LOS ANGELES COUNTY
COMMISSION ON HIV

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

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RESCHEDULED
EXECUTIVE COMMITTEE "SPECIAL" MEETING

Thursday, February 5, 2026
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.*

Register Here to Join Virtually

https://lacountyboardofsupervisors.webex.com/weblink/register/rcab4b48416c136c98adf7cfba48cf036

To Join by Telephone: 1-213-306-3065
Password: EXECUTIVE Access Code: 2534 247 0218

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.

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://hiv.lacounty.gov/membership-and-recruitment
For application assistance, email hivcomm@lachiv.org

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

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

EXECUTIVE COMMITTEE

Thursday, February 5, 2026 | 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 to access the Terrace Conference Room (9th flr) where our meetings are held.*

MEMBERS OF THE PUBLIC:
To Register + Join by Computer:
https://lacountyboardofsupervisors.webex.com/weblink/register/r23421af5f2c7eea94051fc037b494030
To Join by Telephone: 1-213-306-3065
Password: EXECUTIVE Access Code: 2532 458 7348

EXECUTIVE COMMITTEE MEMBERS			
Danielle Campbell, PhD, MPH, Co-Chair	*Joseph Green, Co-Chair*	Miguel Alvarez (Executive At-Large)	Alasdair Burton (Executive At-Large)
Erika Davies (SBP Committee)	Kevin Donnelly (PP&A Committee)	Arlene Frames (SBP Committee)	Katja Nelson, MPP (Public Policy Committee)
Mario J. Pérez, MPH (DHSP)	Dechelle Richardson LOA (Executive At-Large)	Daryl Russel (PP&A Committee)	
QUORUM: 6			

AGENDA POSTED: January 30, 2026

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

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

I. ADMINISTRATIVE MATTERS

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

II. PUBLIC COMMENT 1:10 PM – 1:13 PM

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

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

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

IV. REPORTS

7. COH Staff Report 1:15 PM – 1:20 PM

A. Commission (COH)/County Operational Updates

(1) EO BOS Bi-Weekly Reports & Annual Report Development

(2) EO BOS Sunset Review Updates

(3) Ralph M. Brown Act Updates Per SB 707

8. Co-Chair Report 1:20 PM – 2:10 PM

A. COH Effectiveness Review & Restructuring Project
   (1) Bylaws & Ordinance Follow Up
   (2) Membership Drive Status
   (3) Ad Hoc Workgroup Established to Determine Proposed Membership Slate
B. COH x DHSP Prevention Planning Collab
C. February 12, 2026 COH Meeting Agenda Development
   (1) Venue: Jesse Park Auditorium
   (2) Acknowledgement of Service and Appreciation
   (3) Ordinance Updates
   (4) Proposed Membership Slate for Approval
   (5) Office of AIDS, California Planning Group Updates
   (6) COH x DHSP Prevention Planning Collab
D. Welcoming the New Cohort: Inaugural Meeting Planning (March 12, 2026)
E. 2026 COH Workplan & Meeting Schedule Development
F. Conferences, Meetings & Trainings (*An opportunity for members to share information and resources material to the COH's core functions, with the goal of advancing the Commission's mission*)
   (1) April 8-10 NMAC Biomedical HIV Prevention Summit
   (2) July 26-31 International AIDS Conference (IAS)
   (3) August 4-7 National Ryan White Conference: Abstract Submission
   (4) September 17-20 United States Conference on AIDS (USCHA): Host Committee Participation Request

9. Division of HIV and STD Programs (DHSP) Report 2:10 PM – 2:25 PM

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

10. Standing Committee Report 2:25 PM – 2:40 PM

A. Planning, Priorities and Allocations (PP&A) Committee
   (1) 2027-2031 Integrated HIV Plan Development Updates
   (2) PY 36 PP&A Meeting Schedule and Workplan
   (3) PSRA Contingency Plan Updates
B. Operations Committee
C. Standards and Best Practices (SBP) Committee
   (1) Mental Health Service Standards | **MOTION #3**
   (2) Service Standards Schedule

10. Standing Committee Report (cont'd) 2:25 PM – 2:40 PM

D. Public Policy Committee (PPC)

(1) County, State and Federal Policy & Budget Updates

a. Committee Sunset & Transition Activities

b. HUD-Funded Programs Classified as Federal Public Benefits Updates

c.

E. **Caucus, Task Force, and Work Group Reports:** 2:40 PM – 2:50 PM

(1) Aging Caucus

(2) Black/AA Caucus

a. February 5th NBHAAD x Black History Month Event in Partnership with LAC Parks & Recreation (Jesse Owens Auditorium)

b. February 7th Youth Listening Session in Partnership with LAC Youth Commission (UCLA)

(3) Consumer Caucus

(4) Transgender Caucus

(5) Women's Caucus

(6) Housing Task Force

V. NEXT STEPS 2:50 PM – 2:55 PM

11. Task/Assignments Recap

12. Agenda development for the next meeting

VI. ANNOUNCEMENTS 2:55 AM – 3:00 PM

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

VII. ADJOURNMENT 3:00 PM

14. Adjournment of the special Executive Committee meeting on February 5, 2026.

PROPOSED MOTIONS	
MOTION #1	Approve the Agenda Order as presented or revised.
MOTION #2	Approve the meeting minutes, as presented or revised.
MOTION #3	Approve the Mental Health Service Standards, as presented or revised.

LOS ANGELES COUNTY
COMMISSION ON HIV

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

Approved by COH 6/8/23

CODE OF CONDUCT

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

All participants and stakeholders should adhere to the following:

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

HYBRID MEETING GUIDELINES, ETTIQUETTE & REMINDERS

(Updated 7.15.24)

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

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

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

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

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

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

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

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

LOS ANGELES COUNTY COMMISSION ON HIV

2026 MEMBERSHIP ROSTER| UPDATED 2.3.26

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

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: 40

Division of HIV and STDs Contracted Community Services

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

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

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

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

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 2/3/26

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

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
DOLAN (SBP Member)	**Caitlyn**	Men's Health Foundation	Vulnerable Poplulations (YMSM)
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			Medical Transportation Services
DONNELLY	**Kevin**	Unaffiliated representative	No Ryan White or prevention contracts
FINLEY	**Jet**	Unaffiliated representative	No Ryan White or prevention contracts
FRAMES	**Arlene**	Unaffiliated representative	No Ryan White or prevention contracts
GERSH (SBP Member)	**Lauren**	APLA Health & Wellness	Benefits Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Intensive Case Managemenet Services
			Nutrition Support (Food Bank/Pantry Service)
			Oral Health
			STD-Ex.C
			HERR
			Biomedical HIV Prevention Services
			Medical Transportation Services
			Data to Care Services
			Residential Facility For the Chronically Ill (RCFCI)
GONZALEZ	**Felipe**	Unaffiliated representative	No Ryan White or Prevention Contracts
GREEN	**Gerald**	Minority AIDS Project	Benefits Specialty
GREEN	**Joseph**	Unaffiliated representative	No Ryan White or prevention contracts
GUTIERREZ	**Joaquin**	Unaffiliated representative	No Ryan White or prevention contracts
HARDY	**David**	University of Southern California	No Ryan White or prevention contracts
HERRERA	**Ismael "Ish"**	Unaffiliated representative	No Ryan White or prevention contracts
JONES	**Terrance**	Unaffiliated representative	No Ryan White or prevention contracts
KOCHEMS	**Lee**	Unaffiliated representative	No Ryan White or prevention contracts
LESTER (PP&A Member)	**Rob**	Men's Health Foundation	Core HIV Medical Services - AOM; MCC & PSS
			Biomedical HIV Prevention Services
			Vulnerable Poplulations (YMSM)
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			Medical Transportation Services
MARTINEZ (PP&A			Core HIV Medical Services - AOM; MCC & PSS
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MARTINEZ (PP&A Member)	**Miguel**	Children's Hospital Los Angeles	HTS - Storefront
			Biomedical HIV Prevention Services
			Medical Transportation Services
MARTINEZ-REAL	**Leonardo**	Unaffiliated representative	No Ryan White or prevention contracts
MAULTSBY	**Leon**	In the Meantime Men's Group	Promoting Healthcare Engagement Among Vulnerable Populations
MENDOZA	**Vilma**	Unaffiliated representative	No Ryan White or prevention contracts
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	No Ryan White or prevention contracts
NELSON	**Katja**	APLA Health & Wellness	Benefits Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Intensive Case Managemenet Services
			Nutrition Support (Food Bank/Pantry Service)
			Oral Health
			STD-Ex.C
			HERR
			Biomedical HIV Prevention Services
			Medical Transportation Services
			Data to Care Services
			Residential Facility For the Chronically Ill (RCFCI)
PATEL	**Byron**	Los Angeles LGBT Center	Core HIV Medical Services - AOM; MCC & PSS
			Vulnerable Populations (YMSM)
			Vulnerable Populations (Trans)
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HTS - Social and Sexual Networks
			Biomedical HIV Prevention Services
			Medical Transportation Services
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
RICHARDSON	**Dechelle**	No Affiliation	No Ryan White or prevention contracts
RUSSEL	**Daryl**	Unaffiliated representative	No Ryan White or prevention contracts
SALAMANCA	**Ismael**	City of Long Beach	Benefits Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Biomedical HIV Prevention Services

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

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

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, December 18, 2025

COMMITTEE MEMBERS P = Present | A = Absent | EA=Excused Absence | AB2449=Virtual | Public: Virtual *Not eligible for AB2449 | LOA=LeaveofAbsence			
Danielle Campbell, PhD, MPH, Co-Chair	P	Arlene Frames	EA
Joseph Green, Co Chair	P	Arburtha Franklin	P
Miguel Alvarez	P	Vilma Mendoza	P
Alasdair Burton	P	Katja Nelson	P
Erika Davies	EA	Mario J. Perez	A
Kevin Donnelly	P	Dechelle Richardson (LOA)	EA
		Dary Russell	P
COMMISSION STAFF AND CONSULTANTS			
Dawn Mc Clendon; Lizette Martinez, MPH; Jose Rangel-Garibay, MPH; and Sonja D. Wright, DACM			

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

I. ADMINISTRATIVE MATTERS

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

2. **INTRODUCTIONS, ROLL CALL, & CONFLICTS OF INTEREST STATEMENTS**
   Commissioner DCampbell conducted roll call; quorum subsequently reached.

3. **ROLL CALL (PRESENT)**: Miguel Alvarez, Kevin Donnelly, Arburtha Franklin, Vilma Mendoza, Dary Russel, Danielle Campbell and Joseph Green

4. **APPROVAL OF AGENDA**

   MOTION #1: Approve the Agenda order, as presented or revised. (MOTION #1: Approved by Consensus.)

5. **APPROVAL OF MEETING MINUTES**

   MOTION #2: Approve the Executive Committee minutes, as presented or revised. (MOTION #2: Approved by Consensus.)

II. PUBLIC COMMENT

6. **OPPORTUNITY FOR MEMBERS OF THE PUBLIC TO ADDRESS THE COMMISSION ON ITEMS OF INTEREST THAT ARE WITHIN THE JURISDICTION OF THE COMMISSION.**

   No public comment.

III. COMMITTEE NEW BUSINESS ITEMS

7. **OPPORTUNITY FOR COMMITTEE MEMBERS TO RECOMMEND NEW BUSINESS ITEMS FOR THE FULL BODY OR A COMMITTEE LEVEL DISCUSSION ON NON-AGENDIZED MATTERS NOT POSTED ON THE AGENDA, TO BE DISCUSSED AND (IF REQUESTED) PLACED ON THE AGENDA FOR ACTION AT A FUTURE MEETING, OR MATTERS REQUIRING IMMEDIATE ACTION BECAUSE OF AN EMERGENCY, OR WHERE THE NEED TO TAKE ACTION AROSE SUBSEQUENT TO THE POSTING OF THE AGENDA.**

   Committee members raised concerns regarding COH, Committee and Caucus Co-Chair term expirations in relation to the COH's ongoing effectiveness review, restructuring process, and the anticipated seating of the new Commission cohort in March 2026. Members discussed the importance of leadership continuity during a critical budget and transition period, noting potential risks associated with electing new or inexperienced Co-Chairs prior to the onboarding of the new cohort. Refer to Agenda Item #9(C).

IV. REPORTS

8. **COH STAFF REPORT**

   A. Commission (COH)/County Operational Updates

   (1) Approved Revisions to Bylaws and Next Steps. Staff thanked the committee for its commitment and dedication in shepherding the process and approving the revised Bylaws at the December 11, 2025 Commission meeting. The BOS Executive Office and Health Deputies have been notified, and Health Deputies will assist in identifying candidates to fill the five Board-appointed seats. Staff are working with County Counsel to advance the corresponding Ordinance amendments through the BOS approval process.

(2) HRSA Project Officer Call – December 9, 2025. Staff participated in a joint HRSA Project Officer call with DHSP, which will occur quarterly to strengthen coordination and partnership. During the discussion, COH leadership raised concerns regarding the timeliness of data sharing needed to support informed decision-making and recommended identifying a designated DHSP point of contact to promote consistency and accuracy in information shared with the Commission. Both COH and DHSP affirmed their commitment to continued collaboration to improve data-sharing timeliness and strengthen coordination moving forward.

(3) COH Sunset Review Cycle. Staff provided a brief overview of the Commission's sunset review cycle and shared that requested documents and information are being prepared for submission by the extended February 1, 2026 deadline.

(4) 2025 BOS Annual Report. Staff shared that preparation of the Annual Report is underway and will focus on highlighting key Commission successes and accomplishments. Committees will be invited to contribute highlights for inclusion.

(5) DHS Positive Care Program Updates. Staff provided updates regarding concerns raised about the DHS Positive Care Program. The identified point of contact, Dr. Christopher Brown, shared that additional time is needed to coordinate HIV cascade data and indicated he will follow up once a clearer timeline is established, with the earliest anticipated availability in January to present to the COH.

(6) Brown Act Updates. Staff shared updates on Ralph M. Brown Act changes under SB 707, effective January 1, 2026, and noted that staff are awaiting additional guidance from County Counsel to ensure consistent and compliant implementation. Key impacts include expanded just cause for remote participation, reasonable accommodation provisions allowing remote participation by members with disabilities to count as in-person attendance, updated protocols for technical disruptions, and requirements for two-way audio and video participation. Staff will provide further updates once formal guidance is received from County Counsel.

- Committee requested clarification on what classifies as a physical or mental disability.

(7) Technical Assistance Funding Opportunities. Staff reported that, considering ongoing budget constraints and anticipated funding shifts, technical assistance funding remains an important tool to support capacity building, planning, and systems improvement. Staff will continue to monitor and pursue opportunities aligned with Commission priorities.

9. Co-Chair Report The COH Co-Chairs provided updates and facilitated discussion on the following items:

A. Annual Conference Calls to Action – Next Steps

Co-Chairs reflected on calls to action emerging from the November 13, 2025 Annual Conference. Discussion focused on strengthening community relationships, improving visibility, and advancing coordinated follow-up efforts with the following suggestions:

- Explore hosting a community awards ceremony as part of the Annual Conference.
- Increase community visibility by holding Commission meetings in community-based locations.
- Conduct targeted outreach to community-based organizations in areas where Commission meetings are hosted.
- Encourage DHSP-contracted providers to attend and participate in Commission meetings.
- Develop a standard letter template inviting community partners to engage with and participate in Commission meetings.

B. December 11, 2025 Commission Meeting – Follow-Up & Feedback

Co-Chairs facilitated a discussion regarding feedback from the December 11, 2025 Commission meeting. Members raised concerns related to voting procedures, the transparency of consent calendar items, and the use of roll call votes for significant actions affecting Commission structure, governance, and funding, including approval of the revised Bylaws. Members emphasized the importance of clarity, process integrity, and maintaining confidence in Commission decision-making. Some members expressed concern that they were not fully aware they were approving the revised Bylaws and noted that the approval process felt expedited.

In response, the Co-Chairs and other Committee members noted that the Effectiveness Review and Bylaws revision process has been underway for more than a year and has included regular reporting to the Commission, multiple opportunities for discussion, and the development of FAQs and other supporting materials to promote transparency, community engagement, and member understanding. It was further noted that, ahead of the December 11 meeting, the COH Co-Chair conducted an intentional call down to ensure members were present and prepared to vote on the Bylaws. Additionally, during the December 11 meeting, a motion to reconsider the Bylaws approval was made and did not pass. It was also noted that Commissioners have a professional and fiduciary responsibility to come prepared to meetings and informed on items requiring action.

- The Committee requested that staff confirm with County Counsel and the Parliamentarian that the process used to approve the revised Bylaws was proper.

C. Co-Chair Terms

Co-Chairs facilitated discussion regarding the timing of COH, Committee and Caucus co-chair terms considering the COH's ongoing effectiveness review, restructuring process, and anticipated seating of the new COH cohort in March 2026. Members underscored the importance of leadership continuity during a critical transition and budget period and expressed concern about electing new Co-Chairs prior to onboarding the new cohort. Following discussion, the Committee moved to extend the current co-chair terms through the first meeting of the newly seated COH, committees and caucuses. Discussion also addressed who would preside over the first meeting of the newly seated Commission cohort. Options discussed included electing a member to preside over that meeting and then opening nominations for the term, having staff or a Parliamentarian preside, or having the outgoing Co-Chairs preside over the meeting.

MOTION #3: Extend the COH and subordinate working units' co-chair terms through the first meeting of the new cohort. (MOTION #3: Approved via Roll Call Vote: MAlvarez, ABurton, KDonnelly, AFranklin, VMendoza, KNelson, DRussell, DCampbell & JGreen)

D. COH Effectiveness Review & Restructuring Project

The Committee engaged in an in-depth discussion regarding the Commission's ongoing Effectiveness Review and Restructuring Project. Co-Chairs and staff provided context on the scope and intent of the restructuring effort, noting that the process has been underway for more than a year and has included regular updates to the Executive Committee and full Commission, consultation with County Counsel and the Parliamentarian, and multiple opportunities for member input.

Discussion focused on implementation considerations following the Commission's approval of the revised Bylaws at the December 11, 2025 meeting, including alignment with proposed Ordinance amendments currently being advanced through the Board of Supervisors approval process. Members emphasized the importance of clearly delineating roles, responsibilities, and decision-making authority across the restructured Commission, its committees, and caucuses.

Committee members discussed leadership continuity during the transition period, including harmonizing leadership cycles across committees and caucuses to promote stability and

institutional knowledge as the new Commission cohort is seated. Members also discussed the need for clear orientation, training, and onboarding materials to support new members and reinforce shared understanding of governance processes.

Updates were provided on the membership drive, including dissemination of revised recruitment materials, updates to the membership application and Commissioner duty statement, and the interview process. Members reiterated the importance of transparency, fairness, and avoiding conflicts of interest in the interview process, and emphasized the need to ensure diverse representation, including unaffiliated consumers, consistent with the Commission's statutory and community engagement goals.

Co-Chairs also provided updates on the ongoing membership drive, including dissemination of recruitment materials, revisions to the membership application and Commissioner duty statement, and the interview process. Members reiterated the importance of avoiding conflicts of interest in the interview process and emphasized the need for diverse, unaffiliated consumer representation.

E. Advocacy and Letter Writing Efforts Regarding ADAP Rebate Funds
Co-Chairs facilitated discussion regarding potential advocacy strategies related to the timely release of ADAP rebate funding, particularly in the event of delays or gaps in Ryan White Program (RWP) funding that could result in service disruptions. Strategies discussed included coordinating a letter-writing campaign among Ryan White planning councils and working with the County's CEO Legislative Affairs and Intergovernmental Relations (LAIR) office to develop a sign-on letter. Members emphasized the importance of a unified approach, alignment with other Ryan White planning councils, and meaningful consumer engagement with elected officials. Staff noted that consultation with the County's CEO LAIR office will be necessary to determine the most appropriate advocacy approach.

- Staff to follow up and coordinate with the Public Policy Committee Co-Chairs and the County's CEO LAIR office.
- Include this item on the agenda for the February 12, 2026 Commission on HIV meeting

F. Conferences, Meetings & Trainings (*An opportunity for members to share information and resources material to the COH's core functions, with the goal of advancing the Commission's mission*).

10. Division of HIV and STD Programs (DHSP) Report. *DHSP not presented; no report provided.*

11. Standing Committee Reports

A. Planning, Priorities and Allocations (PP&A) Committee No updates/reports

B. Operations Committee

- The Committee shared that it finalized revised membership materials, including the membership application, Commissioner duty statement, and interview questions.
- The Committee discussed the proposed interview panelist pool and noted concerns regarding the limited participation of unaffiliated consumers, as well as issues related to both perceived and actual conflicts of interest. The Committee opposed the inclusion of individuals employed by DHSP-contracted agencies on the interview panel and determined that DHSP-contracted individuals would not participate as panelists. As a result, Terry Smith and Damone Thomas were excluded from the interview panel.
  - ➢ Staff will identify additional unaffiliated consumers to participate in the interview panel pool.

C. Standards and Best Practices (SBP) Committee *No report/updates.*

D. Public Policy Committee (PPC) *No report/updates.*

E. Caucus, Task Force, and Work Group Reports

(1) Aging Caucus: Refer to LA County Local Aging & Disability Services: Public Hearings

(2) Black Caucus: *No report/updates*

(3) Consumer Caucus: *No report/updates*

(4) Transgender Caucus: *No report/updates*

(5) Women's Caucus: *No report/updates*

(6) Housing Taskforce: *No report/updates*

V. NEXT STEPS

13. Task/Assignments Recap

- ✓ All approved motions are final
- ✓ Staff will follow up on action items reflected in the meeting minutes.

14. Agenda development for the next meeting. *To be determined*

VI. ANNOUNCEMENTS

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

No announcements

.VIII. ADJOURNMENT

16. Meeting adjourned 3:05PM.

LOS ANGELES COUNTY
COMMISSION ON HIV

Ralph M. Brown Act Updates

Effective Date: January 1, 2026

This handout summarizes recent updates and clarifications related to the Brown Act, **pertaining to subsidiary bodies such as the Commission on HIV**.

Remote Participation & "Just Cause"

Expanded Just Cause includes:

- Personal illness
- Caregiving responsibilities
- Military service
- Care of an immunocompromised family member
- Other qualifying circumstances under statute

Invocation of just cause must be reflected in the meeting minutes. Minutes must not include medical or personal details, and no information may be included that would violate HIPAA or privacy protections.

Disability & Reasonable Accommodation

Commissioners with a physical or mental disability, as defined by the Americans with Disabilities Act, may request a reasonable accommodation to participate in meetings remotely. When approved, remote participation is treated the same as in-person attendance for purposes of quorum, voting, and participation. Remote participation will include both audio and video, except that a Commissioner may participate by audio only if a physical condition related to their disability requires them to remain off camera. The Commissioner must disclose whether any individual age 18 or older is present in the room.

AB 2449 Extension

AB 2449 provisions allowing limited remote participation have been extended through 2030. All associated conditions and transparency requirements remain in effect.

Technical Disruptions During Meetings

If a technical disruption occurs, staff must attempt to restore access for up to one hour. If restoration is unsuccessful, the body may make a finding on the record and recess, continue, or adjourn the meeting.

Remote Meetings During a Proclaimed Local Emergency

Remote meetings remain allowable when there is a proclaimed local emergency assumably declared by the BOS/Health Officer.

Transparency & Information Requirements

A copy of the Brown Act must be provided to all Commissioners.

Commission Restructure Transition & Timeline (Updated 2.5.26 – Subject to Change)

Note: The Executive Committee (EC) will continue decision-making in keeping with this timeline if a COH meeting is cancelled.

Phase 1: Restructure Report & Recommendations

Task/Activity	Responsible Party	Timeline / Status
Present restructuring report and recommendations.	Consultants	May 8, 2025 – COH Meeting • Timeline walk-through provided • Full presentation at 5/22/25 EC meeting ✅ Completed
Present restructuring report and recommendations.	Consultants	May 22, 2025 – Executive Committee Meeting • Straw poll result: Exhibit B and reduced membership seats ✅ Completed

Phase 2: Drafting & Review of Updated Bylaws

Task/Activity	Responsible Party	Timeline / Status
Present updated proposed bylaws (based on restructuring report, recommendations, and feedback). Begin 30-day public comment period. Send bylaws and ordinance to County Counsel (CoCo) for review.	Commission Staff, Consultants, COH Co-Chairs	June 26, 2025 – Executive Committee Meeting ✅ Completed
Present updated proposed bylaws; coordinate final layers of review (CoCo, EO) and prepare for BOS approval of ordinance. Cover letter to BOS to include timeline and March 1, 2026 start date (aligned with RW Program Year).	Commission Staff	July 10, 2025 – COH Meeting Public comment: June 27 – July 27, 2025 ✅ Completed in Part

Phase 3: Executive Committee & Final COH Actions

Task/Activity	Responsible Party	Timeline / Status
Executive Committee review of proposed bylaws changes (in lieu of cancelled COH meetings) to prepare for final COH vote.	Executive Committee	July – November 2025 ✅ Completed full review of public comments.
COH approve bylaws and submit ordinance to BOS for approval.	Commission Staff, Commissioners	December 11, 2025 ✅ Approved. County Counsel and Parliamentarian were subsequently consulted and confirmed that approval by consent was appropriate.
Updated BOS Health Deputies on approved revised Bylaws, membership drive, and proposed Ordinance Review revisions.	Commission staff	December 17, 2025 ✅ Completed. Sent comprehensive update to BOS Health Deputies and BOS EO.

Phase 5: Review of Proposed Revisions to Ordinance

Task/Activity	Responsible Party	Timeline / Status
Work with County Counsel to review, clarify, and align proposed Ordinance revisions with the approved Bylaws in preparation for BOS review and approval.	Commission Staff & County Counsel	December 11, 2025 to January 30, 2026 ✅ Completed
Submit proposed Ordinance to the CEO HMHS for inclusion on the February 11 HMHS agenda as a precursor to placement on the BOS agenda for approval.	Commission Staff, County Counsel & Executive Office	January 30, 2025 ✅ Completed
BOS approval of revised Ordinance	Commission Staff	March 3, 2026 ⏳ Pending

Phase 4: Membership Transition & Recruitment

Task/Activity	Responsible Party	Timeline / Status
Highlight proposed restructure COH at Annual Conference.	COH Co-Chairs	November 13, 2025 ✅ Completed
Disseminate transitional membership application and open nominations process to all stakeholder constituencies (including current Commissioners).	Commission Staff	December 17, 2025 – January 9, 2026 ✅ Completed
Organize and verify applications for completeness and accuracy.	Commission Staff	Application deadline: January 9, 2026 ✅ Completed

Phase 5: Membership Interview & Selection Process		
Task/Activity	**Responsible Party**	**Timeline / Status**
Conduct membership interviews. *Proposed Interview Panel includes academic partners, EO Commission Services representative, former Co-chairs/members not reapplying, 1–2 members from other neighboring planning councils, 1–2 consumers not reapplying, Collaborative Research / Next Level Consulting, COH staff.*	Interview Panel (5–6 members)	January 9–23, 2026 ✅ Completed
Select initial cohort of candidates to recommend for nomination. *Independent Ad hoc workgroup established by COH co-chairs to ensure a fair, transparent, and conflict of interest-free process; membership is time-limited and subject to the same criteria as interview panelists.*	Independent Ad Hoc Workgroup	February 6, 2026 ⏳ Pending
COH approves initial cohort.	Commissioners	February 12, 2026 ⏳ Pending
Forward nominations to EO/BOS for appointment.	Commission Staff	February 12, 2026 ⏳ Pending

Phase 6: BOS Appointments & Launch		
Task/Activity	**Responsible Party**	**Timeline / Status**
BOS appointment of first cohort of new members	BOS	February – Early March 2026 ⏳ Pending
First meeting of newly restructured Commission on HIV.	—	March 12, 2026 ⏳ Pending

Los Angeles County Commission on HIV and Division of HIV and STD Programs

(Updated) HIV Prevention Planning Discussion – Meeting Summary

Wednesday, January 14, 2026
10:00am-12:00pm

Commission on HIV Office
510 S. Vermont, Los Angeles, CA 90020
14th floor, Conference Room 14K16
*Please check in with security on the 9th floor

Attendees:

Miguel Alvarez, Dahlia Ale-Ferlito, Al Ballesteros, LeRoy Blea (remote), Dr. Danielle Campbell, Dr. Siri Chirumamilla, Jesse Clark, Joaquin Gutierrez, Dr. Michael Green, Uyen Kao, Lizette Martinez, Miguel Martinez, Dawn Mc Clendon, Katja Nelson, Pamela Ogata, Mario J. Pérez, Julie Tolentino, Paulina Zamudio

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Purpose of the Meeting

This meeting was convened to create space for an honest, grounding conversation about where HIV prevention planning in Los Angeles County has been, where it is now, and what is realistically possible moving forward. The intent was to align understanding between the Commission and DHSP, ground the discussion in historical context, surface current challenges, and begin asking the necessary question: what does prevention planning look like now?

This was a listening, grounding, and alignment discussion — not a decision-making meeting.

Historical Context: How Prevention Planning Worked

Participants grounded the discussion in the early years of HIV prevention planning in Los Angeles County, dating back to the mid-1990s.

During that period:

- The Prevention Planning Committee (PPC) was a dedicated, CDC-funded body focused exclusively on prevention planning.
- Planning centered on science, epidemiology, and policy, and was grounded in shared data and evidence.

- Parity, Inclusion, and Representation (PIR) were core principles, ensuring diverse and equitable participation.
- All participants had access to the same tools, data, and information, creating a common understanding of the work.
- Prevention providers were required by DHSP to participate, which ensured consistent engagement and accountability.
- Strong partnerships existed with academic and research institutions, including CHIPTS, to share prevention science and research.
- UCSF produced fact sheets focused on impacted communities (for example, Black women), ensuring prevention planning reflected both data and lived experience.
- A comprehensive needs assessment was conducted, most recently in 2016, and was critical in elevating community voice.
- This period was described as a strong marriage of science and programs, with planning clearly informing practice.

This grounding was shared not to suggest returning to past structures, but to clarify that today's challenges are largely the result of lost funding, infrastructure, authority, and participation requirements — not a lack of will or expertise.

Integration and the Commission's Role Since 2013 (Updated)

It was acknowledged during the discussion that when the Commission integrated in 2013, it was not fully positioned to meet the moment in terms of assuming the entire role previously held by the Prevention Planning Committee.

While the Commission serves as a HRSA-mandated planning body operating as an integrated planning body, it did not fully absorb all prevention planning functions previously supported by dedicated CDC funding and infrastructure. That said, participants were clear that the Commission has made meaningful and substantive efforts to advance prevention planning within its scope and authority, including:

- Developing prevention standards
- Creating a status-neutral continuum spanning prevention, care, and treatment
- Conducting multiple community listening sessions that elevated community voice across the entire sexual health continuum, not exclusively care and treatment
- Developing a comprehensive HIV Plan that explicitly includes prevention planning and prevention-related activities
- Engaging members of the prevention community through planning and engagement efforts
- Conducting a Knowledge, Attitudes, and Beliefs (KAB) assessment to assess knowledge and skills related to prevention

- Responding to DHSP requests for prevention priorities when prevention funding was compromised, and providing priority recommendations that DHSP subsequently implemented

These efforts reflect intentional work by the Commission to support prevention planning, even in the absence of clear federal guidance, a formal prevention planning mandate, or dedicated prevention planning funding.

What Changed: Barriers and Challenges Now

Participants were clear that the current prevention planning environment is fundamentally different and more constrained.

Key challenges discussed included:

- Loss of dedicated CDC funding for prevention planning, significantly reducing capacity for structured planning, staffing, and facilitation.
- Elimination of required participation by prevention providers, contributing directly to fewer prevention stakeholders in planning environments.
- Defunding of behavioral prevention, narrowing prevention efforts largely to testing and biomedical strategies.
- A resource-deprived environment, where the immediate priority is preventing growth in new HIV infections.
- Limited large-scale stakeholder collaboration and reduced participation in Commission meetings; much prevention work now occurs outside public planning spaces.
- No comprehensive needs assessment since 2016, limiting systematic access to community voice.
- CDC's shift away from evidence-based behavioral prevention after jurisdictions could not demonstrate sustained behavioral change.
- Despite significant investments, HIV incidence has not declined as expected.
- Unlike the Ryan White Program, CDC HIV prevention does not require a community planning body, resulting in limited formal accountability.
- Very minimal guidance from HRSA and CDC on integrated prevention and care planning.
- Reduced regional and state-level coordination, though an opportunity exists to re-engage through integrated plan development.
- EHE funding was rolled into the CDC HIV Prevention grant; while many positive outcomes emerged, progress was dampened by COVID.
- Loss of partnerships with large systems (hospitals, schools, and others) that previously played a role in prevention.

Core Questions Raised During the Discussion

What Does Prevention Look Like Now?

Participants emphasized that prevention today should:

- Reflect a status-neutral approach
- Offer a menu of services across prevention, care, and support
- Be clear about who is delivering which services
- Explore how partners can help address funding gaps (e.g., 340B resources, big pharma)

There was recognition that prevention planning must adapt to today's constraints while remaining strategic and intentional.

Community Engagement and Representation

A recurring concern was the lack of a robust community planning apparatus. Participants discussed:

- The need to intentionally engage prevention consumers and HIV-negative individuals in the new Commission cohort
- The reality that broad and large-scale participation has diminished
- The importance of rebuilding trust, access, and meaningful engagement

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Priority Populations for Prevention Focus

Participants identified populations where prevention efforts could have the greatest impact, including:

- Black transgender women
- Latina transgender women
- Black women
- Young Latino gay men
- People experiencing homelessness

These populations were discussed in the context of disproportionate impact and ongoing gaps in prevention access.

System Coordination and Opportunities

Several coordination opportunities were noted:

- Second District (SD2) will convene a stakeholder group to determine how Opioid Settlement funds are allocated, presenting an opportunity for alignment with HIV prevention.
- DHSP noted the EHE Steering Committee has been reduced to an ad hoc structure, and there is an opportunity to better connect that group with the Commission.
- It was suggested that EHE Steering Committee members be invited into prevention planning conversations, ideally in person, to discuss strategy.
- CHIPTS noted a continued focus on collaboration, though no funding is currently available.
- The City of Los Angeles AIDS Coordinator's Office has technical assistance mini-grants that may support prevention-related efforts.

Recommendations

The recommendations were identified to support continued prevention planning:

- Establish a structure for an ongoing prevention coalition to support coordination, engagement, and planning.
- Develop regular email updates to share prevention information and maintain communication with partners.
- Identify partners to support meeting space for in-person prevention planning and coalition meetings.

Agreed-Upon Next Steps

- Conduct a comprehensive inventory of existing HIV prevention-related resources to clarify what programs, funding, and infrastructure are currently available (DHSP)
- Coordinate a follow up meeting with prevention stakeholders for continued prevention planning. (DMcClendon (COH) & JTolentino (DHSP))

Closing

The conversation repeatedly returned to the central question: **what now?** Participants acknowledged that the landscape has changed — funding, authority, players, and guidance are not what they once were. At the same time, there was clear agreement that **prevention planning cannot stop**. This meeting marked an important pause to recalibrate, reconnect, and begin shaping a prevention planning approach that reflects today's realities.

2026 Commission on HIV Master Work Plan *Subject to Change

This Workplan guides the activities of the Los Angeles County Commission on HIV for the Ryan White HIV/AIDS Program (RWHAP) Part A Program Year (March 1 – February 28) and serves as a governance and planning document aligned with the Commission's revised Bylaws and applicable federal, state, and County requirements. The Workplan outlines Commission-level planning, oversight, needs assessment, priority setting, evaluation, and community engagement activities. To promote clarity and shared accountability, lead committees responsible for each activity are identified through color coding throughout the Workplan. Designed to support coordination across the Commission, its committees, and caucuses, this Workplan guides meeting and planning cycles and may be refined as needed to reflect programmatic, structural, or operational changes, while remaining aligned with governing requirements.

ACRONYMS & LEGEND	
• **COH:** Commission on HIV • **DHSP:** Division on HIV and STD Programs, LA County Dept of Public Health • **BOS:** Board of Supervisors • **HRSA:** Health Resources and Services Administration • **MCE:** Membership and Community Engagement Committee • **PP&A:** Planning, Priorities, and Allocations Committee • **SBP:** Standards and Best Practices Committee	• **EO:** LA County BOS Executive Office • **CEO LAIR:** LA County Chief Executive Office Legislative Affairs and Intergovernmental Relations • **OA:** California Office of AIDS • **CHIPTS:** Center for HIV Identification, Prevention, and Treatment Services. Lead Committee Color Legend: EXEC MCE PP&A SBP

#	Objective	Lead Committee/ Working Unit	Partners needed	Timeline	Notes/Comments
1	Develop 2026 workplan	Executive, MCE, PP&A, SBP, All working units		March-June	
2	Develop Annual Report to BOS	Executive, MCE, PP&A, SBP, All working units	All committees and working units	Jan-Feb	
3	Conduct Commissioner Orientation	Executive, MCE		March	
4	Conduct subordinate working unit orientation	Executive, MCE, PP&A, SBP, All working units	All Committees and working units	Mar-Apr	
5	Establish policy priorities and updates to Commissioners, as needed.	Executive	CEO LAIR, DHSP	Ongoing	
6	Plan and implementation of the COH Annual Conference	Executive, Annual Conference Planning Workgroup	OA, DHSP Provider, community, and academic partners, stakeholder groups	Sep-Feb	DHSP to provide annual update on directives. DHSP and OA provide progress on integrated plan.
7	Establish and monitor Commission Operational Budget	Executive	DHSP, EO	Ongoing	
8	Establish and monitor MOU with DHSP	Executive	DHSP	Ongoing	
9	Develop COH Agenda	Executive	DHSP, OA, all committees & working units	Ongoing	
10	Monitor progress on COH workplan	Executive	All committees and working units	Ongoing	Report at Executive and COH meeting or as needed. Standing co-chair report includes progress update.
11	Complete HRSA Application and Reporting Requirements	Executive	MCE, PP&A, DHSP	Jul-Sep, ongoing	

#	Objective	Lead Committee/ Working Unit	Partners needed	Timeline	Notes/Comments
12	Conduct COH administrative and operational oversight activities, as appropriate.	Executive	All committees and working units	Ongoing	
13	Conduct annual COH Bylaw Administrative Review	Executive MCE	HRSA PO, County Counsel	Jan-Feb	Collaborate with MCE to review associated policies.
14	Conduct HIV Prevention Planning, as appropriate	Executive	DHSP, CHIPTS, prevention providers/stakeholders	Ongoing	
15	Develop and conduct Commissioner Orientation & Mandatory Training	MCE	All Committees and Caucuses	Ongoing	
16	Develop, review, and implement COH Policies and Procedures, revise as needed.	MCE	Executive	Ongoing	Approval process from MCE to EC to COH
17	Develop and implement Mentorship Program	MCE	All committees and caucuses	Ongoing	
18	Review membership participation and attendance	MCE		Quarterly	
19	Ensure COH membership and recruitment align with all federal requirements	MCE	All committees and caucuses	Ongoing	
20	Collaborate with CA Office of AIDS and DHSP to develop 2027-2031 Integrated HIV Plan	PP&A	DHSP, CDPH OA, All committees and working units	Ongoing	Final COH approval in May and submission to HRSA in June
21	Complete annual needs assessment	PP&A	All working units, DHSP, MCE, EO PIO	Ongoing	Needs assessments must conclude before data summit; Data to be reviewed during data summit* **may be delayed one year due to COH restructure*
22	Conduct priority setting and resource allocation process	PP&A	DHSP, All committee and working units	Ongoing	All voting members must complete the PSRA training & attend the virtual data summit to be eligible to vote.

#	Objective	Lead Committee/ Working Unit	Partners needed	Timeline	Notes/Comments
					Virtual summit to be held in June with priorities and allocations up for final COH approval in Sept.* ** Must be submitted to HRSA at the end of Sept.*
23	Review and monitor RWHAP Part A/MAI expenditures	PP&A	DHSP, all working units, All other HIV providers not receiving Part A funds	Quarterly	Schedule to be determined in collaboration with DHSP; data needed to help identify other funding sources for HIV services within LAC
24	Conduct review/revisions of service standards, as needed.	SBP	DHSP, all working units, Executive	September	
25	Conduct the Assessment of the Efficiency of the Administrative Mechanism	SBP	DHSP, All RWP Part A providers	Oct-Feb, ongoing	
26	Review and monitor Clinical Quality Management Reports	SBP Consumer Caucus	DSHP CQM	Ongoing	Request service category evaluation reports from DHSP CQM team; this would augment the service utilization reports the COH currently receives.
27	Develop and monitor program directives	SBP PP&A	DHSP	Ongoing	
28	Compile best practices as related to HIV care and prevention	SBP		Ongoing	

Committee Roles & Responsibilities Matrix

Description / Purpose

This matrix outlines the core roles, responsibilities, and scope of authority for each standing committee, ad hoc workgroup, and caucus of the Commission on HIV. It is intended to promote clarity, accountability, and alignment with the Commission's revised Bylaws, the Ryan White HIV/AIDS Program Part A Planning Guide, and HRSA Integrated HIV Prevention and Care Planning requirements. Committees operate within their defined scope and bring recommendations forward to the full Commission for consideration and action, as appropriate.

Standing Committees

Executive Committee

- Governance oversight and coordination across committees and caucuses
- Finalizes full Commission meeting agendas with staff
- Ensures alignment of committee and caucus workplans with Commission priorities and the Integrated HIV Plan
- Addresses time-sensitive or procedural matters as delegated
- Elevates committee recommendations to the full Commission

Membership & Community Engagement Committee (MCE)

- Oversees recruitment, onboarding, retention, and engagement of members and committee-only members
- Monitors reflectiveness and compliance with federal and ordinance requirements
- Oversees member orientation and required trainings
- Supports community engagement and outreach

Planning, Priorities & Allocations Committee (PP&A)

- Oversees needs assessment activities and data review
- Leads the Priority Setting and Resource Allocation (PSRA) process
- Identifies service gaps, disparities, and emerging needs
- Ensures alignment with the Integrated HIV Plan
- Develops planning and funding recommendations

Standards and Best Practices (SBP) Committee

- Reviews and recommends standards of HIV care
- Reviews quality management findings and system improvement opportunities
- Incorporates consumer perspectives on access and quality of care
- Coordinates with DHSP and partners on care standards
- Brings standards-related recommendations forward

Ad Hoc Committees & Workgroups

- Established for a defined purpose, scope, and timeframe
- Conduct time-limited or task-based work
- Report findings and recommendations to the sponsoring body
- Sunset upon completion unless formally extended

Caucuses

- Provide culturally specific perspectives and lived experience
- Identify emerging issues and community priorities
- Support community engagement and education
- Serve in an advisory capacity

Committee-Only Members

- Serve on assigned committees and contribute technical or lived expertise
- May vote on matters within their assigned committee, as permitted by the Bylaws
- Do not vote on actions of the full Commission
- Support committee discussions and deliverables

LOS ANGELES COUNTY
COMMISSION ON HIV

2026 Commission on HIV Master Calendar

This calendar complements the 2026 Commission, Committee, and Caucus Workplans and provides a high-level, one-page view of standing meeting schedules and governance alignment. Dates shown reflect proposed standing meetings and may be refined as needed based on operational, programmatic, or governance considerations.

2026–2027 At-a-Glance Planning Grid

Focus Area / Timeframe	Jan–Feb 2026	Mar–Apr 2026	May–June 2026	Jul–Aug 2026	Sep–Oct 2026	Nov–Dec 2026	Jan–Feb 2027
Full Commission Meetings		Mar 12/April 9	May 14	Jul 9	Sep 10		Jan 14 / Feb 11 – Annual Conference
Executive Committee		Mar 26 / Apr 23	Jun 25	Aug 27	Sep 24		Jan 28
Membership & Community Engagement (MCE) Committee		Mar 26 / Apr 23	Jun 25	Aug 27	Sep 24		Jan 28
Planning, Priorities & Allocations Committee		Mar 17 / Apr 21	May 19	Jul 21	Sep 15	Nov 17	Jan 19
Standards & Best Practices (SBP) Committee	Feb 8	Mar 16 / Apr 20	Jun 15	Aug 17	Oct 19		
Caucuses	Refer to MCE Committee						

LOS ANGELES COUNTY
COMMISSION ON HIV

Standing Meeting Framework

1. **Full Commission meets on the second Thursday, 9AM-12PM**, as reflected in the calendar or as otherwise instructed by the Commission or Executive Committee.
2. **Executive Committee meets on the fourth Thursday, 1-3PM**, as reflected in the calendar or as otherwise instructed by the Executive Committee.
3. **Membership and Community Engagement (MCE) Committee meets on the fourth Thursday, 10AM-12PM**, as reflected in the calendar or as otherwise instructed by the Executive Committee.
4. **Planning, Priorities & Allocations (PP&A) Committee meets on the third Tuesday, 1:30-3:30PM**, as reflected in the calendar or as otherwise instructed by the Committee.
5. **Standards & Best Practices (SBP) Committee meets on the third Monday, 10AM-12PM**, as reflected in the calendar or as otherwise instructed by the Committee.

Pursuant to the Commission Bylaws approved on December 11, 2025, "[T]he Commission and its committees shall meet a minimum of six (6) times per year. Meetings shall be held at a time and location determined by the Co-Chairs, the Executive Committee, or committee Co-Chairs. The Executive Committee, Co-Chairs, or committee Co-Chairs may convene additional meetings as needed to meet operational and programmatic needs. The Commission's Annual Conference replaces one regularly scheduled Commission meeting."

LOS ANGELES COUNTY
COMMISSION ON HIV

PUBLIC POLICY COMMITTEE ACTIVITIES TRANSITION DOCUMENT

PURPOSE: The Public Policy Committee (PPC) developed this document to outline the policy-related activities that will transition to the Executive Committee once the new Commission cohort is established.

BACKGROUND: As part of the Commission restructuring process, the PPC was sunset as of February 2, 2026. Within the new Commission structure, the Executive Committee will absorb some of the core activities the PPC was responsible for completing. The Executive Committee will act in accordance with the role of the Commission on HIV, as dictated by Los Angeles County Code 3.29.090. Consistent with the Commission Bylaws Article VI, Section 3, no Ryan White HIV/AIDS Program (RWHAP) Part A funds are used to support policy-related activities. Activities beyond the scope of RWHAP Part A are conducted in alignment with County legislative protocols and are supported through non-RWHAP Part A resources. The Commission Bylaws, Article X, Section 3, Subsections L thru O, outline policy-related activities beyond the scope of the RWHAP Part A.

RECOMMENDATIONS: To ensure the continuation of policy-related activities within the new Commission structure, the Public Policy Committee proposes that the Executive Committee adopt the following recommendations:

- Add a standing agenda item for both the Executive Committee and the full Commission meetings focused on public policy to ensure ongoing visibility.
- Designate a qualified individual within the committee and/or Commission to provide regular updates to the Commission leadership and membership on:
    - Policy issues impacting the local HIV service delivery system
    - Local, state, and federal legislative and budget advocacy opportunities
- Determine the scope and responsibilities for the "Public Policy" designee.
- Establish narrowly focused, time-limited workgroup(s) or taskforce(s), as needed, to address specific policy issues.
- Establish policy priorities consistent with the service priorities set by the COH through the Priority Setting and Resource Allocation (PSRA) process and the Integrated HIV Care and Prevention Plan.
- Collaborate with the Los Angeles Chief Executive Office (CEO) Legislative Affairs and Intergovernmental Relations (LAIR) to provide training to educate and support Commission members, consumers, providers, and the public in engaging with legislative process.
- Initiate and advance policy efforts that strengthen HIV care, treatment, prevention, and related services.
- Facilitate communication and recommend policy positions to government and legislative officials, the Board of Supervisors, County departments, and other stakeholders, in alignment with County legislative protocols.

LOS ANGELES COUNTY
COMMISSION ON HIV
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2025 PUBLIC POLICY PRIORITIES

The Public Policy Committee (PPC) of the Los Angeles County Commission on HIV (COH) developed the "2025 Public Policy Priorities" document with the purpose of providing a framework to guide the development of the PPC's 2025-26 Legislative Docket; Items included are not intended to be exhaustive. The PPC and COH are committed in supporting and encouraging innovative efforts to reduce bureaucracy and barriers to accessing services, increase funding, and enhance HIV and Sexually Transmitted Infection (STI) care and prevention service delivery in Los Angeles County. With a renewed urgency, the PPC remains steadfast in its commitment to preserve, protect, and maintain services critical to ending the HIV epidemic.

The PPC recommends the Commission on HIV endorse and prioritize the following issues. The PPC will identify and support legislation, local policies, procedures, and regulations in 2025 that address the following priorities (listed in no order):

Funding

a. Maintain and preserve federal funding for Medicaid, Medicare, and HIV/AIDS programs such as the Ryan White HIV/AIDS Program (RWHAP) and the Ending the HIV Epidemic (EHE) initiative; And support stronger compatibility between the RWHAP, Medicaid, and other systems of care.

Systemic and Structural Racism

a. Establish health equity through the elimination of barriers and addressing of social determinants of health such as: implicit bias; access to care; education; social stigma, (i.e., homophobia, transphobia, and misogyny); housing; mental health; substance abuse; income/wealth gaps; and criminalization.
b. Reduce and eliminate the disproportionate impact of HIV/AIDS and STIs in Black/African American, Latino, and other at higher risk for the acquisition and transmission of HIV disease.
c. Address the impact of humanitarian crises on the HIV continuum of care and service delivery including HIV/STI prevention services.

Racist Criminalization and Mass Incarceration

a. Eliminate discrimination against or the criminalization of people living with or at risk of HIV/AIDS including those who exchange sex for money (e.g., Commercial Sex Work).
b. Support the efforts of Measure J, the Alternatives to Incarceration and closure of Men's Central Jail and seek increased funding for services and programming through Measure J as well as through redistribution of funding for policing and incarceration.

Housing

a. Improve systems, strategies and proposals that expand affordable housing, as well as prioritize housing opportunities for people living with, affected by, or at risk of transmission of HIV/AIDS.
b. Improve systems, strategies, and proposals that prevent homelessness for people living with, affected by, or at risk of contracting HIV/AIDS.
c. Promote Family housing and emergency financial assistance as a strategy to maintain housing.

Mental Health

a. Expand and enhance mental health services for people living with, affected by, or at risk of contracting HIV/AIDS.

Sexual Health and Wellness

a. Increase access to care and treatment for People Living with HIV/AIDS (PLWHA).
b. Increase access to prevention services such as Pre-Exposure Prophylaxis (PrEP), Post-Exposure Prophylaxis (PEP), for the prevention of HIV, and Doxycycline PEP (Doxy PEP) for the prevention of STIs.

Prevention services include HIV/STI screening, biomedical interventions, non-biomedical/behavioral interventions, social services, and harm reduction.

c. Increase comprehensive HIV/STI counseling, testing, education, outreach, research, harm reduction services including syringe exchange, and social marketing programs.
d. Advance and enhance routine HIV testing and expanded linkage to care.
e. Maintain and expand funding for access and availability of HIV, STI, and viral hepatitis services.
f. Preserve funding and accessibility to Pre-Exposure Prophylaxis Assistance Program (PrEP-AP).

Substance Use and Harm Reduction

a. Advocate for substance use services to PLWHA including services and programs associated with methamphetamine use and HIV transmission.
b. Expand harm reduction services (including and not limited to syringe exchange, safe administration sites, over-dose prevention strategies) across all of Los Angeles County.

Consumers

a. Advocate and encourage the empowerment and engagement of People Living with HIV/AIDS (PLWH/A) and those at risk of acquiring HIV with a focus on young MSM, African American MSM, Latino MSM, transgender persons, women of color, and the aging.
b. Incentivize participation by affected populations in planning bodies and decision-making bodies.

Aging (Older Adults 50+)

a. Create and expand medical and supportive services for PLWHA ages 50 and over.

Women's Health and Wellness

a. Create and expand medical and supportive services for women living with HIV/AIDS such as family housing, transportation, mental health, childcare, and substance abuse.
b. Advocate for women's bodily autonomy in all areas of health care services including and not limited to full access to abortions, contraception, fertility/infertility services and family planning.

Transgender Health and Wellness

a. Create and expand medical and supportive services for transgender PLWHA.
b. Promote and maintain funding for the Transgender Wellness Fund.

General Health Care

a. Provide access to and continuity of care for PLWHA focusing on communities at highest risk for the acquisition and transmission of HIV disease.
b. Expand access to and reduction of barriers (including costs) for HIV/AIDS, STD, and viral hepatitis prevention and treatment medications.
c. Provide trauma informed care and harm reduction strategies in all HIV health care settings.

Service Delivery

a. Incorporate COVID strategies to reduce administrative barriers, increase access to health services and encourage the development of an HIV vaccine.

Data

a. Use data, without risking personal privacy and health, with the intention of improving health outcomes and eliminating health disparities among PLWHA.
b. Promote distribution of resources in accordance with the HIV burden within Los Angeles County.

Workforce

a. Support legislation and policies that combat workforce shortage crisis and protect and increase workforce capacity and incentive people to join/stay in the HIV workforce.

LOS ANGELES COUNTY
COMMISSION ON HIV

Proposed 2026 Public Policy Priorities

PURPOSE: To ensure the continuation of policy-related activities within the new Commission structure, the Executive Committee will establish policy priorities consistent with the service priorities set by the Commission through the Priority Setting and Resource Allocation (PSRA) process and the Integrated Plan.

BACKGROUND: The Executive Committee acts in accordance with the role of the Commission on HIV, as dictated by Los Angeles County Code 3.29.090. Consistent with Commission Bylaws Article VI, Section 3, no Ryan White HIV/AIDS Program (RWAHP) Part A funds are used to support policy-related activities. Activities beyond the scope of the RWHAP Part A are conducted in alignment with County legislative protocols and are supported through non-RWHAP resources.

RECOMMENDATIONS: The Executive Committee recommends that the Commission endorse and prioritize the following issues to preserve, protect, and expand services that are critical to ending the HIV epidemic:

Funding for local, state, and federal HIV/AIDS Programs

- Defend, maintain, and expand funding for the Ryan White HIV/AIDS Program; Ending the HIV Epidemic initiative; Housing Opportunities for persons with AIDS (HOPWA) program; the Pre-Exposure Prophylaxis Assistance Program (PrEP-AP); and HIV, Sexually Transmitted Infections (STI), and viral hepatitis prevention and healthcare services.

Access to Prevention and Healthcare Services for People Living with HIV/AIDS (PLWH)

- Expand access and reduce barriers for HIV healthcare and support services (housing, mental health and wellness) for People Living with HIW (PLWH) focusing on those most vulnerable to HIV including women, transgender individuals, black, and Latino individuals.
- Expand access and reduce barriers for HIV/STI prevention, healthcare, and support services for those most vulnerable including access to prevention services such as Pre-Exposure Prophylaxis (PrEP), Post-Exposure Prophylaxis (PEP) for the prevention of HIV, and Doxycycline PEP (Doxy PEP) for the prevention of STIs. Prevention services include HIV/STI screening, biomedical interventions, non-biomedical/behavioral interventions, social services, and harm reduction services (e.g. syringe exchange programs, safe administration sites, and over-dose prevention strategies).

Eliminating Systemic and Structural Racism

- Defend and promote health equity by addressing social determinants of health including healthcare, housing, education, quality jobs, and safe environments and their impact on the HIV continuum of care and service delivery including HIV/STI prevention services.
- Reduce criminalization of PLWH and those most vulnerable to HIV including those who exchange sex for money (e.g. commercial sex work).

Workforce and Service Delivery Improvements

- Increase incentives for people to join and stay in the HIV workforce to combat staff shortages
- Promote collecting, analyzing, and using data while protecting privacy to improve health outcomes and eliminate health disparities among PLWH.
- Incentivize and encourage the empowerment and engagement of PLWH and those most vulnerable to HIV in planning bodies and community advisory boards.

CDPH
Health and Human Services Agency
California Department of Public Health

Erica Pan, MD, MPH
Director and State Public Health Officer

Gavin Newsom
Governor

January 30, 2026

Dear Colleague:

The sharing of used syringes remains the most common mode of transmission for hepatitis B and hepatitis C, and the second most common mode of HIV transmission in California. Over thirty years of extensive research and data collection has repeatedly found that increased access to sterile syringes significantly lowers rates of transmission and saves lives without increasing rates of drug use.

As of January 1, 2026, two new laws have gone into effect that support continued access to harm reduction and syringe services. The laws help maintain critical public health services and protect the ability of providers to offer these and other services to unhoused people.

Assembly Bill (AB) 309: Hypodermic Needles and Syringes removed the sunset date from California Business and Professions Code (BPC) 4145.5 which allows physicians and pharmacists to furnish syringes without a prescription to a person 18 years of age and older, and allows a person 18 years or older to obtain syringes for personal use from a physician or pharmacist without a prescription.

California physicians and pharmacists play a key role in the state's strategy to prevent the spread of HIV, HCV, and other infectious diseases. In areas without syringe services programs, physicians and pharmacists serve as the primary access points for people to obtain sterile syringes. The removal of these sunset dates makes these provisions permanent and allows for continued syringe access through pharmacies, as well as through physicians working in health clinics, street medicine teams, emergency departments and other settings.

Senate Bill (SB) 634 added Section 53069.44 of the Government Code which prohibits local jurisdictions from adopting or enforcing ordinances that prohibit support services to unhoused people. Section 53069.44 prevents local jurisdictions from adopting or enforcing ordinances that prohibit "a person or organization from providing support services, including legal services or medical care, to a person who is homeless or assisting a person who is homeless with any act related to basic survival."

"Act related to basic survival" includes but is not limited to assisting with or providing items to assist with any of the following:

- Eating and drinking, including food and water.

- Sleeping, including provision of blankets and pillows.
- Protecting oneself from the elements.
- Other activities and items necessary for immediate personal health and hygiene.

"Support services" are defined as including non-housing services described in paragraph (4) of subdivision (e) of Section 50243 of the Health and Safety Code, which include but are not limited to: harm reduction services, street outreach, coordination with street-based health care services, and hygiene services for people living in encampments and unsheltered individuals.

The number of programs providing harm reduction services has significantly increased in the last decade. As more California counties provide harm reduction services, SB 634 adds protections for the people and organizations offering these services.

For questions and more information about AB 309 or SB 634, please email james.wilson@cdph.ca.gov.

Sincerely,

Marisa Ramos, PhD
Chief, Office of AIDS
California Department of Public Health

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Resources

- CDPH/Office of AIDS - Syringe Services & Harm Reduction
- CDPH/Office of AIDS - HIV Laws: HIV Prevention
- Related research: Interventions to prevent HIV and Hepatitis C among people who inject drugs: Latest evidence of effectiveness from a systematic review (2011 to 2020) - ScienceDirect
- Related research: Impact of harm minimization interventions on reducing blood-borne infection transmission and some injecting behaviors among people who inject drugs: an overview and evidence gap mapping | Addiction Science & Clinical Practice | Springer Nature Link

LA County Aims to Keep People Sheltered and Housed by Focusing on Proven Programs

Board of Supervisors Approves New County Department of Homeless Services and Housing Spending Plan with Significant Funding for Interim and Permanent Housing

LOS ANGELES - The Board of Supervisors unanimously approved the $843 million Spending Plan for the Los Angeles County Department of Homeless Services and Housing (HSH) in fiscal year 2026-27, prioritizing core programs and services that have proven most effective in reducing homelessness with a focus on serving disproportionately impacted populations, including families, youth, and survivors of domestic violence.

This Spending Plan is funded with $659.9 million in anticipated voter-approved tax revenue from Measure A, $62.8 million from one-time Measure A carryover, $48.4 million from one-time Measure H carryover, and $72.5 million in State Homeless Housing, Assistance and Prevention (HHAP) grant dollars.

The plan funds significant investments in housing with $277 million for interim housing and nearly $239 million for permanent housing across the County. The budget includes Measure A funding for:

- **65** to deploy specialized outreach and engagement countywide, providing nearly **16,000 engagements** with people experiencing unsheltered homelessness annually.
- **3,671 Time-Limited Subsidies** to quickly provide housing support to people who have recently fallen into homelessness.
- **3,675 locally-funded rental subsidies** to support people in permanent supportive housing.
- Wraparound case management services for **24,250** people living in permanent housing support them in remaining stably housed.
- **6,185 interim housing beds** to bring people off the streets and safely indoors as quickly as possible.
- **Homelessness prevention support** for**:**
    - **750 households** through the Homelessness Prevention Unit, which uses predictive analytics to identify and support clients at the highest risk of homelessness.
    - **500 youth** through the Youth Homelessness and Prevention Program, a new initiative to provide direct housing assistance for youth at higher risk of long-term homelessness.
- **4,200 applications and appeals** to connect people at risk of or experiencing homelessness with benefits advocacy services, including **1,200** applications and appeals for veterans.

- **$16 million** in investments mandated by Measure A and essential to system oversight, transparency, and equity tracking.
- **$11 million** for Homeless Solutions Innovations to fund initiatives such as demonstration and engagement projects.

LA County administers 60% of the Measure A revenue for homeless services programs, including 15% ($97 million) that goes directly to local jurisdictions to address homelessness in their communities. The remaining 40% goes to the Los Angeles County Affordable Housing Solutions Agency (LACAHSA) ($385 million) and Los Angeles County Development Authority ($32.3 million) to make housing more affordable and help people stay in their homes.

County Leaders Respond:

“I’m encouraged that improved Measure A revenue projections are allowing us to close gaps in several key priorities the Board of Supervisors identified just weeks ago, including outreach and interim housing to support encampment resolutions,” said **Los Angeles County Board Chair and First District Supervisor Hilda L. Solis.** “As a County, we are beginning to see real progress in reducing the number of people experiencing homelessness, and I’m hopeful these strategic investments will help us build on that momentum. By prioritizing housing resources and pairing them with effective outreach, we can continue bringing our unhoused neighbors indoors while balancing care for our most vulnerable residents with our responsibility to maintain safe and accessible public spaces.”

“This year we saw an improved resident engagement and input process for informing the County's budget allocation of Homeless Services funding. I look forward to seeing the County's new Homeless Services and Housing Department advance into a consensus building model of constituent engagement as directed in the motion establishing the department. This budget prioritizes rental payment support for people who have experienced homelessness, to help prevent people who just got off our streets from joining the rising tide of people becoming unhoused,” said **Supervisor Holly J. Mitchell, Second District**. “I want to be clear that resolving encampments and unsheltered homelessness continues to be a priority for me and my constituents. I look forward to continuing to engage and work on solutions for how we can increase the number of people coming off the streets and into housing so we can finally achieve a net positive of people being housed.”

“This year marks a pivot for homelessness spending in Los Angeles County. We are taking our responsibility seriously—moving funds out of LAHSA into the Department of Homeless Services and Housing, built on accountability, transparency, and rigorous oversight,” said **Supervisor Lindsey P. Horvath, Third District**. "With federal neglect and state cuts, we have to do more with less, and we will—backed by

Measure A investments in local cities and affordable housing. We will continue to focus on accountability, stretching every local dollar to its greatest impact, holding cities accountable for building housing, and ensuring these investments reach the people who need them most."

"We need to recognize how unique and important it is that LA County voters care so deeply about addressing the homelessness crisis that they have agreed to tax themselves to get people the help they need," said **Supervisor Janice Hahn, Fourth District**. "One of the most important parts of Measure A is that it spreads funding and responsibility to our cities. The County will continue to lead – but we cannot and should not do this work alone."

"This spending plan reflects our commitment to invest in strategies that are proven to reduce homelessness and stabilize lives," said **Supervisor Kathryn Barger, Fifth District**. "By prioritizing housing, outreach, and accountability, we have a clear focus on results. Our responsibility is to ensure these dollars translate into real, measurable progress for communities across Los Angeles County."

You can review the full Fiscal year 2026-27 Department of Homeless Services and Housing Measure A, Measure H, and Homeless Housing, Assistance, and Prevention Program Spending Plan here. You can find additional information about the Spending Plan process here.

About the Department of Homeless Services and Housing

The mission of the Department of Homeless Services and Housing (HSH) is to lead a unified countywide response to homelessness that combines housing, health, and social services. In collaboration with partners, HSH delivers a variety of innovative programs and initiatives to prevent and end homelessness, including connecting people to interim and permanent housing, supporting clients with benefits assistance, providing wraparound clinical services, employing targeted homelessness prevention, and overseeing encampment outreach efforts. The department was formed following a motion passed by the Los Angeles County Board of Supervisors in April 2025 and was officially launched January 1, 2026. Lean more at homeless.lacounty.gov.

LOS ANGELES COUNTY COMMISSION ON HIV

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

MENTAL HEALTH SERVICES

(Approved by SBP on 02/03/26)

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

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

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

Service Standards: Ryan White HIV/AIDS Programs

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Introduction

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

General Eligibility Requirements for Ryan White Services

- Be diagnosed with HIV or AIDS with verifiable documentation.
- Be a resident of Los Angeles County
- Have an income at or below 500% of Federal Poverty Level.

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

Service Description

Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessments, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professional typically include psychiatrists, psychologists, and licensed clinical social workers. Mental Health Services are allowed only for People Living with HIV (PLWH) who are eligible to receive HRSA RWHAP services.

Mental Health Service Components

Mental Health Services are short-term or sustained therapeutic interventions provided by mental health professionals who specialize in-for clients experiencing acute and/or ongoing psychological distress. See Appendix A for a description of mental health professionals.

Mental Health Services include:

- Individual, Family, and Group counseling/psychotherapy
- Psychiatric medication assessment, prescription and monitoring
- Drop-in psychotherapy groups
- Crisis intervention

SCREENING AND ASSESSMENT

Agencies contracted to provide mental health services will screen clients and conduct an assessment as appropriate. A mental health assessment is completed during a collaborative interview in which the client's biopsychosocial history and current presentation are evaluated to determine diagnosis and treatment plan.

Reassessments are indicated when there is significant change in the client's status, or when the client re-enters treatment. To reduce client assessment burden, agencies should utilize existing assessments such as those performed by Medical Care Coordination (MCC) teams, as a tool to inform treatment plan development. Clients receiving crisis intervention or drop-in psychotherapy groups require a brief assessment of the presenting issues that supports the mental health treatment modality chosen.

SCREENING AND ASSESSMENT	
STANDARD	DOCUMENTATION
Mental health assessments will be completed by mental health provider within two visits, but in no longer than 30 days.	Completed assessment in client file to include: • Detailed mental health presenting problem • Psychiatric or mental health treatment history • Mental status exam • Complete DSM five axis diagnosis
Reassessment conducted as needed or at a minimum of once every 12 months.	Progress notes or new assessment demonstrating reassessment in client file.
For closed group/drop-in group therapy, providers will pre-screen clients to determine if the client is good fit for the group and if the group would provide a service that meets the client's need(s).	Completed pre-screen assessment in client file to include documentation of Informed Consent, explanation of the limits of confidentiality of participating in group therapy, and description of client mental health needs.
Assessments and reassessments completed by unlicensed providers will be cosigned by licensed clinical supervisors.	Co-signature of licensed provider on file in client chart.

TREATMENT PLANS

Agencies should develop treatment plans for clients receiving mental health services with the exception of clients receiving drop-in psychotherapy groups and crisis interventions. Treatment plans outline the course of treatment and are developed in collaboration with the client and their mental health service provider. Mental health assessments and treatment plans should be developed concurrently. Treatment plans must be finalized within two weeks of the completion of the mental health assessment. Treatment plans must be developed by the same mental health provider that conducts the mental health assessments. Treatment plans will be reviewed and revised at a minimum of every 12 months.

TREATMENT PLANS	
STANDARD	DOCUMENTATION
Mental health assessments and treatment plans are developed concurrently and collaboratively with the client. Treatment plans must be finalized within two weeks of the completion of the mental health assessment and developed by the same mental health provider that conducts the mental health assessment.	Completed, signed treatment plan on file in client chart to include: • Statement of problem(s), symptom(s) or behavior(s) to be addressed in treatment • Goals and objectives • Interventions and modalities proposed • Frequency and expected duration of services • Referrals (e.g. day treatment programs, substance use treatment, etc.)

Client treatment plans are reviewed and/or revised at a minimum of every 12 months.	Documentation of treatment plan revision in client chart.
Treatment plans completed by unlicensed providers will be cosigned by licensed clinical supervisor.	Co-signature of licensed provider on file in client record.

TREATMENT PROVISION

Treatment provision consists of ongoing contact and clinical interventions with (or on behalf) of the client necessary to achieve treatment plan goals. All modalities and interventions in mental health treatment will be guided by the needs expressed in the treatment plan See **Appendix B** for Descriptions of Treatment Modalities.

TREATMENT PROVISION	
STANDARD	DOCUMENTATION
Interventions and modalities will be determined by treatment plan.	Treatment plan signed and dated by mental health provider and client in client file.
Treatment, as appropriate, may include counseling about: • Sexual health including prevention and HIV transmission risk behaviors • Stigma • Substance use • Treatment adherence • Development of social support systems • Community resources • Maximizing social and adaptive functioning • The role of spirituality and religion in a client's life • Disability, death, and dying • Exploration of future goals	Progress note, signed and dated by mental health provider detailing counseling sessions in client file.
Progress notes for all mental health treatment provided will document progress through treatment provision.	Signed, dated progress note in client chart to include: • Date, type of contact, time spent • Interventions/referrals provided • Progress toward Treatment Plan goals • Newly identified issues • Client response
Progress notes completed by unlicensed providers will be cosigned by licensed clinical supervisor.	Co-signature of licensed provider on file in client record.

INFORMED MEDICATION CONSENT

Informed Medication consent is required of every patient receiving psychotropic medications. Providers will comply with state laws and licensing board policies related to Informed Medication Consent for psychotropic medications.

INFORMED MEDICATION CONSENT

STANDARD	DOCUMENTATION
An informed Medication Consent will be completed for all patients receiving psychotropic medications. Whenever a new psychotropic medication is prescribed, the client will receive counseling on medication benefits, risks, common side effects, side effect management, and timetable for expected benefit.	Completed, signed, and dated Informed Medication Consent on file in client chart indicating the patient has been counseled on: • Medication benefits • Risks • Common side effects • Side effect management • Timetable for expected benefit
Informed Medication Consents completed by unlicensed providers will be cosigned by medical doctor board-eligible in psychiatry.	Co-signature of licensed provider on file in client record.

CRISIS INTERVENTION

Crisis intervention is an unplanned service provided to an individual, couple or family experiencing psychosocial distress. These services focus on reversing and stabilizing crisis-related deterioration of functioning. Crisis intervention can be provided face-to-face or via telehealth as appropriate. Client safety must be assessed and addressed under crisis situations. Crisis intervention services may occur as often as necessary to ensure client safety and maintenance of baseline functioning.

CRISIS INTERVENTION	
STANDARD	MEASURE
Crisis intervention services will be offered to clients experiencing psychological distress. Client safety will be continuously assessed and addressed.	Signed, dated progress notes in client chart to include: • Date, time of day, and time spent with or on behalf of the client • Summary of crisis event • Interventions and referrals provided • Results of interventions and referrals • Follow-up plan
Progress notes completed by unlicensed providers will be cosigned by licensed clinical supervisor	Co-signature of licensed provider on file in client record.

TRIAGE/REFERRAL/COORDINATION

Clients requiring a higher level of mental health intervention than a given agency is able to provide must be referred to another agency capable of providing the service. These services may include neuropsychological testing, day treatment programs, and in-patient hospitalization. Referrals to other services including case management, treatment advocacy, peer support, medical treatment, and dental treatment will be made as appropriate. Agencies will maintain regular contact with the client's primary care provider as clinically indicated.

TRIAGE/REFERRAL/COORDINATION	
STANDARD	DOCUMENTATION

As needed, providers will refer clients to full range of mental health services including: • Neuropsychological testing • Day treatment programs • In-patient hospitalization	Signed, dated progress notes to document referrals in client chart.
As needed, providers will refer to other services including case management, treatment advocacy, peer support, medical treatment, and dental treatment.	Signed, dated progress notes to document referrals in client chart.
Providers will maintain regular contact with a client's primary care provider as clinically indicated.	Documentation of contact with primary medical providers in progress notes.

CASE CONFERENCES

Programs will conduct monthly interdisciplinary discussions of selected clients to assist in problem-solving related to a client's progress toward mental health treatment plan goals and to ensure that professional guidance and high-quality mental health treatment services are being provided. All members of the treatment team available, including case managers, treatment advocates, medical personnel, etc., are encouraged to attend. Documentation of case conferences shall be maintained within each client record in a case conference log.

CASE CONFERENCES	
STANDARD	DOCUMENTATION
Interdisciplinary case conferences will be held for each active client based on acuity and need.	Case conference documentation, signed by the supervisor, on file in client chart to include: • Date, name of participants, and name of client • Issues and concerns • Follow-up plan • Clinical guidance provided • Verification that guidance has been implemented

CLIENT RETENTION AND CASE CLOSURE

Agencies will strive to retain clients in mental health treatment. A broken appointment policy and procedure to ensure continuity of service and retention of clients is required. Follow-ups can include telephone calls, written correspondence and/or direct contact, and efforts to maintain a client's participation in care. Case closure is a systematic process for discharging clients from mental health services. The process includes the completion of a Case Closure Summary (CCS) to be maintained in the client record. Case closure will be initiated if the patient does not receive mental health services or is unable to be contacted within a one-year period.

CLIENT RETENTION AND CASE CLOSURE	
STANDARD	DOCUMENTATION

Agencies will develop a broken appointment policy to ensure continuity of service and retention of clients.	Written policy on file at provider agency.
Agencies will provide regular follow-up procedures to encourage and help maintain a client in mental health treatment.	Documentation of attempts to contact in progress notes. Follow-up may include: • Telephone calls • Written correspondence • Electronic Medical Record • Direct contact
Agencies will develop case closure criteria and procedures.	Case closure criteria and procedures on file at provider agency. Cases may be closed when the patient: • Successfully attains psychiatric treatment goals • Relocates out of the service area • Becomes eligible for benefits or other third-party payer (e.g. Medi-Cal, private medical insurance, etc.) • Has had no direct program contact in a one-year period • Is ineligible for the service • No longer needs the service • Discontinues the service • Is incarcerated long term • Utilizes the service improperly or has not complied with the client services agreement • Had died
Regular follow-up will be provided to clients who have dropped out of treatment without notice.	Documentation of attempts to contact in progress notes.
A Case Closure Summary will be completed for each client who has terminated treatment.	Signed, and dated Case Closure Summary on file in client chart to include: • Course of treatment • Discharge diagnosis • Referrals made • Reason for termination
Case Closure Summaries completed by unlicensed providers will be cosigned by licensed clinical supervisor.	Co-signature of licensed provider on file in client chart.

STAFFING REQUIREMENTS AND QUALIFICATIONS

Providers of mental health services will be master's or doctoral level graduate students in counseling, marriage and family therapy, nursing (with specialized mental health training), psychiatry, psychology, or social work.

Psychiatric treatment services are provided by medical doctors' board-eligible in psychiatry or a Physician Assistant. A psychiatrist may work in collaboration with a psychiatric resident, or RN/NP. While state law governs prescription of medication, it is recommended that physicians licensed as such by the state of California shall prescribe all prescriptions for psychotropic medications. If an NP is utilized to provide medications, they must do so according to standardized protocol and under the supervision of a psychiatrist.

All staff will possess the ability to provide developmentally and culturally appropriate care for clients living with and affected by HIV. All clinical staff will have previous experience or training utilizing appropriate treatment modalities in practice.

All staff will participate in orientation and training before beginning treatment provision. If providers are unlicensed, they must be clinically supervised in accordance with the requirements of the licensing board of their respective professions. Graduate-level interns must be supervised according to the requirement of their respective programs and to the degree that ensures appropriate practice.

Mental health providers should have training and experience with HIV/AIDS related issues and concerns. Providers will participate in continuing education or Continuing Medical Education (CME) on the topics of HIV and mental health issues every two years.

Practitioners providing mental health services to people living with HIV should possess knowledge about the following:

- HIV disease and current medical treatments
- Medication interactions (for psychiatrists)
- Psychosocial issues related to HIV/AIDS
- Cultural issues related to communities affected by HIV/AIDS
- Mental disorders related to HIV and other medical conditions
- Mental disorders that can be induced by prescription drug use
- Adherence to medication regimens
- HIV/AIDS legal and ethical issues
- Sexuality, gender, and sexual orientation issues
- Substance use theory, treatment, and practice

Finally, practitioners and staff must be aware of and able to practice under the legal and ethical obligations as set forth by California state law and their respective professional organizations. Mental health services providers are advised to seek legal advice when they are unsure about issues and the level/ethical ramifications of their actions.

STAFFING REQUIREMENTS AND QUALIFICATIONS	
STANDARD	MEASURE
Agencies will ensure that all staff providing psychiatric treatment services will be licensed, supervised by a medical doctor board-eligible in psychiatry, accruing hours toward licensure or a registered graduate student enrolled in counseling, social work, psychology or marriage and family therapy program.	Documentation of licensure/professional/student status on file.

Mental health providers are trained and knowledgeable in HIV/AIDS. Agencies will provide orientation prior to providing services.	Documentation of training on file.
Treatment providers will practice according to California state law and the ethical codes of their respective professional organizations.	Chart review will ensure legally and ethically appropriate practice.
Psychiatric treatment providers will possess skill, experience and licensing qualifications appropriate to provision of psychiatric treatment services.	Resume and current license on file.
Unlicensed psychiatric and mental health professionals will receive supervision in accordance with state licensing requirements. The Division on HIV and STD Programs (DHSP) will be notified immediately in writing if a clinical supervisor is not available.	Documentation of supervision on file.
Mental health service staff will complete documentation required by program.	Administrative supervisor will review documentation periodically.

ADMINSTRATIVE SUPERVISION

Programs will conduct client record reviews to assess that all required mental health documentation is completed properly in a timely manner and secured within the client records.

ADMINISTRATIVE SUPERVISION	
STANDARD	MEASURE
Programs shall conduct record reviews to ensure appropriate documentation.	Client record review, signed and dated by reviewed on file to include: • Checklist of required documentation • Written documentation identifying steps to be taken to rectify missing or incomplete documentation • Date of resolution for omissions

UTILIZING INTERNS, ASSOCIATES, AND TRAINEES

A significant portion of mental health services are provided by interns, associates and trained (IATs). While this process expands capacity by developing a well-trained workforce and provides increased access through cost effective services, extra care must be taken to ensure that high quality, ethical counseling and psychotherapy services are maintained. See **Appendix C** for additional information on Utilizing Interns, Associates, and Trainees (IATs).

UTILIZING INTERNS, ASSOCIATES, AND TRAINEES	
STANDARD	MEASURE
Programs using IATs will provide an orientation and training program of no less than 24 hours to be completed before IATs begin providing services.	Documentation of training/orientation on file at provider agency.

IATs will be assigned cases appropriate to experience and scope of practice and that can likely be resolved over the course of the IAT's internship.	Record of case assignment on file at provider agency.
Programs will provide IATs with clinical supervision in accordance with all applicable rules and standards.	Record of clinical supervision on file at provider agency.
IATs will inform clients of their status as an intern and the name of the supervisor covering the case.	Internship notification form, signed by the client and the therapist on file in client chart.
Termination/transition/transfer will be addressed at the beginning of assessment, treatment inception and six weeks prior to termination.	Signed, dated progress notes confirming termination/transition/transfer on file in client chart.
At termination the IAT and client will discuss accomplishments, challenges, and treatment recommendations.	Signed, dated progress notes detailing this discussion on file in client chart.
Clients requiring services beyond the IAT's internship will be referred immediately to another clinician.	Singed, dated, Client Transfer Form (CTF) in client chart.
All clients place don a waiting list will be offered the following options: • Telephone contact • Transition group • Crisis counseling	Signed, dated CTF that details the transfer plan on file in client chart.

Appendix A: Mental Health Service Providers

Providers of mental health services include licensed practitioners and unlicensed practitioners who practice under the supervision of a licensed mental health professional and as mandated by their respective licensing bodies. Mental health psychiatric treatment services are provided by medical doctors (MDs) board-eligible in psychiatry. A psychiatrist may collaborate with a psychiatric resident or registered nurse/nurse practitioner (RN/NP) under the supervision of a medical doctor board-eligible in psychiatry. All prescriptions shall be prescribed solely by physician licensed by the state of California.

Licensed Practitioners:

- **Licensed Clinical Social Workers (LCSW):** LCSWs possess a master's degree in social work (MSW). LCSWs are required to accrue 3,000 hours of supervised professional experience to qualify for licensing. The Board o Behavioral Science Examiners regulates the provision of mental health services by LCSWs.
- **Licensed Marriage and Family Therapists (LMFT):** LMFTs possess a master's degree in counseling. LMFTs are required to accrue 3,000 hours of supervised counseling or psychotherapy experience to qualify for licensing. The Board of Behavioral Science Examiners regulates the provision of mental health services by LMFTs.
- **Nurse Specialists and Practitioners:** Registered nurses (RNs) who hold a master's degree as a nurse practitioner (NP) in mental health or a psychiatric nurse specialist (PNS) are permitted to diagnose and treat mental disorders. NPs may prescribe medications in accordance with standardized procedures or protocols, developed and approved by the supervising psychiatrist, NP

and facility administrator. Additionally, the NP must furnish and order medications under a psychiatrist's supervision.

To qualify for prescribing medications, NPs must complete:

- At least six months of psychiatrist-supervised experience in the ordering of medications or devices
- A course in pharmacology covering the medications to be furnished or ordered

RNs who hold a bachelor's degree are permitted to provide psychoeducational services but are not allowed to diagnose or treat mental disorders independently. Nurses and NPs are regulated by the California State Board of Nursing.

- **Psychiatrists:** Psychiatrists are physicians (medical doctors or MDs) who have completed an internship and psychiatric residency. They are licensed by the state medical board, which regulates their provision of services, to practice independently. They are certified or eligible for certification by the American Board of Psychiatry. They have ultimate clinical authority but function collaboratively with multidisciplinary teams, which may include psychiatric residents or NPs. They initiate all orders for medications.

  They provide HIV/AIDS mental health treatment services as follows:

  - Examination and evaluation of individual patients
  - Diagnosis of psychiatric disorders
  - Medication treatment planning and management
  - Medical psychotherapy
  - Supervision of allied health professionals through a defined protocol
  - Participation and leadership in interdisciplinary case conferences including signing off on diagnoses and treatment plans
- **Psychologists:** Psychologists possess a doctoral degree in psychology or education (PhD, PsyD, EdD). Psychologists are required to accrue 3,000 hours of supervised professional experience to qualify for licensing. The Board of Psychology regulates the provision of mental health services by psychologists.

Unlicensed Practitioners:

- **Marriage family therapist (MFT) interns; psychological assistants, post-doctoral fellows and trainees; and social work associates:** Interns, assistants, fellows, and associates are accumulating supervised experience as part of their preparation for licensing or certification. They have completed graduate work in counseling, psychology or social work. These providers required direct supervision by a licensed mental health practitioner as mandated by their respective licensing bodies.

Marriage family therapist (MFT) trainees and social work interns: Trainees and interns are in the process of obtaining their master's degrees and completing the necessary practicum or field work in a site approved by their academic institutions. Trainees and interns require direct supervision by a licensed mental health practitioner at the approved site as mandated by their respective licensing bodies.

Appendix B: Description of Treatment Modalities

Ongoing psychiatric sessions: Mental health treatment should include counseling regarding knowledge of modes of transmission, prevention, risk and harm reduction strategies (as well as root causes and underlying issues related to increased HIV transmission behaviors). Substance use, treatment adherence, development of social support systems and community resources as indicated by the client's circumstance are important areas to be explored. Focus should also be placed on maximizing social and adaptive functioning. The role of and –when present in a client's life—spirituality and religion should be understood and utilized as a strength when present. If clients begin to deteriorate physically, emotional distress can be relieved by helping them prepare for disability, even death. For the client whose health has improved, exploration of future goals including returning to school or work is indicated. When a signed release has been completed, sources of support and care can be recommended to significant others and family members.

The provision of specific types of psychotherapy (behavioral, cognitive, post-modern, psychodynamic) is guided by the individual client's need and based on published practice guidelines and research. For those clients on psychotropic medications, side effects of these agents should be assessed at each visit, along with the provision of education regarding such medications, within the scope of the provider's practice. As indicated, these clients will be referred to the prescribing physician for further information.

Individual counseling/psychotherapy: Individual counseling or psychotherapy may be either short- or long-term in duration, depending on the needs outlined in the treatment plan. Short-term or brief therapy lasts up to 12 sessions and can be most useful when client goals are specific and circumscribed. Longer-term therapy provides a means to explore more complex issues that may interfered with a client's quality of life. Even in the case of longer-term therapy, specific, short-term, mutually defined goals are recommended to focus treatment and measure progress.

Family counseling/psychotherapy: The impact of HIV on the family system can be enormous. The overall goal of family counseling/psychotherapy is to help families improve their functioning, given the complications of living with HIV. Interventions with the family system can be especially effective in helping children and caregivers with behavioral problems and symptoms.

Couples counseling/psychotherapy: This modality is most appropriate where the presenting problem is dissatisfaction or conflict within a relationship that impacts a person living with HIV. In cases of domestic violence, couples counseling should not begin until the provider determines the appropriateness of this modality based upon the progress both parties have made in individual or group treatment and the fact that current violence is no longer a risk. If these criteria are not met, members of such couples should be referred for individual or group treatment.

Group psychotherapy treatment: Group treatment can provide opportunities for increased social support vital to those isolated by HIV.

While groups may be led by a single leader, significant benefits arise when utilizing two co-facilitators:

- Fewer group cancellations due to facilitator absence
- Increased change that important individual and group issues will be explored
- Members can witness different skills and styles of the therapists
- Increased opportunity to work through transference relationships

Group treatment can be provided in a variety of formats:

- **Closed psychotherapy groups** typically require a process for joining and terminating. Closed groups usually have a set number of group members (between six and ten). This format provides an opportunity to build group cohesion and for members to take part in active interpersonal learning. These groups can be time limited or ongoing, issue specific or more general in content.
- **Open psychotherapy groups** do not require ongoing participation from clients. The group membership shifts from session to sessions, often requiring group leaders to be more structured and active in their approach. These groups can be especially useful to clients requiring immediate support, but unsure about making a commitment to ongoing treatment.

Drop-in groups can also be offered as a mental health service, as long as at least one of the leaders of the group is a mental health provider as defined in this standard.

- **Drop-in groups** do not have an ongoing membership. Instead of a psychotherapeutic focus, these groups focus on such functions as providing topic-specific education, social support and emotional encouragement. As such, they do not require inclusion in a client's treatment plan, nor is a full mental health assessment required to access this service.

Psychiatric evaluations, medication monitoring and follow-up: Psychiatrists shall use clinical presentation, evidence-based practice guidelines and specific treatment goals to guide the evaluation, prescription and monitoring of appropriate medication.

For medication monitoring and follow-up, visit frequency should be at a minimum:

- Once every two weeks in the acute phase
- Once every month in the sub-acute phase
- Once every three months in the maintenance phase

For those patients on psychotropic medication, side effects of these agents shall be assessed at each visit, along with the provision of education regarding their medications. In addition, these patients should regularly be counseled about the importance of adherence to psychotropic medications.

Appendix C: Utilizing Interns, Associates, and Trainees (IATs)

Programs utilizing IATs will give thoughtful attention to:

- **Training:** Programs utilizing IATs will provide an orientation and training program of no less than 24 hours of instruction focusing on the specifics of providing HIV mental health services. This orientation/training will be completed before IATs begin providing services.
- **Case assignment:** IATs will only be assigned cases that are appropriate to their experience and scope of practice. Additionally, IAT should not be assigned cases that require an intervention that is longer term than the IAT's internship. Such cases should be referred to staff clinicians or referred out.
- **Supervision:** Programs will provide IATs with clinical supervision in accordance with all applicable rules and standards. Supervisors, or other appropriate mental health staff will always be available to IAT that they are providing direct services to clients.

IATs will explicitly inform their clients of their intern status at the beginning of treatment. A document that acknowledges IAT status and details the case supervisor's name will be signed by the client and IAT and placed in the client record. The issue of termination/transition/transfer (due to a therapist's IAT status) will be addressed at the beginning of the assessment, at treatment inception and revisited six weeks prior to IAT termination.

IATs will consult with the clinical supervisor prior to the termination/transition intervention with a client. As part of the termination process, the IAT and client will discuss the client's treatment accomplishments, challenges, preference for future treatment and treatment recommendation. As is true throughout the treatment process, the clinical supervisor will provide oversight for the termination/transition process and cosign the IAT documentation.

While every effort should be made to ensure that IATs will not provider services for clients whose Treatment Plans extend past the internship term, it is recognized that in some cases, clients require unanticipated additional and/or ongoing treatment to meet the stated goals of their treatment plans. In such cases, special care must be given to the transfer of these clients.

Programs will endeavor to transfer IAT clients immediately to another clinician or outside program.

If a client must be placed on a waiting list for transfer to another clinician or IAT, programs will provide the following options for ongoing monitoring and crisis care:

- **Telephone contact:** Existing mental health staff or IAT will attempt contact at least twice a month to every client on the transfer waiting list to monitor current mental status and asses for emergent crises.
- **Transition group:** All clients on a transfer waiting list will be offered the opportunity to attend a transition group or another existing support group to monitor current mental status and assess for emergent crises.
- **Crisis counseling:** Utilizing both monitoring mechanisms noted above, all clients on a transfer waiting list will be informed of the availability of crisis counseling designated for them on an as needed basis.

Program will complete a Client Transfer Form (CTF) detailing the transfer plan for each IAT transfer.

HOLLY J. MITCHELL
LOS ANGELES COUNTY SUPERVISOR ◆ 2ND DISTRICT

COUNTY OF LOS ANGELES DEPARTMENT OF
Parks & Recreation

Volunteers of America

INNER CITY VISIONS
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BLACK HISTORY MONTH

Celebrate Black History Month with LA County Parks and honor the achievements, contributions, and resilience of Black Americans. Enjoy workshops, art exhibits, music, storytelling, and community activities that showcase the richness of Black culture and heritage. Let's come together to celebrate history, culture, and community!

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WE CAN END HIV IN OUR COMMUNITIES ONCE & FOR ALL

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
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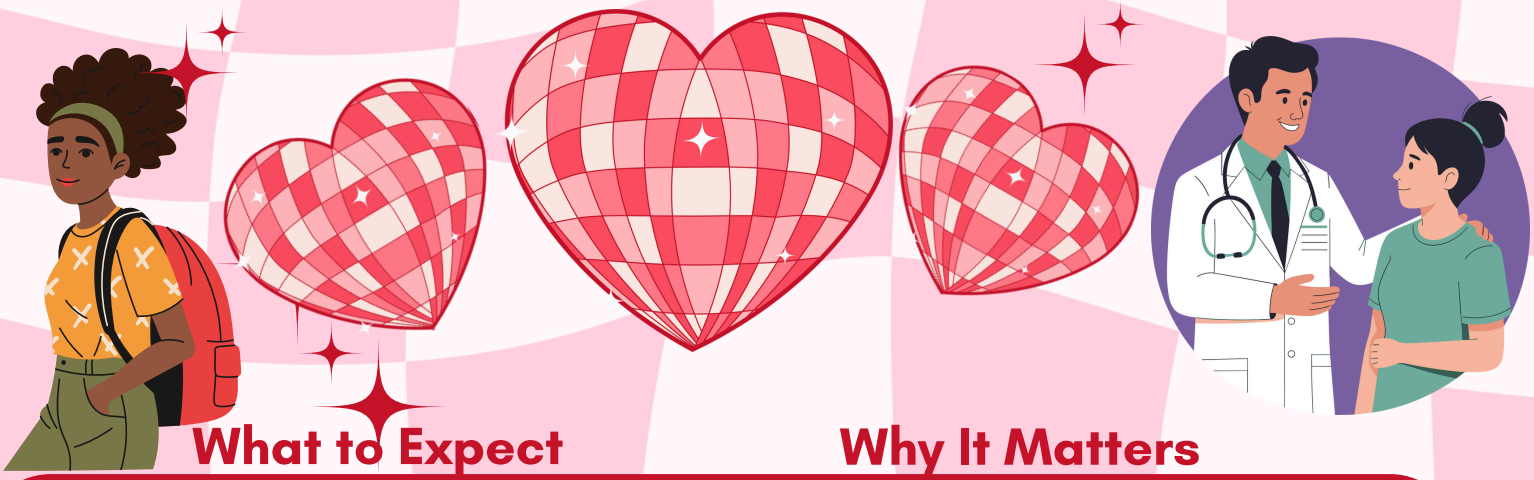
THURSDAY
FEBRUARY 5TH, 2026
6:00PM–8:00PM

JESSE OWENS PARK
9651 S WESTERN AVE,
LOS ANGELES, CA 90047

Youth Listening Session

THE BLACK CAUCUS, A COMMUNITY ADVISORY BODY OF LOS ANGELES COUNTY, IN PARTNERSHIP WITH FIRST STAR BRUIN GUARDIAN SCHOLARS AND LA COUNTY YOUTH COMMISSION, INVITES YOU TO A YOUTH COMMUNITY LISTENING SESSION— A SAFE, SUPPORTIVE SPACE CREATED BY AND FOR YOUNG PEOPLE.



What to Expect

- INTERACTIVE GROUP ACTIVITIES
- TRUSTED ADULTS AND COMMUNITY PARTNERS , SUPRISE GUEST SPEAKERS
- VALENTINE'S MONTH-THEMED FUN
- FOOD, GAMES, AND CONNECTION

Why It Matters

EACH YOUNG PERSON WILL RECEIVE A $50 VISA GIFT CARD FOR PARTICIPATING.

YOUR VOICE WILL HELP CREATE SAFER, MORE SUPPORTIVE SPACES FOR YOUNG PEOPLE—BASED ON WHAT YOU ACTUALLY NEED.

Date: February 7th Time : 10am-2pm Location: UCLA Campus

❗ Exact location will be shared one week before the event.
For more info please email youthcommission@bos.lacounty.gov.

EXECUTIVE OFFICE BOARD OF SUPERVISORS COUNTY OF LOS ANGELES

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share your concerns with us.

HIV + STD Services Customer Support Line

(800) 260-8787

Why should I call?

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

Will I be denied services for reporting a problem?

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

Can I call anonymously?

Yes.

Can I contact you through other ways?

Yes.

By Email:
dhspsupport@ph.lacounty.gov

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

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

Estamos Escuchando

Comparta sus inquietudes con nosotros.

Servicios de VIH + ETS
Línea de Atención al Cliente

(800) 260-8787

¿Por qué debería llamar?

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

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

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

¿Puedo llamar de forma anónima?

Si.

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

Si.

Por correo electronico:
dhspsupport@ph.lacounty.gov

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

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