Infographic). They also hosted a webinar in recognition of National HIV/AIDS and Aging Awareness Day on September 18 featuring a presentation about Medicare from the Health Insurance Counseling and Advocacy Program. Lastly, in 2024, they hosted another webinar about the CalFresh Program to learn more about resources that are important for the health of people aging with HIV and their families.

The committee is currently developing resource packets and capacity building presentations on various topics including insurance, housing, food, and care-giving.

- **CPG Drug User Health Committee:**

The Drug User Health Committee's mission is to address health and racial disparities in people who use drugs, especially men who have sex with men related to HIV, HCV, STIs, and fatal overdose, as well as to inform and advise the CPG.

Currently, they are recruiting community members into their group to plan next steps and projects for the upcoming year.

For more information on CPG, please visit our CPG webpage.

Strategy 5: Racial and Social Justice Training

The CDC offers free capacity building assistance (CBA) through training, technical assistance, and other resources to reduce HIV infection and improve health outcomes for people with HIV in the United States. Its CBA Provider Network provides CBA on a vast variety of HIV preventions related topics, including enhancing cultural competency for a successful HIV program, cultural responsiveness and humility for people who inject drugs (PWID), diversity, equity, and inclusion, motivational interviewing, planning a condom distribution program, and so much more! To submit a CBA request, please contact the Local Capacity Building and Program Development Unit at CBA@cdph.ca.gov.

MENTAL HEALTH & SUBSTANCE USE

Strategy 3: Build Harm Reduction Infrastructure

RESOURCE: Harm Reduction Toolkit for Shelter Settings

During an emergency, people who use drugs are often at a higher risk of withdrawal and overdose

due to being displaced and away from their regular source of substances. While shelters are an invaluable resource during emergencies, they traditionally have not planned for serving people who use drugs. To help shelters prime themselves to handle situations surrounding drug use that may arise, Rize Massachusetts and Grayken Center for Addiction developed a harm reduction toolkit on shelter settings and substance use.

The toolkit summarizes harm reduction strategies that can be employed in shelter settings. Each practice is categorized as, already established, partially established, inconsistently implemented, or aspirational practices to be implemented in the future. The toolkit also offers tips and tricks for shelters to help implement harm reduction policies.

View the Shelter Settings Toolkit.

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

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?

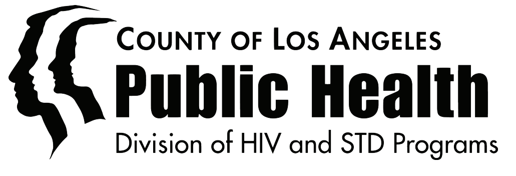
Yes.

Can I contact you through other ways?

Yes.

By Email:
dhspsupport@ph.lacounty.gov

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



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