LOS ANGELES COUNTY
COMMISSION ON HIV

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

Get in touch: hivcomm@lachiv.org

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https://tinyurl.com/y83ynuzt

****CHANGE IN MEETING LOCATION****

COMMISSION ON HIV MEETING

Thursday, October 9, 2025
9:00am-12:00pm (PST)

JESSE OWENS COMMUNITY REGIONAL PARK GYMNASIUM
9651 S. WESTERN AVE., LOS ANGELES, CA 90047
MAP/DIRECTIONS – CLICK HERE

Agenda and meeting materials will be posted on our website at http://hiv.lacounty.gov/Meetings

Register Here to Join Virtually

https://lacountyboardofsupervisors.webex.com/weblink/register/r13109093f75d36f45284cc7dae30d69b

Notice of Teleconferencing Sites

California Department of Public Health, Office of AIDS
1616 Capitol Ave, Suite 74-616, Sacramento, CA 95814

Bartz-Altadonna Community Health Center
43322 Gingham Ave, Lancaster, CA 93535

Public Comments

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

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

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

Accommodations

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

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

together.

WE CAN END HIV IN OUR COMMUNITIES ONCE & FOR ALL

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

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

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

THURSDAY, OCTOBER 9, 2025 | 9:00 AM – 12:00 PM

****CHANGE IN MEETING LOCATION****

JESSE OWENS COMMUNITY REGIONAL PARK GYMNASIUM
9651 S. WESTERN AVE., LOS ANGELES, CA 90047
MAP/DIRECTIONS – CLICK HERE

NOTICE OF TELECONFERENCING SITES
California Department of Public Health, Office of AIDS
1616 Capitol Ave, Suite 74-61, Sacramento, CA 95814

Bartz-Altadonna Community Health Center
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MEMBERS OF THE PUBLIC: TO JOIN VIRTUALLY, REGISTER HERE:
https://lacountyboardofsupervisors.webex.com/weblink/register/r13109093f75d36f45284cc7dae30d69b
JOIN BY PHONE: +1-213-306-3065 Access code: 2536 534 3073

AGENDA POSTED: October 6, 2025

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

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

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

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

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

1. ADMINISTRATIVE MATTERS

A.	Call to Order, Roll Call/COI & Meeting Guidelines/Reminders		9:00 AM – 9:03 AM
B.	Approval of Agenda	**MOTION #1**	9:03 AM – 9:05 AM
C.	County Land Acknowledgment		9:05 AM – 9:07 AM
D.	Consent Calendar	**MOTION #2**	9:07 AM – 9:10 AM
E.	Approval of Meeting Minutes	**MOTION #3**	9:10 AM – 9:12 AM

2. HOLDING SPACE FOR OUR COMMUNITIES – REFLECTIVE SILENCE 9:12 AM – 9:15 AM

3. PUBLIC & COMMISSIONER COMMENTS

A. Public Comment *(Opportunity for members of the public to address the Commission on items of interest that are within the jurisdiction of the Commission. For those who wish to provide public comment may do so in person, electronically HERE, or by emailing hivcomm@lachiv.org. If providing oral public comments, comments may not exceed 2 minutes per person.)* 9:15 AM – 9:20 AM

B. Commissioner Comment *(Opportunity for Commission members to address the Commission on items of interest that are within the jurisdiction of the Commission. Comments may not exceed 2 minutes per member.)* 9:20 AM – 9:25 AM

4. ADMINISTRATIVE REPORTS – I 9:25 AM – 10:25 AM

A. COH Staff Report 9:25 AM – 9:30 AM

(1) PY 35 & 36 Operational Budget & Staffing Updates
(2) Updated 2025 COH Workplan & Meeting Schedule
(3) BOS Executive Office Commission Assessment Report

B. COH Co-Chair Report 9:30 AM – 9:45 AM

(1) Code of Conduct Reminder
(2) September 18, 2025 Special Executive Committee Meeting Recap
(3) Annual Conference Proposed Agenda
(4) Caucuses, Workgroups & Taskforces: Subordinate Working Units Updates to Meeting Schedules and DEI Concerns
(5) 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*)

C. Division of HIV/STD Programs (DHSP) (RWP Grantee/Part A Representative) Report 9:45 AM – 10:00 AM

(1) Ryan White Program Funding & Services Update
(2) CDC HIV Prevention Funding & Services Update
(3) EHE Program and Funding Update
(4) Other Updates

5. COMMUNITY PARTNER/REPRESENTATIVE REPORTS – I 10:00 AM – 10:45 AM

D. California Office of AIDS (OA) Report (Part B Representative) 10:00 AM – 10:30 AM
(1) California Planning Group (CPG) Updates
(2) California Integrated HIV Plan Overview Presentation

E. Housing Opportunities for People Living with AIDS (HOPWA) Report 10:30 AM – 10:35 AM

F. Ryan White Program (RWP) Parts C, D, and F Report 10:35 AM – 10:40 AM

G. Cities, Health Districts, Service Planning Area (SPA) Report 10:40 AM – 10:45 AM

6. STANDING COMMITTEE REPORTS – I 10:45 AM – 11:15 AM

(Updates from committees, caucuses, and task forces are summarized in the Key Takeaways document included in the meeting packet. Attendees are encouraged to review the document for the latest highlights, action items, and key developments across the Commission's working bodies.)

A. Planning, Priorities & Allocations (PP&A) Committee
(1) RW PY 34 Utilization Reports
(2) RW PY 35 & 36 Priority Setting & Resource Allocations (PSRA) Process & Updates
a. PY 35 & PY 36 Re-Allocations
b. PY 36 Letter of Assurance

B. Operations Committee
(1) New Committee Leadership – Miguel Alvarez & Vilma Mendoza
(2) Membership Management
a. Seat Change | Dr. Leon Maultsby from Part C Representative to Provider Representative #1 **MOTION #4**
b. Resignations & Vacancies
(3) Membership Materials Review Workgroup Updates
(4) Outreach & Recruitment Workgroup Updates

C. Standards and Best Practices (SBP) Committee
(1) Transitional Case Management Service Standards | **MOTION #5**
(2) Patient Support Services (PSS) Service Standards Review Updates
(3) Service Standards Schedule

D. Public Policy Committee (PPC)
(1) County, State and Federal Policy & Budget Updates
(2) 2025 Policy Priorities Updates
(3) 2025 Legislative Docket Updates
(4) Transition Activities in Anticipation of Restructure

E. Caucus, Task Force, and Work Group Reports
(1) Aging Caucus
(2) Black Caucus
(3) Consumer Caucus
(4) Transgender Caucus
(5) Women's Caucus
(6) Housing Taskforce

7. COMPREHENSIVE EFFECTIVENESS REVIEW & RESTRUCTURING PROJECT 11:15 AM – 11:45 AM

A. Overview Refresher

B. Prevention Planning

C. Outreach, Engagement & Recruitment Strategies

(1) Commission on HIV Restructure & Bylaws Revision Process — FAQ

D. Timeline & Next Steps

8. MISCELLANEOUS

A. Public Comment 11:45 AM – 11:50 AM

(Opportunity for members of the public to address the Commission of items of interest that are within the jurisdiction of the Commission. For those who wish to provide public comment may do so in person, electronically HERE, or by emailing hivcomm@lachiv.org. If providing oral public comments, comments may not exceed 2 minutes per person.)

B. Commission New Business Items 11:50 AM – 11:55 AM

(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, or where the need to act arose after the posting of the agenda.)

C. Announcements 11:55 AM – 12:00 PM

(Opportunity for members of the public to announce community events, workshops, trainings, and other related activities. Announcements will follow the same protocols as Public Comment.)

D. Adjournment and Roll Call 12:00 PM

Adjournment of the regular October 9, 2025, Commission meeting in memory of Commissioner Russell Ybarra.

PROPOSED MOTION(S)/ACTION(S)	
MOTION #1	Approve meeting agenda, as presented or revised.
MOTION #2	Approve meeting minutes, as presented or revised.
MOTION #3	Approve Consent Calendar, as presented or revised.
CONSENT CALENDAR	
MOTION #4	Approve Seat Change for Dr. Leon Maultsby from Part C Representative to Provider Representative #1, as presented or revised.
MOTION #5	Approve the Transitional Case Management Service Standards, as presented or revised.

LOS ANGELES COUNTY COMMISSION ON HIV

COMMISSION ON HIV MEMBERS

Danielle Campbell, PhD, MPH, Co-Chair	*Joseph Green, Co-Chair*	Dahlia Alé-Ferlito	Miguel Alvarez
Jayda Arrington	Al Ballesteros, MBA	LeRoy Blea	Alasdair Burton
Mikhaela Cielo, MD	Sandra Cuevas	Mary Cummings	Erika Davies
Kevin Donnelly	Kerry Ferguson (*Alternate)	Arlene Frames	Arburtha Franklin
Rev. Gerald Green (**Alternate)	Felipe Gonzalez	Joaquin Gutierrez (**Alternate)	David Hardy, MD
Ismael Herrera (LOA)	Terrance Jones	William King, MD, JD, AAHIVS	Lee Kochems, MA
Leonardo Martinez-Real	Leon Maultsby, MHA, DBH	Vilma Mendoza	Jeremy Mitchell aka Jet Findley
Paul Nash, CPsychol, AFBPsS FHEA	Katja Nelson, MPP	Byron Patel, RN	Mario J. Pérez, MPH
Dechelle Richardson	Daryl Russell	Ismael Salamanca	Sabel Samone-Loreca (**Alternate)
Harold Glenn San Agustin, MD	Martin Sattah, MD	DeeAna Saunders	LaShonda Spencer, MD
Lambert Talley (*Alternate)	Carlos Vega-Matos (**Alternate)	Jonathan Weedman	

MEMBERS:	**40**
QUORUM:	**21**

LEGEND:

LoA = Leave of Absence; not counted towards quorum

Alternate*= Occupies Alternate seat adjacent a vacancy; counted toward quorum

Alternate**= Occupies Alternate seat adjacent a filled primary seat; counted towards quorum in the absence of the primary seat member

LOS ANGELES COUNTY
COMMISSION ON HIV

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

VISION

A comprehensive, sustainable, accessible system of prevention and care that empowers people at-risk, living with or affected by HIV to make decisions and to maximize their lifespans and quality of life.

MISSION

The Los Angeles County Commission on HIV focuses on the local HIV/AIDS epidemic and responds to the changing needs of People Living With HIV/AIDS (PLWHA) within the communities of Los Angeles County. The Commission on HIV provides an effective continuum of care that addresses consumer needs in a sensitive prevention and care/treatment model that is culturally and linguistically competent and is inclusive of all Service Planning Areas (SPAs) and Health Districts (HDs).

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Approved by COH 6/8/23

CODE OF CONDUCT

APPROVED BY OPERATIONS COMMITTEE ON 05/25/23; COH 06/08/23
Approved (11/12/1998); Revised (2/10/2005; 9/6/2005); **Revised (4/11/19; 3/3/22, 3/23/23; 5/30/23)**

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

PARLIAMETARY PROCEDURES – QUICK GUIDE

BASED ON ROBERTS RULES OF ORDER (2025)

1. QUORUM

A quorum is the minimum number of members who must be present to conduct official business. No motions or votes can occur without a quorum. The Commission's quorum is 20 members (as stated on the agenda and subject to change). If quorum is lost during the meeting, only informational updates or discussion may continue—no actions or votes can be taken until quorum is reestablished.

2. MAKING A MOTION

Members propose action by saying, "I move that…". Requires a second before discussion. Only one motion on the floor at a time.

3. SPEAKING & DISCUSSION

Raise your hand and wait to be recognized. Stay on topic; avoid side conversations. Speak once before speaking again.

4. VOTING (ROLL CALL)

The Co-Chair will call for a roll call vote for all motions requiring Commission action. Each member responds "Yes," "No," or "Abstain" when their name is called. Results are recorded in the official minutes, and abstentions are noted when stated aloud.

5. AMENDING

Say, "I move to amend the motion by…". Requires a second, then vote on the amendment first.

6. POINT OF ORDER

Used to address a procedural error or breach in decorum. Co-Chair pauses to rule or clarify.

7. POINT OF CLARIFICATION (PROPERLY: POINT OF INFORMATION)

Ask factual questions during discussion. Say, "Point of Information," and wait to be recognized.

8. TABLING / POSTPONING

To delay an item: "I move to table…" or "…postpone until [date]."

9. DECORUM & RESPECT

Speak through the Co-Chair. Be concise and kind. Uphold the Code of Conduct—respect, integrity, and collaboration.

10. QUICK TIP

When in doubt—ask! Co-Chairs and staff are here to help keep meetings inclusive and on track.

Updated 9.12.25

Meeting Schedule

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

January - December 2025

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

The Commission on HIV (COH) convenes several caucuses and other subgroups to harness broader community input in shaping the work of the Commission around priority setting, resource allocations, service standards, improving access to services, and strengthening PLWH voices in HIV community planning. Currently, the Commission convenes the Aging Caucus, Black Caucus, Consumer Caucus, Transgender Caucus and the Women's Caucus. Caucuses meet virtually unless otherwise announced. For meeting dates and times, contact COH staff directly or email hivcomm@lachiv.org.

LOS ANGELES COUNTY COMMISSION ON HIV

2025 MEMBERSHIP ROSTER| UPDATED 10.7.25

SEAT NO.	MEMBERSHIP SEAT	Commissioners Seated	Committee Assignment	COMMISSIONER	AFFILIATION (IF ANY)	TERM BEGIN	TERM ENDS	ALTERNATE
1	Medi-Cal representative			***Vacant***		July 1, 2023	June 30, 2025	
2	City of Pasadena representative	1	EXC|SBP	Erika Davies	City of Pasadena Department of Public Health	July 1, 2024	June 30, 2026	
3	City of Long Beach representative	1	PP&A	Ismael Salamanca	Long Beach Health & Human Services	July 1, 2023	June 30, 2025	
4	City of Los Angeles representative	1	SBP	Dahlia Ale-Ferlito	AIDS Coordinator's Office, City of Los Angeles	July 1, 2024	June 30, 2026	
5	City of West Hollywood representative	1	PP&A	Dee Saunders	City of West Hollywood	July 1, 2023	June 30, 2025	
6	Director, DHSP **Non Voting*	1	EXC	Mario Pérez, MPH	DHSP, LA County Department of Public Health	July 1, 2024	June 30, 2026	
7	Part B representative	1		Leroy Blea	California Department of Public Health, Office of AIDS	July 1, 2024	June 30, 2026	
8	Part C representative			***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 ***(pending)***	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		David Hardy ,MD	University of Southern California	July 1, 2023	June 30, 2025	
18	Provider representative #8	1	SBP	Martin Sattah, MD	Rand Shrader Clinic, LA County Department of Health Services	July 1, 2024	June 30, 2026	
19	Unaffiliated representative, SPA 1			***Vacant***		July 1, 2023	June 30, 2025	Kerry Ferguson (SBP)
20	Unaffiliated representative, SPA 2				*Unaffiliated representative*	July 1, 2024	June 30, 2026	
21	Unaffiliated representative, SPA 3	1	OPS	Ish Herrera ***(LOA)***	*Unaffiliated representative*	July 1, 2023	June 30, 2025	Joaquin Gutierrez (OPS)
22	Unaffiliated representative, SPA 4	1	PP	Jeremy Mitchell (aka Jet Finley)	*Unaffiliated representative*	July 1, 2024	June 30, 2026	Lambert Talley (PP&A)
23	Unaffiliated representative, SPA 5			***Vacant***	*Unaffiliated representative*	July 1, 2023	June 30, 2025	
24	Unaffiliated representative, SPA 6	1	OPS	Jayda Arrington	*Unaffiliated representative*	July 1, 2024	June 30, 2026	
25	Unaffiliated representative, SPA 7	1	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	Reverend Gerald Green (PP&A)
33	Unaffiliated representative, at-large #2	1	PPC	Terrance Jones	*Unaffiliated representative*	July 1, 2023	June 30, 2025	
34	Unaffiliated representative, at-large #3	1	EXC|PP&A	Daryl Russell, M.Ed	*Unaffiliated representative*	July 1, 2024	June 30, 2026	
35	Unaffiliated representative, at-large #4	1	EXC	Joseph Green	*Unaffiliated representative*	July 1, 2023	June 30, 2025	
36	Representative, Board Office 1	1	PP&A	Al Ballesteros, MBA	JWCH Institute, Inc.	July 1, 2024	June 30, 2026	
37	Representative, Board Office 2	1	EXC	Danielle Campbell, PhDC, MPH	T.H.E Clinic, Inc. (THE)	July 1, 2023	June 30, 2025	
38	Representative, Board Office 3	1	EXC|PP	Katja Nelson, MPP	APLA	July 1, 2024	June 30, 2026	
39	Representative, Board Office 4			***Vacant***		July 1, 2023	June 30, 2025	
40	Representative, Board Office 5	1		Jonathan Weedman	ViaCare Community Health	July 1, 2024	June 30, 2026	
41	Representative, HOPWA			***Vacant***		July 1, 2023	June 30, 2025	
42	Behavioral/social scientist	1	EXC|PP	Lee Kochems, MA	*Unaffiliated representative*	July 1, 2024	June 30, 2026	
43	Local health/hospital planning agency representative			***Vacant***		July 1, 2023	June 30, 2025	
44	HIV stakeholder representative #1	1	EXC|OPS	Alasdair Burton	No affiliation	July 1, 2024	June 30, 2026	
45	HIV stakeholder representative #2	1	PP	Paul Nash, CPsychol AFBPsS FHEA	University of Southern California	July 1, 2023	June 30, 2025	
46	HIV stakeholder representative #3			***Vacant***		July 1, 2024	June 30, 2026	
47	HIV stakeholder representative #4	1	PP	Arburtha Franklin	Translatin@ Coalition	July 1, 2023	June 30, 2025	
48	HIV stakeholder representative #5	1	PP	Mary Cummings	Bartz-Altadonna Community Health Center	July 1, 2024	June 30, 2026	
49	HIV stakeholder representative #6	1	EXC|OPS	Dechelle Richardson	No affiliation	July 1, 2023	June 30, 2025	
50	HIV stakeholder representative #7	1	PP&A	William D. King, MD, JD, AAHIVS	W. King Health Care Group	July 1, 2024	June 30, 2026	
51	HIV stakeholder representative #8	1	EXC|OPS	Miguel Alvarez	No affiliation	July 1, 2024	June 30, 2026	
	TOTAL:	37						

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: 44

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated **10/7/25**

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ALE-FERLITO	**Dahlia**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
ALVAREZ	**Miguel**	No Affiliation	No Ryan White or prevention contracts
ARRINGTON	**Jayda**	Unaffiliated representative	No Ryan White or prevention contracts
BALLESTEROS	**Al**	JWCH, INC.	Benefits Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Mental Health
			Oral Health
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HTS - Syphilis, DX Link TX - CSV
			Biomedical HIV Prevention
			Data to Care Services
			Medical Transportation Services
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

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
GUTIERREZ	**Joaquin**	Unaffiliated representative	No Ryan White or prevention contracts
HARDY	**David**	University of Southern California	No Ryan White or prevention contracts
HERRERA	**Ismael "Ish"**	Unaffiliated representative	No Ryan White or prevention contracts
JONES	**Terrance**	Unaffiliated representative	No Ryan White or prevention contracts
KOCHEMS	**Lee**	Unaffiliated representative	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
LESTER (PP&A Member)	**Rob**	Men's Health Foundation	Core HIV Medical Services - AOM; MCC & PSS
			Biomedical HIV Prevention Services
			Vulnerable Poplulations (YMSM)
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			Medical Transportation Services
MARTINEZ (PP&A Member)	**Miguel**	Children's Hospital Los Angeles	Core HIV Medical Services - AOM; MCC & PSS
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			Biomedical HIV Prevention Services
			Medical Transportation Services
MARTINEZ-REAL	**Leonardo**	Unaffiliated representative	No Ryan White or prevention contracts
MAULTSBY	**Leon**	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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
NELSON	**Katja**	APLA Health & Wellness	Benefits Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Intensive Case Managemenet Services
			Nutrition Support (Food Bank/Pantry Service)
			Oral Health
			STD-Ex.C
			HERR
			Biomedical HIV Prevention Services
			Medical Transportation Services
			Data to Care Services
			Residential Facility For the Chronically Ill (RCFCI)
PATEL	**Byron**	Los Angeles LGBT Center	Core HIV Medical Services - AOM; MCC & PSS
			Vulnerable Populations (YMSM)
			Vulnerable Populations (Trans)
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HTS - Social and Sexual Networks
			Biomedical HIV Prevention Services
			Medical Transportation Services
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
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
			HTS - Social and Sexual Networks
			Medical Transportation Services

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

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

510 S. Vermont Ave, 14th Floor, Los Angeles, CA 90020
TEL. (213) 738-2816
WEBSITE: hiv.lacounty.gov | EMAIL: hivcomm@lachiv.org

COMMITTEE ASSIGNMENTS

Updated: September 2, 2025
Assignment(s) Subject to Change

EXECUTIVE COMMITTEE		
Regular meeting day: 4th Thursday of the Month **Regular meeting time: 1:00-3:00 PM** **Number of Voting Members= 13 | Number of Quorum= 8**		
COMMITTEE MEMBER	**MEMBER CATEGORY**	**AFFILIATION**
Danielle Campbell, PhDc, MPH	**Co-Chair, Comm./Exec.***	**Commissioner**
Joseph Green	**Co-Chair, Comm./Exec.***	**Commissioner**
Miguel Alvarez	Co-Chair, OPS	Commissioner
Alasdair Burton	At-Large	Commissioner
Erika Davies	Co-Chair, SBP	Commissioner
Kevin Donnelly	Co-Chair, PP&A	Commissioner
Arlene Frames	Co-Chair, SBP	Commissioner
Arburtha Franklin	Co-Chair, Public Policy	Commissioner
Vilma Mendoza	Co-Chair, OPS	Commissioner
Katja Nelson, MPP	Co-Chair, Public Policy	Commissioner
Dèchelle Richardson	At-Large	Commissioner
Darryl Russell	Co-Chair, PP&A	Commissioner
Mario Pérez, MPH	DHSP Director	Commissioner

OPERATIONS COMMITTEE		
Regular meeting day: 4th Thursday of the Month **Regular meeting time: 10:00 AM-12:00 PM** **Number of Voting Members= 7 | Number of Quorum= 5**		
COMMITTEE MEMBER	**MEMBER CATEGORY**	**AFFILIATION**
Miguel Alvarez	**Committee Co-Chair***	**Commissioner**
Vilma Mendoza	**Committee Co-Chair***	**Commissioner**
Jayda Arrington	*	Commissioner
Alasdair Burton	At-Large	Commissioner
Joaquin Gutierrez *(alternate to Ish Herrera)*	*	Alternate
Ismael Herrera *(LOA)*	*	Commissioner
Leon Maultsby, DBH, MHA	*	Commissioner
Dèchelle Richardson	At-Large	Commissioner

PLANNING, PRIORITIES & ALLOCATIONS (PP&A) COMMITTEE		
Regular meeting day: 3rd Tuesday of the Month **Regular meeting time: 1:00-3:00 PM** **Number of Voting Members= 13| Number of Quorum= 8**		
COMMITTEE MEMBER	**MEMBER CATEGORY**	**AFFILIATION**
Kevin Donnelly	**Committee Co-Chair***	Commissioner
Daryl Russell, M.Ed	**Committee Co-Chair***	Commissioner
Al Ballesteros, MBA	*	Commissioner
Felipe Gonzalez	*	Commissioner
Reverend Gerald Green	*	Alternate
William D. King, MD, JD, AAHIVS	*	Commissioner
Rob Lester	*	Committee Member
Miguel Martinez, MPH	*	Committee Member
Harold Glenn San Agustin, MD	*	Commissioner
Ismael Salamanca	*	Commissioner
Dee Saunders	*	Commissioner
LaShonda Spencer, MD	*	Commissioner
Lambert Talley	*	Commissioner
Carlos Vega-Matos *(alternate to Kevin Donnelly)*	*	Alternate
Michael Green, PhD	DHSP staff	DHSP

PUBLIC POLICY (PP) COMMITTEE		
Regular meeting day: 1st Monday of the Month **Regular meeting time: 1:00-3:00 PM** **Number of Voting Members= 8 | Number of Quorum= 5**		
COMMITTEE MEMBER	**MEMBER CATEGORY**	**AFFILIATION**
Arburtha Franklin	**Committee Co-Chair***	Commissioner
Katja Nelson, MPP	**Committee Co-Chair***	Commissioner
Mary Cummings	*	Commissioner
Jet Finley *(alternate to Terrance Jones)*	*	Alternate
OM Davis *(LOA)*	*	Committee Member
Terrance Jones	*	Commissioner
Lee Kochems	*	Commissioner
Leonardo Martinez-Real	*	Commissioner
Paul Nash, CPsychol AFBPsS FHEA	*	Commissioner

STANDARDS AND BEST PRACTICES (SBP) COMMITTEE		
Regular meeting day: 1st Tuesday of the Month Regular meeting time: 10:00AM-12:00 PM Number of Voting Members = 11 | Number of Quorum = 6		
COMMITTEE MEMBER	**MEMBER CATEGORY**	**AFFILIATION**
Arlene Frames	**Committee Co-Chair***	**Commissioner**
Erika Davies	**Committee Co-Chair***	**Commissioner**
Dahlia Alè-Ferlito	*	Commissioner
Mikhaela Cielo, MD	*	Commissioner
Sandra Cuevas	*	Commissioner
Caitlyn Dolan	*	Committee Member
Kerry Ferguson	*	Alternate
Lauren Gersh	*	Committee Member
Sabel Samone-Loreca *(alternate to Arlene Frames)*	*	Alternate
Mark Mintline, DDS	*	Committee Member
Byron Patel, RN, ACRN	*	Commissioner
Martin Sattah, MD	*	Commissioner

AGING CAUCUS
Regular meeting day/time: 2nd Tuesday Every Other Month @ 1pm-3pm **Co-Chairs: Kevin Donnelly & Paul Nash** ***Open membership****

CONSUMER CAUCUS
Regular meeting day/time: 2nd Thursday of Each Month; Immediately Following Commission Meeting **Co-Chairs: Damone Thomas & Ismael (Ish) Herrera** ***Open membership to consumers of HIV prevention and care services****

BLACK CAUCUS
Regular meeting day/time: 3rd Thursday of Each Month @ 4PM-5PM (Virtual) **Co-Chairs: Leon Maultsby & Dechelle Richardson** ***Open membership****

TRANSGENDER CAUCUS
Regular meeting day/time: 3rd Thursday Quarterly @ 10AM-11:30 AM **Co-Chairs: Chi Chi Navarro & Diamond Paulk** ***Open membership****

WOMEN'S CAUCUS

Regular meeting day/time: Virtual - 3rd Monday Bi-monthly @ 2-3:00pm
The Women's Caucus Reserves the Option of Meeting In-Person Annually
Co-Chairs: Shary Alonzo & Dr. Mikhaela Cielo
Open membership

HOUSING TASKFORCE

Regular meeting day/time: Virtual – 4th Friday of Each Month @ 9AM – 10AM
Co-Chairs: Katja Nelson & Dr. David Hardy
Open membership

POLICY/PROCEDURE #08.2107	Consent Calendar	Page 1 of 3

NO PROPOSED CHANGES, 4/10/2008

ADOPTED, 1/10/2008

SUBJECT: **"Consent Calendar" procedures at Commission and other meetings.**

PURPOSE: **To provide instructions for the "Consent Calendar" procedures at the Los Angeles County Commission on HIV and other, related Commission meetings.**

BACKGROUND:

- The Commission regularly takes action on multiple items at its monthly meetings. As a result, the Commission is pressured to give complex actions adequate consideration and due diligence, but must rush through motions in order to conclude the meetings on time.

- At the November 2, 2007 Commission meeting, members suggested using a Consent Calendar to expedite the motions that have unanimous support and do not necessitate discussion or debate. The Executive Committee formally endorsed the Consent Calendar practice at its December 3, 2007 meeting.

POLICY:

1) The "Consent Calendar" is a procedural mechanism to expedite Commission business by allowing the body to approve all motions on the consent calendar collectively without debate or dialogue.

2) Commission members or members of the public may set aside (or "pull") an item from the Consent Calendar for any reason in order for the body to discuss and/or vote on it at its appointed time on the agenda. Reasons for setting aside an item include an accompanying presentation, a desire to discuss, address and/or review the item, to register a contrary or opposing vote, and/or to propose an amendment to the motion.

3) Any item that would generate an opposing vote must be removed from the Consent Calendar and returned to its normal place on the agenda.

4) Those items that remain on the Consent Calendar (that have not been "pulled") will be approved collectively in the single Consent Calendar motion. The Consent Calendar motion must be approved unanimously by quorum of the voting membership that is present.

5) The motions that have been set aside will be addressed according to their order on the agenda. Removing an item from the Consent Calendar does not preclude a later vote on that item, nor its approval at a later point on the agenda.

6) Voting members are allowed to register their abstentions from individual items on the Consent Calendar during the Consent Calendar vote.

PROCEDURE(S):

1. **Consent Calendar**: All "action" motions on the Commission's (or other meetings') agendas are automatically placed on the Consent Calendar. "Procedural" motions (e.g., approval of the agenda, approval of the minutes) are not part of the Consent Calendar.

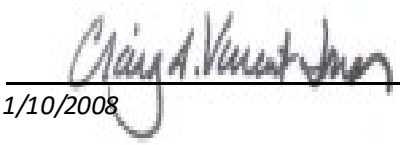
2. **Setting Aside Consent Calendar Items**: An item may be "pulled" from the Consent Calendar by any Commission member, member of the public, or staff member for any reason. The most common reasons for setting aside a Consent Calendar item are:
   a) There is a presentation that accompanies the item.
   b) The member has a question or would like information about the item.
   c) The member would like to see to discuss the item or see it discussed.
   d) The member would like to amend/substitute the motion.
   e) There is an opposing vote.

3. **Items Removed from the Consent Calendar**: "Pulling" an item from the Consent Calendar does not preclude that motion from being considered at a later point on the agenda:
   a) Setting aside a Consent Calendar item returns that item to its regular place on the agenda, where it is addressed at its appointed time.
   b) That motion will be voted on, in agendized order, unless the body chooses to postpone, amend or substitute it when it is considered.

4. **Approving the Consent Calendar**: The Consent Calendar approval vote must be unanimous.
   a) There is no discussion about the Consent Calendar approval, except to pull specific items.
   b) As with all Commission motions, a quorum must be present to vote on it.
   c) As a vote without objections, the Consent Calendar motion does not necessitate a roll call.
   d) Items that generate an opposing vote for the Consent Calendar approval must be removed from the Consent Calendar for later consideration on the agenda.
   e) Voting members may register "abstentions" for individual items on the Consent Calendar.

DEFINITIONS:

- **Abstain/Abstention**: when a voting member acknowledges his/her presence, but declines to vote "aye" or "no" on a motion.
- **"Action" Item/Motion**: a motion that leads to action by the Commission. In the context of this policy, "action" motions are placed on the Consent Calendar.
- **Consent Calendar**: a procedural vehicle for a public voting body to collectively approve all of its "action" motions that do not require discussion or debate.
- **Motion**: the proposed decision or action that the Commission formally moves and votes on.
- **"Procedural" Item/Motion**: a motion necessary for meeting procedural requirements (approving the agenda or minutes). In the context of this policy, "procedural" motions are not placed on the Consent Calendar.
- **"Pull" (an Item/Motion)**: removing or setting aside an item/motion from the Consent Calendar and returning it to its original place on the agenda for discussion/consideration.

NOTED AND APPROVED:  **EFFECTIVE DATE:** January 10, 2008

Original Approval: 1/10/2008 *Revision(s):*

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Avenue, 14th Floor, Los Angeles CA 90020 • TEL (213) 738-2816
EMAIL: hivcomm@lachiv.org • WEBSITE: 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.

COMMISSION ON HIV (COH)

July 10, 2025 MEETING MINUTES

ST. ANNE'S CONFERENCE & EVENT CENTER
FOUNDATION ROOM
155 N. Occidental Blvd, Los Angeles, CA 90026
CLICK HERE FOR MEETING PACKET

TELECONFERENCE SITES:
California Department of Public Health, Office of AIDS
1616 Capitol Ave, Suite 74-61, Sacramento, CA 95814

Bartz-Altadonna Community Health Center
43322 Gingham Ave, Lancaster, CA 93535

1. ADMINISTRATIVE MATTERS

A. CALL TO ORDER, ROLL CALL/COI & MEETING GUIDELINES/REMINDERS

Joe Green, Commission on HIV (COH) Co-Chair, called the meeting to order at 9:05 AM, and reviewed meeting guidelines and reminders; see packet. Jim Stewart, Parliamentarian, conducted roll call.

ROLL CALL (PRESENT): D. Ale-Ferlito, M. Alvarez, J. Arrington, A. Ballesteros, A. Burton, M. Cielo, E. Davies, K. Donnelly, K. Ferguson, J. Finley, A. Franklin, F. Gonzalez, J. Gutierrez, D. Hardy, T. Jones, W. King, L. Martinez-Real, L. Maultsby, V. Mendoza, P. Nash, K. Nelson, B. Patel, M. Perez, D. Richardson, D. Russell, I. Salamanca, S. Samone-Loreca, H. San Agustin (AB2449), D. Saunders, L. Talley, J. Weedman (AB2449), C. Vega-Matos, R. Ybarra, Danielle Campbell (AB2449), and J. Green.

B. APPROVAL OF AGENDA

MOTION #1: Approve meeting agenda, as presented or revised. √ Passed by Consensus

C. COUNTY LAND ACKNOWLEDGEMENT

J. Green read the County's Land Acknowledgement to recognize the land originally and still inhabited and cared for by the Tongva, Tataviam, Kizh, and Chumash Peoples; see meeting packet for full statement.

D. CONSENT CALENDAR

MOTION #2: Approve meeting agenda, as presented or revised. √ Passed by Consensus

E. APPROVAL OF MEETING MINUTES

MOTION #3: Approve meeting minutes, as presented or revised. √ Passed by Consensus

2. HOLDING SPACE FOR OUR COMMUNITIES – REFLECTIVE SILENCE

J. Green asked all to acknowledge the privilege of those present compared to immigrants facing deportation (e.g., the car wash attendant in West Hollywood and the ice cream vendor in Santa Monica detained by ICE). Acknowledgment was also given to those who can no longer be present due to a lack of funding and budget cuts. The audience was asked to take a moment to reflect on everyone who is affected, both inside and outside the room.

3. PUBLIC & COMMISSIONER COMMENTS

F. **Public Comment**

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

- No public comment.

G. **Commissioner Comment**

Opportunity for Commission members to address the Commission on items of interest that are within the jurisdiction of the Commission.

- A. Franklin announced that the Translatin@ Coalition in collaboration with Children's Hospital Los Angeles (CHLA) was granted funding to continue HIV testing for an additional year.
- Chi Chi Navarro thanked all for attending today's Commission meetings and for having the willingness to partake in difficult conversations.

2. COMPREHENSIVE EFFECTIVENESS REVIEW & RESTRUCTURING PROJECT

A.J. King, Next Level Consulting, led the restructuring effort. Input was gathered from in-person and virtual focus groups and stakeholder meetings. Recommendations were reviewed and approved by the Executive Committee in May and June 2025. The purpose of the restructuring efforts is: (1) to address HRSA's administrative and technical findings, (2) to meet current HIV planning demands with fewer resources, and (3) to improve efficiency, especially given quorum challenges with the current 51-member structure.

The following highlights the suggested restructuring changes:

Commission Membership:

- Reduced from 51 to 32 members (a 37% reduction).
- New composition focuses on:
  - 15 required Ryan White seats.
  - 1/3 unaffiliated consumers.
  - 5 Board representatives.
- The recipient, Division of HIV and STDs (DHSP), (grantee) is now non-voting and not counted for quorum.

Committee Structure Options Considered:

Two restructuring models (Exhibit A and B) were proposed:

- Exhibit A (More Radical):
  - Reduced from 5 to 3 committees.
  - Eliminated the Public Policy Committee.
  - Shifted much of the planning and operations work to the full body or the Executive Committee.
- Exhibit B (Chosen Model):
  - Retains more committee structure but still consolidates responsibilities.
  - Eliminated Public Policy Committee; its duties go to the Executive Committee.
  - Renamed the Operations Committee to Membership and Community Engagement.
  - Maintains Executive, Planning, Priorities & Allocations (PP&A), Standards and Best Practices (SBP), and Membership and Community Engagement committees.

Meeting Frequency:

- Reduced from monthly to six meetings per year for both the full body and committees.

Bylaws Revisions:

Term Limits:

- Terms set at 2 years, renewable for up to 3 consecutive terms.
- Requires a 1-year break before reapplying to encourage new voices and perspectives.
- Clarified roles of the recipient agency (non-voting).
- Tightened conflict of interest language (per HRSA recommendations).
- Defined Code of Conduct for both commissioners and the public.
- Added details about inter-commission grievance procedures.

The bylaws revision Public Comment period runs through July 27, 2025, and the revised bylaws are posted

on the Commission's website. Feedback will be shared with the Executive Committee before final approvals. There is an upcoming bylaws training for commissioners and the public, a detailed transition timeline has been shared in meeting packets, and final implementation will occur in phases over the coming months.

AJ emphasized the importance of community input and encouraged all participants to review the draft bylaws, ask questions, and participate in shaping the Commission's future.

The following summary highlights clarifications and questions answered:

- Public Comments and Executive Meeting: All public comments received by Sept 27th will be reviewed by the Executive Committee; late comments may be emailed to commissioners. Community members are encouraged to submit public comments and attend the Executive Committee meeting to understand the proposed changes.
- Bylaw Changes and Committee Structure: Bylaws are being revised to better reflect Ryan White legislative requirements, not to copy other regions. The suggested name change from "Operations" to "Membership & Community Engagement" is for clarity and professionalism. Participants are invited to submit feedback on names and structure for executive committee review.
- Voting and Approval Timeline: The Executive Committee approved changes only for public comment purposes, not final adoption. The full Commission will vote in October, and County Counsel review will follow only after full body approval
- Commission Composition: The new structure is 32 members, including 15 required Ryan White categories, 5 Board of Supervisors representatives, 1 academic/data specialist, and at least 1/3 Unaffiliated Consumers (UC), flexibility to add non-voting subject matter experts is retained.
- Bylaw Details and Accessibility: Bylaws are 24 pages; some requested simplification for consumer readability; however, the document has already been condensed from a longer version. Members are encouraged to think creatively about improving quorum, committee structure, or co-chair roles.
- Term Limits and Reappointments: New rule: three consecutive 2-year terms (6 years total), previous service does not count as terms reset with the new structure, staggered terms will be implemented to avoid mass turnover, members with terms ending in June 2025 do not need to reapply immediately; reapplication for the new structure begins October–November.

Concerns were raised around (1) the potential for fewer meetings to hinder progress, despite potential convenience or cost savings, (2) a request for clarity on cost impacts and how restructuring will result in savings was made, and (3) the importance of maintaining diversity in the reduced commission size was emphasized.

MANAGEMENT/ADMINISTRATIVE REPORTS – I

A. Executive Director/ Staff Report

Executive Director, Cheryl Barrit, delivered a detailed staff report covering administrative updates, budget

realities, and future planning for the LA County Commission on HIV as follows: Here's a concise summary:

Commission Schedule & Annual Conference

- August and September meetings are canceled.
    - The Annual Conference planning is underway, and the Executive Committee will review programming recommendations. The focus of the conference will include updates from the Division of HIV and STDs (DHSP) and possible guest speakers in policy and community activation.

Budget and Funding Challenges

- The Commission faces significant and unprecedented budget cuts due to: (1) County-wide financial strain, (2) Decreased property tax revenue, and (3) State and federal funding instability.
    - Traditional funding comes from the 10% administrative cap of Ryan White Part A funds, which must be shared with DHSP. DHSP previously supplemented this funding with additional sources, but these sources are now limited.
- The Board of Supervisors Executive Office has directed all commissions to reduce costs and undergo a review of function and efficiency.
- Previous budgets ranged around $1.2 million, but the new starting point for negotiations is $500,000.
    - Significant cuts to operational costs have already been proposed (e.g., giving up dedicated office spaces, cutting personnel/staffing). C. Barrit emphasized that there will not be the same level of funding or staffing as in the past, and future staffing may consist of only 1–2 people.
- The Commission was reminded of its core duties as a Planning Council (PC) under the Ryan White Care Act in that PCs are independent decision-making bodies, not advisory boards, that report to the Board of Supervisors (BOS), not DHSP.
- The current restructuring and challenges are not unique, and other commissions have gone through similar changes.
- Historical context was provided, including the Commission's evolution and current administrative alignment. C. Barrit emphasized the need for the Commission to: (1) Focus on core legal functions tied to Ryan White funding, (2) Align staff and commissioner expectations with reduced resources, and (3) Prepare for ongoing negotiations with DHSP and the Executive Office regarding operations under a much smaller budget. It was emphasized that the current financial model is unsustainable. Negotiations will continue in good faith, but significant changes are imminent and necessary.

B. COH Co-Chair Report

The following report was provided:

- The Operations Committee Co-chair seats were vacated because one co-chair took a leave of absence, and the other was non-responsive to communications from staff. Nominations to fill these seats will open later this month.

- Several resignations were acknowledged: Andre Molette (due to CDC funding cuts), former Co-chair Bridget Gordon, and Rita Garcia. Thanks were expressed for their service.
- Carl Halfman, the Office of AIDS, Part B seat, was replaced by Leroy Blea.
- Attendees shared recent conference and meeting updates (e.g., NASM conference in Los Angeles, praising the quality of panels and community building, and the Human Services Commission meeting in West Hollywood, where social services funding increased from $7 million to $8 million thanks to advocacy by the mayor.
- There was discussion about the California Planning Group's (CPG) current representative being on leave, raising the need for a temporary replacement or additional support. The executive committee will follow up on this issue.

C. Division of HIV/STD Programs (DHSP) (RWP Grantee/Part A Representative) Report

Mario Perez, Director, DHSP, introduced Dr. Ekow Sey, Chief of the HIV and STD Surveillance Division, and his team.

- Dr. Sey highlighted the importance of the Medical Monitoring Project (MMP), a 20-year federal initiative that provides critical, annual, population-based data on people living with diagnosed HIV.
- MMP collects detailed information beyond diagnosis, such as mental health, housing, stigma, adherence to treatment, and social factors, which is not typically captured in routine clinical data.
- The federal government unexpectedly terminated funding for MMP, which impacts ongoing surveillance and planning efforts locally, including Los Angeles County (LAC).
- The termination of MMP threatens the ability to track key issues like stigma, housing instability, access to care, and behavioral health challenges.
- Dr. Sey spoke to the resilience of the Commission and hope for future solutions.

Yingbo Ma presented data from 2020–2023 showing:

- MMP participants closely reflect the broader HIV-positive population in LA County.
- Over half rely on public insurance (Medi-Cal), especially Black and Latino communities, indicating Medicaid's critical role.
- Many face challenges like homelessness, food insecurity, and unemployment, which impact health and care engagement.
- LA County shows slightly better HIV care continuum outcomes compared to national averages.
- Mental health issues (anxiety, depression) and substance use are significant concerns.
- HIV-related stigma remains a barrier, especially for communities of color.
- Most participants use viral suppression (ex: U=U "Undetectable = Untransmittable") to protect partners.
- Gaps exist in support services, especially dental care, with 28% reporting unmet needs.
- Those not regularly engaged in care are more likely to miss needed services.

The loss of MMP funding severely limits the ability to monitor and respond effectively to the lived experiences and needs of people living with HIV (PLWH), impacting resource allocation and intervention planning.

M. Perez responded to questions about budget and operational challenges amid funding cuts, explaining that both DHSP and the Department of Public Health (DPH) are assessing essential operational needs and staff allocations to maintain critical support amid staff reductions.

M. Perez provided a detailed overview of the Ryan White program's federal funding structure, highlighting the strict 10% administrative cost cap on grants (e.g., $5 million administrative maximum on a $50 million grant) and the extensive compliance and management requirements tied to it. M. Perez noted that meeting all these federal requirements within the capped administrative budget is challenging, necessitating discussions on how to streamline costs or seek additional funding, though legislative changes are unlikely.

M. Perez provided updates on HIV prevention funding, sharing that after delays, LAC received its CDC High-Impact HIV Prevention Services grant, allowing investments to continue through the end of the year. DHSP prioritized funding for its highest-performing HIV/STD screening and biomedical prevention programs (PrEP, PEP, DoxyPEP) while some lower-performing programs lost funding. They also allocated funds for surveillance and program evaluation, per CDC requirements.

M. Perez announced upcoming meetings to discuss prevention planning and expressed concern about the need for targeted HIV housing and homelessness prevention planning amid funding pressures. He emphasizes ongoing efforts to use resources efficiently while maintaining essential services and community engagement.

The following updates were provided about the Ryan White and Health Resources and Services Administration (HRSA) EHE funding:

- LAC has received only partial awards for Ryan White (Part A) and HRSA EHE grants totaling about $26 million, while expecting around $54-50 million; a significant funding shortfall.
    - Ryan White Part A includes a formula award based on people living with HIV (PLWH) and a supplemental award. Part B comes from the state. Final awards are expected by the end of July; however, there are no guarantees on amounts, especially the supplemental portion, which was $16 million last year.
- The county has $71.3 million in contractual obligations across 83 contracts in 12 service categories, averaging over $5 million per month.
- During COVID and prior years, extra funds from EHE and other sources were invested in services like medicine, oral health, food, emergency financial aid, and legal services. Attempts to roll over unspent funds to the next year were denied.
- Due to the funding gap, a 30% across-the-board cut to all Ryan White contracts was implemented to align spending with available funds. Providers have until February 2026 to adjust their budgets.
- The County is proactively planning for possible increased cuts if final awards are lower than expected, prioritizing services based on Commission recommendations.

- Nationwide, other jurisdictions are also experiencing delayed and partial Ryan White funding, but many are less prepared. LAC is somewhat ahead in contingency planning.
- The County is facing broader fiscal challenges, including a large budget deficit, decreased property tax revenue, and legal costs limiting financial flexibility.
- The County hopes for a full award close to $50 million but is preparing for the possibility of continued shortfalls and must maintain resilience.

4. **STANDING COMMITTEE REPORTS – I**

The meeting skipped standing committee reports to hear a presentation by Gilead. Please refer to the meeting packet for committee, caucus, and task force reports.

5. PRESENTATION- PURPOSE Study Presented by Catherine Chien, MD and Suzanne Molino PharmD (Gilead Sciences, Inc)

Gilead scientists reported on a new HIV prevention option recently FDA-approved called Lenacapavir (brand name YEZTUGO), a long-acting injectable given twice a year. This medication targets adolescent girls and cisgender women, especially in sub-Saharan Africa, where HIV rates are high and oral PrEP options have had adherence and efficacy challenges due to stigma and other barriers.

The presentation covered the Purpose 1 study, which included a diverse group of adolescent girls and young women aged 16-25, including pregnant and lactating individuals, addressing inclusion, reproductive choice, and participant support. The study used a novel design comparing active treatments to background HIV incidence instead of a placebo, due to ethical reasons.

Results showed zero HIV infections in the Lenacapavir group, demonstrating superiority over the background incidence rate of 2.4 per 100 person-years. Other PrEP options studied (F/TDF and F/TAF) did not show superiority in this comparison. The presentation highlighted the importance of community involvement, person-centric design, and addressing disparities in HIV prevention access.

The data was well-received at the IAS conference with significant enthusiasm from the scientific community.

Please refer to the meeting packet for the presentation slides.

6. MISCELLANEOUS

A. **Public Comment.** ***(Opportunity for members of the public to address the Commission of items of interest that are within the jurisdiction of the Commission. For those who wish to provide public comment may do so in person, electronically HERE, or by emailing hivcomm@lachiv.org. If providing oral public comments, comments may not exceed 2 minutes per person.)***

No public comment.

B. **Commission New Business Items** ***(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, or where the need to act arose after the posting of the agenda.)

No new committee business.

C. Announcements ***(Opportunity for members of the public to announce community events, workshops, trainings, and other related activities. Announcements will follow the same protocols as Public Comment.)***

- Transitional Case Management: Public comment period is open from June 26th to July 26th.
- Aging Caucus: "The Power of Aging" event is scheduled for September 19th.
- Consumer Caucus: Meeting is 30 minutes after the Commission meeting ends.

D. Adjournment and Roll Call: Adjournment for the meeting of July 10, 2025.

The meeting adjourned at 12:43 PM in memory of Jewel Thais-Williams. Jim Stewart conducted roll call.

ROLL CALL (PRESENT): D. Ale-Ferlito, M. Alvarez, A. Ballesteros, A. Burton, M. Cielo, E. Davies, K. Donnelly, K. Ferguson, A. Franklin, F. Gonzalez, J. Gutierrez, T. Jones, W. King, L. Martinez-Real, L. Maultsby, V. Mendoza, P. Nash, K. Nelson, B. Patel, M. Perez, D. Richardson, D. Russell, I. Salamanca, H. San Agustin (AB2449), D. Saunders, L. Talley, J. Weedman (AB2449), R. Ybarra, Danielle Campbell (AB2449), and J. Green.

MOTION AND VOTING SUMMARY		
MOTION 1: Approve meeting agenda, as presented or revised.	Passed by Consensus	**MOTION PASSED**
MOTION 2: Approve the April 10, 2025, Commission on HIV meeting minutes, as presented or revised.	Passed by Consensus.	**MOTION PASSED**
MOTION 3: Approve Consent Calendar, as presented or revised.	Passed by Consensus.	**MOTION PASSED**
MOTION 4: Approve the Assessment of the Efficiency of the Administrative Mechanism (AEAM) Report, as presented or revised.	Passed by Consent Calendar.	**MOTION PASSED**
MOTION #5: Approve New Member Application for Leroy Blea | State Office of AIDS, Part B Representative (seat #7), as presented or revised.	Passed by Consent Calendar.	**MOTION PASSED**

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

FOR DISCUSSION /PLANNING PURPOSES ONLY
12.04.24; 12.30.24; 01.06.25; 2.19.25; 03.09.25; 03.24.25; 03.30.25; 4.19.25; 4.28.25; 7.23.25; 9.25.25
June, August and September Cancellations approved by the Executive Committee on 4/24/25

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

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

~~5/8/25 @ St. Anne's Conference Center~~	• ~~Year 33 Utilization Report for RW Support Services Presentation (DHSP/Sona Oksuzyan, PhD, MD, MPH)~~ ~~(Move to PP&A 5/1/25 meeting)~~ • ~~Unmet Needs Presentation (DHSP/Sona Oksuzyan, PhD, MD, MPH)~~ ~~(Move to PP&A meeting, date TBD)~~ • ~~Approve 20% RWP funding scenario allocations~~ • ~~COH Restructuring Workgroups Report and Discussion~~ • ~~Housing Task Force Report of Housing and Legal Services Provider Consultations~~
~~**6/12/25**~~	• ~~**CANCELLED**~~
~~7/10/25 @ Vermont Corridor~~	• ~~COH Restructuring/Bylaws Updates~~ • ~~Medical Monitoring Project (Dr. Ekow Sey, DHSP) CONFIRMED~~ • ~~PURPOSE Study (Requested by Suzanne Molino, PharmD, Gilead Sciences, Inc.); CONFIRMED~~
~~8/14/25~~	~~**CANCELLED**~~
~~9/11/25~~	~~**CANCELLED**~~
10/9/25 @ Jesse Owens	~~**Vote on Revised COH Bylaws**~~ ***Update: Vote on Proposed Bylaws Rescheduled Tentatively to December 11 COH Meeting.***
11/13/25 @ St. Anne's	ANNUAL MEETING
12/11/25 @ Chace Burton (MDR)	Proposed: Vote on Revised COH Bylaws

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

America's HIV Epidemic Analysis Dashboard (AHEAD) - Host a virtual educational session on 9/11/25 – *Postponed until further notice.*

DISCLAIMER: THIS AGENDA REPRESENTS A DRAFT OUTLINE OF THE ANNUAL CONFERENCE PROGRAM. SPEAKERS, SESSION TOPICS, AND PARTICIPANTS HAVE NOT YET BEEN CONFIRMED AND ARE SUBJECT TO REVISION. AN UPDATED VERSION WILL BE CIRCULATED ONCE CONFIRMATIONS ARE FINALIZED.

2025 COMMISSION ON HIV ANNUAL CONFERENCE

Resilience in Uncertain Times: Science, Policy, and Community in Action

Sergeant in Arms: Arburtha Franklin

Thursday, November 13, 2025 | 9am to 3pm
(3-4pm: Networking Reception & Art Gallery)

St. Anne's Conference & Event Center
155 N. Occidental Blvd., Los Angeles CA 90026

PROGRAM OUTLINE		NOTES/COMMENTS
8:30am - 9:00am	**Breakfast / Registration**	
9:00am - 9:15am	**Welcome and Opening Remarks by Co-Chairs**	*Community Connection Activity*
9:15am – 9:45am	**Reimagining the Commission: A New Era of Impact** Joseph Green and Danielle Campbell, MPH, PhD, COH Co-Chairs AJ King, MPH, Next Level Consulting and Collaborative Research	

9:45am - 10:30am	**The State of HIV/STIs in Los Angeles County** Mario Perez, Director (or designee), Division of HIV and STD Programs, LA County Department of Public Health	
10:30am-11:15am	**Science in Action, Research for Change: Advancing Global and Local Efforts to End HIV [PANEL]** 1. CRISPR Gene Therapy for HIV (Dr. Paula Cannon and Dr. John Zaia)* 2. Chimeric Antigen Receptors on NK Cells to Combat HIV Infection (Jocelyn Kim, MD, PhD, UCLA) 3. Mobile Enhanced Prevention Support (MEPS) (Dr. Nina Harawa) 4. Autonomy and Health Outcomes of Black/African Americans at Risk for and Living with HIV (Dr. LaShonda Spencer) 5. Translating HIV Scientific Breakthroughs into Care: A Local Primary Care Physician's Perspective (Dr. William King) 6. California HIV/AIDS Research Program (CHRP): Statewide Research Priorities and Funding Opportunities (Rhodri Dierst-Davies, PhD, MPH, Director) Additional Sub-Topics: 7. Strategies to Increase Minority Representation in Research 8. Clinical Trials: Perspectives from Clinicians and Participants **Moderator: Committee Co-Chairs – TBD**	**Dr. Paula Cannon (USC Keck School of Medicine, Los Angeles)- Renowned for her work in gene editing and HIV cure research using CRISPR/Cas9. Dr. John Zaia (City of Hope, Duarte, CA)- Involved in gene therapy and stem cell transplant research for HIV; very well connected in the Southern California research community*
11:15AM - 11:20AM	**WELLNESS BREAK**	*Wellness Activity TBD*

11:20am –12:00pm	**Policy & Legislation: Safeguarding HIV Programs Amid Censorship and Funding Threats to Research [PANEL]** 1. Jacob Fraker, Legislative Consultant for the LGBTQ Caucus · California State Senate 2. Craig Pulsipher, Equality California 3. Katja Nelson, Local Affairs Specialist, Government Affairs Division, APLA Health 4. Supervisor Holly Mitchell, District 2 5. Bamby Salcedo, President & CEO, TransLatin@ Coalition, LA 6. Senator Caroline Menjivar* 7. Steven Shoptaw, PhD, Center Director, Administrative Core, CHIPTS, UCLA 8. Jeffrey Klausner, MD, MPH, Clinical Professor of Medicine, Infectious Diseases, Population and Public Health Sciences, Klausner Research Group, USC 9. Raphael J. Landovitz, MD, MSc, Center Director, Core Co-Director, Combination Prevention Core, CHIPTS **Moderator: Public Policy Committee Co-Chairs**	**SD20 (Los Angeles County - SF Valley and Burbank) Assignments: Vice-Chair LGBTQ Caucus, Commissioner California Commission on the Status of Women and Girls, Chair of Budget Subcommittee #3 on Health & Human Services*
12:00pm-1:00pm	**LUNCH AND NETWORKING**	
1:00pm-1:20pm	**Keynote Speaker: Maxine Waters (HIV Prevention Now Act (H.R. 5126))**	*Submitted Speaker Request – Pending Response; Need to Identify a Back-Up*
1:20pm-1:30pm	**WELLNESS BREAK**	*Wellness Activity TBD*

1:30pm-2:15pm	**Community Engagement & Advocacy: Strategies for Collective Action [PANEL]** 1. Gerald Garth, ED, AMAAD Institute 2. Bamby Saucedo, CEO & Founder, Translatin@ Coalition 3. Shellye Jones, CDU, DrewCARES 4. Kevin Pizarro, Outreach Coordinator, UCLA Health CARE Center 5. The Impulse Group 6. East Los Angeles Women's Center (ELAC) 7. CHRLA 8. NHAN/NMAC 9. Global Advisory Board Representative **Moderator: Miguel Alvarez, Commissioner**	
2:15pm-2:30pm	**Commission on HIV: A Year in Review** **Moderators: COH Co-Chairs**	*Develop and showcase a highlight video of the Commission's activities and impact stories*
2:30m-2:45pm	**Community Call to Action** Opportunity for participants to brainstorm/identify ideas for collective action using information from morning keynote speaker and panel discussion. 1. How to include Minorities in Research **Moderator: TBD ***	**Recommendations: Joaquin Gonzalez, Joe Green, LeRoy Blea, Chi Chi Navarro*
2:45pm – 2:50pm	**Public Comments & Announcements**	
2:50pm-3:00pm	**Closing, Evaluations and Recognitions**	

3:00pm-4:00pm	**Networking Reception: Art Legacy Exhibition & Raffle:** To close our Annual Meeting, we will host a special exhibition of art created by and commissioned from artists living with HIV, generously gifted to the Commission on HIV over 20 years ago. These works reflect resilience, creativity, and the lived experiences of our community. Many of the artists are no longer with us, and we honor their memory and their contribution to the fight against HIV. *As a way of extending their legacy, the Commission will hold a raffle to gift these art pieces—preferably to community-based organizations—so that the stories and spirit of the artists continue to inspire, educate, and bring visibility to the ongoing movement for equity and care.*

Special Executive Committee Meeting "Recap"

Thursday, September 18, 2025 | 1:00 – 3:00 PM

CLICK HERE FOR MEETING PACKET

Purpose of the Meeting

Led by Danielle Campbell, MPH, PhD, Commission Co-Chair and AJ King, MPH, Consultant, Next Level Consulting, the Executive Committee convened a special session to level set on the Commission's role in HIV prevention within its function as an integrated prevention and care planning body. The session was designed to:

- Clarify expectations between the Commission and the Division of HIV and STD Programs (DHSP)
- Capture strategies to elevate prevention in the Commission's ongoing restructuring, including membership composition, bylaws revisions, and workplan development.
- Engage a broad range of prevention stakeholders and invited guests—including former Prevention Planning Committee members, Prevention Planning Workgroup members, consumers, and community partners—to inform and support the discussion.

Refer to Discussion Guide in meeting packet.

Key Discussion Points

Defining "Prevention"

The meeting opened with the guiding question: *What is prevention*?

Attendees described prevention broadly, emphasizing a status-neutral, syndemic approach that integrates multiple strategies:

- U=U and treatment as prevention (viral suppression prevents transmission).
- Biomedical interventions: PrEP, PEP, TasP, HIV/STI testing.
- Social determinants of health (SDOH): housing, mental health, substance use, poverty.
- Integration of STIs and behavioral health as part of prevention.
- Harm reduction strategies and person-centered approaches.

Participants emphasized that the Commission does not need to "do it all," but can play a central role as a connector, convener, and advocate, leveraging the work of community partners and providers.

Historical Role of the Prevention Planning Committee (PPC)

- Conducted needs assessments of populations at risk (distinct from newly diagnosed).
- Reviewed data and developed syndemic and "fair-share" models in partnership with academic experts.
- Created a resource inventory of prevention services and funding.
- Identified research trends and leveraged evidence to shape planning.

Prevention Planning Workgroup (PPW)

- Created a training schedule of knowledge gaps identified by the analysis of the knowledge, attitudes, and beliefs (KAB) survey to build Commissioner capacity.
- Developed a status neutral framework
- Reviewed Prevention Services Standards
- Provided prevention recommendations to PP&A

DHSP's Expectations and Opportunities

Identified gaps where the Commission can add value:

- Explore innovative prevention programs.
- Developing a resource inventory to track programs and funding across the county.
- Carrying out needs assessments focused on prevention populations. **Clarification: The Commission's listening sessions focus on sexual health, with prevention intentionally integrated into the discussions*.

How DHSP can strengthen partnership with the Commission:

- Improve the data request and sharing process—create a clear, standardized pathway for Commission access to DHSP data.
- Provide ongoing updates to support Commission deliberations on prevention priorities. *Note: Participants expressed appreciation for the recent transparency in prevention portfolio updates and requested that this level of sharing be maintained moving forward*.

Elevating Prevention in the New Commission Structure

- **Membership**: Prevention expertise must be explicitly represented in membership composition—by designated seats (providers, researchers, and those with lived prevention experience), not just by scope.
- **Consumers:** Increase participation of prevention consumers (e.g., individuals on PrEP/PEP, frequent HIV/STI testers, participants in prevention CABs, recipients of non-biomedical prevention services).
- **Standing agenda item**: Add a dedicated prevention item at every full Commission meeting to keep prevention visible and ensure accountability.

- **Education**: Provide ongoing prevention education to members, such as reviving the CHIPTS Colloquia and reestablishing a bi-directional relationship with the research community.
- **Metrics**: Clarify and define prevention outcomes, such as "retained in care on PrEP," and define the PrEP continuum for greater precision and usefulness in planning.

Additional Themes Raised

- **Harm reduction lessons**: Language matters, "people first"; provide information and respect consumer autonomy.
- **Mental health as prevention**: Behavioral health support is a core prevention strategy.
- **Ending the HIV Epidemic (EHE)**: Incorporate Ending the HIV Epidemic (EHE) activities and reference materials into the Commission's prevention planning to ensure alignment with local strategies and best practices.
- **Historical context**: The former Prevention Planning Committee could present lessons learned to inform the Commission's next steps.

CDPH, Office of AIDS (OA) Overview on the Integrated HIV Plan & Prevention

Presentation by LeRoy Blea, CDPH OA – refer to PPT slides in meeting packet:

- OA will create jurisdiction-specific surveillance profiles for LA County to guide planning.
- Two integrated plans will be developed:
  - ✓ A federally compliant version (sanitized to meet federal data and language requirements).
  - ✓ An internal/legacy version retaining full demographic and gender data for meaningful local planning.
- The integrated plan will:
  - ✓ Incorporate a syndemic approach, grounded in social determinants of health.
  - ✓ Integrate LA County's needs assessment and other data, with clear, measurable objectives.
  - ✓ Build upon existing processes and strengths already in place.
- OA encouraged LA County to request technical assistance on refining the PrEP continuum.
- OA and DHSP will continue to meet regularly with Commission staff to ensure alignment on integrated planning activities.

Recommendations & Actionable Next Steps

1. **Standing Prevention Agenda Item**
   - ✓ Add a recurring prevention-focused item to all full Commission meeting agendas.
   - ✓ Use this space to highlight prevention data, emerging issues, and program updates to ensure prevention remains a standing priority.
2. **Bylaws & Restructuring – Prevention Integration**
   - ✓ Ensure prevention expertise and consumer representation are explicitly incorporated into membership composition and committee structures.
   - ✓ Map designated seats for providers, researchers, and individuals with lived prevention experience.
3. **Quarterly Prevention Data Briefs**
   - ✓ Develop a quarterly data briefing process with DHSP, beginning with the PrEP continuum and disparities.
   - ✓ Include plain-language summaries for consumers and technical detail for providers and policymakers.
4. **Prevention Resource Inventory**
   - ✓ Establish and maintain a living, shared inventory of prevention programs, funding streams, and points of access.
   - ✓ Update quarterly and align with DHSP's portfolio to reduce duplication and identify gaps.
5. **Technical Assistance on Prevention/PrEP Continuum**
   - ✓ Submit a formal TA request through OA to refine the prevention continuum for LA County.
   - ✓ Use this to define metrics such as "retained in care on PrEP," initiation, persistence, and re-engagement.
6. **Standardized Data Request & Sharing Process**
   - ✓ Collaborate with DHSP to design a standardized process for prevention data requests, including clear templates, timelines, and points of contact.
   - ✓ Build on recent positive steps in prevention portfolio transparency, ensuring this level of sharing is sustained.
7. **Ongoing Member Education & Engagement**
   - ✓ Re-establish prevention-focused education opportunities (e.g., CHIPTS Colloquia) to bring research and practice back to the Commission.
   - ✓ Strengthen a bi-directional relationship with the research community to inform policy and program design.
8. **Community Engagement & Needs Assessment**
   - ✓ Integrate prevention more explicitly into the Commission's listening sessions on sexual health.
   - ✓ Use findings to shape a prevention-specific needs assessment that complements care-focused assessments.

9. **Alignment with EHE & Best Practices**
   - ✓ Request from DHSP and Incorporate Ending the HIV Epidemic (EHE) activities and materials into the Commission's prevention planning.
   - ✓ Ensure objectives and strategies align with both local best practices and federal/state priorities.
10. **Historical Context & Lessons Learned**
   - ✓ Engage former Prevention Planning Committee members to provide a historical briefing on past prevention planning efforts.
   - ✓ Use lessons learned to guide future prevention planning and avoid duplication.

LOS ANGELES COUNTY
COMMISSION ON HIV

Subordinate Working Units Meeting Decision-Making Tool

(July 2025)

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

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

The PURGE Test

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

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

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

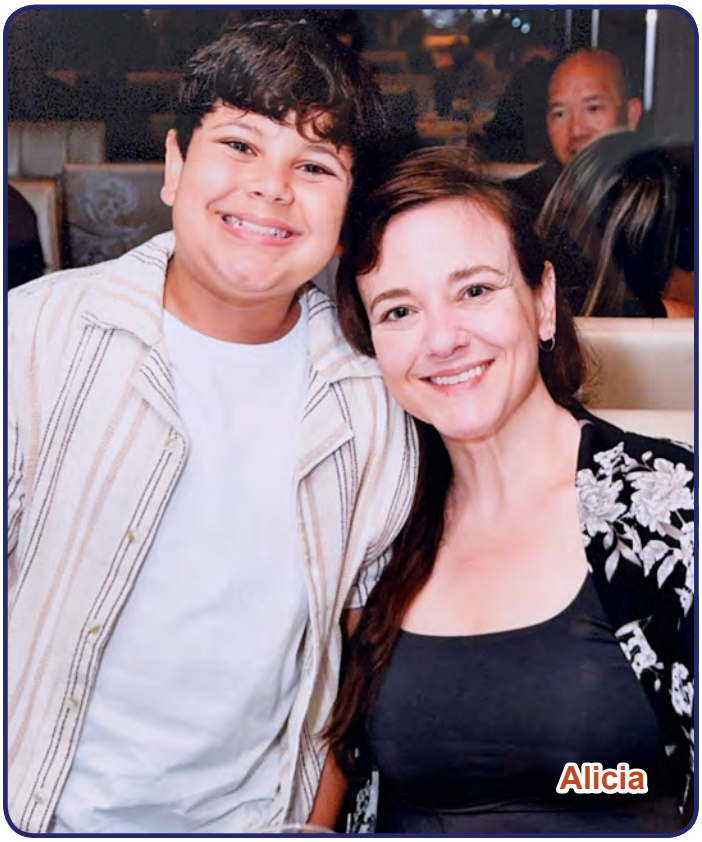
the OA Voice
Issue: September 2025
CDPH California Department of Public Health

INSIDE:

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

STAFF HIGHLIGHT

Alicia Vargas


Alicia

OA is pleased to announce that **Alicia Vargas** has graciously accepted the position of Chief of the Program Integrity and Operations (PIOS) Section in the ADAP Branch.

Alicia's journey with state service began in the OA in June 2017, where she started as the Supervising Program Technician II of the ADAP Client Services Unit (CSU). Within just six months, she was promoted to Staff Services Manager I in the CSU, playing a pivotal role in establishing the new unit and the ADAP call center, grievance processes for the branch, and participating in agile system development and Project Approval Lifecycle of the ADAP Enrollment System. In September 2019, Alicia took on another challenge by leading the formation of the Quality Assurance and Training Unit in ADAP. She was instrumental in devising and implementing new quality assurance processes and overhauling the training curriculum for ADAP staff, enrollment workers, and contractors.

Since June 2021, Alicia has been serving as the Chief of the ADAP Client Services, Quality Assurance, and Training Section. During this time, she has significantly improved team building across the section and branch, facilitated the ADAP Team Building Workgroup and events, coordinated audit responses for the ADAP Branch, and ensured program compliance. Alicia also created and maintained onboarding and recruiting resources for branch staff, led the ADAP webpage revamp workgroup, participated in RFP and RFA reviews, participated in the May revise and November estimate process, and developed and implemented the OA Stakeholder Learning Collaborative. She attended NASTAD's Trauma-Informed Approaches Learning Community, co-facilitated the 21-Day Challenge for Racial and Health Equity, and in 2023, received the

department's Superior Accomplishment Award for outstanding achievement and performance in service to the department.

Before joining CDPH, Alicia spent 14 years in the healthcare and healthcare insurance industries, managing front offices, accounts payable, accounts receivable, and supervising staff. She has taken part in State Supervisory Training and Leadership for the Government Manager programs at California State University of Sacramento, and in 2019, she was invited back to mentor and sponsor a Leadership for the Government Supervisor cohort.

In her spare time, Alicia is often found volunteering at her son, Lucca's school or cheering him on at his soccer or basketball games. She is an avid animal lover and plant enthusiast, taking care of her dog Winston, cat Sheldon, and over 70 potted plants! Alicia and her husband Jesse also enjoy cooking, reading, hiking, traveling, walking the Del Rio Trail, and practicing yoga.

Congratulations on your new role, Alicia!

COMMUNITY PARTNER SPOTLIGHT

Highlighting the Critical Role of our HIV Planning Councils, Commissions and Groups

CDPH would like to highlight the critical work at the planning tables of our HIV Councils, Commission and Groups throughout California. Working in 8 grant areas throughout the state, these bodies are primarily responsible for the priority setting and resource allocation of HRSA Part A dollars that funds critical core medical and support services for low-income people living with HIV. These groups also help to advise HIV prevention work. Their efforts are a critical part of the effectiveness of HIV work and why we're able to aim towards getting to zero HIV deaths, zero HIV stigma, and zero new HIV infections in California.

Six of these groups co-authored the California's *Integrated Plan* and *Implementation Blueprint*, and all these groups are partners in addressing HIV as a syndemic with HCV and other STIs through a social determinants of health lens. If you are part of the communities represented by the groups below, please consider joining your home planning body or supporting their work by adding your voice, skills, and insight to their community events and activities throughout the year. At these meetings you will find amazing and talented individuals to include people living with HIV, those whose communities are most impacted by HIV, and their allies and advocates. You will find people grappling directly with how to address social determinants of health barriers to make sure that all communities benefit from the life-saving tools and resources that are available to treat and prevent HIV. CDPH/OA does our best to help with their important work and learn from their communities how the State can partner with their best next steps of getting to zero in California. We hope to see you at one of these planning tables in the future!

- Inland Empire HIV Planning Council - Serving Riverside and San Bernardino Counties
- Los Angeles Commission on HIV
- Oakland TGA HIV Planning Council - Serving Alameda and Contra Costa Counties
- Orange County HIV Planning Council
- San Diego HIV Planning Group
- Sacramento TGA HIV Health Services Planning Council - Serving El Dorado, Placer, Yolo and Sacramento Counties
- HIV Commission | Public Health | County of Santa Clara
- San Francisco HIV Community Planning Council - Serving Marin, San Francisco, and San Mateo Counties

HIV AWARENESS

September 18th is National HIV/AIDS and Aging Awareness Day (NHAAD). This day is observed to celebrate the strength and resilience of long-term survivors. The discovery of antiretroviral therapy (ART) and advanced research has led to many effective treatments which have allowed people living with HIV to live full and healthier lives. Due to advancements in treatment, a person living with HIV (PLWH), in care, and virally suppressed, has a similar life expectancy to one living without HIV. However, long-term survivors face unique challenges such as HIV-related comorbidities, co-infections and other health complications. Stigma, discrimination and uninformed health care providers are barriers to comprehensive care. This day is observed to raise awareness about challenges faced by those aging with HIV and advocate for all aging adults to get tested and know their status.

September 27th is National Gay Men's HIV/AIDS Awareness Day (NGMHAAD). This day is observed to end HIV stigma and encourage HIV testing, prevention, and treatment among gay and bisexual men. While we have made progress with HIV prevention and treatment, challenges such as stigma, homophobia, racism, and discrimination still contribute to barriers to care and prevention, particularly for Black/African American and Latine men. NGMHAAD continues to raise awareness about HIV, encourages conversation around stigma, and the importance of testing.

GENERAL UPDATES

Clinical Quality Management (CQM)

The OA CQM Program is excited to announce the 2025–2026 revisions to the *2024–2027 CQM Plan* are now published and available on OA's CQM Program webpage.

These annual updates reflect key adjustments to program goals and activities, and quality improvement strategies within OA.

If you have any questions or feedback, please contact rw.partbcqm@cdph.ca.gov.

Mpox

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

Digital assets continue to be available for LHJs and CBOs on DCDC's Campaign Toolkits website.

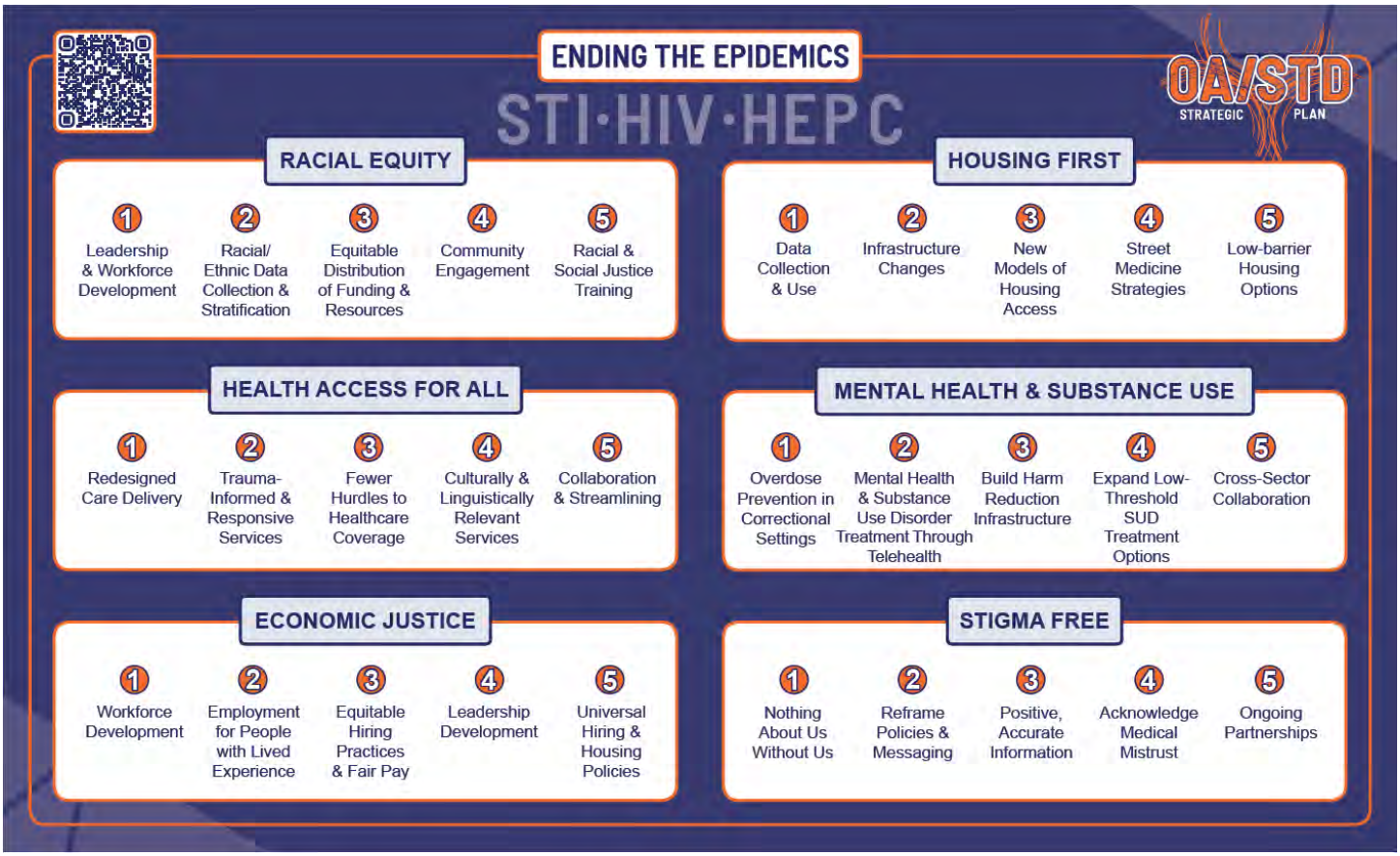
HIV/STI/HCV Integration

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

ENDING THE EPIDEMICS STRATEGIC PLAN OA/STD

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

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



STIs, through a Social Determinants of Health lens.

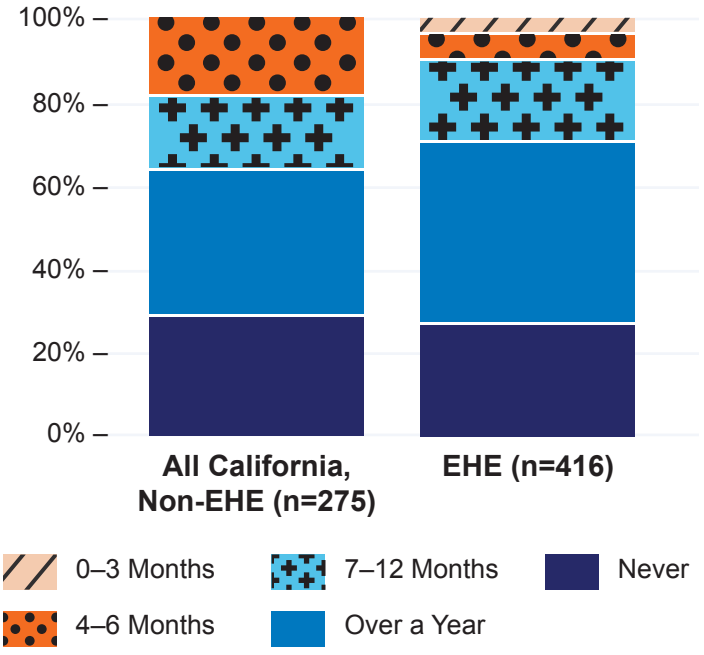
For technical assistance in implementing the *Strategic Plan*, California LHJs and CBOs can vist Facente Consulting's webpage.

HEALTH ACCESS FOR ALL

Strategy 1: Redesigned Care Delivery

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

HIV Test History Among Individuals Who Ordered TakeMeHome Kits, July 2025



TAKEMEHOME

Additional Key Characteristics	EHE	All California, Non-EHE
Of those sharing their gender, were cisgender men	53.5%	59.5%
Of those sharing their race or ethnicity, identify as Hispanic or Latinx	39.3%	37.5%
Were 17-29 years old	41.4%	42.6%
Of those sharing their number of sex partners, reported 3 or more in the past year	39.8%	43.9%

In July, 275 individuals in 34 counties ordered self-test kits, with 202 (73.5%) individuals ordering 2 tests. Additionally, OA's existing TakeMeHome Program continues in the six California Consortium Phase I Ending the HIV Epidemic in America counties. Between the program's initiation in September 1, 2020, and July 31, 2025, 18,424 tests have been distributed. This month, mail-in lab tests (including dried blood spot tests for syphilis, and Hepatitis C, as well as 3-site tests for gonorrhea and chlamydia) accounted for 152 (36.5%) of the 416 total tests distributed in EHE counties. Of those ordering rapid tests, 211 (79.9%) ordered 2 tests.

Survey Highlights	EHE	All California, Non-EHE
Would recommend TakeMeHome to a friend	94.9%	94.4%
Identify as a man who has sex with other men	46.9%	51.2%
Reported having been diagnosed with an STI in the past year	8.2%	9.8%

Since September 2020, 2,023 test kit recipients have completed the anonymous follow up survey from EHE counties; there have been 887 responses from the California expansion since January 2023.

HEALTH ACCESS FOR ALL

Strategy 3: Fewer Hurdles to Healthcare Coverage

As of August 31, 2025, there are 293 PrEP-AP enrollment sites and 231 clinical provider sites that currently make up the PrEP-AP Provider network.

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

As of August 31, 2025, the number of ADAP clients enrolled in each respective ADAP Insurance Assistance Program are shown in the table at the top of page 7.

RACIAL EQUITY

Strategy 4: Community Engagement

The fourth annual virtual ***Ending the Syndemic Symposium*** is happening this month!

(continued on page 7)

Active PrEP-AP Clients by Age and Insurance Coverage:

Current Age	PrEP-AP Only		PrEP-AP With Medi-Cal		PrEP-AP With Medicare		PrEP-AP With Private Insurance		TOTAL	
	N	%	N	%	N	%	N	%	N	%
18 - 24	315	11%	---	---	---	---	11	0%	326	12%
25 - 34	928	33%	---	---	---	---	132	5%	1,060	38%
35 - 44	688	25%	---	---	1	0%	112	4%	801	29%
45 - 64	377	14%	1	0%	4	0%	90	3%	472	17%
65+	28	1%	---	---	89	3%	8	0%	125	4%
TOTAL	**2,336**	**84%**	**1**	**0%**	**94**	**3%**	**353**	**13%**	**2,784**	**100%**

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

Current Age	Latinx		American Indian or Alaskan Native		Asian		Black or African American		Native Hawaiian/ Pacific Islander		White		More Than One Race Reported		Decline to Provide		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
18 - 24	190	7%	1	0%	35	1%	20	1%	1	0%	43	2%	5	0%	31	1%	326	12%
25 - 34	589	21%	2	0%	99	4%	89	3%	2	0%	199	7%	8	0%	72	3%	1,060	38%
35 - 44	470	17%	5	0%	63	2%	47	2%	2	0%	160	6%	7	0%	47	2%	801	29%
45 - 64	257	9%	---	---	32	1%	13	0%	1	0%	126	5%	1	0%	42	2%	472	17%
65+	13	0%	---	---	4	0%	5	0%	---	---	95	3%	---	---	8	0%	125	4%
TOTAL	**1,519**	**55%**	**8**	**0%**	**233**	**8%**	**174**	**6%**	**6**	**0%**	**623**	**22%**	**21**	**1%**	**200**	**7%**	**2,784**	**100%**

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

Gender	Latinx		American Indian or Alaskan Native		Asian		Black or African American		Native Hawaiian/ Pacific Islander		White		More Than One Race Reported		Decline to Provide		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Female	42	2%	---	---	3	0%	14	1%	1	0%	10	0%	---	---	12	0%	82	3%
Male	1,407	51%	7	0%	212	8%	157	6%	4	0%	593	21%	19	1%	166	6%	2,565	92%
Trans	59	2%	---	---	14	1%	1	0%	1	0%	10	0%	2	0%	2	0%	89	3%
Unknown	11	0%	1	0%	4	0%	2	0%	---	---	10	0%	---	---	20	1%	48	2%
TOTAL	**1,519**	**55%**	**8**	**0%**	**233**	**8%**	**174**	**6%**	**6**	**0%**	**623**	**22%**	**21**	**1%**	**200**	**7%**	**2,784**	**100%**

All PrEP-AP charts prepared by: ADAP Fiscal Forecasting Evaluation and Monitoring (AFFEM) Section, ADAP and Care Evaluation and Informatics Branch, Office of AIDS. Client was eligible for PrEP-AP as of run date: 08/31/2025 at 12:00:42 AM Data source: ADAP Enrollment System. Site assignments are based on the site that submitted the most recent application.

ADAP Insurance Assistance Program	Number of Clients Enrolled	Percentage Change from July
Employer Based Health Insurance Premium Payment (EB-HIPP) Program	590	1.20%
Office of AIDS Health Insurance Premium Payment (OA-HIPP) Program	5,802	0.05%
Medicare Premium Payment Program (MPPP)	2,330	0.39%
Total	**8,722**	**0.22%**

Source: ADAP Enrollment System

the ENDING THE SYNDEMIC Symposium IV

- September 23rd, 12:00–4:00 PM
- September 24th, 9:00 AM–1:00 PM
- September 25th, 12:00–4:00 PM

The *Ending the Syndemic Symposium IV, 2025* is sponsored by CDPH/OA and will offer an opportunity for California Counties and their funded Community Programs to share best practices and innovations in serving the communities most impacted by HIV, HCV, and STIs.

Each day of the Symposium will have a particular theme we are asking speakers and panelists to address. The theme of Day 1 is **Stigma Free Services**, Day 2 is **Economic Justice**, and Day 3 is **Housing First**.

This Symposium is free and open to any partner working to end the syndemic of HIV, STIs and HCV in California.

We look forward to seeing you at the Symposium!

Register for the Symposium.

(Note: Simultaneous Spanish translation will be available at all sessions of the Symposium.)

RACIAL EQUITY

Strategy 5: Racial and Social Justice Training

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

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

CDPH
California Department of Public Health

Syndemic Efforts to End the HIV Epidemic: Integrated Plan Update

Planning, Priorities and Allocations Committee Meeting

Los Angeles County Commission on HIV

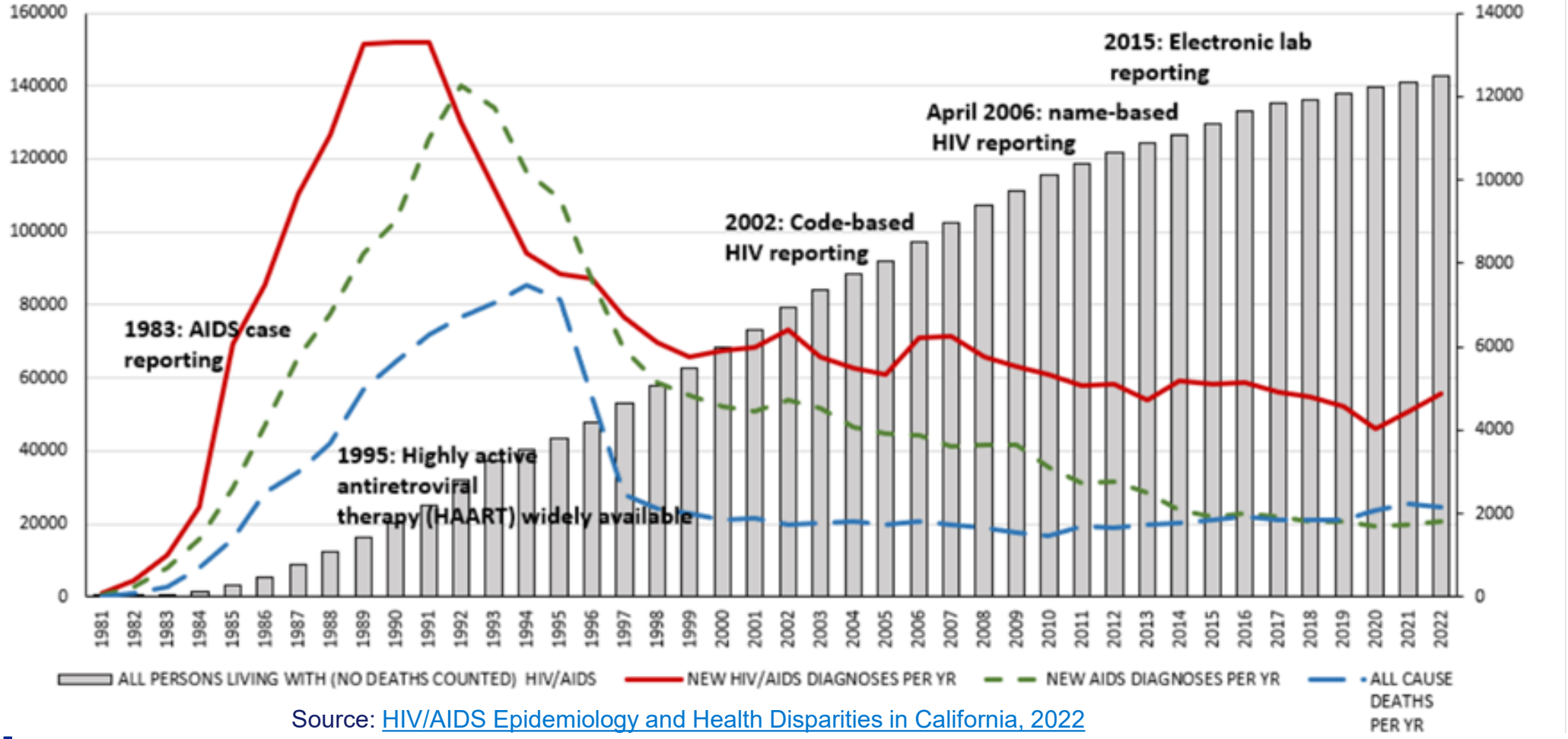
October 9, 2025

Leroy Blea, MPH
Ending the Epidemics Manager
California Department of Public Health, Office of AIDS

Overview

- Looking back and forward
- EHE Plans and Outcomes
- Integrated Strategic Plan
- Implementation Blueprint
- What's next?
- Resources

HIV/AIDS Diagnoses, Deaths and Persons Living with HIV or AIDS in California: 1981-2022



Source: [HIV/AIDS Epidemiology and Health Disparities in California, 2022]

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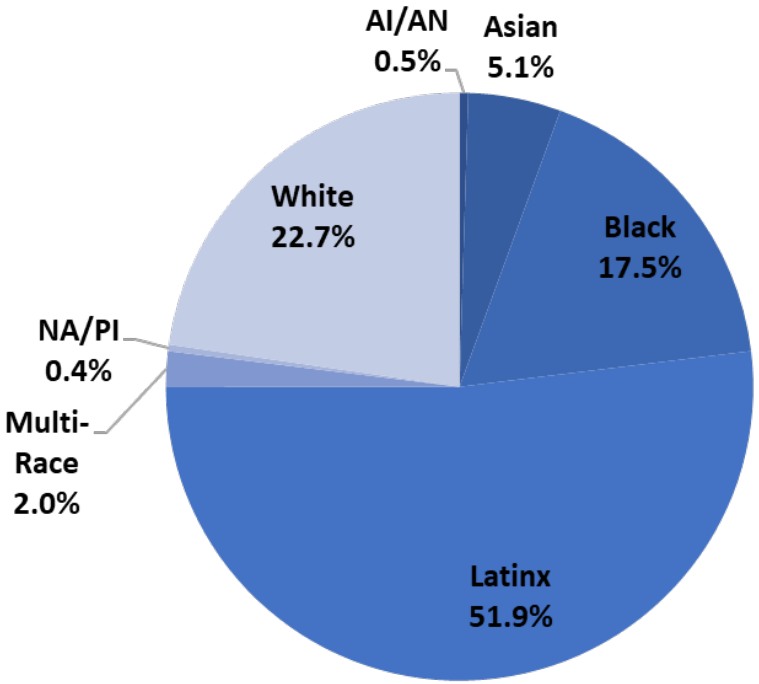
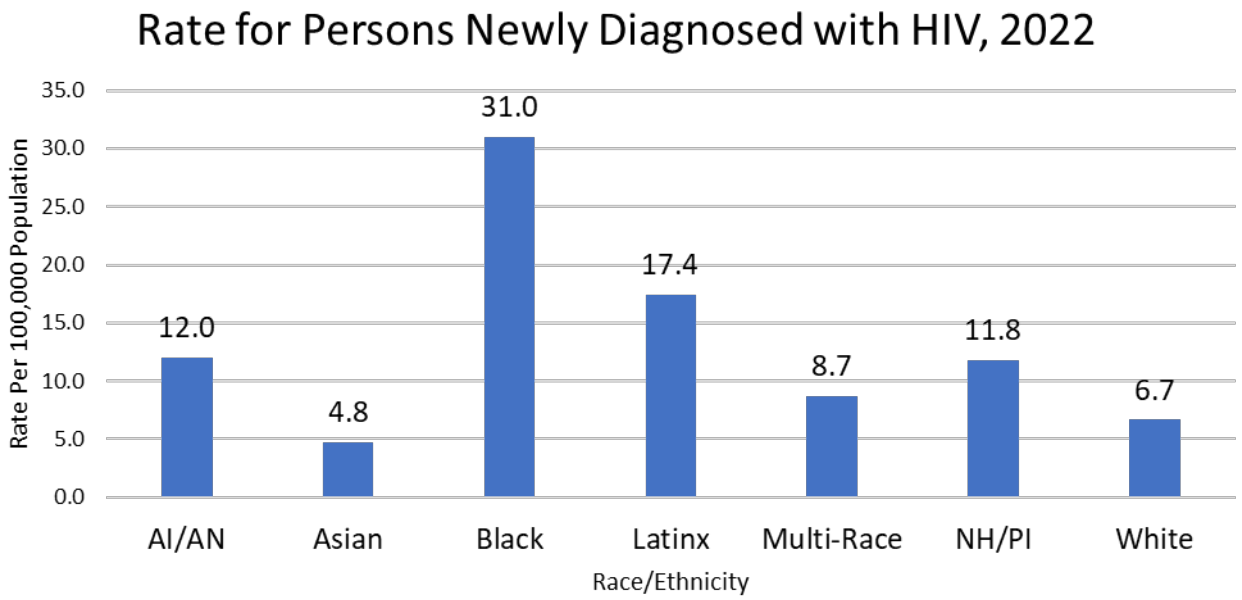
Race/Ethnicity of Persons Newly Diagnosed with HIV: California, 2022





Source: HIV/AIDS Surveillance, eHARS data as of December 31, 2023

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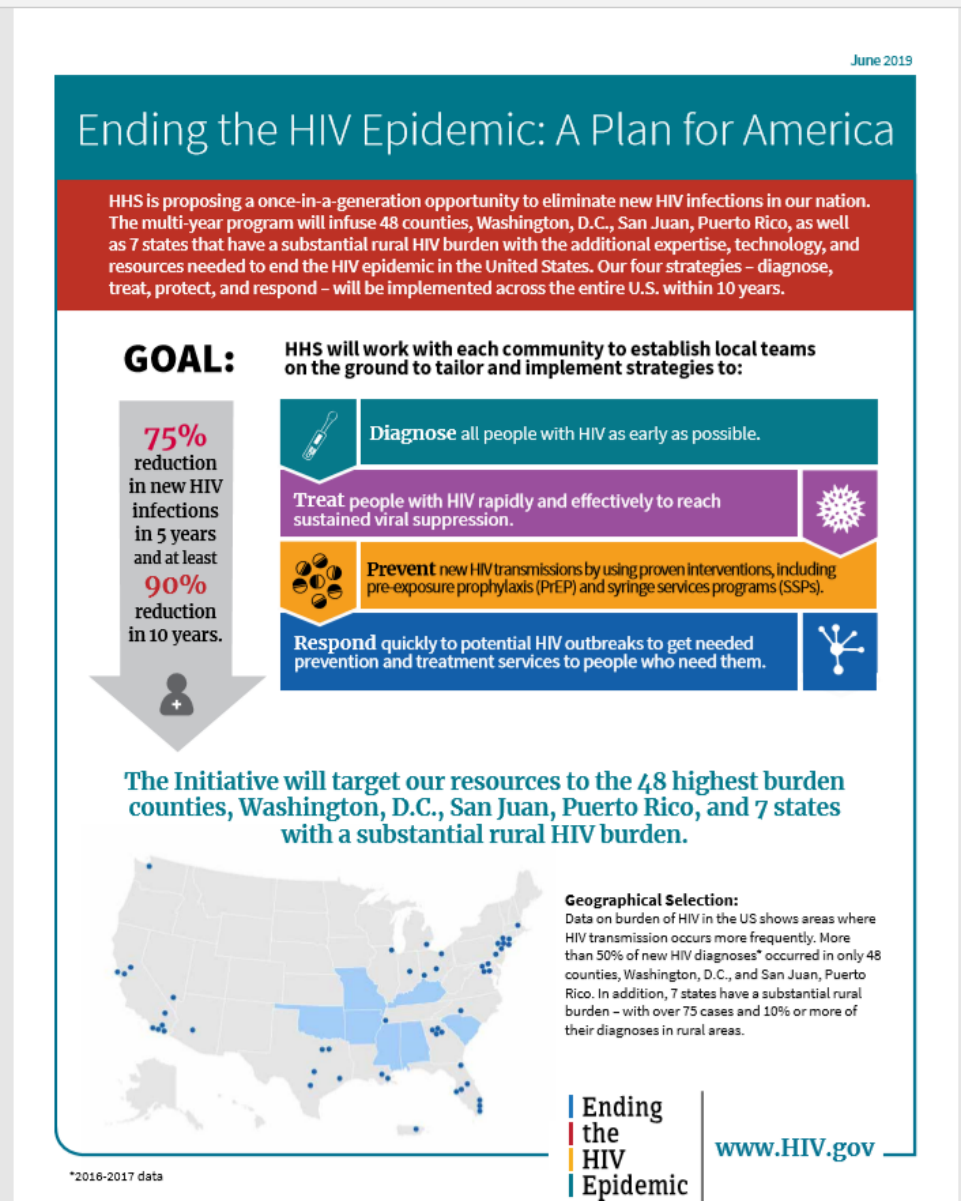
California Consortium EHE Plans

- *Community Engagement*
- Epidemiological Snapshot
- Situational Analysis
- EHE Plans

  Counties:

  Alameda, Orange, Riverside, Sacramento, San Bernardino, and San Diego. Los Angeles and San Francisco.



Selected Pilot Interventions: Linking to programs and services

Mobile Services

- Deployed to parts of the counties with lack of services infrastructure
- Brick and mortar collaborations
- Street Medicine

Testing Expansion

- Focused/ROOT
- Self-testing HIV/STI/HCV
- OraQuick Expansion

PrEP Expansion

- Building capacity of providers to offer PrEP
- Building capacity to link clients with providers-PrEP navigators
- Tele PrEP/PEP

Linkage to Care/Prevention

- Emergency Departments Testing
- Peer navigators/Peer involvement
- Technology solutions/Social Media

Selected Current Initiatives and Highlights

"Do it from home" Takemehome.org videos

- In 6 months, 10.2 M Impressions BIPOC in EHE Counties @$0.03/view
- 23% increase in avg monthly orders
- These spots are running on Ru Paul's Drag Race on MTV Fridays through April to close out the campaign.

Takemehome.org / HIV & STI testing

- Since launce 3/23 we've seen 16.5K orders
- This fiscal year we've seen 9K+ actions (orders or referrals to TTMH) with a $38 cost/action.

Color.com / Tele PrEP & PEP

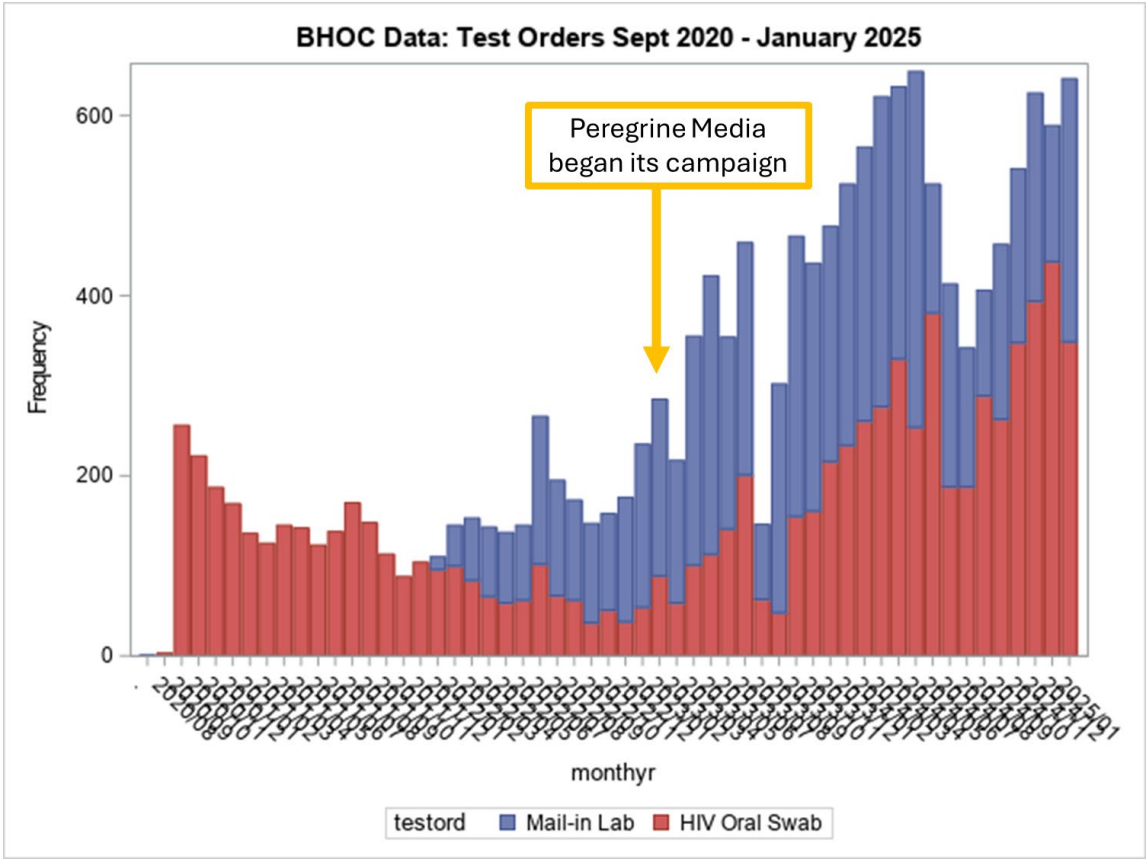
- This fiscal year we've seen 341 consults @ $427
- 74% of users who made an attempt for services qualified for services, 62% of users who scheduled a consult originated from the CDPH campaign

Real Talk

- Our latest series ran in EHE counties prioritizing our young BIPOC populations
- This series ran on YouTube, Facebook, Instagram and CTV
- 6.6M impressions, 6K clicks, 4.5M views to priority populations with an average CPV of $0.02.

Social Media Lessons Learned

- Social media efforts increased program utilization
- Increases our reach to younger, blacker and browner populations
- Use social media providers with existing relationships with dating sites – leverage them
- Pilot media to see what works best
- Creative developed for one project can be adapted to other media: billboards, radio, bus ads
- Customize messages to the site and users
- Respect that each site has intrinsic value to the users
- Ads with call-to-action messages and buttons influence behavior
- Evaluation challenge – we do not see everything that these ads are influencing – health seeking behavior is a proxy
- Use of surveillance matching can help evaluate outcomes



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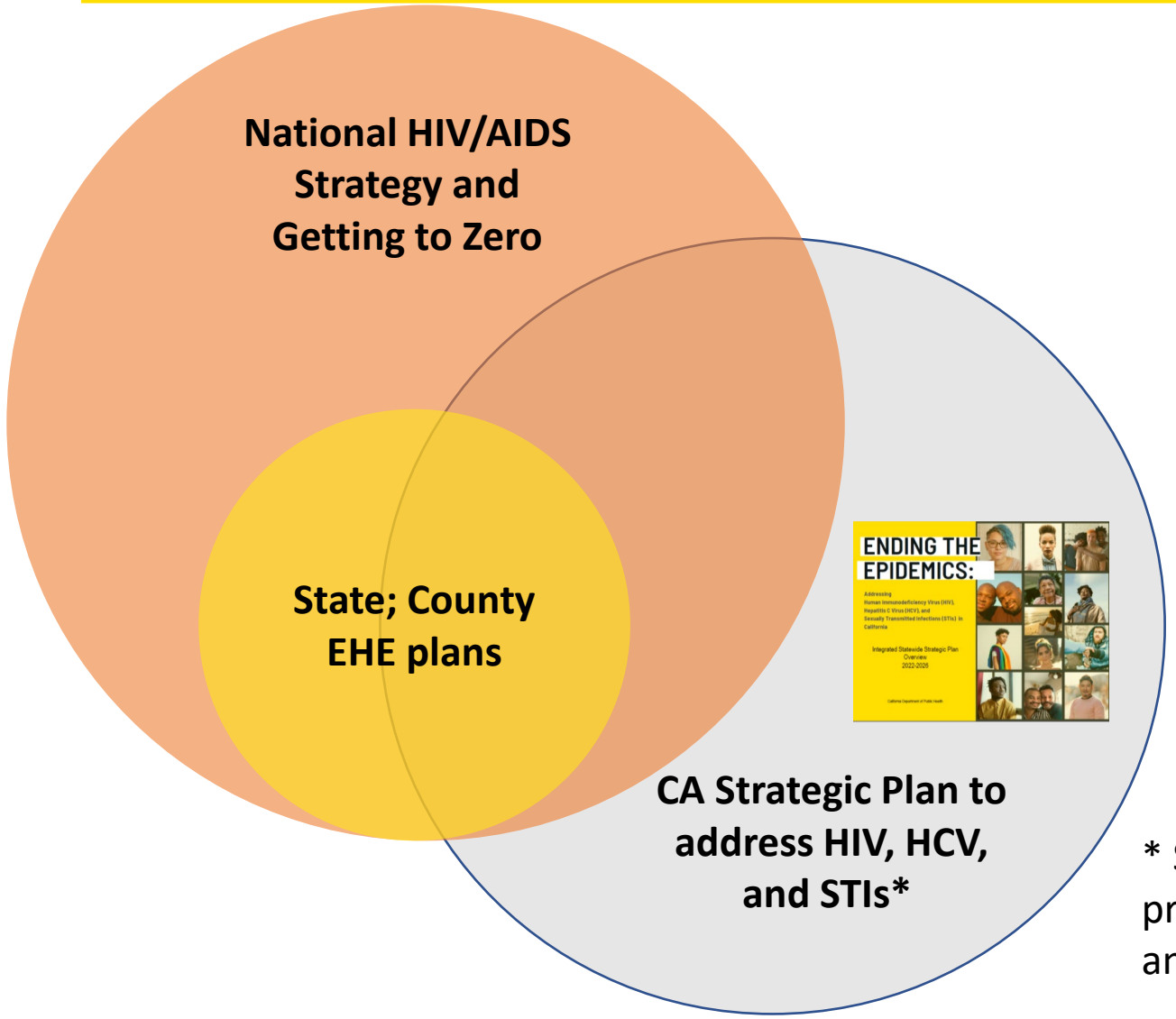
MAKING THE CONNECTION: Multiple Initiatives



Ending the Epidemics Plan: Why and how at a high-level

Implementation Blueprint: Details how

…plus, other programmatic initiatives *(i.e. GTZ, HIV Prevention Group Plans, etc*)

* Strategies proposed meet legislative and programmatic requirements for CDC DHAP and HRSA HAB. CDPH OA/STDCB Leadership

ADAPTED FROM: CDC and HRSA Overview Webinar; October 27, 2021. Available at: https://targethiv.org/library/gearing-integrated-planning-approach-timeline-and-community-engagement

California Statewide Integrated Strategic Plan and Blueprint

30 strategies organized across six social determinants of health:

- Racial equity
- Housing first
- Health access for all
- Mental health and substance use
- Economic justice
- Stigma free

Implementation Blueprint

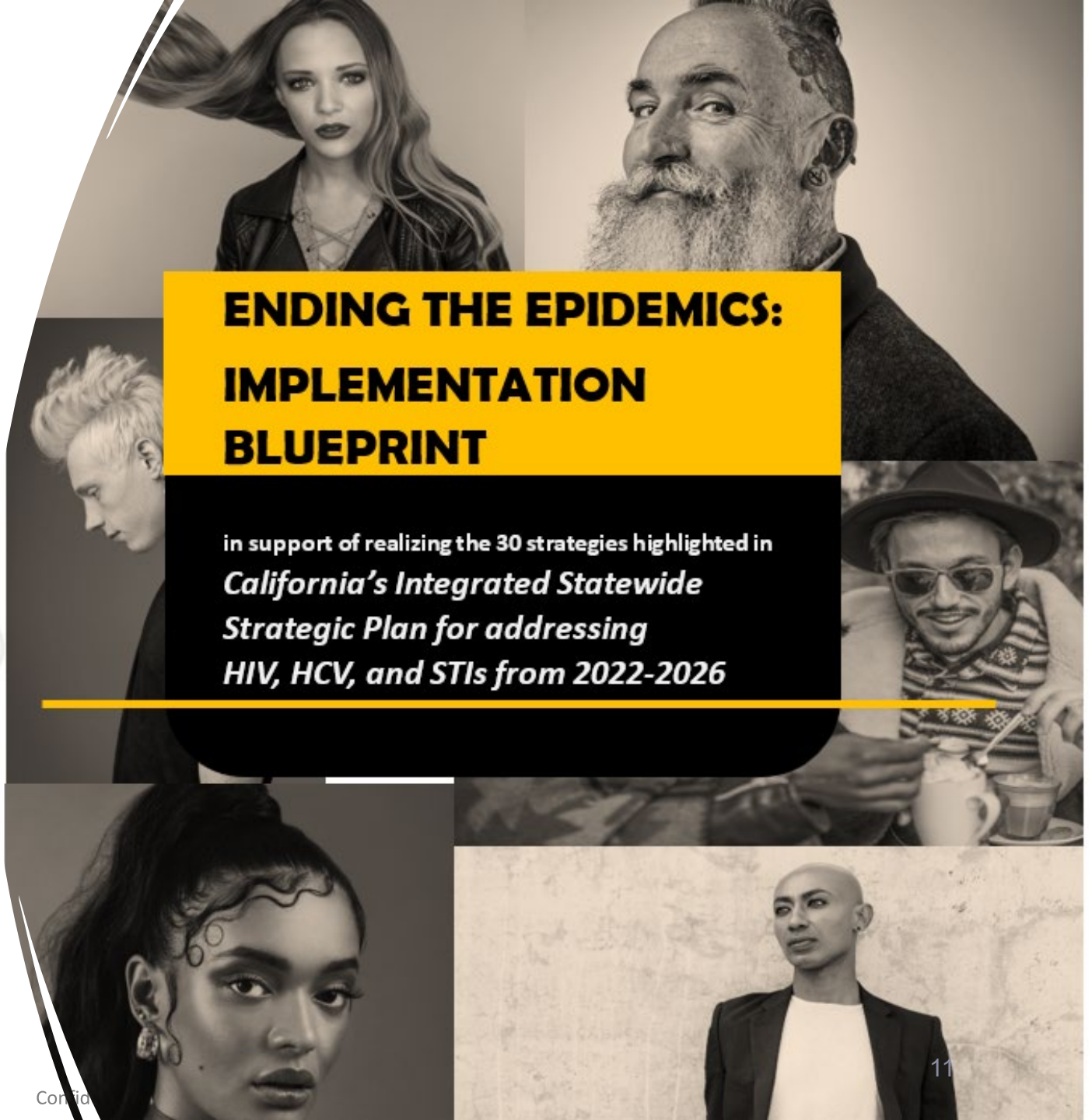
--Specific activities under each of the 30 strategies (156) Community suggestions, not mandates

--Feasibility/scoping phase

--Technical assistance toolkit

--Language bank for RFPs, reports, grants

--Resources to customize the Implementation Blueprint



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Strategy Partners

- EMA/TGA Co-Authors
- California Correctional Health Care Services (CCHCS)
- California Department of Corrections and Rehabilitation (CDCR)
- California Department of Social Services (CDSS)
- California Pathways into Public Health Initiative (Cal-PPH)
- Department of Education (CDE)
- Department of Health Care Services (DHCS)
- Department of Housing and Community Development (DHCD)
- Pacific AIDS Education and Training Center (PAETC)
- California STD/HIV Prevention Training Center (CA PTC)

HIV Planning Councils, Groups and Commissions: Roles

- Review and improve the plan (done)
- Concurrence (done)
- Advise the content and role-out of the Implementation Blueprint (ongoing)
- Participate in Strategy Meetings (ongoing)
- Communicate with community Stakeholders (ongoing)
- Help monitor the plan through updates (ongoing)

Revised Integrated Plan Guidance (2027-2031)

- **Released in February 2025**
- **Similar requirements for integrating HIV prevention, care and surveillance**
- **Needs Assessment**
- **Community Engagement**
- **Language changes to reflect policy shifts**
  - “Health equity,” becomes, “ensuring access to all available tools to improve health outcomes.”
  - Framing “inequities” as “barriers”
  - removes mention of specific racial and ethnic groups and replaces if phrases like, “populations with the highest burden of HIV.”
- **Workplan guidance more defined**
- **Due in June 2026**

Integrated Planning (2022-2026) (2027-2031)

Challenges

- Uncertainty of funding
- Unclear and shifting guidance for allowable activities
- Multi-county collaboration takes coordination, time, resources and adaptation for local use
- Workplan guidance much more defined this year
- Finishing out 2022-2026 in current environment

Strengths

- Collective Impact
- Cost
- Collaboration with STDCB
- Ability to sync with other state-wide plans
- Existing model- internal and external communications tools
- 2 Gap analyses can be used as our needs assessment: PrEP and ADAP
- Ability to leverage all existing work in each LHJ- develop an overall California logic model
- Capacity to do virtual community engagement: Ending the Syndemic Syndemic Symposium
- Implementation Blueprint based workplans

Key Elements of the California 2027-2031 Integrated Planning Process

- **Syndemic work through a social determinants of health lens**
- **Updates to the Integrated Plan and Implementation Blueprint**
  - Data Update
  - Progress
- **Collective impact: 7 co-author counties (SF and Los Angeles)- 7 concurrence bodies**
- **Statewide gap analyses: ADAP and PrEP**
- **Leverage needs assessments of all Part A LHJs**
- **Use of legacy data**
- **Data-based interventions and workplan**
  - EMA/TGA Specific Objectives
- **Meets all requirements set out by HRSA/HAB/CDC**

Timeline of Integrated Plan Drafting (2027-2031)

- Process presentations to HIV Councils/Commissions, Groups; invitations to LHJs (Jun/Jul/Aug/Sep 2025)
  - EMA/TGA Point Person/Committee- Key docs for Needs Ass., SMART Objectives, Communications
- Data Collection/Consultation/Community Engagement (Sep/Oct/Nov 2025)
- Writing, edits and updates begin (October 2025)
- Initial Draft and Updates Complete (December 2025)
- External Comment Period (February 2026)
- Concurrence Roadshow (March/April/May 2026)
- Document -Due to HRSA/HAB/CDC (June 2026)
- Implementation Launch (July-December 2026)
- Plan Activities Begin (January 2027)
  - Ending the Syndemic Symposium 2027
  - Five-year Retrospective Surveillance Report
  - Final PrEP Gap Analysis Report
  - Final ADAP Gap Analysis Report

CDPH

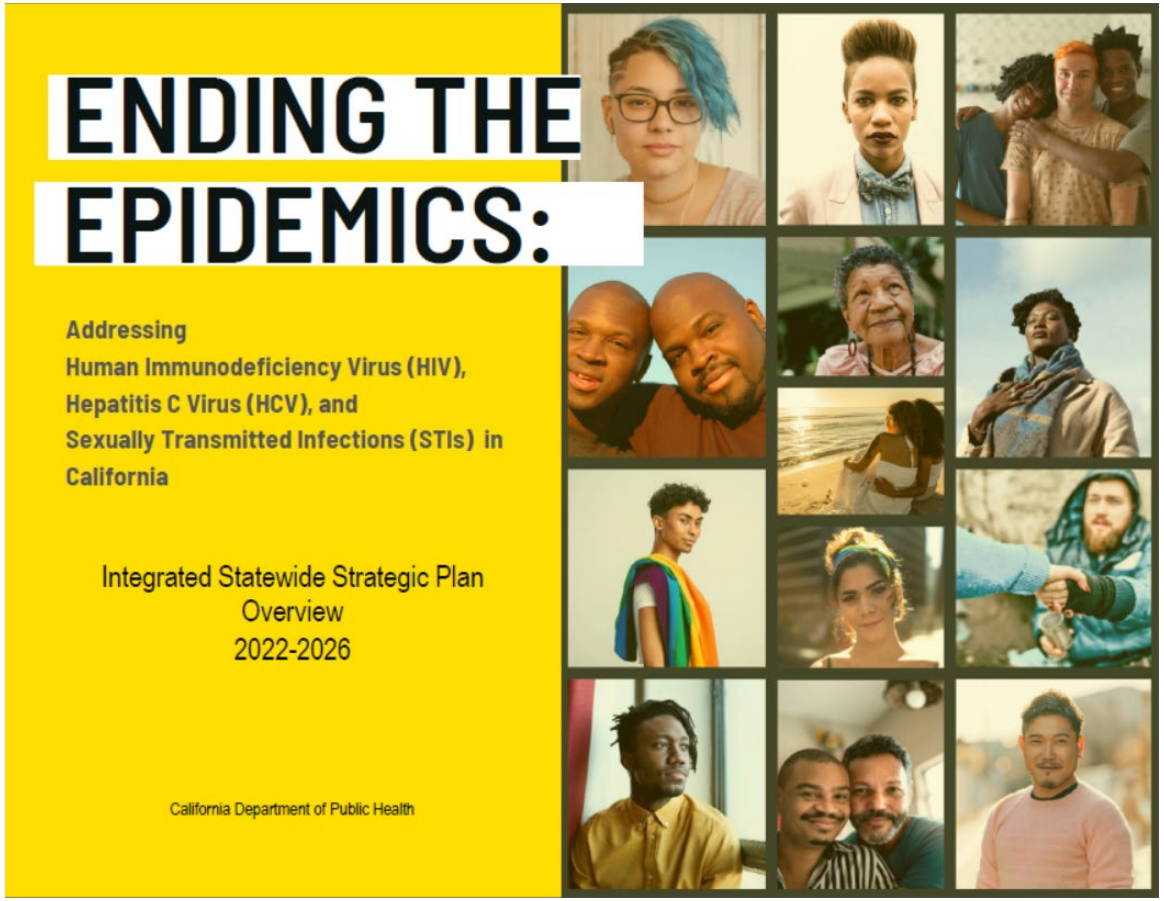
Resources

- https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/integrated-hiv-prevention-care-plan-guidance-2027-2031.pdf

- California HIV Surveillance Report – 2023
- HIV/AIDS Epidemiology and Health Disparities in California, 2022
- CA-Epi-Profile-2017-2021.pdf
- America's HIV Epidemic Analysis Dashboard | AHEAD
- CDPH_StratPlan2021_FINAL_ADA.pdf (ca.gov)
- Implementation-Blueprint.pdf
- California Consortium EHE Plan
- https://facenteconsulting.com/cdph-technical-assistance-request-portal/ (planning support to use the Implementation Blueprint)

- **Contact Information: Leroy.Blea@cdph.ca.gov**

Thank you!



CDPH

Tiena Johnson Hall, General Manager
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October 9, 2025 HOPWA Overview

- Q1 Clients Served: 2,367
- All but 1 contract have been executed
- All project sponsor budgets have been approved
- The funding drawdown system has been populated, but some final adjustments are still being made
- HACLA funding increased by $2.05M to $6,730,543 and 200 clients (up from 175)
- CAPER (Consolidated Annual Performance and Evaluation Report) will be submitted by the November deadline
- Government shutdown impact:
    - Funds are still accessible for drawdown during the shutdown
    - HUD liaison is on furlough
    - LAHD still has access to HUD Technical Assistance

RYAN WHITE HIV/AIDS PROGRAM (RWP) – FREQUENTLY ASKED QUESTIONS

WHAT IS THE RYAN WHITE HIV/AIDS PROGRAM (RWP)?

The RWP is a federal program that provides comprehensive care and support services to people living with HIV who are uninsured or underinsured. It's administered by the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB), and is divided into several "Parts" that fund different types of providers and activities.

PART A – METROPOLITAN AREAS

Funds: Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) with the highest number of people living with HIV.
Purpose: Provides funding to local health departments to deliver medical and support services.
Example: Los Angeles County Department of Public Health receives Part A funds to support local HIV care and treatment networks, including planning through the Commission on HIV.

PART B – STATES AND TERRITORIES

Funds: All 50 states, the District of Columbia, Puerto Rico, and U.S. territories.
Purpose: Provides HIV care and support services statewide.
Includes: The AIDS Drug Assistance Program (ADAP), which helps cover HIV medications for people who can't afford them.

PART C – COMMUNITY HEALTH CENTERS & CLINICS

Funds: Local community health centers, clinics, and hospitals.
Purpose: Supports early intervention services (EIS) and ongoing outpatient medical care.
Focus: HIV testing, linkage to care, medical treatment, and retention in care.

PART D – WOMEN, INFANTS, CHILDREN & YOUTH

Funds: Public and private nonprofit organizations.
Purpose: Provides family-centered HIV care and support services for women, infants, children, and youth living with or affected by HIV.
Focus: Holistic, age-appropriate, and family-focused care.

PART F – SPECIAL INITIATIVES & TRAINING

Funds: Various academic, clinical, and training institutions.
Purpose: Supports key initiatives that strengthen the HIV care system.
Includes: AETCs (AIDS Education and Training Centers), SPNS (Special Projects of National Significance), Dental Programs, and the Minority AIDS Initiative (MAI).

HOW DO ALL THE PARTS WORK TOGETHER?

Each Part plays a unique role in creating a seamless system of care — from providing medications and direct care to training providers and building community capacity — all working toward ending the HIV epidemic.

STANDING COMMITTEES AND CAUCUSES REPORT
KEY TAKEAWAYS | OCTOBER 2025

1. Operations

Link to the Operations Committee meeting packet can be found HERE.
Key outcomes/results from the meeting:

- The Operations Committee last met on September 25, 2025.
- A seat change for Dr. Leon Maultsby from the Part C Representative to the Provider Representative #1 seat was approved.
- The Membership Materials Review Workgroup presented its updates to the (1) Commissioner Duty Statement, (2) Unaffiliated Consumer, Service Provider Area (SPA) Representative Duty Statement, and (3) the Membership Application to the Committee for feedback. The goal was to streamline the documents to align with the Commission's restructuring process.
- The Operations Committee will review and discuss the interview questions recommended by the workgroup at its next meeting. The goal is to capture broader experience and relevant expertise, and to ensure the process is fair and favorable for all applicants.
- The Outreach & Recruitment Workgroup will present their ideas and suggestions for updating the Commission's outreach and recruitment materials at the next Operations Committee meeting.
- As a reminder, new membership applications will be placed on hold unless applicants meet the requirements for the following Unaffiliated Consumer seats: (1) Unaffiliated representative, SPA 1, (2) Unaffiliated representative, SPA 5, (3) Unaffiliated representative, Supervisorial District 2, (4) Unaffiliated representative, Supervisorial 4, and (5) Unaffiliated representative, at-large #1.
- It is anticipated that membership applications will open for all who are interested in joining the Commission in late October or November, with new members expected to be seated by March 2026.

Action needed from full body:

- Please attend the next Operations Committee meeting on October 23, 2025, from 10 AM – 12 PM at the Vermont Corridor.
- Please continue to promote the Commission on HIV's work. A media tool kit is located on the Commission's website.

2. Executive

Link to the September 18, 2025 Special Executive Committee meeting packet can be found HERE. Link to the September 25, 2025 regular Executive Committee meeting packet can be found HERE.

Key outcomes/results from the meeting:

- A special Executive Committee meeting was held on September 18, 2025, to hold a focused discussion on the Commission's role in prevention planning as part of the ongoing restructure process. Prevention stakeholders were invited to participate and contributed to a productive dialogue that generated several recommendations to strengthen the Commission's prevention efforts within an integrated planning framework. A more detailed summary of the discussion can be found **HERE**.
- At its September 25, 2025, meeting, the Committee reviewed and updated the proposed agenda for the November 13, 2025, Annual Conference to ensure it offers a more comprehensive reflection of science and research, policy and legislation, and community engagement and advocacy — all rooted in local community involvement.
- DHSP provided funding updates, noting significant threats to the Ryan White Program and prevention portfolios and resources, with focus on three priority areas: oral health, nutrition, and housing.
- The Committee continued its review of public comments on the proposed bylaws changes but agreed to pause deliberations to allow further discussion on the Commission's role in prevention planning. Leadership and staff subsequently agreed to delay approval of the proposed bylaws until prevention planning discussions are fully vetted and consensus is reached on next steps.

Action needed from full body:

- Committee members are encouraged to stay informed and actively engaged in upcoming discussions to help align the Commission's structure and planning efforts with evolving priorities in prevention, care, and community engagement.
- Save the date of November 13, 2025, for the Annual Conference to be held at St. Anne's Conference Center.
- Attend the next Executive Committee meeting scheduled for October 23, 2025.

3. Planning, Priorities and Allocations (PP&A)

Link to the September 16 Planning, Priorities and Allocations Committee meeting packet can be found HERE.

Key outcomes/results from the meeting:

- DHSP staff, S. Oksuzyan, provided a PY34 Ryan White Program Utilization Report to the committee focusing on core Ryan White Program services; see meeting packet for presentation slides.
    - The report showed a decreased utilization in Ambulatory/Outpatient Medical (AOM) services, Home-Based Case Management services and Mental Health services and an increased utilization in Medical Care Coordination services and Oral Health services. The highest expenditures per client were attributed to Housing and Home-Based Case Management services. The lowest expenditures per client were seen in Mental Health services and AOM services.
    - Engagement, retention in care and viral suppression percentages were higher in RWP clients using Oral Health services, Home-Based Case Management services and Mental Health services.

- DHSP staff requested the Committee review their PY36 allocations and reallocate percentages to include the new Partner Support Services within Non-Medical Case Management Services. Initial PY36 allocations did not include funding for this new service because it was under the solicitation process at the time of allocation.
    - The Committee recommended aligning PY36 reallocations with PY35 allocations with the intent to revisit the allocations at a later date once more data and expenditure reports are available.

Action needed from full body:

- Continue to stay engaged and informed of potential funding threats that may impact HIV care and prevention services. Encourage consumers and providers to attend PP&A monthly meetings.

4. Standards and Best Practices (SBP)

Link to the August 5, 2025 Standards and Best Practices Committee meeting packet can be found HERE.

Key outcomes/results from the meeting:

- Completed review of the Transitional Case Management (TCM) service standards and elevated the document to the Executive Committee for their review and approval at their August 29, 2025, meeting.
- Continued review of the Patient Support Services (PSS) service standards and decided to announce a public comment period starting on August 13, 2025, and ending on September 30, 2025. A notice was sent to the COH listserv, and the document was posted on the COH website **HERE.**
- Began review of the Mental Health Services (MH) service standards and decided to invite mental health providers contracted by DHSP to the October 7, 2025, SBP Committee meeting to gather their feedback.
- Canceled the September 2, 2025, SBP Committee meeting; Next SBP Committee meeting will be on October 7, 2025, from 10am-12pm at the Vermont Corridor.

Action needed from full body:

- Review the **PSS service standards document** and provide comments to assist the SBP Committee in their review of the document. Public comments are due on September 30, 2025.

5. Public Policy

Link to the September 15, 2025 Public Policy Committee meeting packet can be found HERE.

Key outcomes/results from the meeting:

- Cancelled October PPC meeting; At November PPC meeting, the PPC will determine whether to reschedule or cancel December meeting due to potential World AIDS Day event conflicts.

- Decided to develop a document that outlines the PPC activities to be continued in the new COH structure.
- Reviewed changes in status for bills on the 2025-26 Legislative Docket. Added a variety of Senate Bills (SB) that were not included in the docket initially due to timing. COH staff will continue to monitor changes in status for bills on the docket; last day for Governor to sign bills is October 12, 2025.
- The next PPC meeting will be on November 3, 2025, from 1pm-3pm at the Vermont Corridor. The meeting will include a training from the CEO LAIR office.

Action needed from full body:

- Attend the November 3, 2025, PPC meeting and participate in the CEO LAIR overview training.
- Review the 2025-26 Legislative Docket to stay informed in state legislation relevant to the COH.

6. Aging Caucus

Key outcomes/results from the meeting:

- The September Aging Caucus meeting was canceled. Rather, the caucus hosted The Power of Aging educational event on Sept. 19th from 9am-3pm in recognition of National HIV and Aging Awareness Day. The event brought together consumers, service providers, and advocates to address the evolving needs of older adults living with HIV.

Action needed from full body:

- Encourage participation in future Aging Caucus meetings and continue to collaborate and share information on services and resources impacting older adults living with HIV.

7. Black Caucus

Link to the Black Caucus meeting packet can be found HERE.
Key outcomes/results from the meeting:

- The Black Caucus met virtually on September 22, 2025.
- The Caucus is planning listening sessions for: (1) Youth, in partnership with the Los Angeles County Youth Commission and (2) Men Who Do Not Identify as MSM.
- The Caucus will partner with the County of Los Angeles and host a table as part of the County Pavilion at the Taste of Soul on Saturday, October 18, 2025, and is looking for volunteers to help set up and break down, assemble swag bags, manage the table and engage the community with information about HIV, and distribute resource materials. Volunteers are needed in 4-hour shifts beginning at 7am and ending at 4pm (7am – 11am, 11am – 3pm, and 12pm – 4pm). The Black Caucus is also requesting donations for swag bag items. Please contact staff if you would like to volunteer and/or donate items.
- The Caucus discussed hosting their third annual World AIDS Day (WAD) event scheduled for December 5th. Ideas mentioned included: (1) presenting a

comprehensive report from all listening sessions and organizational needs assessments, (2) engaging well-being centers, and (3) honoring those affected by HIV/AIDS.

- The next Black Caucus meeting will be held virtually on either October 14th or October 15th from 4pm – 5pm. Staff will send out the meeting notice once confirmed.

Action needed from full body:

- Please sign up to volunteer at the Taste of Soul on October 18th. If you cannot volunteer, please stop by for a moment to support the Black Caucus's community engagement efforts.
- Please donate goodies for swag bags.
- Please join the next Black Caucus meeting to discuss World AIDS Day event planning and the final plans for the TOS event.

8. Consumer Caucus

Link to the September 11, 2025 Consumer Caucus meeting packet can be found HERE.
Key outcomes/results from the meeting:

- The Caucus reviewed the Patient Support Services (PSS) standard and provided feedback. Caucus members were asked to encourage feedback among other consumers, providers and frontline staff; public comment closes September 30, 2025.
- The Caucus inquired about the eligibility requirements for the Emergency Financial Assistance program, which is now referred to as Emergency Rental Assistance. Staff clarified that the program is currently limited to rental assistance. To qualify, clients must be facing eviction, with assistance capped at $5,000 per client per year, and applications processed through Benefits Specialists.
- Staff will circulate a Doodle Poll to determine availability for the next Caucus meeting, which will focus on continuing the discussion of the stipend program.
- Technical assistance on how to navigate the Commission's website and mandatory e-forms will be scheduled for an upcoming meeting.

Action needed from full body:

- Engage in Commission and Committee meetings by offering consumer perspectives, sharing feedback, and staying informed on key issues impacting HIV services.

9. Transgender Caucus

Link to the August 26, 2025 Transgender Caucus meeting packet can be found HERE.
Key outcomes/results from the meeting:

- COH staff shared updates from the "Subordinate Working Unit Leadership" meeting summary report.
- Canceled their September meeting; COH staff will send poll to members to determine the October meeting date/time.

Action needed from full body:

- N/A

10. Women's Caucus

Link to the September 15, 2025 Women's Caucus meeting packet can be found HERE.
Key outcomes/results from the meeting:

- The Women's Caucus met on September 15 and COH staff shared updates from the "Subordinate Working Unit Leadership" meeting summary report.
- The caucus provided a brief recap of the various listening sessions that were held in June. The group also reviewed their women-centered programming recommendations to address the needs of women living with HIV; see meeting packet for more details. The group identified peer support as a key service needed.
- The caucus reviewed their workplan for the year and noted that all target activities have been completed. They also discussed potential opportunities to collaborate with the Women's HIV Taskforce.

Action needed from full body:

- Encourage participation in future Women's Caucus meetings and continue to collaborate & share information on services/resources impacting women living with HIV.

11. Housing Task Force

- The Housing Taskforce will hold its final meeting October 24, 2025, to discuss and finalize recommendations based on the findings of the HTF's activities to include the housing/legal services provider consultations and consumer survey housing survey. These findings will be incorporated in the next iteration of the Integrated HIV plan (aka Comprehensive HIV Plan) as well as in the Commission's other core functions: planning, priority setting, resource allocations, and service standards.
- Taskforces sunset once the group has completed its deliverables and final recommendations are approved by the Executive Committee. The HTF has successfully completed is its deliverables, thanks to your dedication and commitment

Action needed from full body:

- Review the materials and think of high-level recommendations and low-hanging fruit recommendations that come directly from the findings of the HTF's planning and activities. Ideally, these should be tangible, actionable recommendations that can realistically be advanced.

Los Angeles County Commission on HIV

Program Year 36 (PY36) Reallocations - Part A

Service Category	Service Ranking	Approved PY 35 Allocations[1]	Revised PY 36 Allocations[2]
ADAP Treatments	**9**	0.00%	0.00%
Child Care Services	**18**	0.00%	0.00%
Early Intervention Services (Testing Services)	**11**	2.07%	2.07%
Emergency Financial/Rental Assistance	**2**	4.29%	4.29%
Health Education/Risk Reduction	**13**	0.00%	0.00%
Health Insurance Premium & Cost Sharing Assistance	**15**	0.00%	0.00%
Home and Community-Based Services (Intensive Case Management Home Based)	**17**	3.96%	3.96%
Home Health Care	**16**	0.00%	0.00%
Hospice Services	**28**	0.00%	0.00%
Housing: RCFCI TRCF (Part B)	**1**	11.75%	11.75%
Legal Services	**23**	2.68%	2.68%
Linguistic Services (Language Services)	**27**	0.00%	0.00%
Local AIDS Pharmaceutical Assistance Program	**22**	0.00%	0.00%
Medical Case Management (Medical Care Coordination)	**6**	16.05%	16.05%
Medical Nutritional Therapy	**26**	0.00%	0.00%
Medical Transportation	**10**	1.86%	1.86%
Mental Health Services	**3**	3.64%	3.64%
Non-medical Case Management: Benefits Specialty Services	**5**	2.96%	2.96%
Non-medical Case Management: Patient Support Services	**5**	9.60%	9.60%
Non-medical Case Management: Transitional Case Management-Jails	**5**	0.00%	0.00%
Nutrition Support: Food Bank Home Delivered Meals	**7**	8.27%	8.27%
Oral Health: General Specialty	**8**	18.16%	18.16%
Outpatient Medical Health Services (Ambulatory Outpatient Medical)	**20**	14.71%	14.71%
Outreach Services: Linkage Re-engagement Program (LRP)	**14**	0.00%	0.00%
Psychosocial Support Services	**4**	0.00%	0.00%
Referral	**24**	0.00%	0.00%
Rehabilitation	**25**	0.00%	0.00%
Respite Care	**21**	0.00%	0.00%
Substance Abuse Residential	**19**	0.00%	0.00%
Substance Abuse Services Outpatient	**12**	0.00%	0.00%
Total		100.00%	100.00%

1) Approved by Planning, Priorities, and Allocations Committee on 8/19/25; Approved by Exec. Committee on 8/28/25

2) Recommended by Planning, Priorities, and Allocations Committee on 9/16/25; Approved by Exec. Committee on 9/25/25

Los Angeles County Commission on HIV

Program Year 36 (PY36) Reallocations - Minority AIDS Initiative (MAI)

Service Category	Service Ranking	Approved PY 35 Allocations[1]	Revised PY 36 Allocations[2]
ADAP Treatments	**9**	0.00%	0.00%
Child Care Services	**18**	0.00%	0.00%
Early Intervention Services (Testing Services)	**11**	0.00%	0.00%
Emergency Financial Assistance	**2**	0.00%	0.00%
Health Education/Risk Reduction	**13**	0.00%	0.00%
Health Insurance Premium & Cost Sharing Assistance	**15**	0.00%	0.00%
Home and Community-Based Services (Intensive Case Management Home Based)	**17**	0.00%	0.00%
Home Health Care	**16**	0.00%	0.00%
Hospice Services	**28**	0.00%	0.00%
Housing: Transitional (Rampart Mint)	**1**	100.00%	100.00%
Legal Services	**23**	0.00%	0.00%
Linguistic Services (Language Services)	**27**	0.00%	0.00%
Local AIDS Pharmaceutical Assistance Program	**22**	0.00%	0.00%
Medical Case Management (Medical Care Coordination)	**6**	0.00%	0.00%
Medical Nutritional Therapy	**26**	0.00%	0.00%
Medical Transportation	**10**	0.00%	0.00%
Mental Health Services	**3**	0.00%	0.00%
Non-medical Case Management: Benefits Specialty Services	**5**	0.00%	0.00%
Non-medical Case Management: Patient Support Services	**5**	0.00%	0.00%
Non-medical Case Management: Transitional Case Management-Jails	**5**	0.00%	0.00%
Nutrition Support: Food Bank Home Delivered Meals	**7**	0.00%	0.00%
Oral Health: General Specialty	**8**	0.00%	0.00%
Outpatient Medical Health Services (Ambulatory Outpatient Medical)	**20**	0.00%	0.00%
Outreach Services: Linkage Re-engagement Program (LRP)	**14**	0.00%	0.00%
Psychosocial Support Services	**4**	0.00%	0.00%
Referral	**24**	0.00%	0.00%
Rehabilitation	**25**	0.00%	0.00%
Respite Care	**21**	0.00%	0.00%
Substance Abuse Residential	**19**	0.00%	0.00%
Substance Abuse Services Outpatient	**12**	0.00%	0.00%
Total		100.00%	100.00%

1) Approved by Planning, Priorities, and Allocations Committee on 8/19/25; Approved by Exec. Committee on 8/28/25

2) Recommended by Planning, Priorities, and Allocations Committee on 9/16/25; Approved by Exec. Committee on 9/25/25

Los Angeles County Commission on HIV
Approved Program Year 35 (PY35) Reallocations - Part A

				FY 2025 (PY35)[1]		
Service Category	**Service Ranking**	**Applied Part A Allocation Amount**	**Original COH Part A %**	**Revised Part A Allocation Amount**	**Revised Part A %**	**Notes**
Early Intervention Services (Testing Services)	**11**	$ -	0.00%	$ 777,616.55	2.07%	March-June
Emergency Financial/Rental Assistance	**2**	$ 3,023,661	8.00%	$ 1,611,582.12	4.29%	
Home and Community-Based Services (Intensive Case Management Home Based)	**17**	$ 2,456,724	6.50%	$ 1,487,614.26	3.96%	
Housing: RCFCI TRCF	**1**	$ 343,941	0.91%	$ 4,414,006.96	11.75%	TRCF Part B
Legal Services	**23**	$ 755,915	2.00%	$ 1,006,769.25	2.68%	
Medical Case Management (Medical Care Coordination)	**6**	$ 10,960,770	29.00%	$ 6,029,345.68	16.05%	
Medical Transportation	**10**	$ 695,442	1.84%	$ 698,727.91	1.86%	
Mental Health Services	**3**	$ 7,559	0.02%	$ 1,367,403.01	3.64%	
Non-medical Case Management: Benefits Specialty Services	**5**	$ 1,492,932	3.95%	$ 1,111,954.09	2.96%	
Non-medical Case Management: Patient Support Services	**5**	$ -	0.00%	$ 3,606,337.60	9.60%	
Non-medical Case Management: Transitional Case Management-Jails	**5**	$ 597,173	1.58%	$ -	0.00%	
Nutrition Support: Food Bank Home Delivered Meals	**7**	$ 2,944,290	7.79%	$ 3,106,709.58	8.27%	
Oral Health: General Specialty	**8**	$ 8,050,496	21.30%	$ 6,821,988.00	18.16%	
Outpatient Medical Health Services (Ambulatory Outpatient Medical)	**20**	$ 6,466,854	17.11%	$ 5,525,961.05	14.71%	
Psychosocial Support Services	**4**	$ -	0.00%	$ -	0.00%	
Referral	**24**	$ -	0.00%	$ -	0.00%	
Rehabilitation	**25**	$ -	0.00%	$ -	0.00%	
Respite Care	**21**	$ -	0.00%	$ -	0.00%	
Substance Abuse Residential	**19**	$ -	0.00%	$ -	0.00%	Part B
Total		$ 37,795,758	100.00%	$ 37,566,017	100.00%	

Notes

1) Approved by PP&A Committee on 8.19.25; approved by Exec. Committee on 8.28.25

Los Angeles County Commission on HIV

Approved Program Year 35 (PY35) Reallocations - Minority AIDS Initiative (MAI)

				FY 2025 (PY35)[1]	
Service Category	**Service Ranking**	**Applied MAI Allocation Amount**	**Original COH MAI %**	**Revised MAI [3] Allocation $ Amount**	**Revised MAI[3] %**
ADAP Treatments	**9**	$ -	0.00%	$ -	0.00%
Child Care Services	**18**	$ -	0.00%	$ -	0.00%
Early Intervention Services (Testing Services)	**11**	$ -	0.00%	$ -	0.00%
Emergency Financial Assistance	**2**	$ -	0.00%	$ -	0.00%
Health Education/Risk Reduction	**13**	$ -	0.00%	$ -	0.00%
Health Insurance Premium & Cost Sharing Assistance	**15**	$ -	0.00%	$ -	0.00%
Home and Community-Based Services (Intensive Case Management Home Based)	**17**	$ -	0.00%	$ -	0.00%
Home Health Care	**16**	$ -	0.00%	$ -	0.00%
Hospice Services	**28**	$ -	0.00%	$ -	0.00%
Housing: Transitional (Rampart Mint)	**1**	$ 3,470,916	100.00%	$ 3,350,148	100.00%
Legal Services	**23**	$ -	0.00%	$ -	0.00%
Linguistic Services (Language Services)	**27**	$ -	0.00%	$ -	0.00%
Local AIDS Pharmaceutical Assistance Program	**22**	$ -	0.00%	$ -	0.00%
Medical Case Management (Medical Care Coordination)	**6**	$ -	0.00%	$ -	0.00%
Medical Nutritional Therapy	**26**	$ -	0.00%	$ -	0.00%
Medical Transportation	**10**	$ -	0.00%	$ -	0.00%
Mental Health Services	**3**	$ -	0.00%	$ -	0.00%
Non-medical Case Management: Benefits Specialty Services	**5**	$ -	0.00%	$ -	0.00%
Non-medical Case Management: Patient Support Services	**5**	$ -	0.00%	$ -	0.00%
Non-medical Case Management: Transitional Case Management-Jails	**5**	$ -	0.00%	$ -	0.00%
Nutrition Support: Food Bank Home Delivered Meals	**7**	$ -	0.00%	$ -	0.00%
Oral Health: General Specialty	**8**	$ -	0.00%	$ -	0.00%
Outpatient Medical Health Services (Ambulatory Outpatient Medical)	**20**	$ -	0.00%	$ -	0.00%
Outreach Services: Linkage Re-engagement Program (LRP)	**14**	$ -	0.00%	$ -	0.00%
Psychosocial Support Services	**4**	$ -	0.00%	$ -	0.00%
Referral	**24**	$ -	0.00%	$ -	0.00%
Rehabilitation	**25**	$ -	0.00%	$ -	0.00%
Respite Care	**21**	$ -	0.00%	$ -	0.00%
Substance Abuse Residential	**19**	$ -	0.00%	$ -	0.00%
Substance Abuse Services Outpatient	**12**	$ -	0.00%	$ -	0.00%
Total		$ 3,470,916	100.00%	$ 3,350,148	100.00%

Notes

1) Approved by PP&A Committee on 8.19.25; approved by Exec. Committee on 8.28.25

Ryan White Program Utilization Summary: Core Services
RW Year 34: March 1, 2024 - February 28, 2025

Sona Oksuzyan, Supervising Epidemiologist
Amanda Wahnich, Supervising Epidemiologist
Monitoring and Evaluation Unit
Division of HIV and STD Programs

September 16, 2025

Agenda

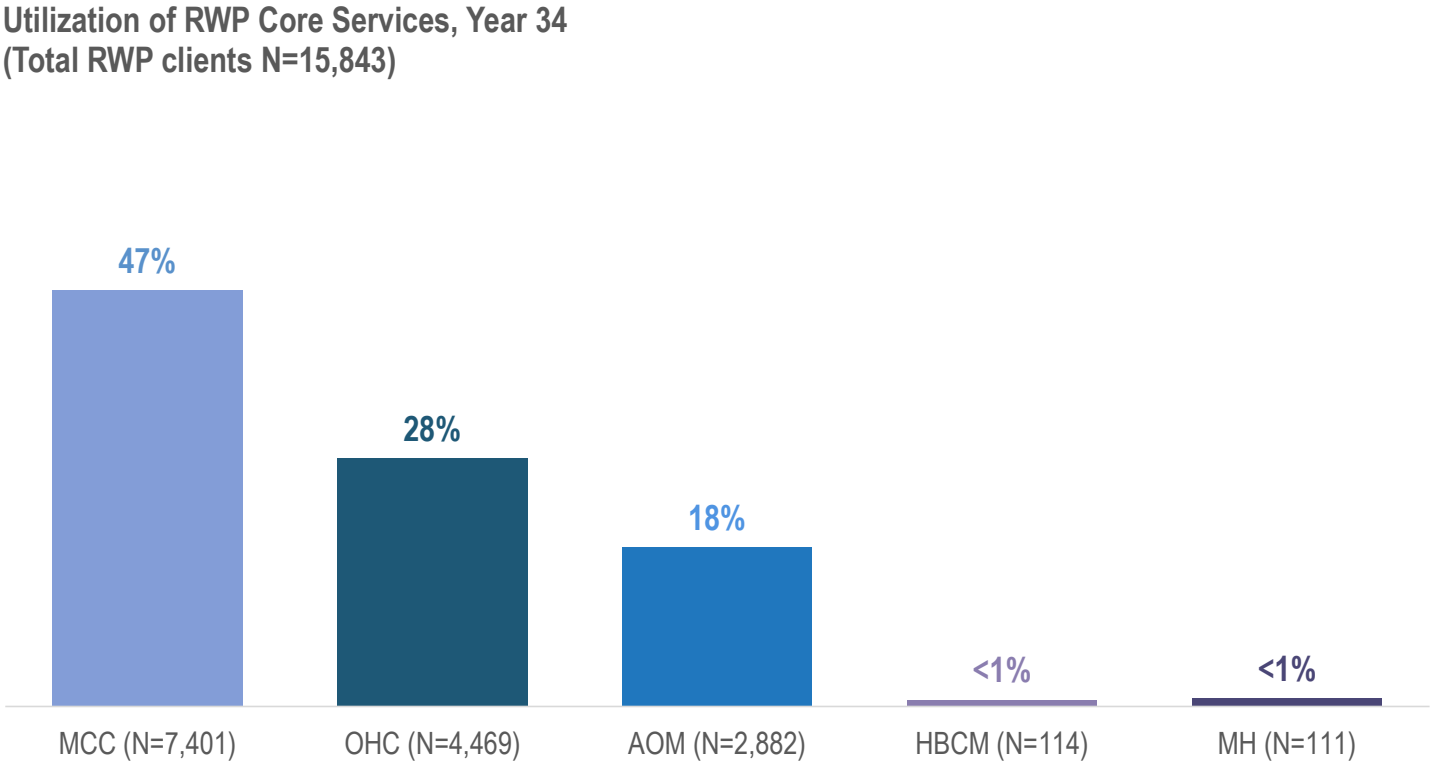
- Core Services Overview
- Core Services Deep Dive Framework
- Core Services Expenditures
- Key Takeaways

County of Los Angeles Public Health

Overview of Core Services

Medical Care Coordination (MCC) 18 contracted sites	Addresses **patients' medical and non-medical needs through coordinated case management** to support continuous engagement in care and adherence to ART
Oral Health Care (OHC) 12 contracted sites	Provides **routine comprehensive oral health care**, including prevention, treatment, counseling, and education
Ambulatory Outpatient Medical (AOM) 18 contracted sites	Provides **comprehensive outpatient care** including primary medical care, HIV medication management, laboratory testing, counseling, nutrition education, case management, support groups, and access to specialized HIV treatment options
Mental Health (MH) 7 contracted sites	Provides **mental health assessment, treatment planning and provision**
Home-Based Case Management (HBCM) 5 contracted sites	Provides c**lient-centered case management and social work activities**, focusing on care for **PLWH who are functionally impaired and require intensive home and/or community-based care**

Medical Care Coordination (MCC) was the most highly used core service in Year 34.



RWP Year 34: Core Service Category Deep Dive Framework & Discussion

Overall Service Utilization and Expenditure Summary	• Client Served • Service Units (Total and Per Client) • Expenditures (Total and Per Client)
Client Demographics	• Gender • Race • Age
Priority Population Engagement	• Latinx MSM • Black/AA MSM • Age ≥ 50 years • Age 13-29 clients • Women of color • Transgender Clients • PWID • Unhoused < 12 months
Health Determinants	• Primary language • Income • Primary insurance • Housing status • Incarceration history
HIV Care Continuum Outcomes	• Engaged in Care • Retained in Care • Suppressed Viral Load

Ambulatory Outpatient Medical (AOM)

- 20% reduction in service utilization in Year 34 compared to Year 33
- 31% reduction in expenditures in Year 34 compared to Year 33

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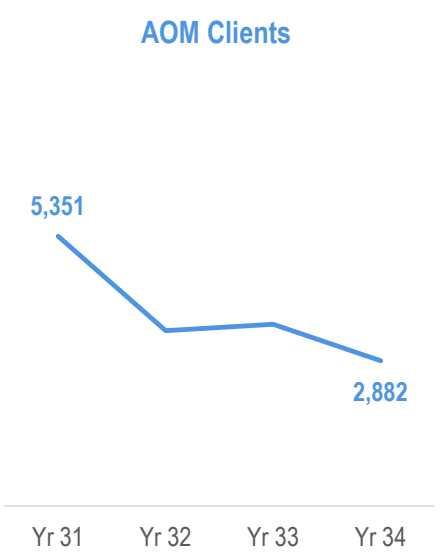
- A total of **2,882 unique clients** received AOM services, which represent almost a fifth (18%) of RWP clients.
- There was an **overall decline in AOM utilization over the last couple of years** largely due to DHS agencies departure from RWP and partially due to Medi-Cal expansion.



AOM Service Utilization & Expenditures Summary, Year 34

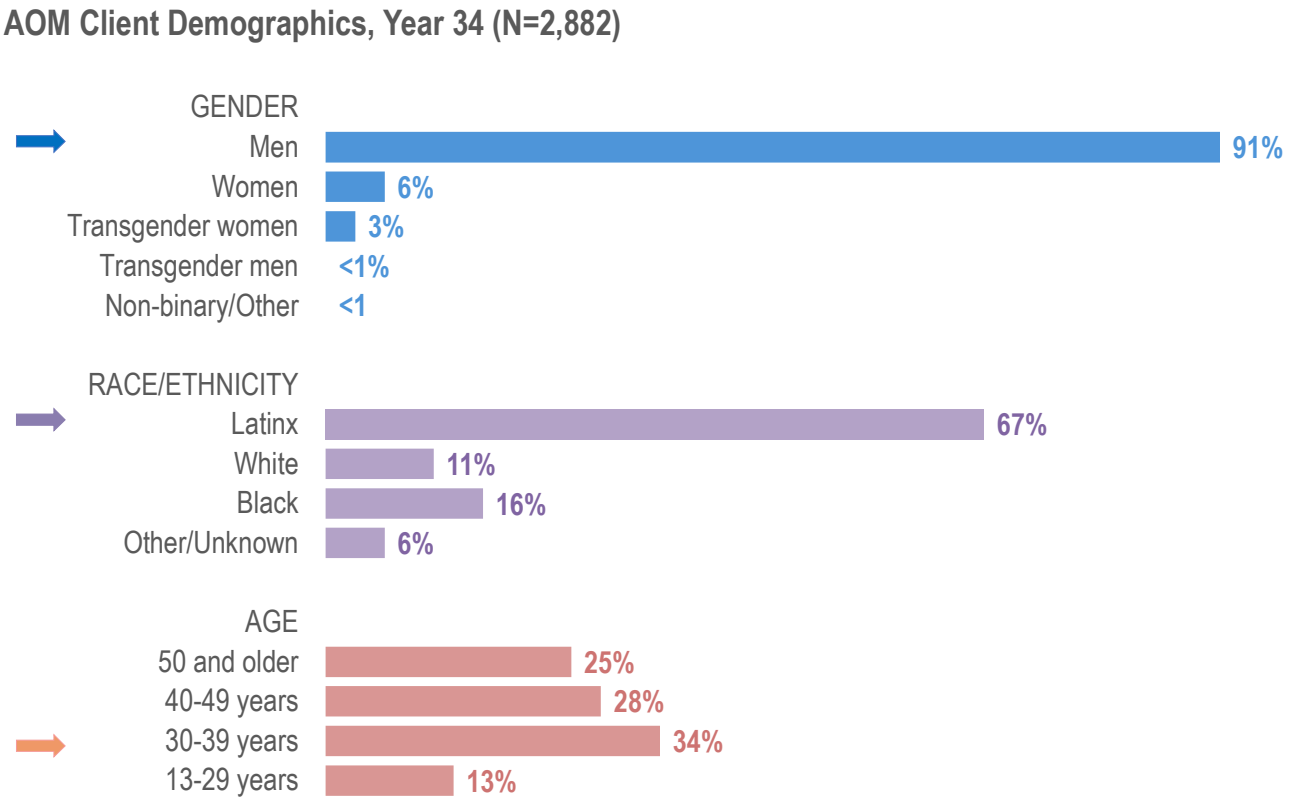
Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditures	Expenditures per client
AOM	**2,882**	Visits/ Procedures	**n/a**	**n/a**	***$5,183,652***	***$1,799***
Fee for Service	**2,882**	**Visits**	**7,480**	**3**	***$3,417,295***	***$1,186***
Supplemental AOM Procedures	2,639	Procedures	53,157	20	*$1,257,972*	*$477*
Medical Subspecialty*					*$508,385*	

Funding Source:

- *RWP Part A - $4,949,495*
- *HIV NCC - $234,157*

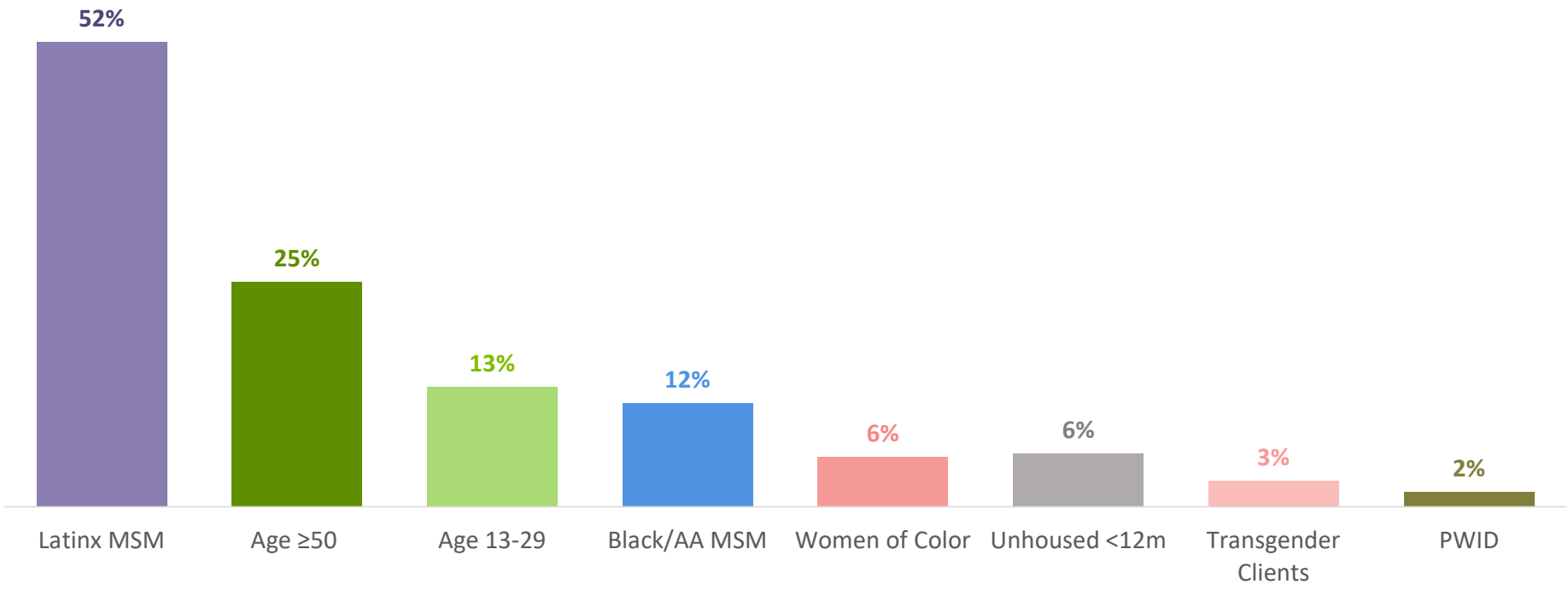
*No data in CaseWatch

AOM clients were predominantly cisgender men, Latinx and people aged 30-39 years old.



AOM services are reaching clients in LAC priority populations*

- **Latinx MSM** clients represented the **largest percentage of AOM clients**
- Clients **age ≥ 50** represented a **quarter of AOM clients**



*Priority population groups are not mutually exclusive, they overlap.

Most AOM clients predominantly spoke English, lived at/below FPL, permanently housed, and no insurance or incarceration history.

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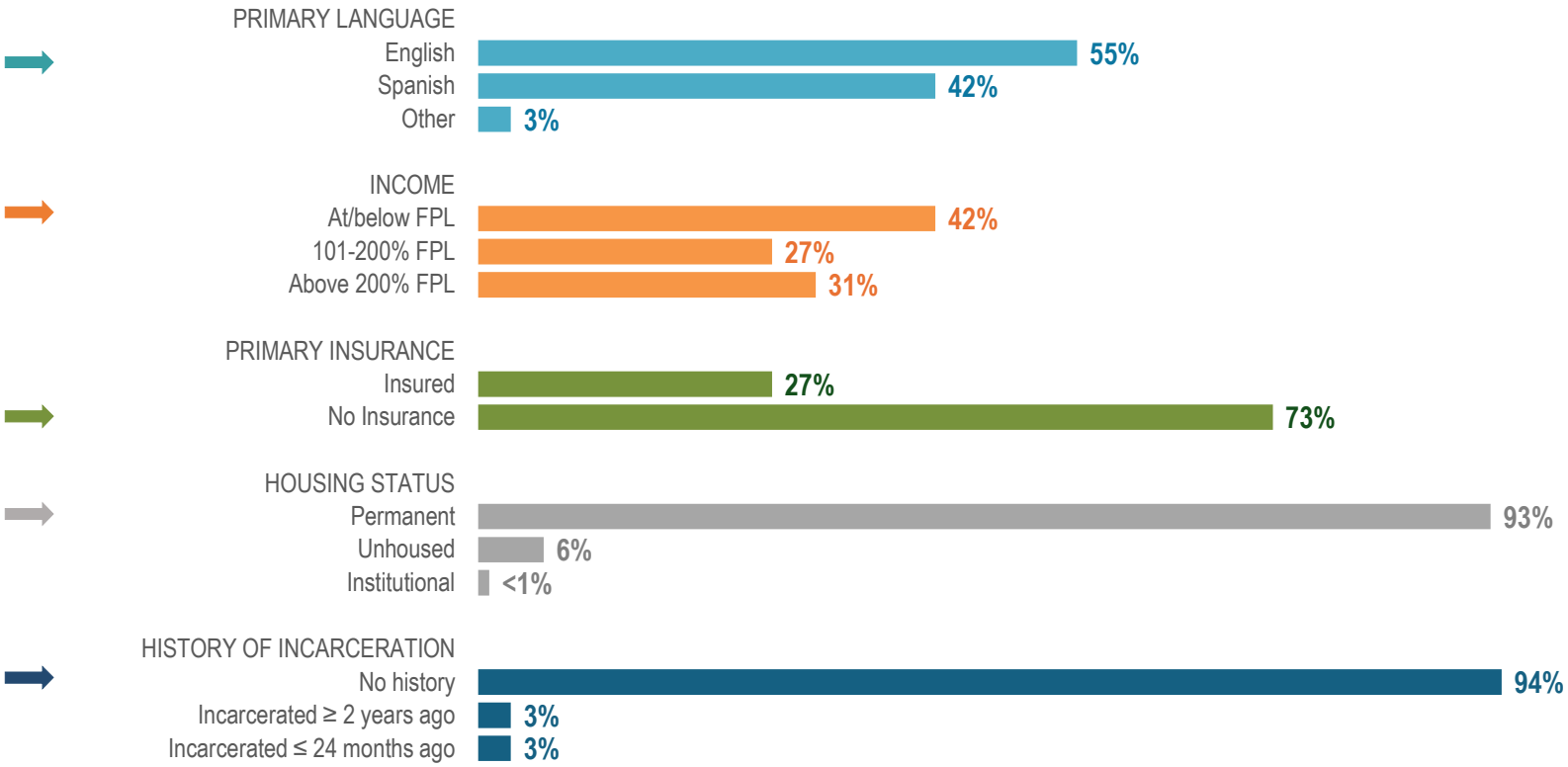
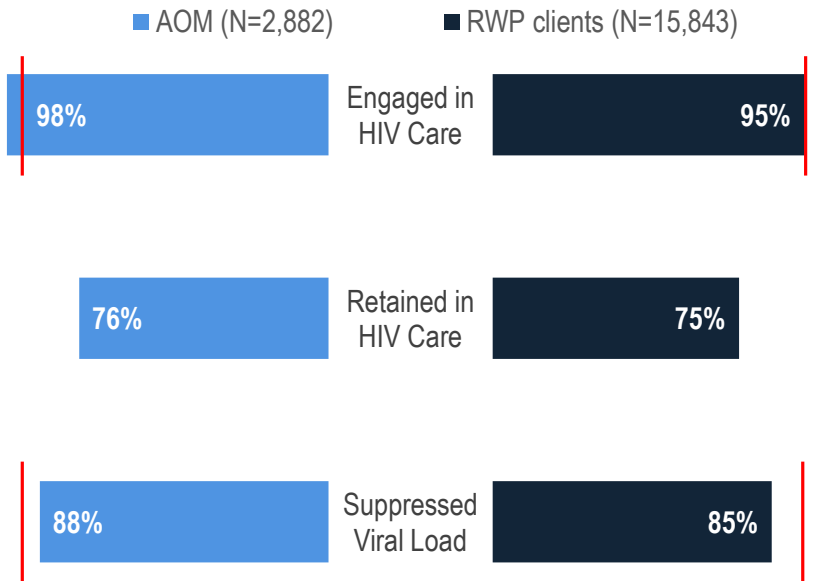
AOM Client Health Determinants, Year 34 (N=2,882)



Overall, AOM Clients had better HIV care outcomes attainment compared to RWP clients

- Engagement[a], retention in care[b], and viral load suppression[c] percentages were higher for AOM clients compared to RWP clients overall, Year 34.
- AOM clients did not meet the EHE target of 95% for viral suppression. However, they met the local target of 95% for engagement in care in Year 34.



Data source: HIV Casewatch as of 5/1/2025

[a]**Engagement in Care** defined as 1 ≥ viral load, CD4 or genotype test reported in the 12-month period based on HIV laboratory data as of 5/5/2025
[b]**Retention in care** defined as 2 ≥ viral load, CD4 or genotype test reported >30 days apart in the 12-month period based on HIV laboratory data as of 5/5/2025
[c]**Viral suppression** defined as most recent viral load test <200 copies/mL in the 12-month period based on HIV laboratory data as of 5/5/2025

Medical Care Coordination (MCC)

Highest utilized RWP service

- 7% increase in service utilization in Year 34 compared to Year 33
- 9% increase in expenditures in Year 34 compared to Year 33

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- A total of **7,401 unique clients** received MCC services, which represent 47% of RWP clients.
- **MCC service utilization** in starting to **have an uptick in Year 34** compared to the previous 2 years.

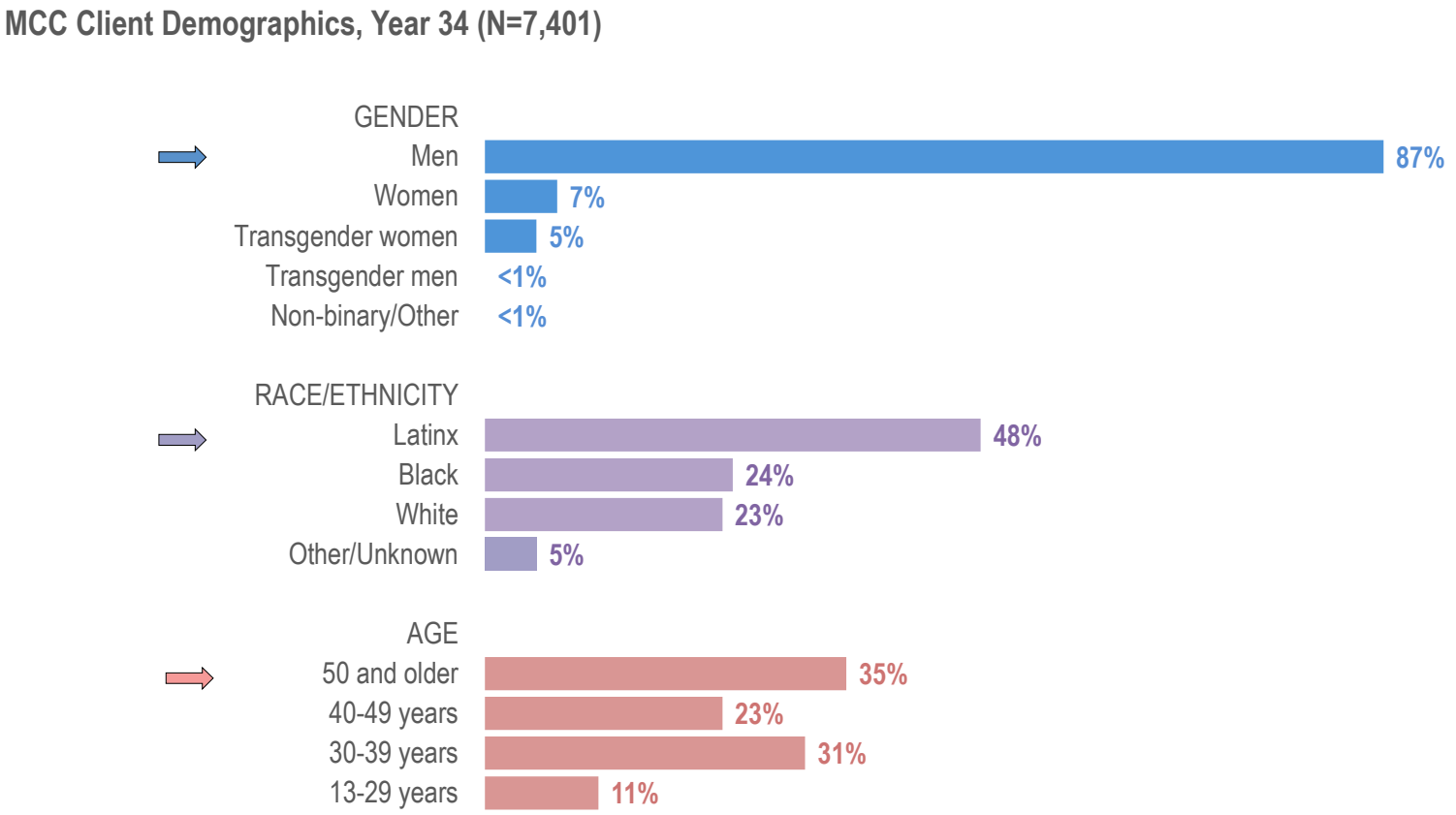
MCC Service Utilization & Expenditures Summary, Year 34

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditures	Expenditures per client
MCC	7,401	Hours	102,451	14	*$11,684,158*	*$1,579*

Funding Source:

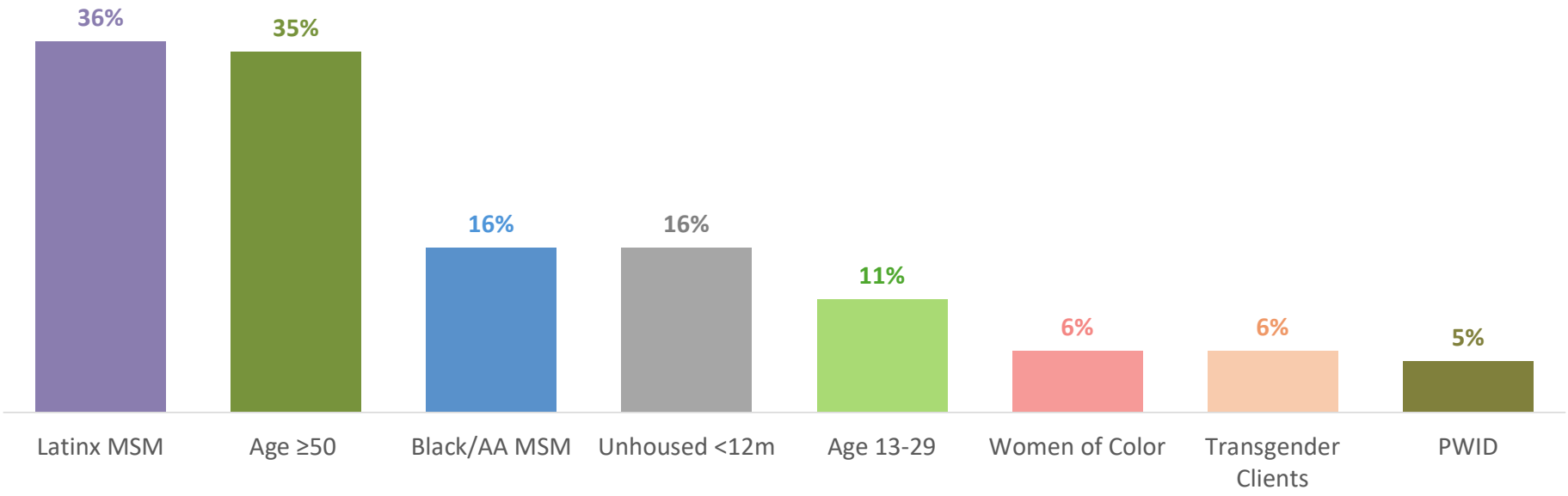
- *Part A - $11,684,158*

MCC clients were predominantly cisgender men, Latinx and people aged 50 and older.



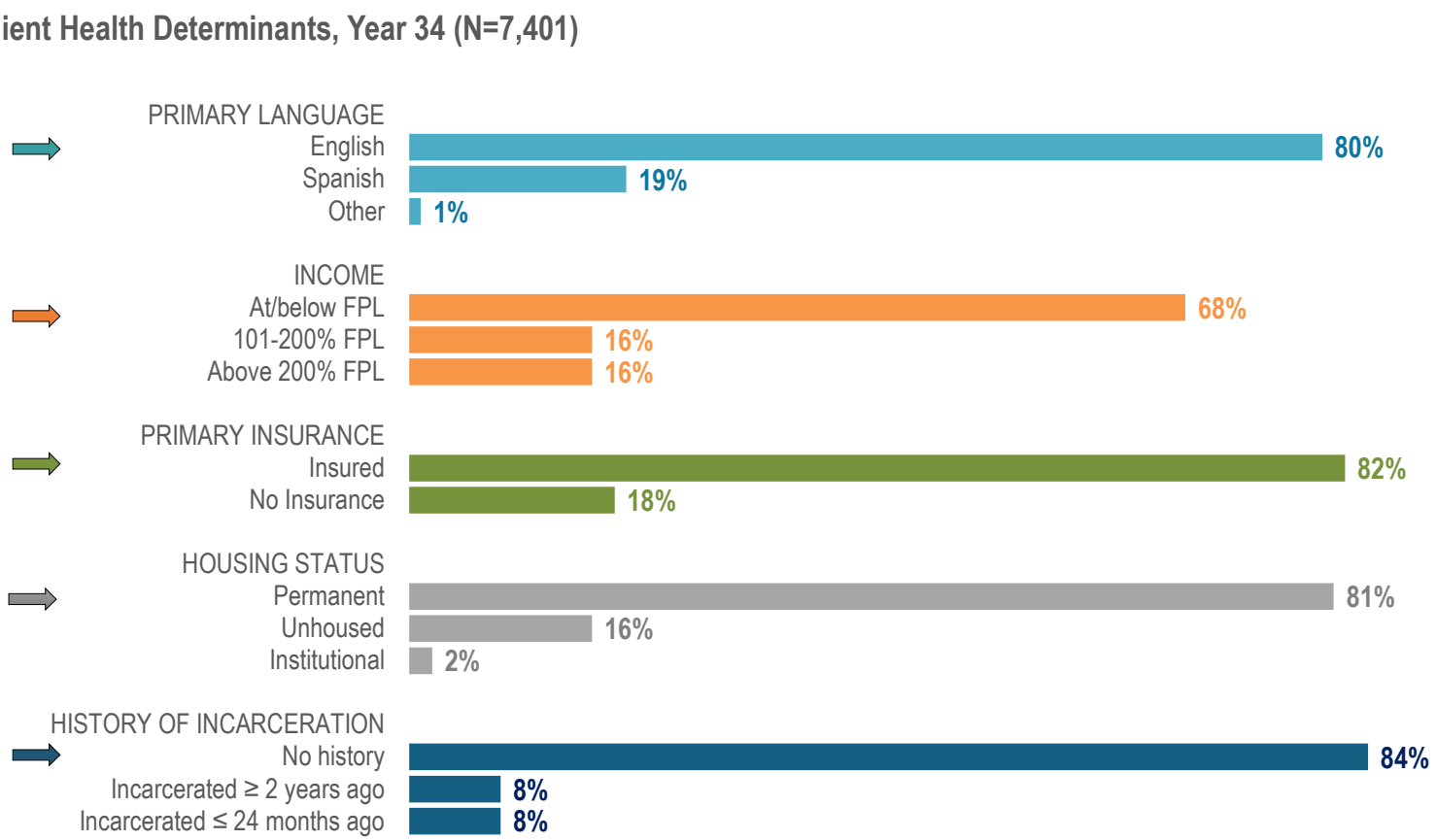
LAC Priority Populations Accessing the MCC Services*, Year 34

- **Latinx MSM** clients represented the largest percentage
- **Clients age ≥ 50** represented over a third of all MCC clients



*Priority population groups are not mutually exclusive, they overlap.

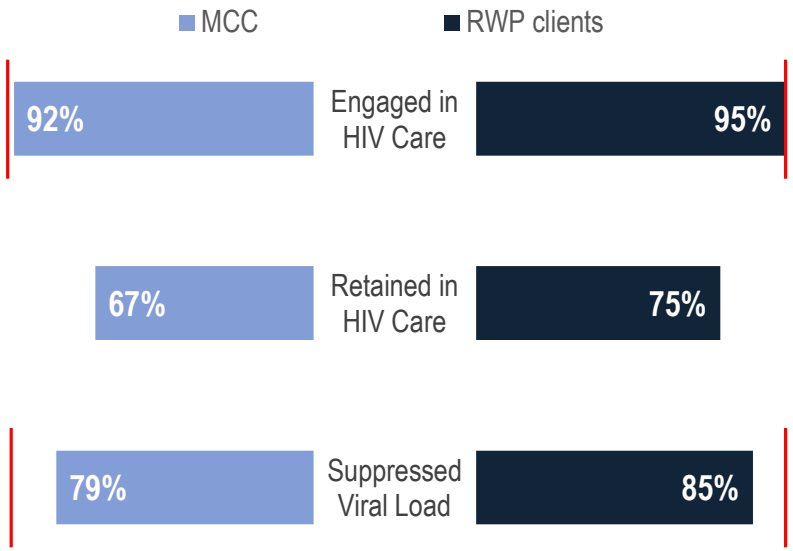
Most of MCC clients spoke English, lived at or below FPL, permanently housed, and no history of incarceration.



Overall, MCC clients had lower HIV care outcome attainment compared to RWP clients.

- Engagement[a], retention[b], and viral load suppression[c] percentages were lower for MCC clients compared to RWP clients overall, Year 34.

- MCC clients did not meet the EHE targets
  - MCC clients have more barriers than RWP overall



Data source: HIV Casewatch as of 5/1/2025

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[c]**Viral suppression** defined as most recent viral load test <200 copies/mL in the 12-month period based on HIV laboratory data as of 5/5/2025

Oral Health Care (OHC)

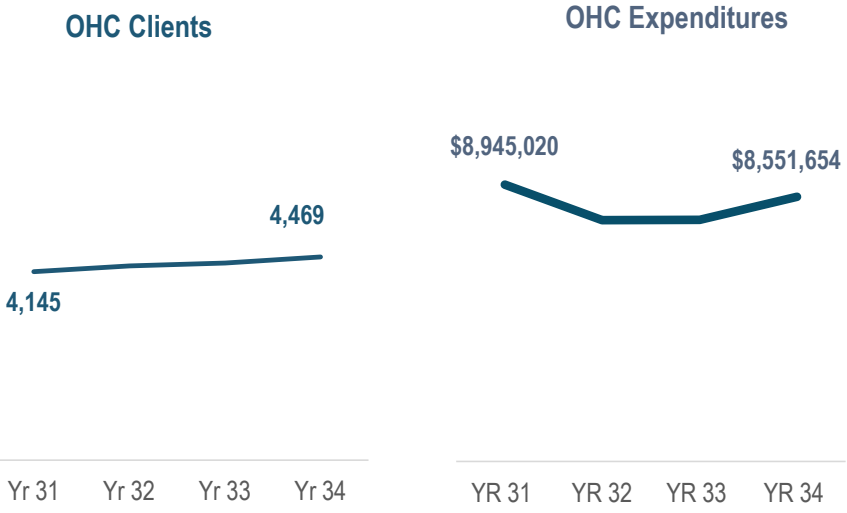
Second highest utilized RWP service

- 3% increase in service utilization in Year 34 compared to Year 33
- 10% increase in expenditures in Year 34 compared to Year 33

A total of **4,469 unique clients** received **Oral Health Care services** representing 28% of RWP clients.

- *General Oral Health* services were provided to **4,185** clients.
- *Specialty Oral Health* services were provided to **986** clients.

Oral Health Care utilization **increased** in the past 4 years.



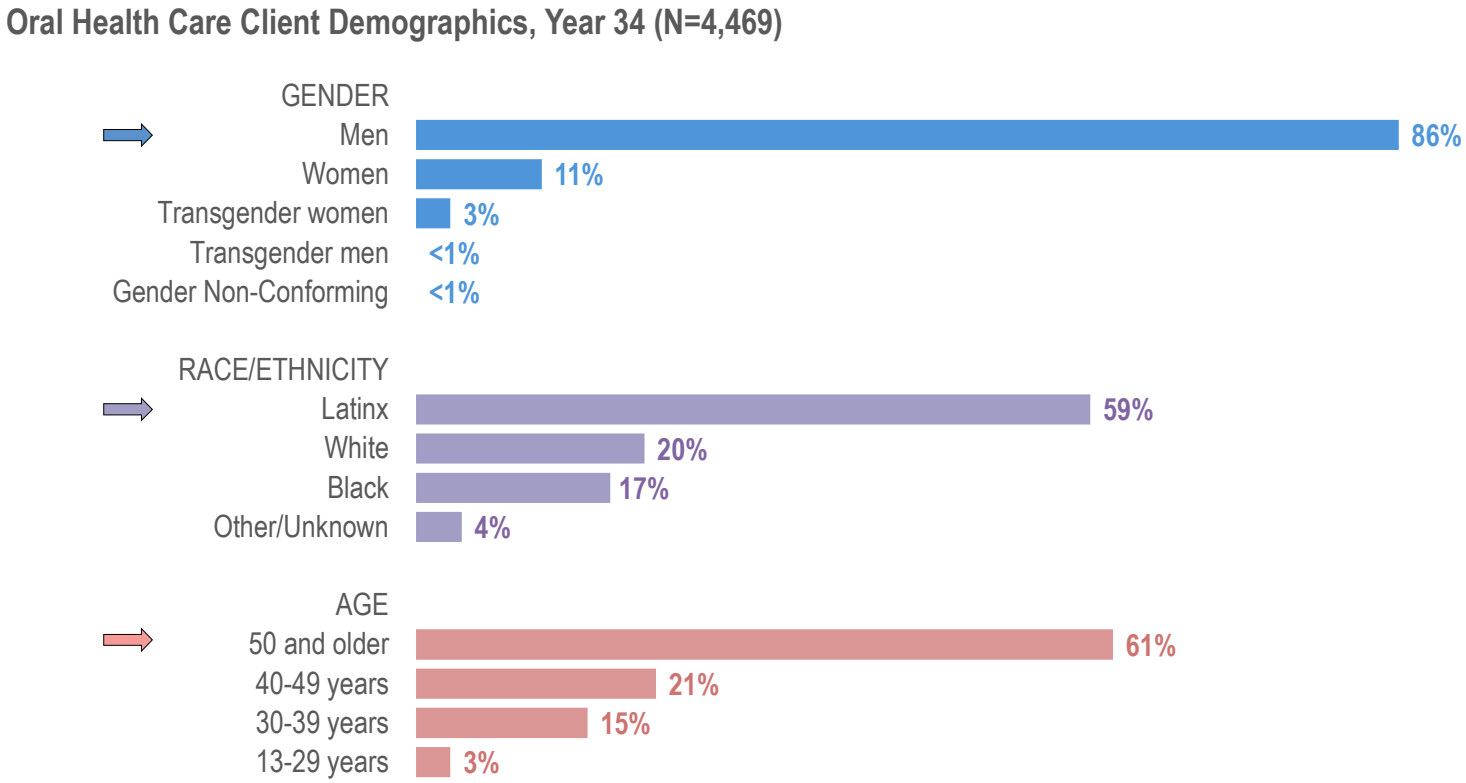
Oral Health Care Service Utilization & Expenditures Summary, Year 34

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditures	Expenditures per client
Oral Health	**4,469**	**Procedures**	**49,240**	**11**	***$8,551,671***	***$1,914***
General	4,185	Procedures	44,064	11	$6,005,983	$1478 $136 per procedure
Specialty	986	Procedures	5,176	5	$2,545,671	$2,582 $492 per procedure

Funding Source:

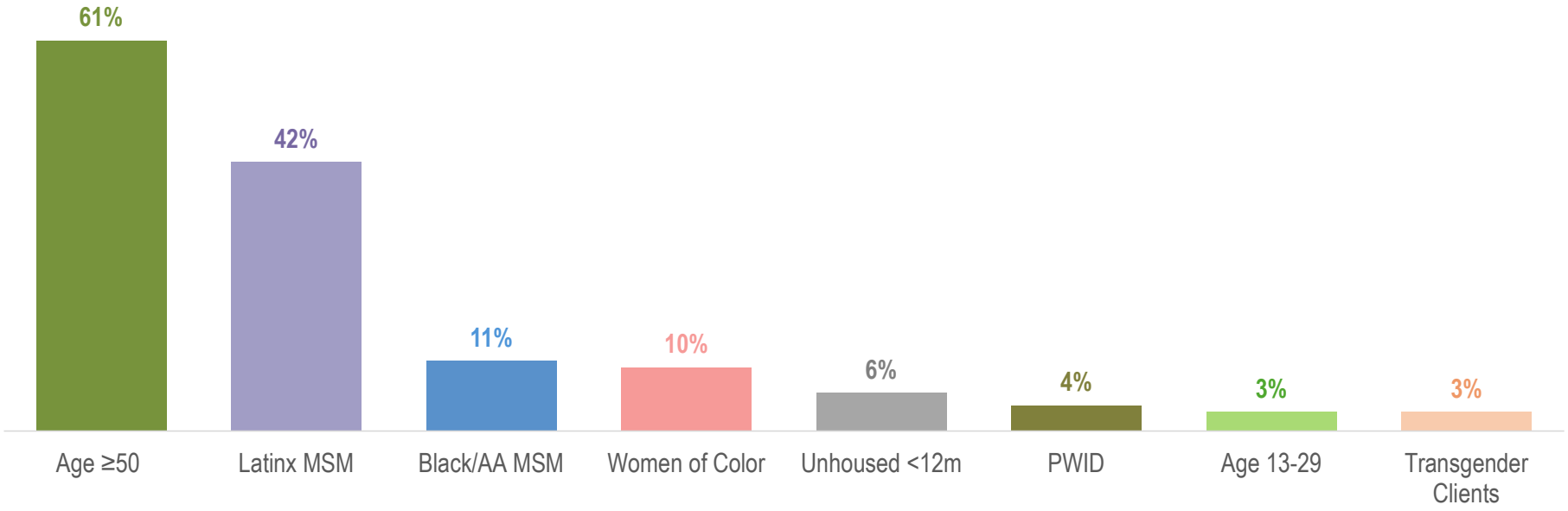
- *Part A - $8,551,654*

Oral Health Care clients were predominantly men, Latinx and people aged 50 and older.



LAC Priority Populations Accessing the OHC Services*, Year 34

- **Clients aged ≥ 50** represented the largest percentage of Oral Health Care clients
- **Latinx MSM clients** were the second largest population served by Oral Health Care
- Percentages for General and Specialty Oral Health Care look similar



*Priority population groups are not mutually exclusive, they overlap.

Most Oral Health Care clients were English-speakers, lived at or below FPL, were insured, permanently housed, and no history of incarceration.

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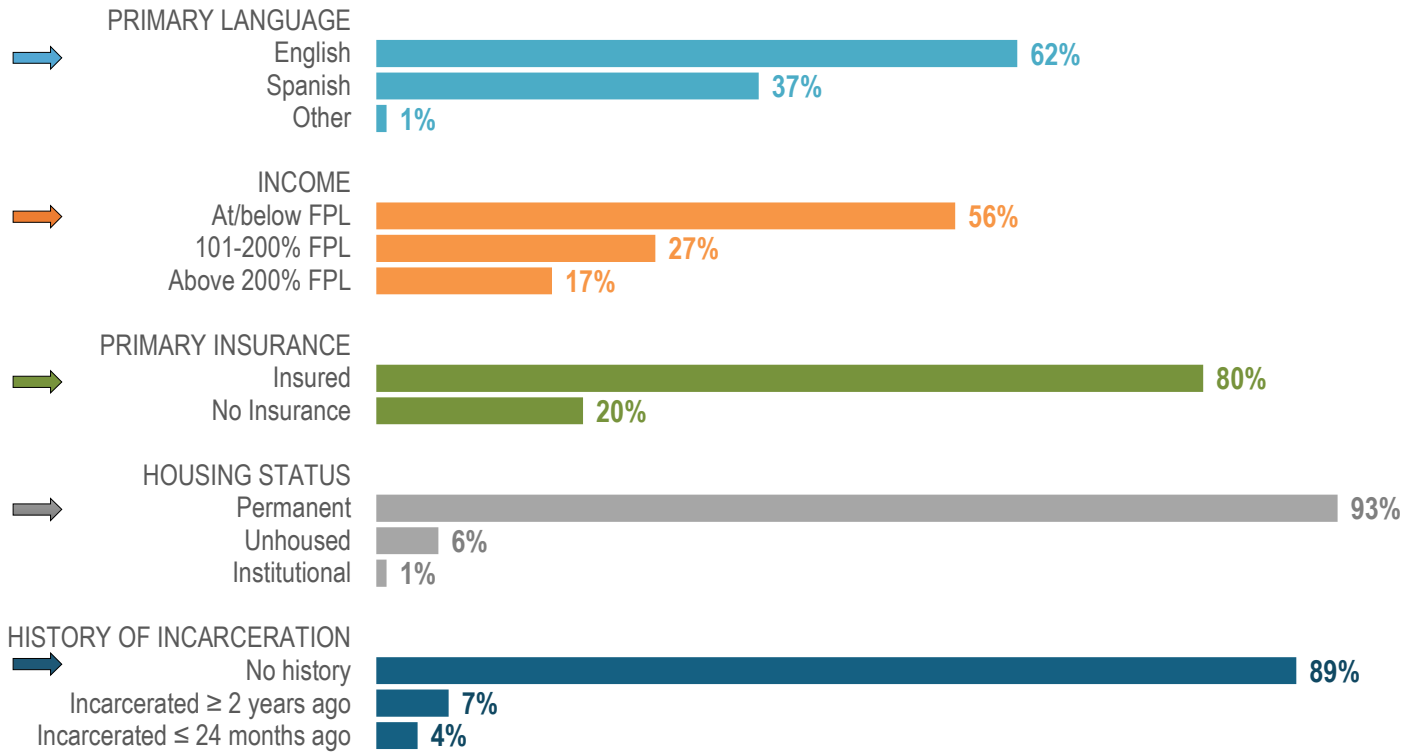
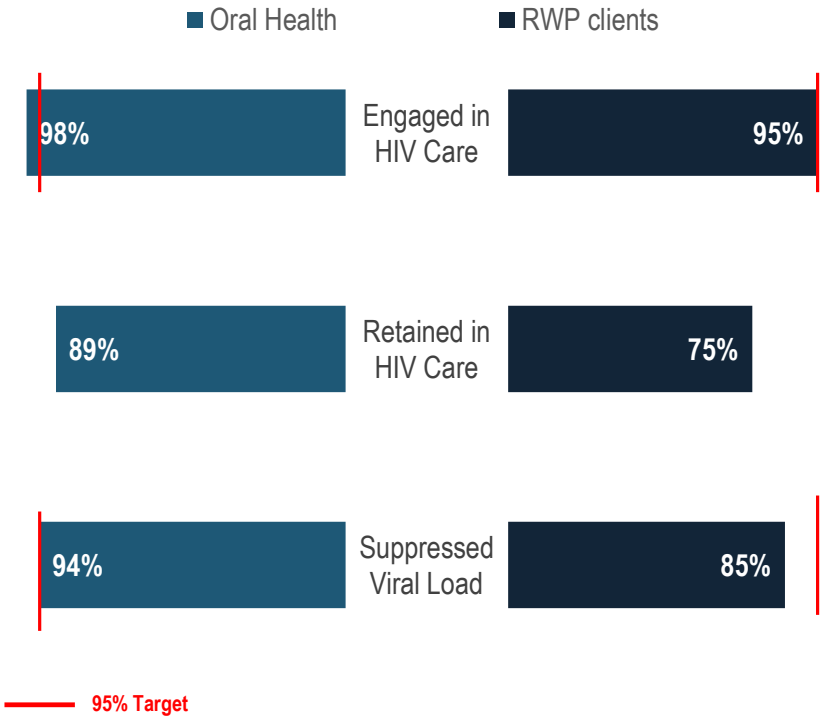
Oral Health Care Health Determinants, Year 34 (N=4,469)



HIV Care Continuum in Oral Health Care clients, Year 34, N=4,469

- Engagement[a], retention in care[b], and viral load suppression[c] percentages were higher for Oral Health Care clients compared to RWP clients overall, Year 34.

- Oral Health Care clients did not meet the EHE target of 95% for viral suppression. However, they met the local target of 95% for engagement in care.



Data source: HIV Casewatch as of 5/1/2025

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[c]**Viral suppression** defined as most recent viral load test <200 copies/mL in the 12-month period based on HIV laboratory data as of 5/5/2025

Home-Based Case Management (HBCM)

- 5% reduction in service utilization in Year 34 compared to Year 33
- 13% reduction in expenditures in Year 34 compared to Year 33

A total of **114 unique clients** received **HBCM services**, representing **<1% of RWP clients**.

- Attendant Care – 10 clients
- Case Management – 113 clients
- Equipment – 1 client
- Homemaker services – 67 clients
- Nutrition services – 26 clients
- Psychotherapy – 35 clients

HBCM utilization decreased in the past 4 years.

HBCM Service Utilization & Expenditures Summary, Year 34

- Homemaker subservice had the highest service utilization overall and per client.
- Case management had the highest expenditure overall and per client.

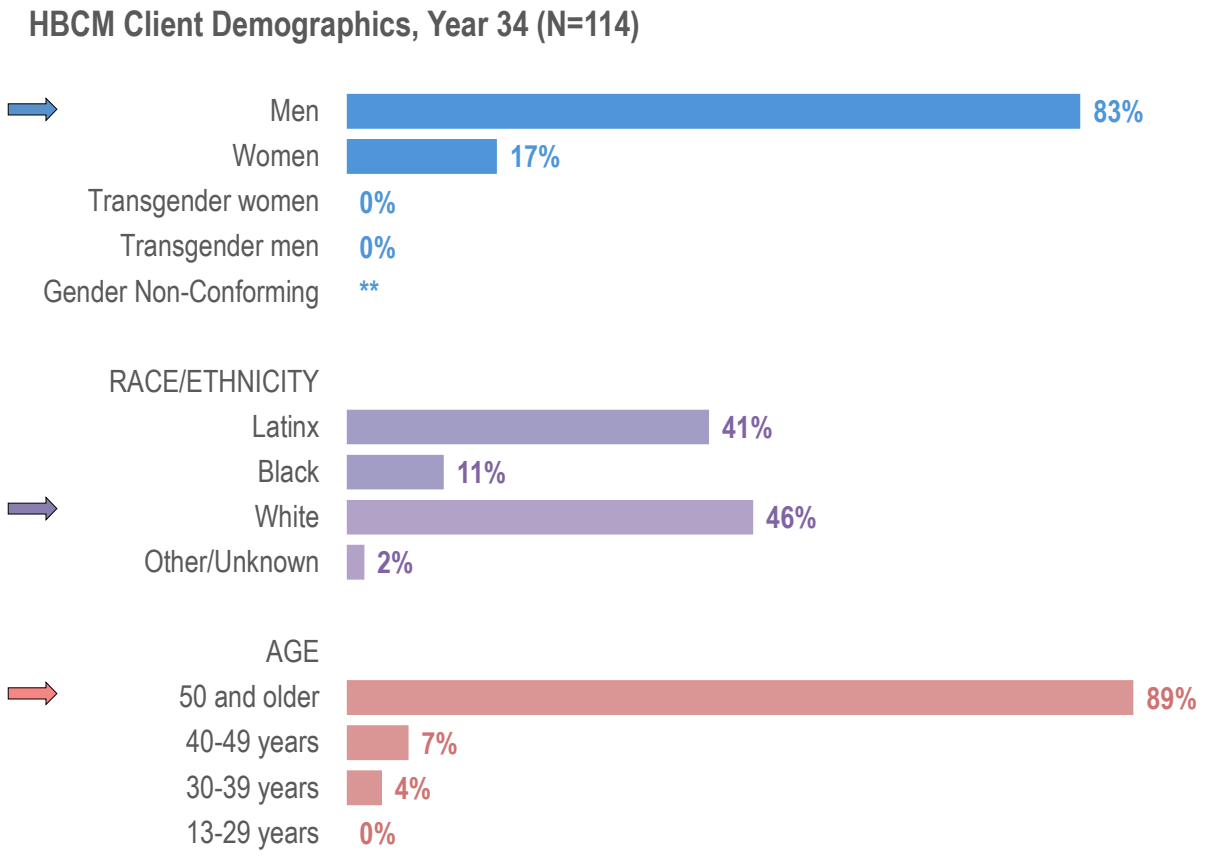
Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditures	Expenditures per client
HBCM	**114**	**Various**	**32,640**	**286**	***$2,503,193***	***$21,958***
Case Management	113	*Hours*	5,209	46	*$1,373,093*	*$12,151*
Homemaker	67	*Hours*	20,348	304	*$660,477*	*$9,858*
Attendant Care	10	*Hours*	2,037	204	*$96,202*	*$9,620*
Psychotherapy CM	35	*Hours*	851	24	*$102,163*	*$2,919*
Durable Medical Equipment	1	*Medical Equipment*	2	2	*$296*	*$296*
Nutrition	26	*Nutritional Supplements*	4,193	161	*$6,077*	*$234*

Funding Source:

- *Part A - $1,670,226*
- *HIV NCC - $832,967*

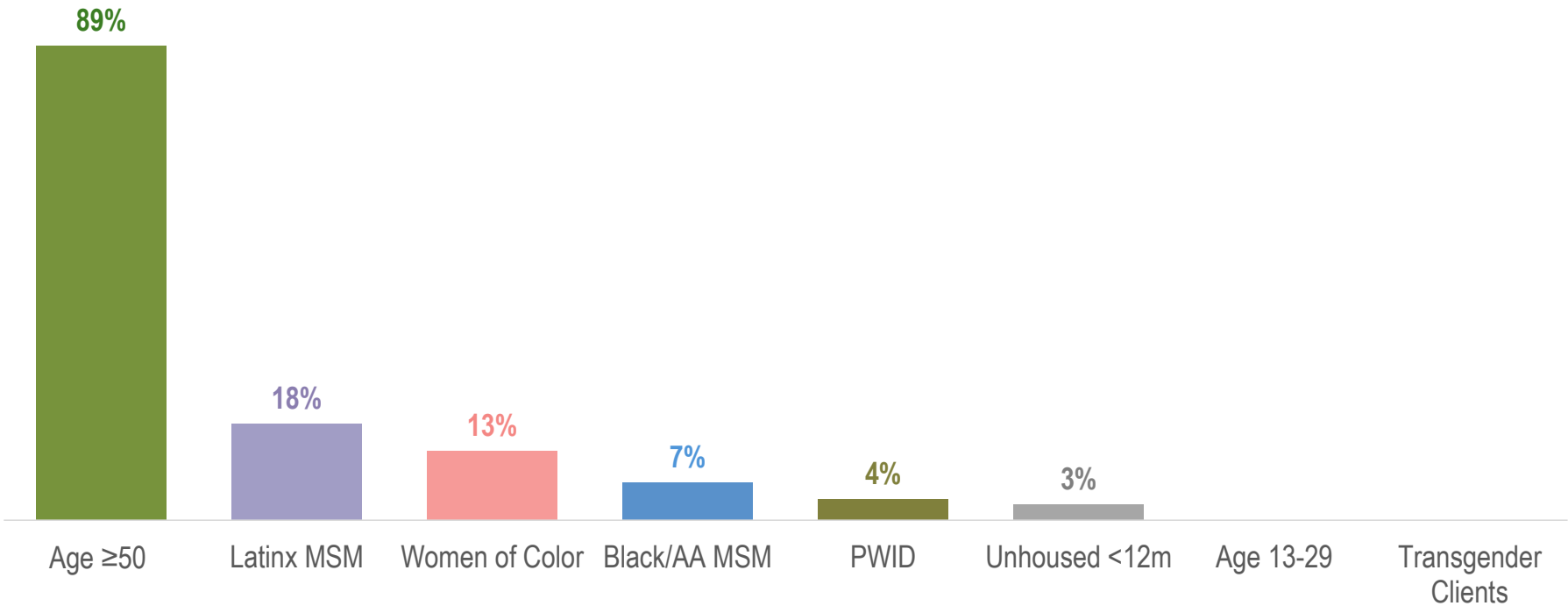
* No information in CaseWatch; we distributed Administrative costs to all HBCM clients

HBCM clients were predominantly men, White and people aged 50 and older.



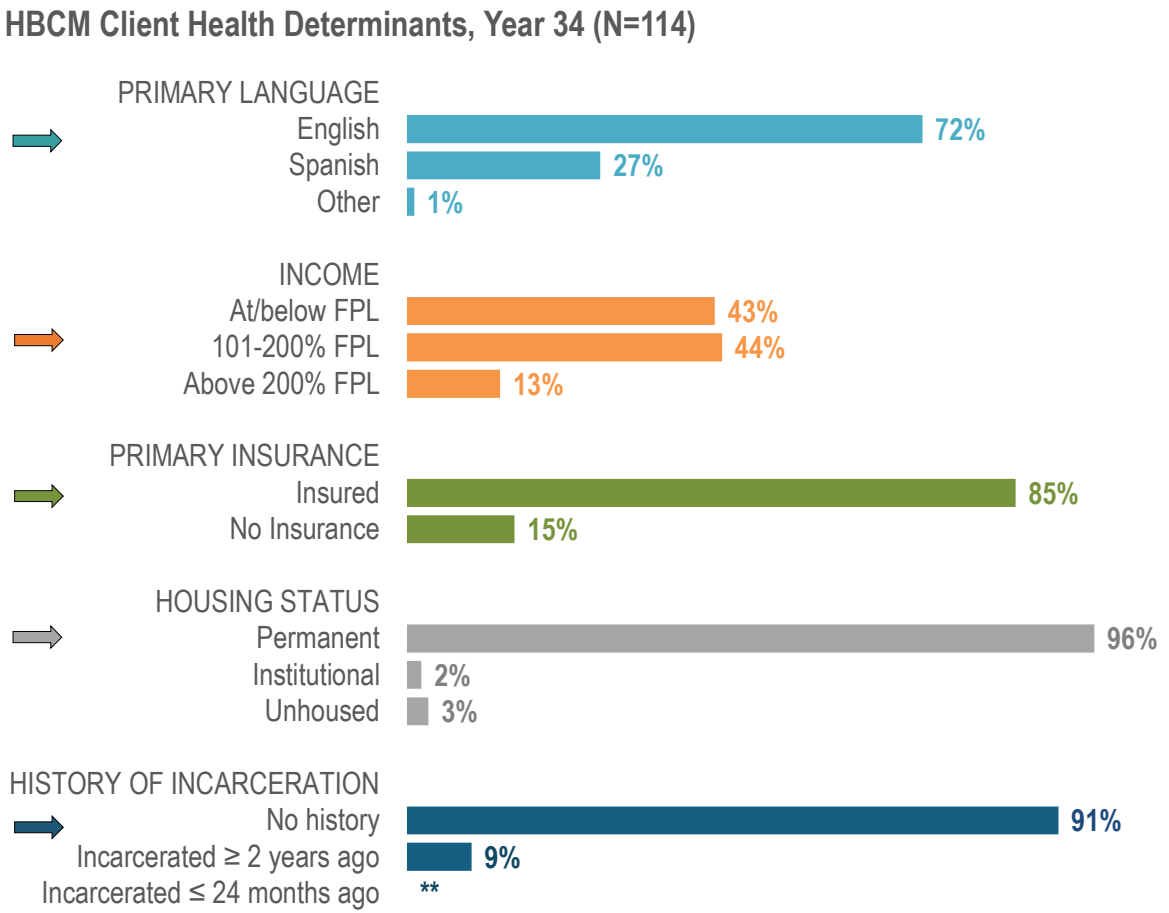
LAC Priority Populations Accessing HBCM Services*, Year 34

- **Clients age ≥ 50** represented the majority of HBCM clients
- **Latinx MSM clients** were the next highest served by HBCM



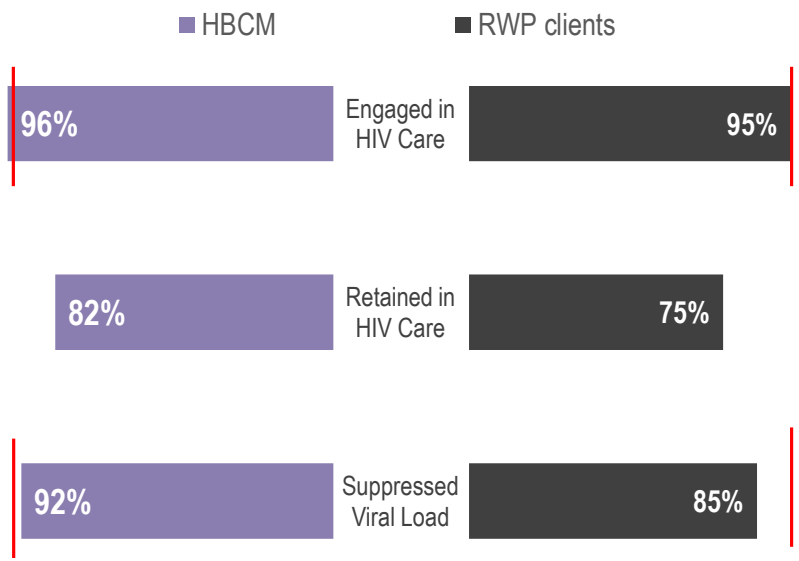
*Priority population groups are not mutually exclusive, they overlap.

Most HBCM clients were English-speakers, lived above FPL, insured, had permanent housing, and no history of incarceration.



HIV Care Continuum in HBCM clients, Year 34 (N=114)

- Engagement[a] and retention in care[b], as well as viral load suppression[c] percentages were higher for HBCM clients compared to RWP clients overall, Year 34.
- HBCM clients met the EHE targets for engagement in care.



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[c]**Viral suppression** defined as most recent viral load test <200 copies/mL in the 12-month period based on HIV laboratory data as of 5/5/2025

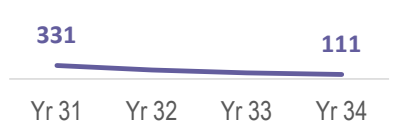
Mental Health (MH) Services

- 5% reduction in service utilization in Year 34 compared to Year 33
- 13% reduction in expenditures in Year 34 compared to Year 33

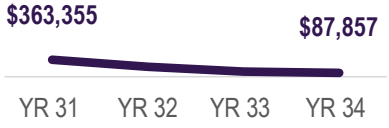
A total of **111 unique clients** received **Mental Health services**, representing **<1% of RWP clients.**

MH utilization decreased in the past 4 years, likely due to a lack of providers within RWP.

MH Clients



MH



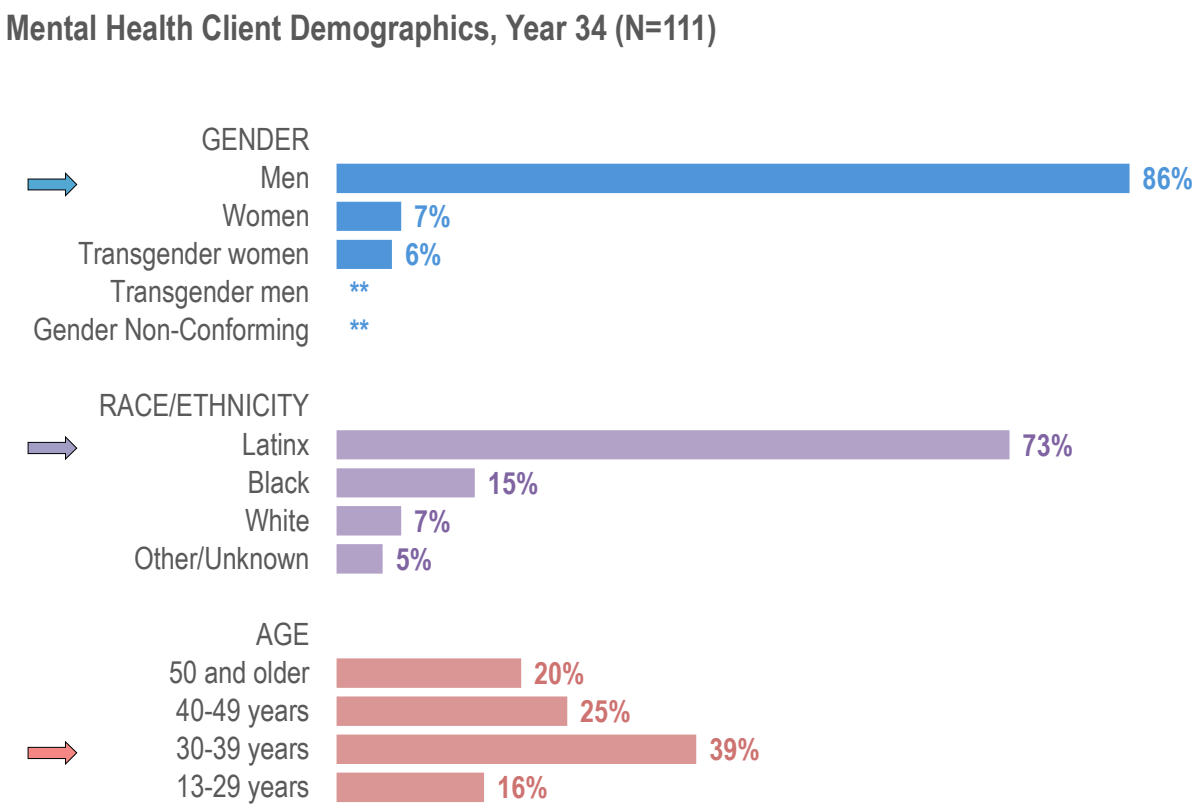
Mental Health Service Utilization & Expenditures Summary, Year 34

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditures	Expenditures per client
Mental Health	**111**	**Sessions**	**547**	**5**	***$87,857***	***$792***

Funding Source:

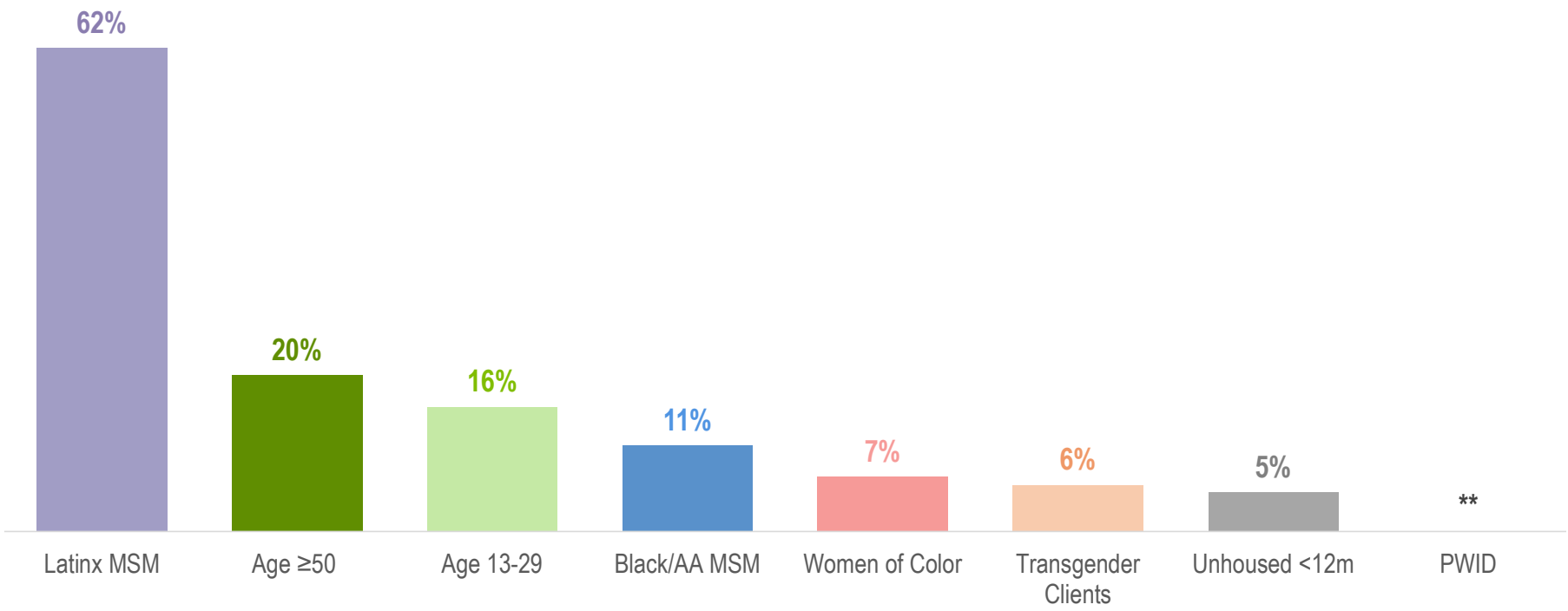
- *Part A - $87,857*

Mental Health Client were predominantly men, Latinx and aged 30-39 years.



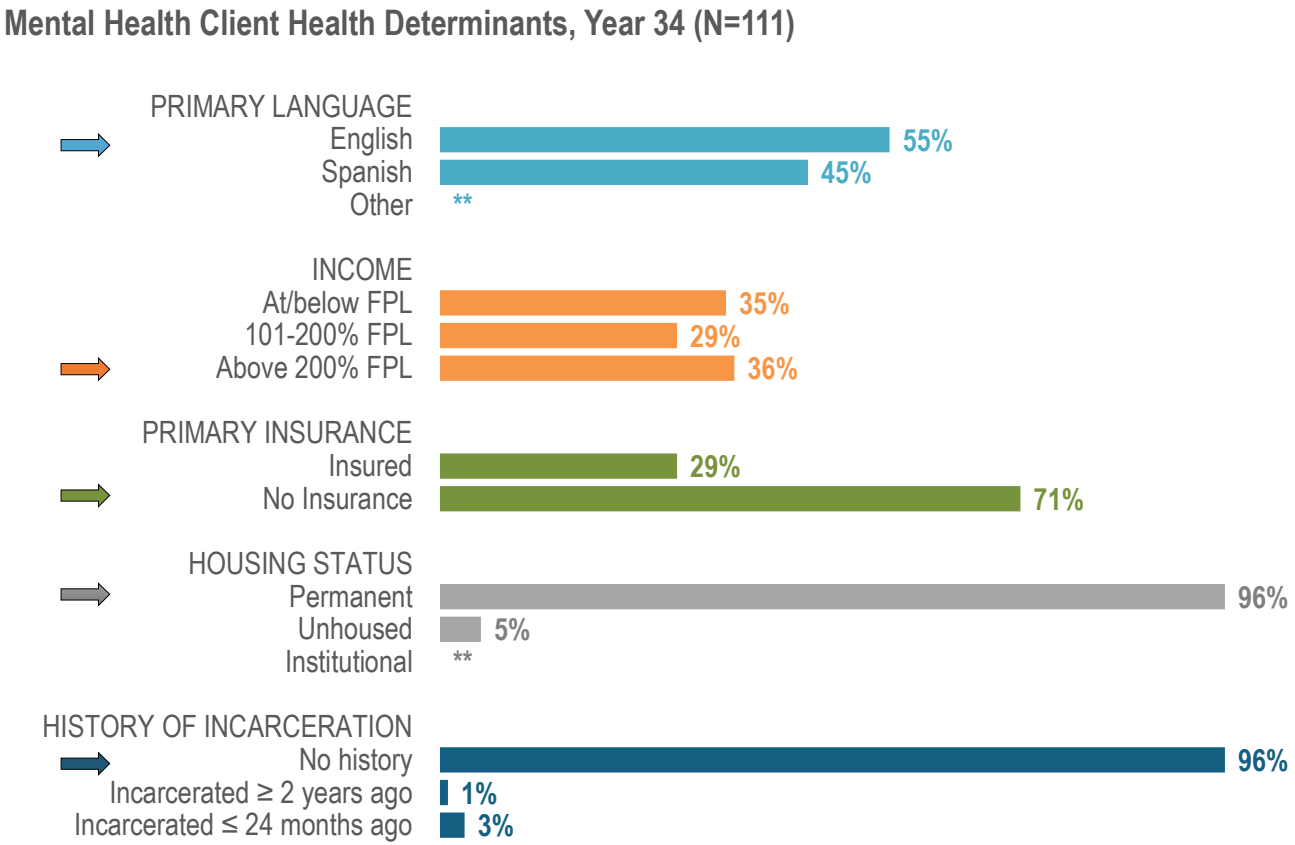
LAC Priority Populations Accessing Mental Health Services*, Year 34

- **Latinx MSM clients** represented the majority of Mental Health clients
- **Clients age ≥ 50** were the next highest priority population served by Mental Health



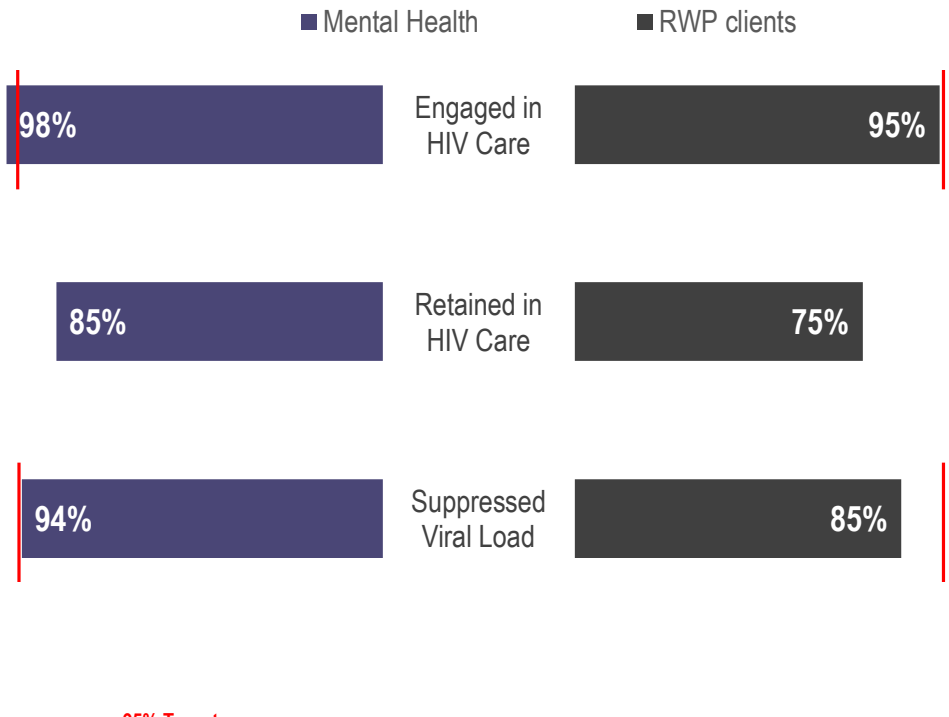
*Priority population groups are not mutually exclusive, they overlap.

MH clients were predominantly English speakers, had varied FPL, uninsured, permanently housed, and had no history of incarceration.



HIV Care Continuum in Mental Health clients, Year 34 (N=111)

- Engagement[a], retention in care[b], and viral load suppression[c] percentages were higher for Mental Health clients compared to RWP clients overall, Year 34.
- Mental Health clients did not meet the EHE target of 95% for viral suppression. However, they met the local target of 95% for engagement in care.



Data source: HIV Casewatch as of 5/1/2025

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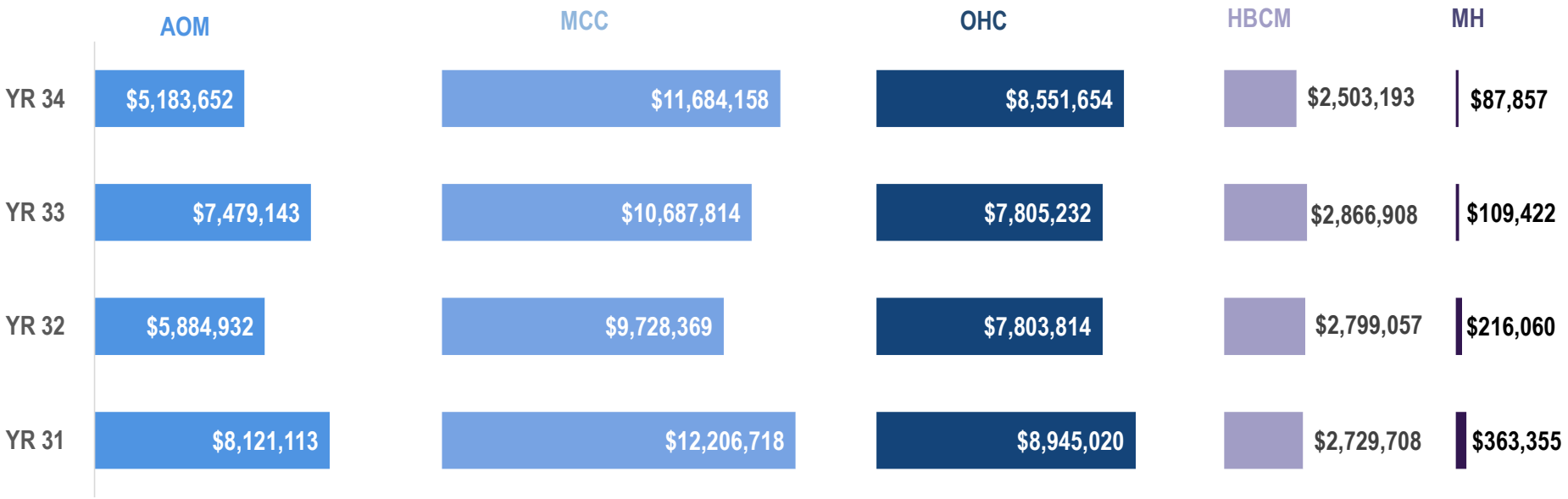
Core RWP Services Expenditures

AOM	*$5,183,652*
MCC	*$11,684,158*
Oral Health	*$8,551,654*
HBCM	*$2,503,193*
Mental Health	*$87,857*

County of Los Angeles Public Health

Expenditures for Years 31-34 by Core Service Category

AOM, **HBCM** and **Mental Health** services expenditures generally decreased since Year 31 with the lowest in Year 34. Expenditures for **Oral Health Care** services gradually increased over four years. **MCC** expenditures varied, increased compared to Years 32-33.



Expenditures per Client for Core RWP Services, Year 34

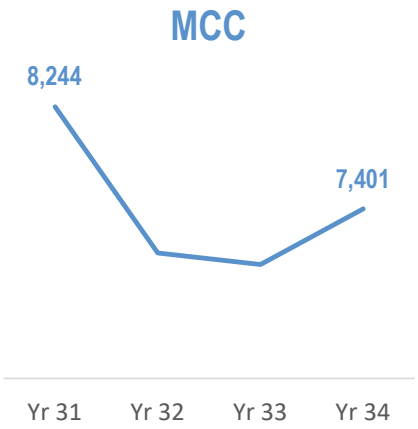
- **The highest expenditures per client** were spent **for HBCM**.
- **The lowest expenditures per client** were spent for **MH**, followed by **AOM** services.

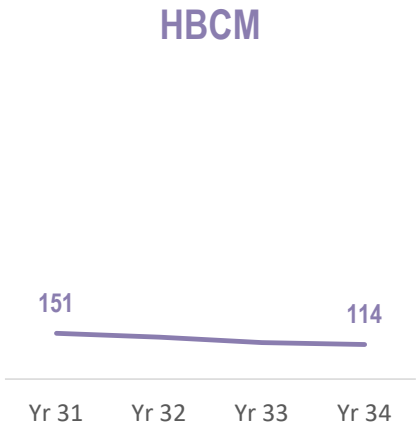
Service Category	Number of clients	% of RWP clients	Expenditures	% of total expenditures	Expenditures per client
MCC	7,401	47%	*$11,684,158*	*19%*	*$1,579*
Oral Health	4,469	28%	*$8,551,654*	*14%*	*$1,914*
AOM	2,882	18%	*$5,183,652*	*8%*	*$1,187*
HBCM	114	< 1%	*$2,503,193*	*4%*	***$21,958***
Mental Health	111	< 1%	*$87,857*	*<1%*	*$792*

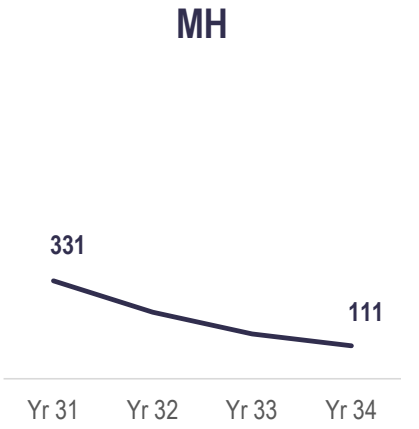
Key Takeaways

- Core Services Utilization
- Client Demographics
- HCC Outcomes
- Expenditures

Core Service Utilization, Years 31-34







Core Service Category	Year 34 Service Utilization Impact	Reasons for Year 34 Impact
AOM	Decreased utilization	DHS departure, Medi-Cal expansion
MCC	Increased utilization	Most consistently utilized service.
OH	Increased Utilization	Recovery from COVID-19 pandemic drop in Year 30
HBCM	Decreased Utilization	Medi-Cal expansion
MH	Decreased Utilization	Lack of MH providers within RWP, Medi-Cal expansion

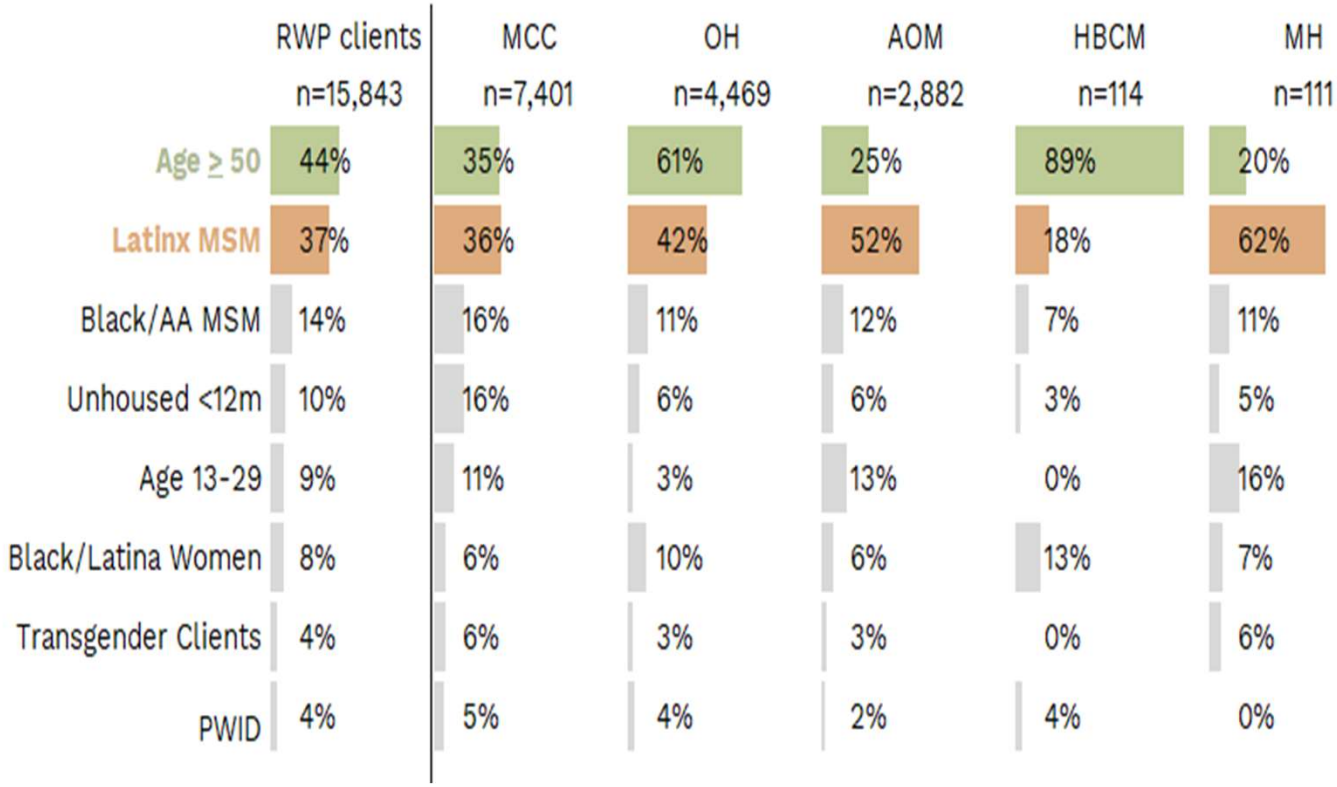
Key Takeaways: Client Demographics

- Primarily **men** across all services.
- Proportionate representation of **Latinx** individuals;
  - except AOM and HBCM with relatively high percentage of white individuals.
- Age distribution varies by service category. However, for all Core services, except AOM, the highest percentage of client were **aged 50 and older**.

	RWP clients n=15,843	MCC n=7,401	OH n=4,469	AOM n=2,882	HBCM n=114	MH n=111
GENDER						
Men	86%	87%	86%	91%	83%	87%
Women	10%	7%	11%	6%	17%	7%
Transgender Women	4%	5%	3%	3%	0%	5%
Trangender Men	0%	<1%	<1%	<1%	0%	<1%
Non-binary/Other	0%	<1%	<1%	<1%	**	<1%
RACE/ETHNICITY						
Latinx	53%	48%	59%	25%	41%	48%
Black	23%	24%	17%	28%	11%	24%
White	21%	23%	20%	34%	46%	23%
Other/Unknown	5%	5%	4%	13%	2%	5%
AGE						
50 and older	44%	35%	61%	25%	90%	35%
40-49 years	22%	23%	21%	28%	7%	23%
30-39 years	25%	31%	15%	34%	4%	31%
13-29 years	9%	11%	3%	13%	0%	11%

Key Takeaways: Priority Population

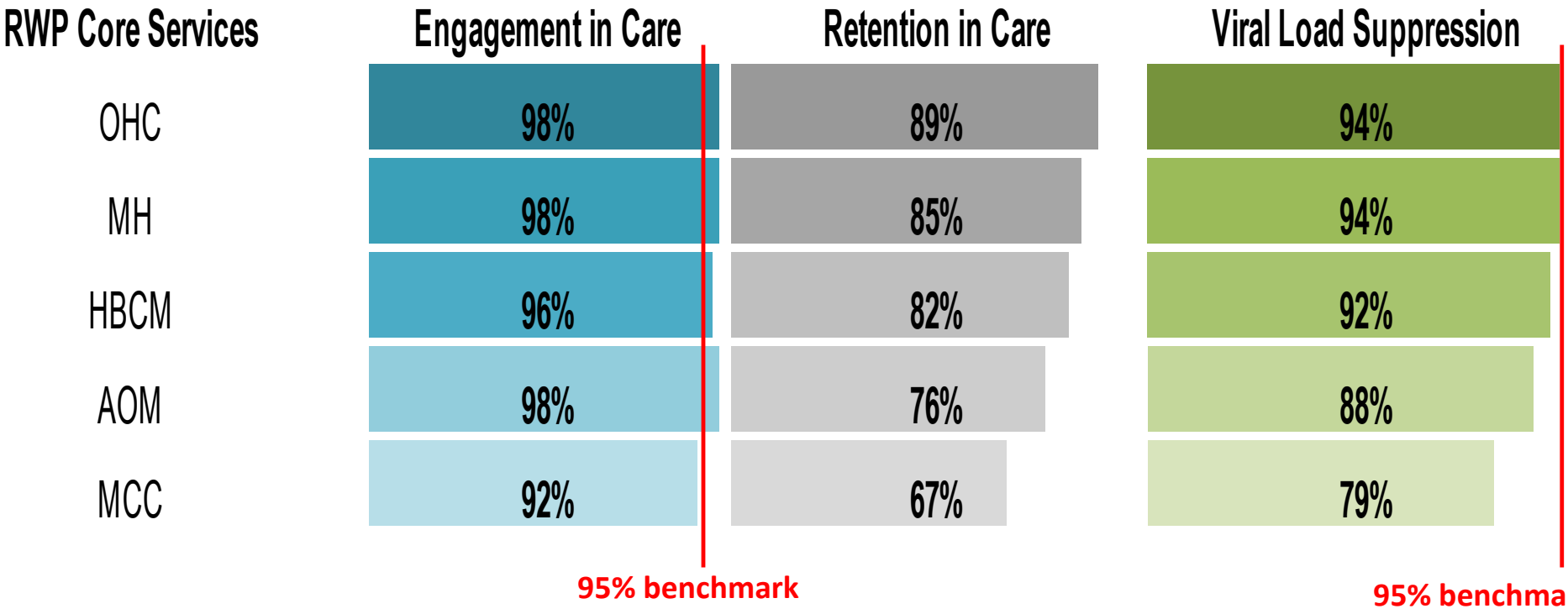
- The top RWP Core services utilized by priority populations were **MCC**, **Oral Health**, and **AOM**.
- Core services utilization among LAC priority population was consistent relative to their size (larger population – higher utilization):
  - **Latinx MSM** and **people aged ≥ 50 and older** were the **highest utilizers** of RWP Core services
    - RWP client **aged 50 and older** were the highest utilizers of Oral Health and HBCM services
    - **Latinx MSM** were the highest utilizers of AOM, MCC and MH services
  - **Lowest utilization** of RWP Core services was among **transgender people, PWID, unhoused** or **youth aged 13-29,** the smallest priority populations.



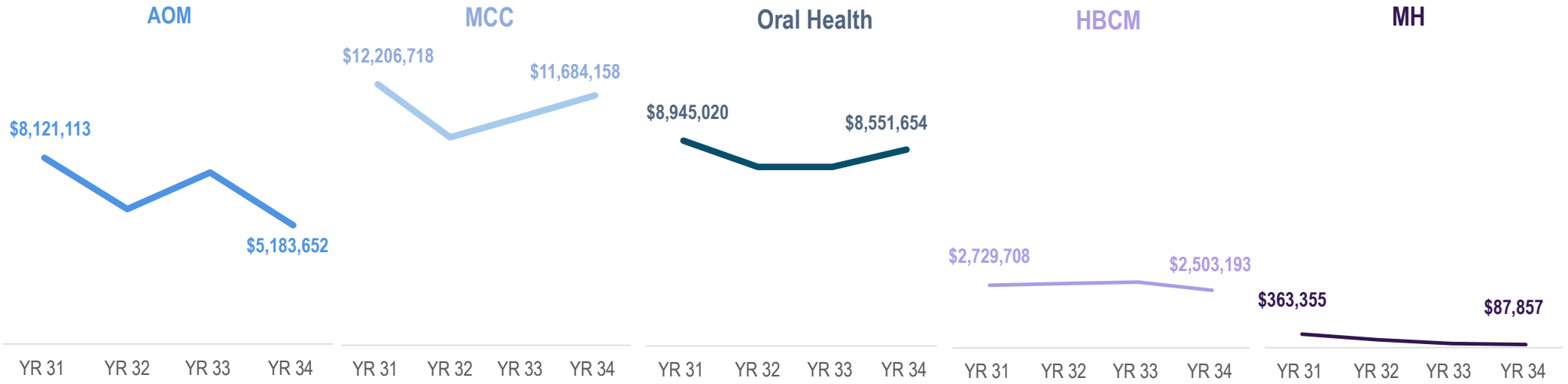
*Priority population groups are not mutually exclusive, clients may overlap

HIV Care Continuum Outcomes, Yr 34

Best outcomes were observed among RWP clients using OHC, HBCM, and MH services.



Key Takeaways - Expenditures



Core Service Category	Expenditures per Service	Expenditures per Clients	Reasons for Year 34 Changes
AOM	Decreased expenditures	Second lowest expenditures per client	Decrease in the number of clients served due to DHS departure and Medi-Cal expansion
MCC	Increased expenditures		Increase in number of clients; most consistently utilized service. Staffing.
OHC	Increased expenditures	Second highest expenditures per client	Recovery from COVID-19 pandemic drop in Year 30
HBCM	Decreased expenditures	Highest expenditures per clients	Decreased number of clients but not a significant decrease in expenditures in Year 34. Staffing.
MH	Decreased expenditures	Lowest expenditures per client	Decreased number of clients due to lack of MH providers within RWP. Medi-Cal expansion.

Next Steps

- Present to COH on the second of two major service clusters
  - Support Services (EFA, Housing, NMCM, Nutrition Support, LRP, Substance Use Residential)
- Examine detailed utilization of RWP services within each LAC priority populations
- Examine RWP by priority population over time

Questions/Discussion

Thank you!

- Acknowledgements
  - Monitoring and Evaluation – Siri Chirumamilla
  - Surveillance – Kathleen Poortinga, Priya Patel
  - PDR – Victor Scott, Michael Green
  - CCS – Paulina Zamudio and the RWP program managers
  - RWP agencies and providers
  - RWP clients

Ryan White Program Utilization Summary, Year 34 (March 1, 2024-February 28, 2025)

Sona Oksuzyan, Supervising Epidemiologist

Monitoring and Evaluation Unit
Division of HIV and STD Programs

August 19, 2025

Overview

- Background
- Methods
- Results
- Key Takeaways
- Next Steps
- Questions/Discussion

Background

- Ryan White Program (RWP) Funding
- RWP Report Updates
- RWP Service Categories

RWP Funding and Report Updates

Ryan White Program (RWP) Annual Funding to DHSP

- Source: Health Resources and Services Administration HIV/AIDS Bureau (HRSA-HAB)

Commission on HIV (COH) RWP DHSP Report

- Utilization Report informs service planning and resource allocation activities

RWP Utilization Report Structure

- Separate reports for core and support service categories to better inform planning activities
- The report is restructured to track utilization across the priority populations identified in the Los Angeles County (LAC) Ending the HIV Epidemic (EHE) Strategic Plan and the LAC Integrated Comprehensive HIV Plan
- While not identified as a priority population in the above plans, persons experiencing homelessness (unhoused people) are included in the utilization report

PRIORITY POPULATIONS

Latinx Men Who Have Sex with Men (MSM)

Black MSM

Cisgender Women of Color

Transgender Persons

Youth (29 years and younger)

PLWH Age ≥ 50

Persons Who Inject Drugs (PWID)

Unhoused RWP Clients

RWP Service Categories

Core Service Categories

- Ambulatory Outpatient Medical (AOM)
- Medical Care Coordination (MCC)
- Oral Health
  - General Oral Health
  - Specialty Oral Health
- Home-Based Case Management (HBCM)
- Mental Health

Support Service Categories

- Emergency Financial Assistance (EFA)
- Housing Services
  - Housing Services (residential care for chronically ill)
  - Housing Services (transitional residential care)
  - Permanent Supportive Housing (rental assistance and subsidies)
- Non-Medical Case Management (NMCM):
  - Benefits Specialty
  - Transitional Incarceration
- Nutritional Services
  - Food Bank
  - Delivered Meals
- Substance Abuse Services Residential
- Outreach (LRP)

Methods

- RWP Report Framework
- Evaluation Framework

RWP Report Framework

Year 34: March 1, 2024-February 28, 2025

Data Sources

- HIV Casewatch: Client characteristics and service use
- HIV Surveillance: Viral load, CD4 and genotype tests
- DHSP Expenditure Reports

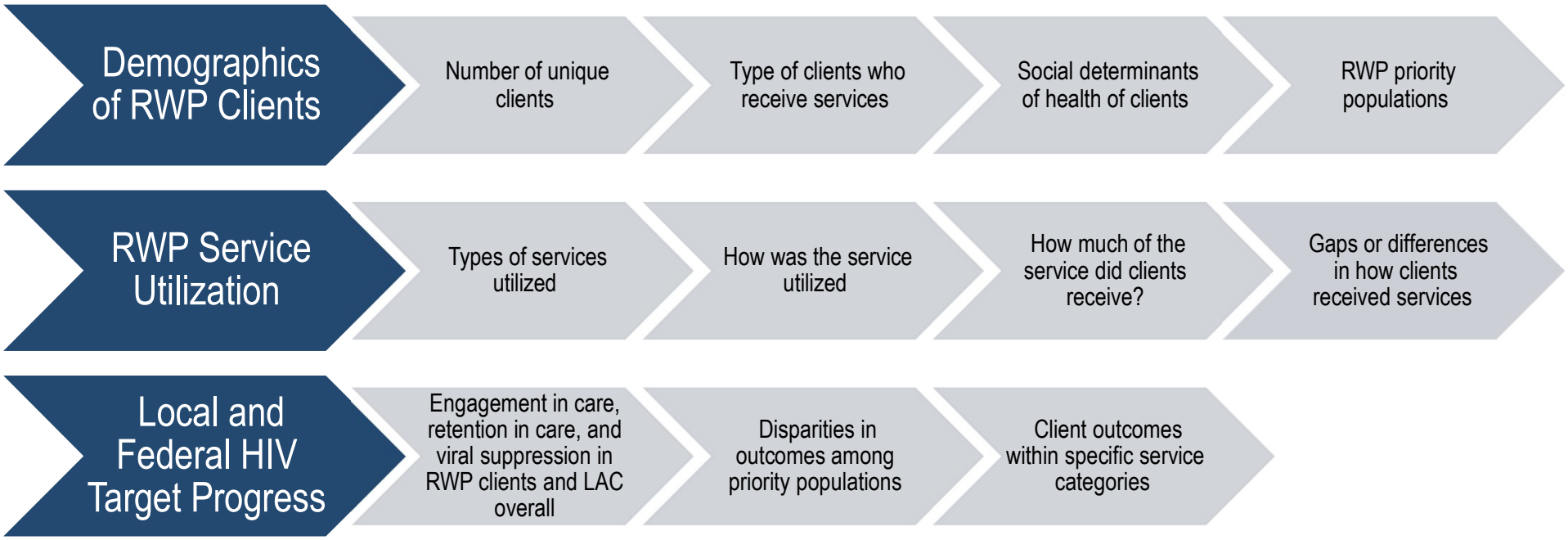
Utilization Indicators

- Total service units = **Number of services units** paid for by DHSP (includes hours, visits, procedures, days, and sessions)
- Total Expenditures = **Total dollar amount** paid by DHSP
- Service units per client = Total number of service units / number of clients who used the service
- Expenditures per client = Total dollar amount / number of clients who used the service

Outcomes

- Engagement in care (attends medical visits)
- Retention in care (consistently attends medical visits over time)
- Viral suppression

Evaluation Framework

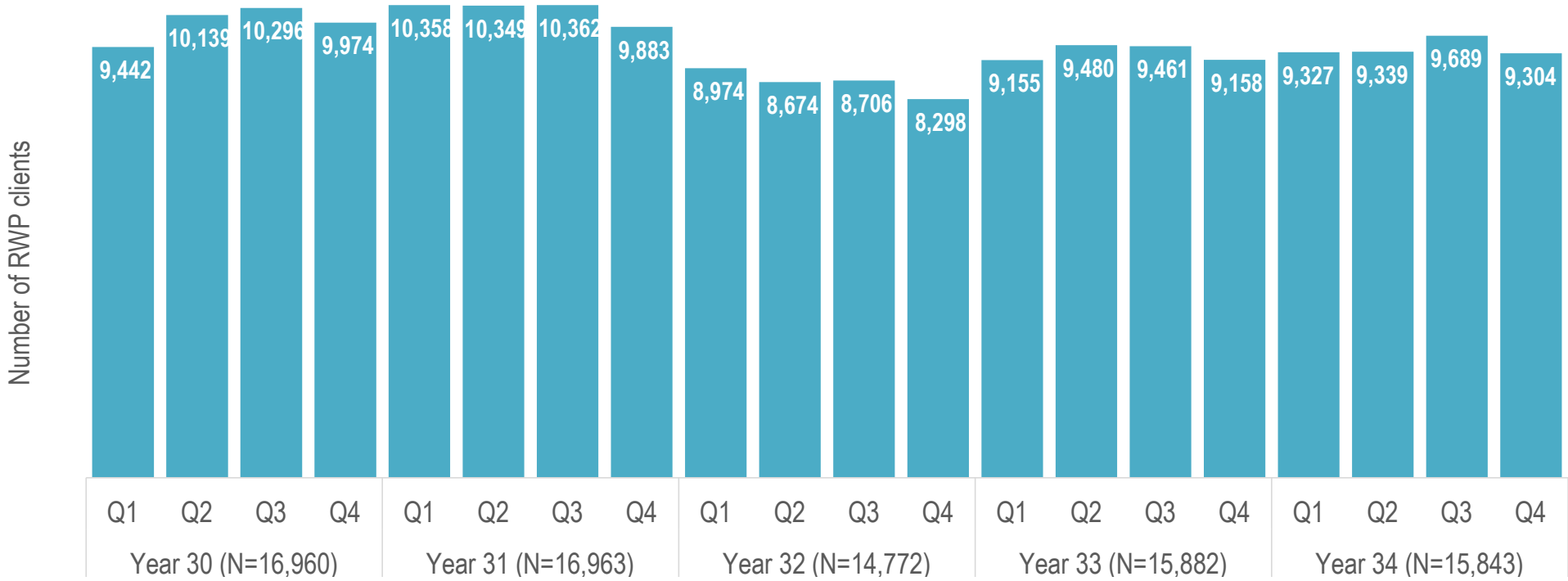


Results: Year 34

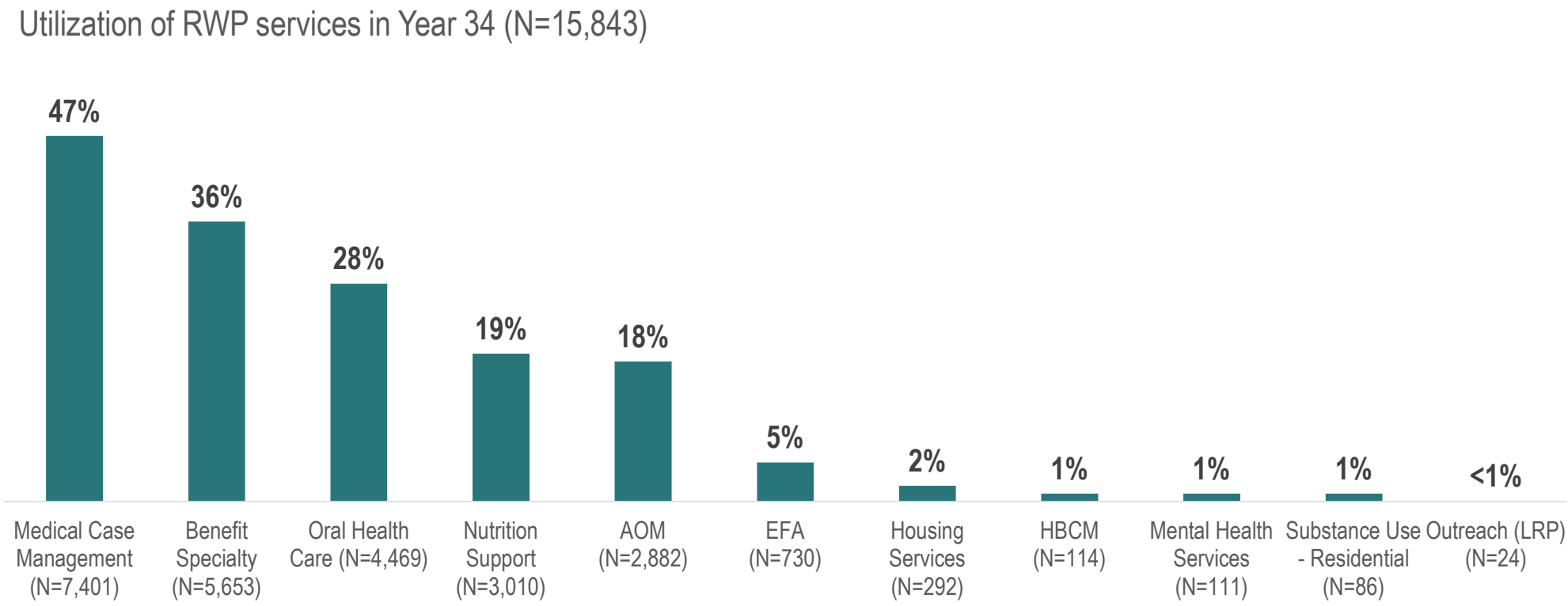
- Service Utilization
- RWP Client Demographics
- RWP Priority Populations
- HIV Care Continuum Outcomes

Utilization remains consistent among contracted providers over the past five years.

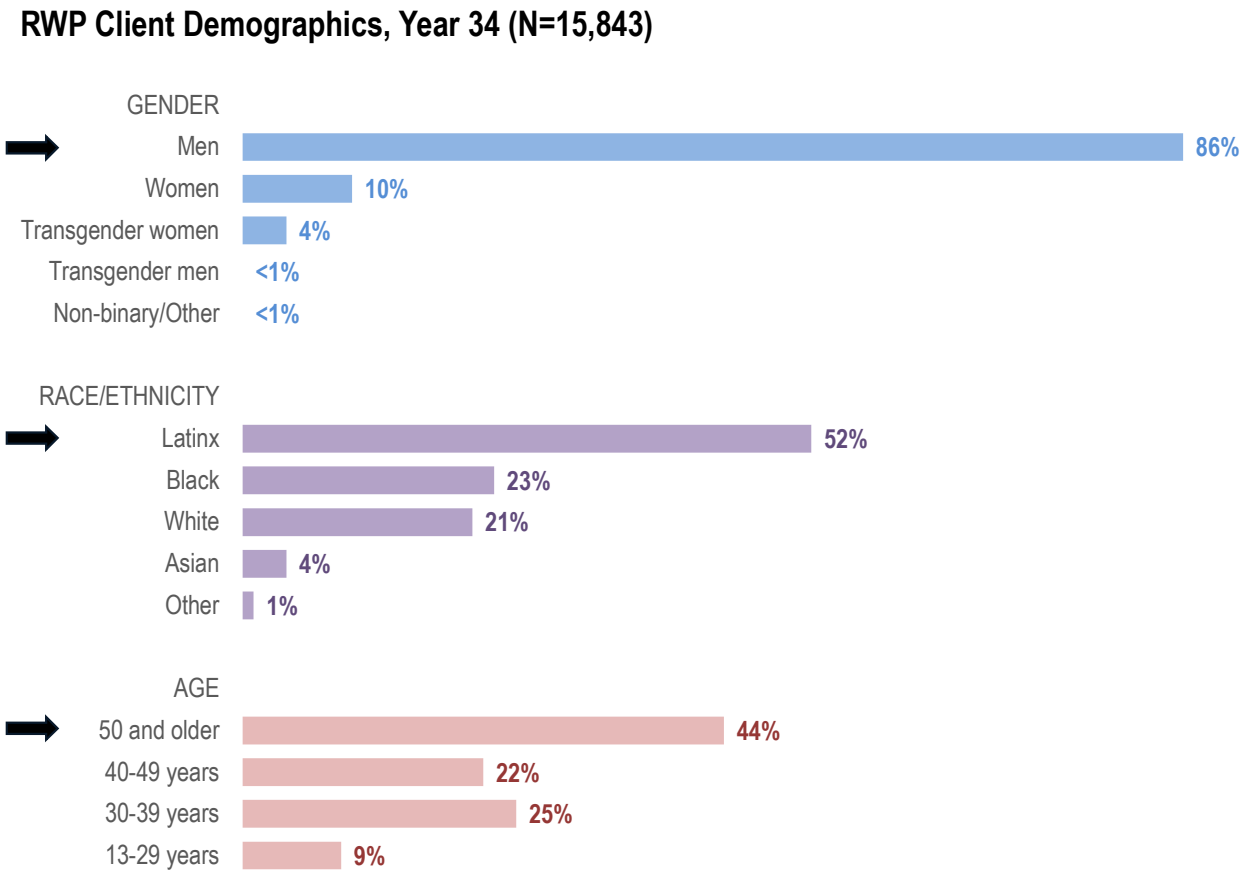
Quarterly RWP Utilization at Funded Agencies, Years 30 (2020) - 34 (2024)



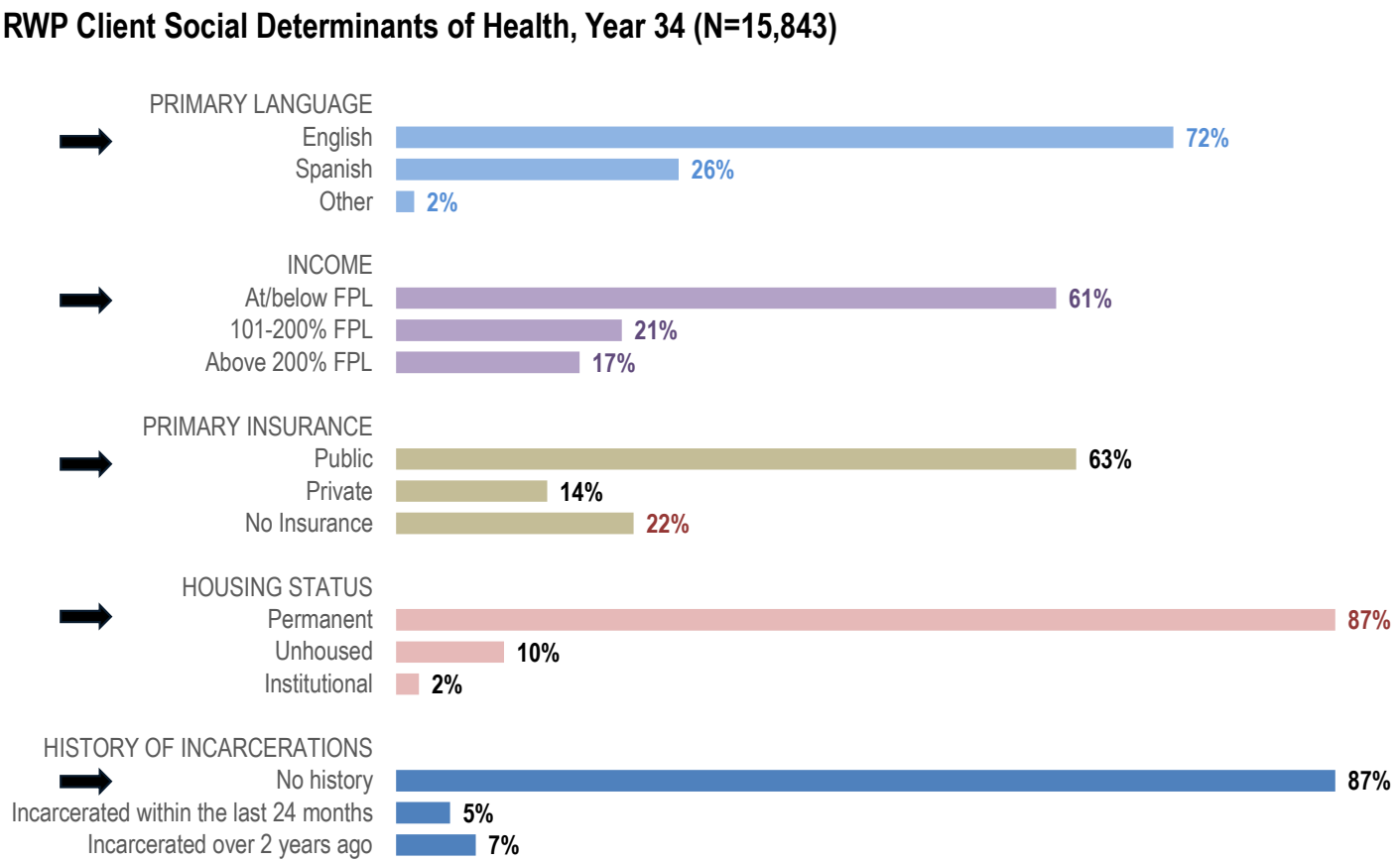
The service utilized the most by RWP clients was MCC program, followed by NMCM (over 40%). The least used services were LRP, SU Residential, MH, HBCM and Housing (1-2%).



In Year 34 most RWP clients identified as male, over half were Latinx, and two out of five were over age 50.

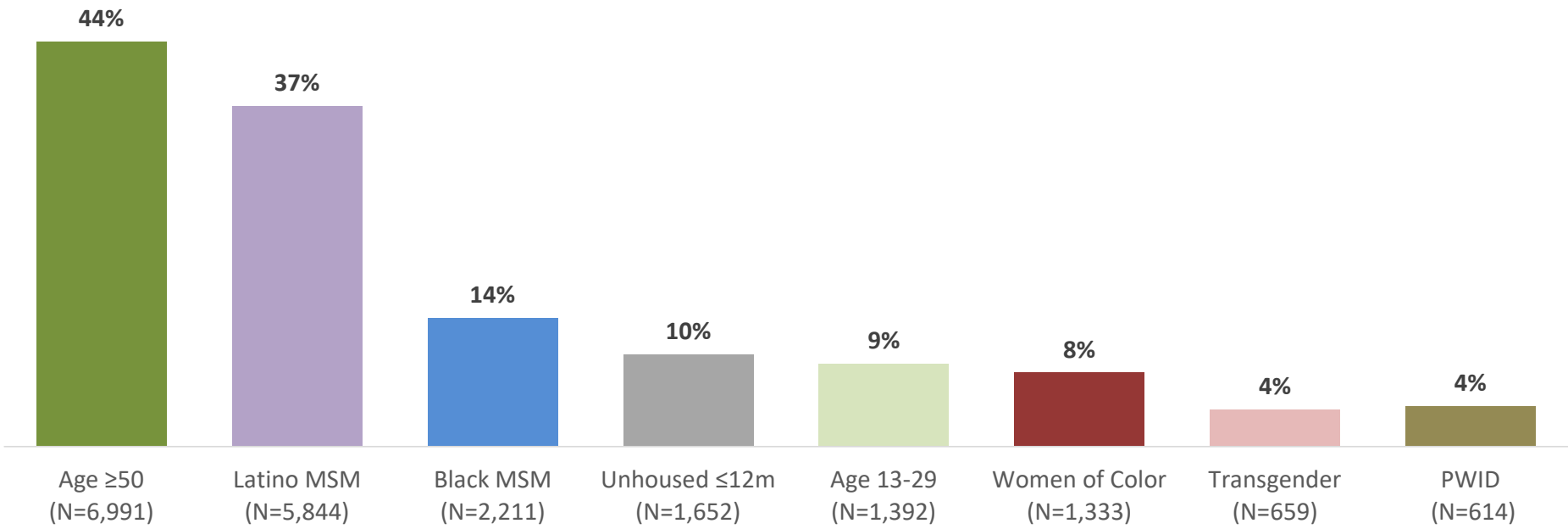


Most RWP clients were English-speakers, lived ≤ FPL, had public health insurance, had permanent housing status and no history of incarceration.



RWP is reaching clients in LAC priority populations*, Year 34

Most of clients (43%) were 50 years of age or older, followed by Latinx MSM.



*Priority population groups are not mutually exclusive, they overlap.

Comparison of LAC Priority Populations[a] for RWP Utilization, Year 34

Population *(% of row population)*	Trans-identified Clients[b]	Latinx MSM[c]	Black MSM[c]	Women of Color	Age 13-29	Age ≥ 50	PWID	Unhoused ≤12m
Trans-identified Clients[b]	***659*** ***(4% of RWP)***	-	-	-	86 13%	206 31%	20 3%	146 22%
Latinx MSM[c]	-	***5,844*** ***(37% of RWP)***	-	-	590 10%	2,282 39%	139 2%	461 8%
Black MSM[c]	-	-	***2,211*** ***(14% of RWP)***	-	280 13%	716 32%	56 3%	287 13%
Women of Color	-	-	-	***1,333*** ***(8% of RWP)***	77 6%	748 56%	24 2%	114 9%
Age 13-29	86 6%	590 42%	280 20%	77 6%	***1,392*** ***(9% of RWP)***	-	22 1.6%	206 14.8%
Age ≥ 50	206 3%	2,282 33%	716 10%	748 11%	-	***6,991*** ***(44% of RWP)***	323 5%	457 7%
PWID	20 3%	139 23%	56 9%	24 4%	22 4%	323 53%	***614*** ***(4% of RWP)***	127 21%
Unhoused ≤12m	146 9%	461 28%	287 17%	114 7%	206 12%	457 28%	127 8%	***1,652*** ***(10% of RWP)***

Data source: HIV Casewatch as of 5/1/2025, HIV Surveillance data as of 5/5/2025

[a]Populations not mutually exclusive

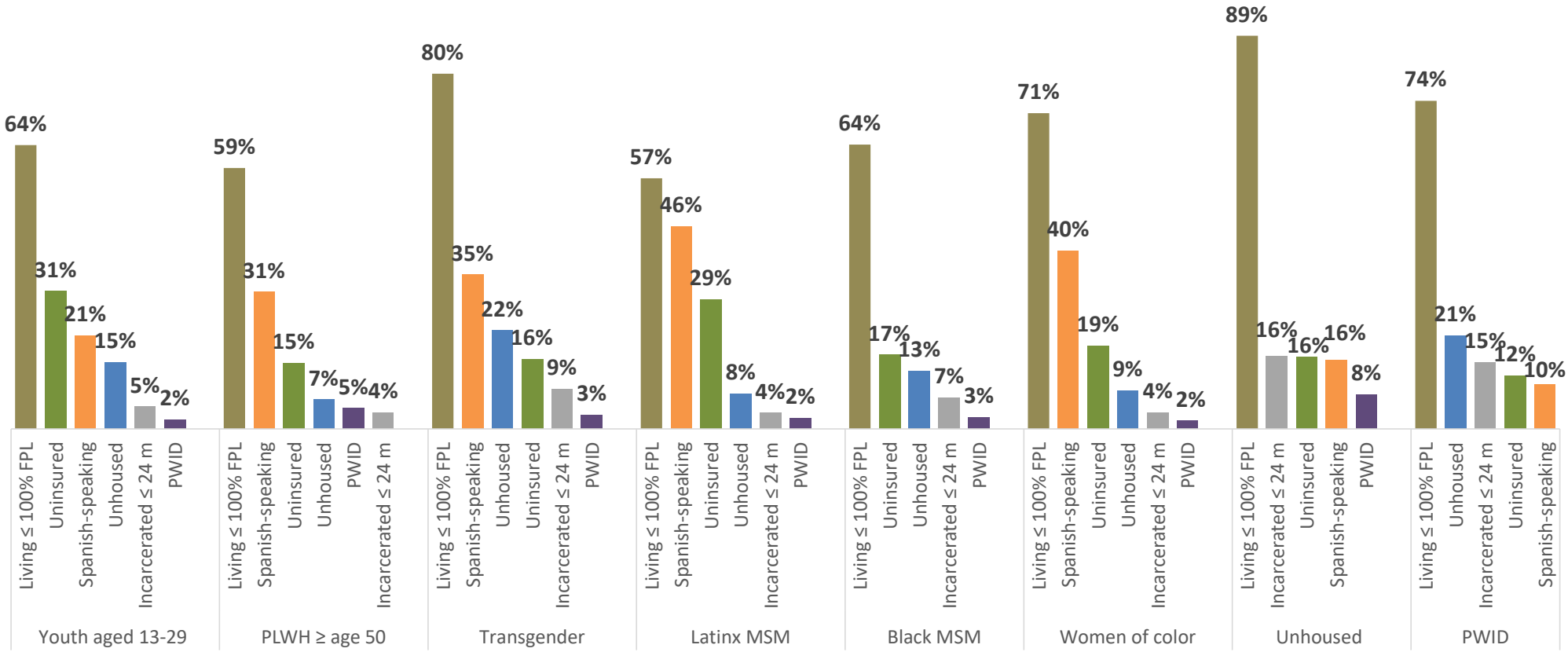
[b]Includes 631 transgender women and 28 transgender men

[c]MSM defined by primary HIV risk category

[d]Reported as unhoused within the 12 months reporting period.

Poverty and having no insurance impacted the highest percent of clients across priority populations, however the other SDOH impacted each population differently.

Social Determinants among LAC Priority Populations, Year 34

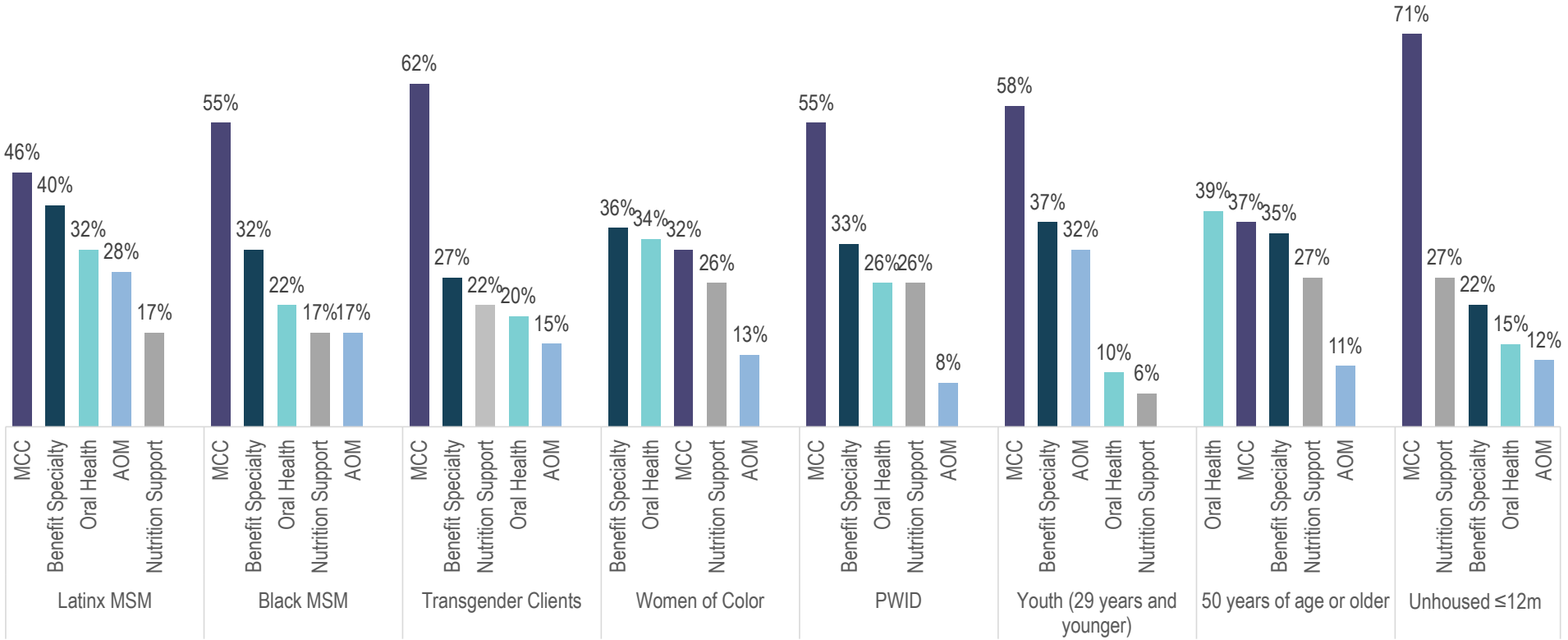


Utilization of RWP Services by LAC Priority Populations, Year 34

Service Category	Latinx MSM	Black MSM	Transgender Clients	Women of Color	Age 12-29	Age ≥ 50	PWID	Unhoused ≤12m
EFA (n=730)	30%	22%	5%	11%	6%	45%	5%	8%
HBCM (n=114)	18%	7%	0%	13%	-	89%	4%	3%
Housing Services (n=292)	33%	13%	7%	12%	7%	44%	9%	38%
MCC (n=7,401)	36%	16%	6%	6%	11%	35%	5%	16%
AOM (n=3,155)	52%	12%	3%	5%	14%	24%	2%	7%
MH Services (n=111)	62%	11%	6%	7%	16%	20%	1%	5%
NMCM (n=5,653)	41%	13%	3%	8%	9%	43%	4%	7%
Nutrition Support (n=3,010)	33%	13%	5%	12%	3%	63%	5%	15%
Oral Health (n=4,469)	42%	11%	3%	10%	3%	61%	4%	6%
SU Residential (n=86)	34%	13%	10%	-	10%	20%	16%	58%

Top 5 RWP Services Utilized by LAC Priority Populations, Year 34

The most utilized RWP service by Latinx MSM, Black MSM, transgender people, PWID, youth and unhoused was MCC. For the majority of priority populations the second most used service was Benefit Specialty. Benefit Specialty was the most used service by women

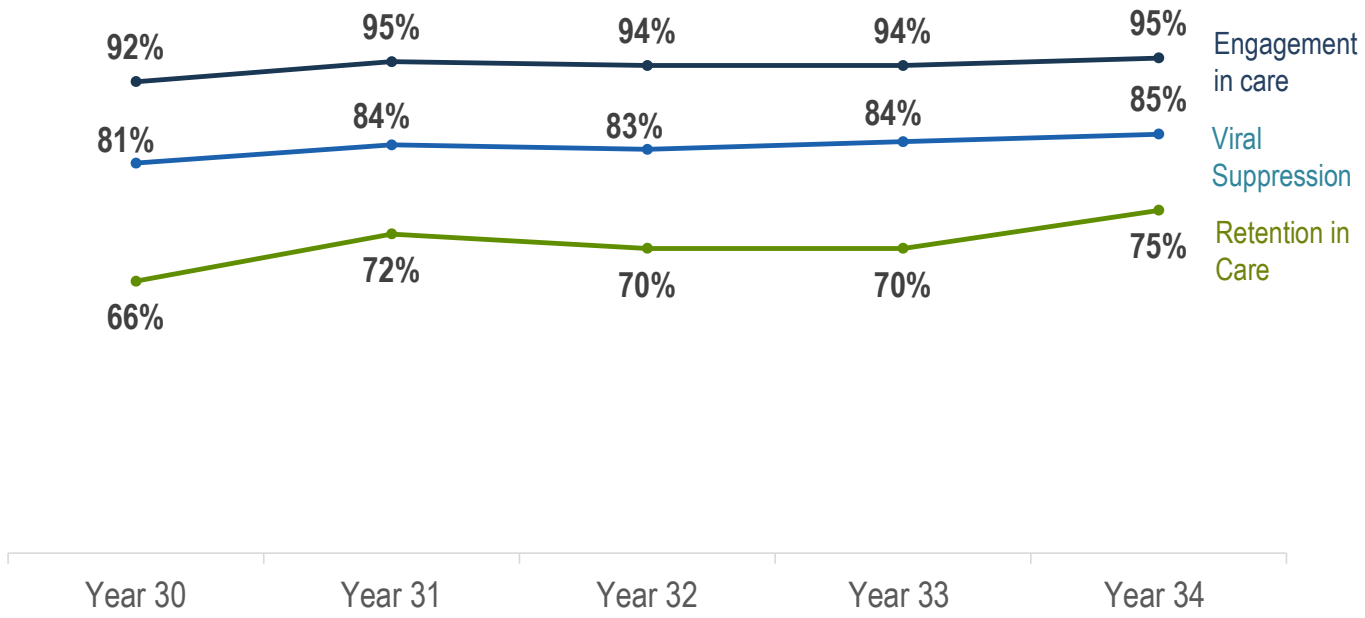


Crosswalk Comparison of RWP Service Category Utilization, Year 34

Service Category (% of row population)	EFA	HBCM	Housing	MCC	AOM	Mental Health	NMCM	Nutrition	Oral Health	LRP	SU Residential
EFA	**730** **5%**	3 <1%	8 1%	450 62%	95 13%	8 1%	404 55%	238 33%	188 26%	-	1 <1%
HBCM	3 3%	**114** **1%**	5 4%	9 8%	5 4%	-	20 18%	43 38%	43 38%	-	-
Housing	8 3%	5 2%	**292** **2%**	124 42%	9 3%	-	77 26%	142 49%	73 25%	4 1%	19 7%
MCC	450 6%	9 0%	124 2%	**7,401** **47%**	1,027 14%	38 1%	1,433 19%	993 13%	1,259 17%	2 <1%	44 1%
AOM	95 3%	5 <1%	9 <1%	1,027 36%	**2,882** **18%**	103 4%	1,266 44%	125 4%	610 21%	2 <1%	-
Mental Health	8 7%	-	-	38 34%	103 93%	**111** **1%**	70 63%	7 6%	31 28%	-	-
NMCM	404 7%	20 <1%	77 1%	1,433 25%	1,266 22%	70 1%	**5,653** **36%**	816 14%	1,450 26%	2 <1%	70 1%
Nutrition	238 8%	43 1%	142 5%	993 33%	125 4%	7 <1%	816 27%	**3,010** **19%**	873 29%	4 <1%	69 2%
Oral Health	188 4%	43 1%	73 2%	1,259 28%	610 14%	31 1%	1,450 32%	873 20%	**4,469** **28%**	1 <1%	17 <1%
LRP	-	-	4 17%	2 8%	2 8%	-	2 8%	4 17%	1 4%	**24** **0%**	-
SU Residential	1	-	19 18%	44 46%	- 4%	- 2%	70 87%	69 82%	17 17%	-	**86** 1%

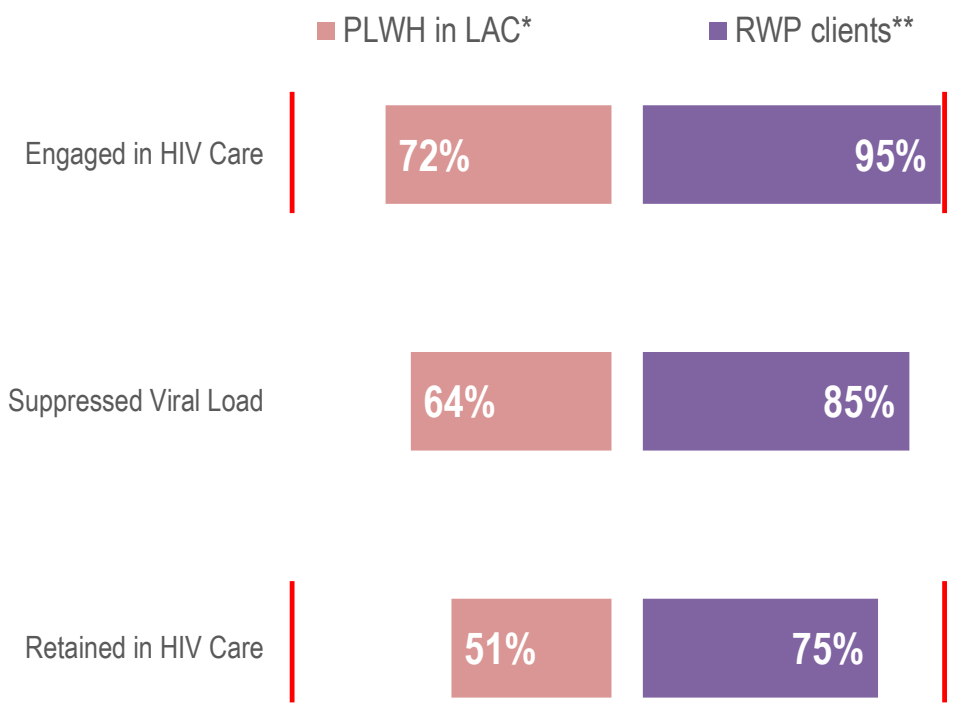
HIV Care Continuum among RWP clients, Years 30-34

Engagement and retention in care and viral suppression continue to gradually increase in the past five year.



HIV Care Continuum in LAC and in RWP clients, Year 34 (N=15,843)

- Engagement[a], retention in care[b] and viral load suppression[c] percentages were higher for RWP clients compared to PLWH in LAC, Year 34.
- RWP overall did not meet the EHE target of 95% for viral suppression or local targets for engagement and retention in care (95%).



[a]**Engagement in Care** defined as 1 ≥ viral load, CD4 or genotype test reported in the 12-month period based on HIV laboratory data as of 5/5/2025

[b]**Retention in care** defined as 2 ≥ viral load, CD4 or genotype test reported >30 days apart in the 12-month period based on HIV laboratory data as of 5/5/2025

[c]**Viral suppression** defined as most recent viral load test <200 copies/mL in the 12-month period based on HIV laboratory data as of 5/5/2025

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

** Data source: HIV Casewatch as of 5/5/2025

HIV Care Continuum (HCC) Outcomes among Priority Populations, Year 34

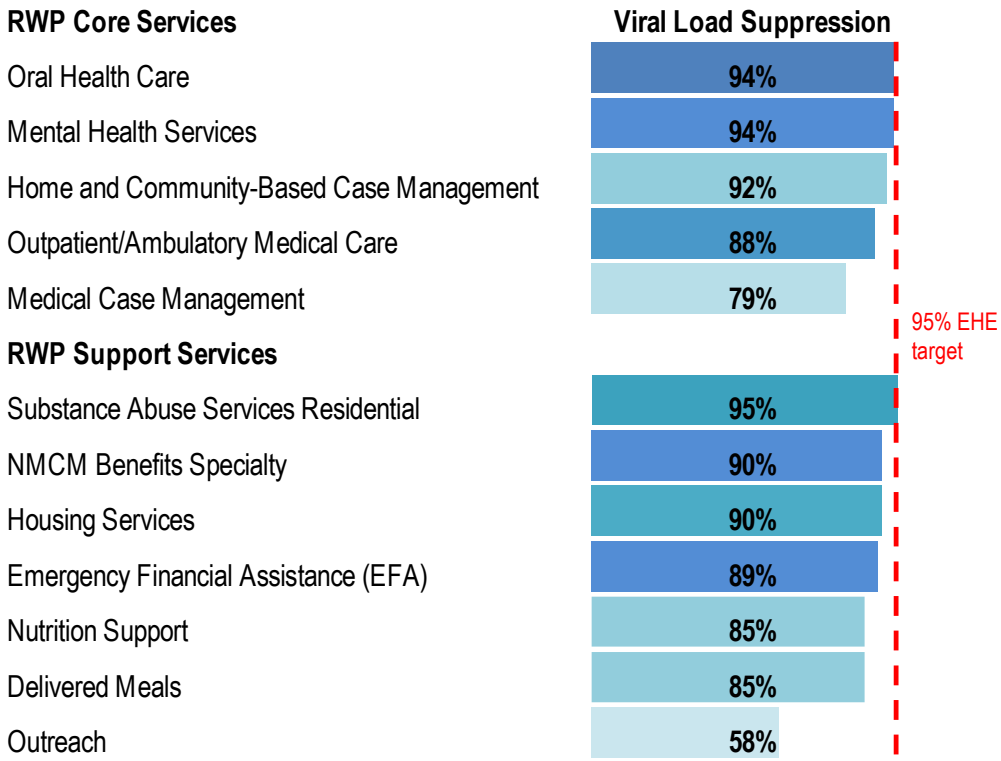
- RWP clients **aged 50 and older had the highest engagement, retention in care and viral suppression**.
- RWP clients **experiencing homelessness had the lowest engagement and retention in care and viral suppression.**
- RWP clients **aged 50 and older, Latinx MSM, Women of color and Transgender people met the target of 95% for engagement in care.**
- None of other LAC priority populations met the EHE or local targets for HCC outcomes.

Priority Population	***No.***	***% of RWHAP Population***	**Engaged in Care**	**Retained in Care**	**Virally Suppressed**
50 years of age or older	6,712	44%	**96%**	**81%**	**89%**
Latinx MSM[c]	5,586	37%	**96%**	78%	87%
Women of color	1,281	8%	**95%**	79%	87%
Transgender Persons[b]	628	4%	95%	76%	81%
Youth (29 years and younger)	1,301	9%	93%	64%	80%
Black MSM[c]	2,049	14%	93%	68%	79%
Persons Who Inject Drugs (PWID)	574	4%	93%	75%	83%
People experiencing homelessness	1,493	10%	**90%**	**67%**	**72%**

[a]Limited to membership in two priority populations; a client could be in more than two priority populations as population definitions are not mutually exclusive
[b]Includes 631 transgender women and 28 transgender men
[c]MSM defined as PLWH who reported male sex at birth, sex with men as primary HIV risk category and non-White race/ethnicity

Viral Suppression among RWP and by Service Category, Year 34 (N=15,843)

- Among all RWP clients, **85% were virally suppressed**
- Only clients of **Substance Use Residential** met the EHE **viral suppression target of 95%**

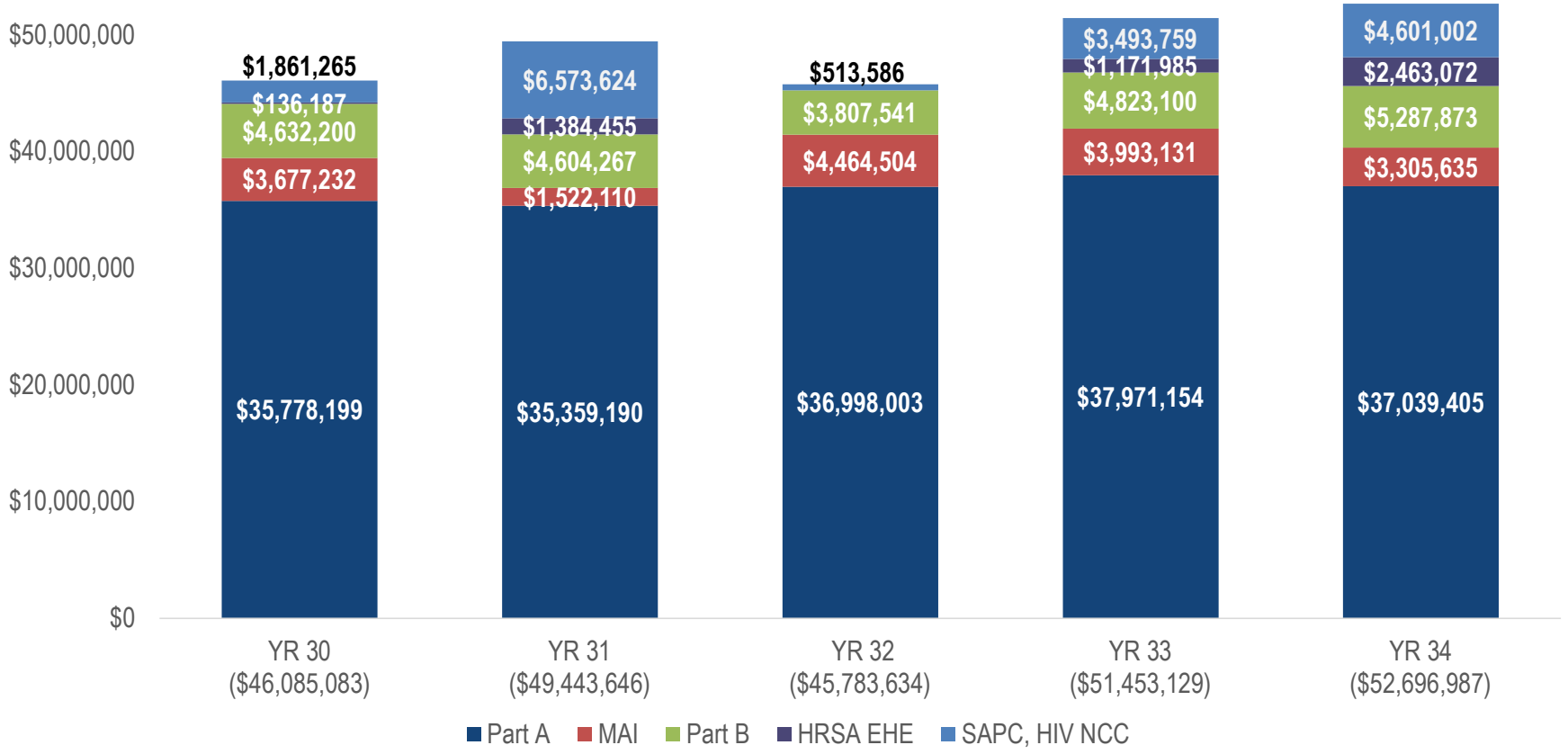


Expenditures

- Expenditures by Funding Source
- Expenditures by Service Category
- Expenditures per Client

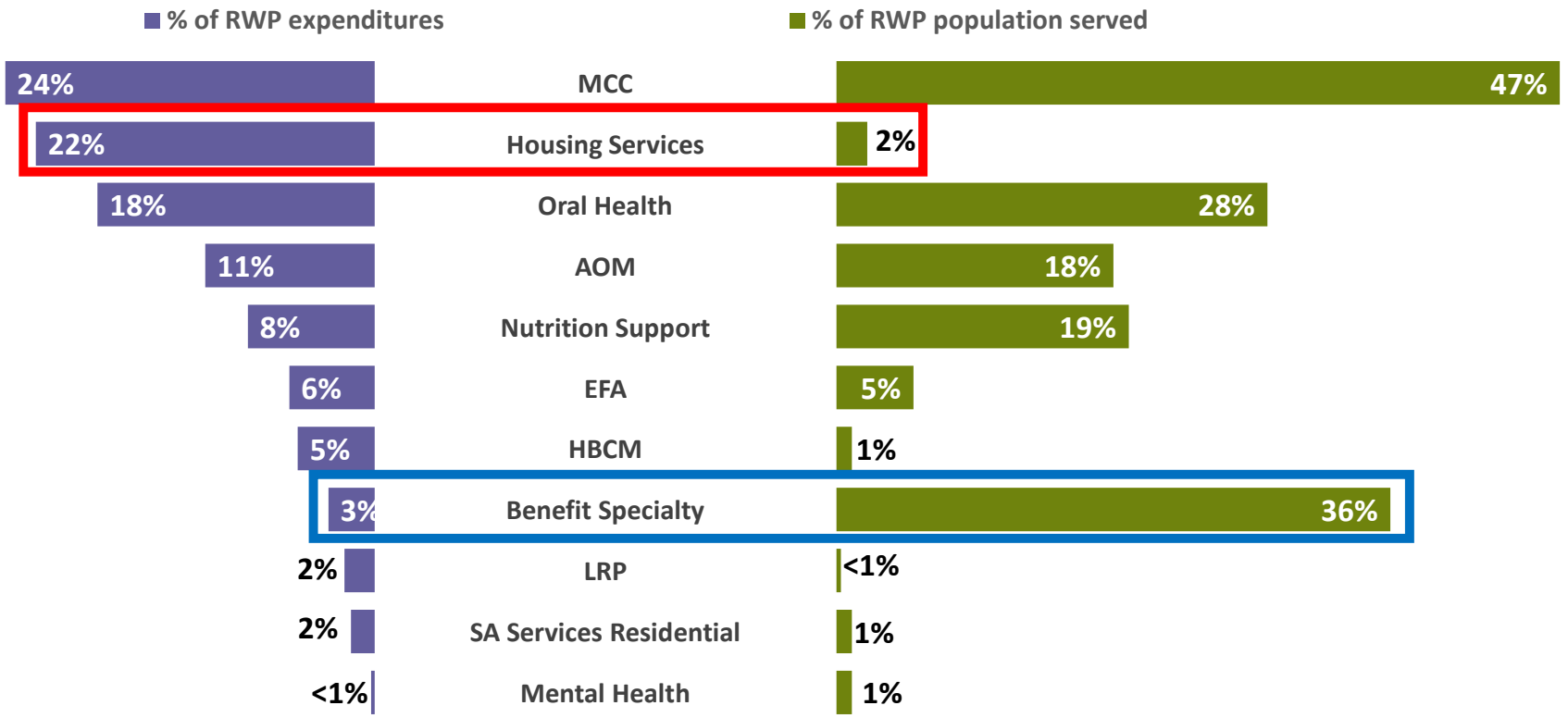
RWP Expenditures by Source of Funding, Years 30-34

Total expenditures increased until YR 33, then slightly dropped in Year 34. Part A and Part B funding gradually increased, MAI, SPAC Non-DMC and HIV NCC funding varied.



The costliest RWP service category compared to the percent of RWP population served was **Housing;** the least costly service was **NMCM**.

RWP Population Served vs Expenditures, Year 34



The highest expenditures per client were spent for LRP, followed by Housing and HBCM. The lowest expenditures per client were spent for Benefit Specialty, Mental Health and Nutrition Support.

County of Los Angeles Public Health

Service Category	Number of clients	Expenditures YR 34	Expenditures per client YR 34
Linkage Re-Engagement Program	24	$917,429	***$38,226***
Housing Services	292	$10,412,224	***$35,658***
Home-Based Case Management	114	$2,503,193	***$21,958***
Substance Abuse Services Residential - Transitional	86	$973,125	*$11,315*
Emergency Financial Assistance	730	$2,975,974	*$4,077*
Oral Health	4,469	$8,551,654	*$1,914*
Medical Outpatient	2,882	$5,183,652	*$1,799*
Medical Care Coordination	7,401	$11,684,158	*$1,579*
Nutrition Support	3,010	$3,928,501	***$1,305***
Mental Health	111	$87,857	***$792***
Benefit Specialty	5,653	$1,522,898	***$269***

Early Intervention Services - $2,143,916
Legal services - $ 1,073,964
Transportation - $738,442

Key Takeaways

- **Utilization of RWP services remains consistent** across community-based agencies
- Most of RWP clients are **male, Latinx, aged 50 and older, English-speakers, living at or below FPL, with public health insurance, with permanent housing and without incarceration history**
- The RWP is **reaching and serving LAC priority populations**

Key Takeaways – Priority Populations

- Service utilization among LAC priority populations is consistent relative to their size with the **highest among RWP clients aged 50 and older, Latinx MSM and Black MSM.**

- While poverty impacts all of the LAC priority populations, they are **differentially impacted by other SDOH**:
  - All priority populations had the highest percentage of people living at or below FPL.
  - High percentage of youth aged 13-29, people ≥ age 50, transgender, Latinx MSM, Black MSM, women of color were uninsured (except transgender) and Spanish-speakers (except Black MSM).
  - Transgender people had the highest percent of unhoused clients
  - Unhoused RWP client had the highest percent of injection drug use and high recent incarcerations.
  - PWID had the second highest percent of unhoused clients and recent incarcerations.

Key Takeaways – Priority Populations (cont.)

- The **top 5 most utilized RWP service** by Latinx MSM, Black MSM, transgender people, PWID, youth and unhoused clients was **MCC** program.
- For most priority populations the second most used service was **Benefit Specialty**.
- **Benefit Specialty** was the most utilized service by women of color.
- **Oral Health** was the most utilized service by people aged 50 and older.

Key Takeaways - HCC

- Engagement, retention in care and viral load suppression were **higher for RWP clients compared to PLWH in LAC** in Year 34.
- Engagement and retention in care and viral suppression continue to **gradually increase in the past 5 years** (Years 30-34).
- **Viral suppression was the highest** for Oral Health, Mental Health and Substance Use – Residential clients.
- **Viral suppression was the lowest** for LRP and MCC clients, as those are clients with the highest needs.

Key Takeaways - Expenditures

- **Part A and Part B expenditures gradually increased.** MAI, EHE, SAPC and HIV NCC expenditures varied over 5 years.
- **Mental Health services had the lowest expenditures** out of all RWP services.
- Although **LRP served the lowest percentage of RWP clients**, **it had the highest expenditures per client**.
- Although **Benefit Specialty and Nutrition Support served large percentage of RWP clients, per client expenditures for those services were among the lowest**.

Next Steps

- Present on two major service clusters
  - Core Services (AOM, MCC, Oral Health, HBCM, Mental Health)
  - Support Services (EFA, Housing, Benefit Specialty, Nutrition Support, LRP, Substance Use Residential)

Questions/Discussion

Thank you!

- **Acknowledgements**
  - Monitoring and Evaluation – Janet Cuanas, Siri Chirumamilla
  - PDR – Victor Scott, Michael Green
  - Surveillance – Edwin Aguilar, Priya Patel, Kathleen Poortinga
  - CCS – Abel Alvarez, Paulina Zamudio
  - RWP agencies and providers
  - RWP clients

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Letter of Assurance from Planning Council Chairs
Fiscal Year (FY) 2026 Non-Competing Continuation (NCC) Progress Report for the Ryan Whie HIV/AIDS Program (RWHAP) Part A HIV Emergency Relief Grant Program

September 26, 2025

Mario J. Pérez, MPH, Director
Division of HIV and STD Programs (DHSP)
Department of Public Health, County of Los Angeles
600 South Commonwealth Avenue, 10th Floor
Los Angeles, CA 90005

Dear Mr. Pérez:

This letter assures that the Commission on HIV (Commission), Los Angeles County's Ryan White Part A Planning Council (PC), has addressed the following items in accordance with the Fiscal Year (FY) 2026 Non-Competing Continuation (NCC) Progress Report for the Ryan White HIV/AIDS Program (RWHAP) Part A HIV Emergency Relief Grant Program. Documentation of detailed reports are provided as links throughout the letter of assurance.

a) Planning

a) i. The Commission on HIV's comprehensive needs assessment cycle coincides with the Integrated HIV Prevention and Care Plan submission timeline (every 4 years). As part of the Integrated Plan (locally known as the 2022-2026 Comprehensive HIV Plan (CHP), the Commission conducted a comprehensive needs assessment in May 24-August 31, 2022, with supplemental, population-focused needs assessments in 2024 and 2025. Multiple assessment activities and methods were utilized to assess the needs of PLWH and persons at risk for HIV in LAC. In addition to the review and analysis of various secondary data, primary qualitative data were collected for planning purposes via facilitated listening sessions for six priority population groups identified in the CHP; an online survey to assess the capacity of the HIV workforce and service system from both provider and community member perspectives (HIV Workforce Capacity and Service System Survey); and facilitated stakeholder meetings. Examples of secondary data reviewed as part of the comprehensive needs assessment include, local and national HIV surveillance data; HIV Care Continuum measures for LAC by subpopulation; Sexually Transmitted Disease (STD) surveillance data; LAC PrEP data; local HIV testing data for DHSP publicly funded testing; unmet needs reports; RWP service utilization; community listening sessions and focus groups; assessment of unmet mental health needs of PLWH; and

local research studies such as UCLA's study on optimizing PrEP delivery to a population of MSM. In addition, listening sessions were conducted to ensure that the perspectives of priority population members and PLWH were reflected in the Integrated Plan. The full content of the most recent needs assessments can be found Section 3, pages 46-70 of the 2022-2026 CHP.

To supplement the CHP's in-depth needs assessment and to help inform its overall planning efforts, the Commission held a series of community listening sessions. An additional listening session was also conducted for the Antelope Valley, a geographically challenged area of the County.

A caucus of the Los Angeles County Commission on HIV and DHSP conducted organizational needs assessments of organizations to identify specific capacity- building supports needed to marshal an effective and culturally tailored response to ending the HIV epidemic in local communities. The organizational needs assessment yielded the following recommendations: expand funding scope to include other health disparities impacting local communities; support organizations' growth and capacity to scale up; provide organizational infrastructure and program sustainability technical assistance; promote opportunities for partnerships/collaborations; develop communication and relationship building strategies; and invest in additional modality assessments.

Additionally, this caucus hosted community listening sessions inclusive of, but not limited to faith-based community, non-traditional HIV providers, and others on April 26, 2024, August 11, 2024, September 26, 2024, October 22, 2024, April 30, 2025, May 13, 2025, July 9, 2025, May 13, 2025, and July 9, 2025. These community listening sessions aimed to describe the sexual health needs of communities in Los Angeles County, guide improvements in HIV prevention and care service delivery, and ensure cultural responsiveness in caring for the diverse communities.

Antelope Valley Community Listening Session (October 28, 2024):

The Antelope Valley community listening session aimed to identify challenges and solutions to address the sexual health and wellness needs of its residents. Los Angeles County is home to almost 10 million people characterized by urban and rural geographic diversity. The Antelope Valley is a vast geographic region in northern Los Angeles County, covering two cities and more than 20 diverse unincorporated communities. The region faces critical issues, including poverty, homelessness, lower college educational attainment, more limited healthcare and food access, and a lack of transportation infrastructure, many of which are driven and exacerbated by the rising cost of living and its geographic isolation.

Other caucuses collaborated to host community listening sessions to expand outreach and opportunity to hear from individuals who do not typically engage in community planning efforts. These listening sessions occurred on June 4, 14, and 30 of this year. To ensure that the Commission's planning remains grounded in and centered around consumer needs, the Consumer Caucus hosted listening sessions on Ryan White Program (RWP) dental services (April 10, 2025) and provider and consumer experiences with navigating RWP and Medi-Cal (California's Medicaid program) enrollments (July 10, 2025).

Navigating RWP and Medi-Cal (July 10, 2025):

Key recurring themes from this listening session include:

- The RWP and Medi-Cal enrollment process is extremely complicated with enormous paperwork burden and a short window period for submitting required documents, leading consumers to rely heavily on benefits specialty staff. Benefits specialty staff indicated that the amount of time spent on assisting clients is a barrier, exacerbated by huge client caseloads.
- Some clients are illiterate and not computer savvy, further delaying the application process.
- Some staff and clients are not aware of the option under Medi-Cal to designate staff as authorized representatives to handle calls and documents submission on behalf of the client.
- More clients are fearful of using RWP and Medi-Cal.

ii. The Commission, DHSP, various stakeholders, and the community-at-large were deeply involved in developing the 2022-2026 CHP. The Commission's Priorities, Planning and Allocations (PP&A) Committee spearheaded the development of the CHP. Commission staff and PP&A leadership met regularly with a project consultant to oversee the development of the plan. The consultant provided regular updates at monthly Commission and PP&A meetings. Providers from Ryan White HIV/AIDS Program Parts B, C, D and F were engaged in the planning process in a variety of ways. To develop the plan, a meeting was convened with 12 representatives from seven different RWP Part C, D and F recipient organizations. Participants identified several key topics to be included in the Integrated Plan including: the need to focus on social determinants of health and co-occurring disorders (especially syphilis, methamphetamine use and mental health issues); workforce development and capacity issues; culturally congruent services; and an aging population of PLWH. Planning team members also met with stakeholders that were involved in the development of other Integrated HIV Plans within or inclusive of LAC to ensure alignment and avoid duplication of efforts. These plans included California's Integrated Statewide Strategic Plan for Addressing HIV, HCV, and STIs from 2022-2026; the Long Beach HIV/STD Strategy, 2019-2021 and the West Hollywood HIV Zero Strategic Plan, 2016-2021. Members of the Commission participated in the California Office of AIDS (OA) statewide planning and coordinated statewide statement of needs process by attending virtual and in-person meetings and having OA staff engage with the PP&A Committee to align goals and elicit community feedback on identifying priority populations. Key issues identified included a need to focus on stigma, social determinants of health and co-occurring disorders (including housing, mental health, and meth use), and broadening substance use prevention efforts.

b) Priority Setting and Resource Allocation (PSRA)

The Planning, Priorities and Allocations (PP&A) Committee leads the PSRA process for the Commission. DHSP and the Commission engages in an ongoing needs assessment process by harnessing data from community listening sessions, HIV and STD surveillance systems, service utilization, Medical Monitoring Project, National Health and Behavioral Surveillance, and local quantitative and qualitative research studies that focus on specific populations or service access issues. Analyses from these data sources consistently show the ongoing demand and need for integrated and comprehensive HIV care and wrap-around services.

b) i.a. To help inform the PSRA discussions, DHSP presented the following data throughout the year to the PP&A Committee: 1) Utilization by Service Category among Ryan White Priority Populations; 2) HIV Care Continuum; 3) HIV health outcomes across Priority Populations; 4) Ryan White Program Utilization Report Summaries; 5) program expenditures information; 6) HIV testing and PrEP client demographic data; and 7) HIV and STD surveillance summaries. The FY 2026 planning process discussed the need for reducing barriers to accessing prevention and care services; worsening affordable housing crisis; increasing need for emergency and ongoing financial assistance and other social services; persistent inequities in HIV health outcomes among communities most impacted by HIV; and continuing reliance on the RWP care system among communities who are unaware and/or distrustful of the larger healthcare system.

The FY 2026 PSRA process occurred under a time of uncertainty and decreases in funding for public health and social services. These recommendations were approved with the understanding that the Commission will need to work with DHSP to continually track and monitor service needs and respond accordingly, given the ongoing funding cuts to safety net programs. The federal budget policies are negatively impacting the State of California's budget and creating service delivery challenges. As a result, the Commission's PSRA decisions were driven by the commitment to preserve a necessary mix of core and support services and ensure that as many PLWH are served with the resources available to Los Angeles County. The FY 2026 service allocations are summarized in the table below:

Type	Rank	Service Category	Part A %	MAI %
Core	**6**	Medical Case Management (MCC)	16.05%	0.00%
Core	**8**	Oral Health	18.16%	0.00%
Core	**20**	Outpatient/Ambulatory Medical Health Services (AOM)	14.71%	0.00%
Core	**11**	Early Intervention Services	2.07%	0.00%
Core	**17**	Home and Community-Based Health Services	3.96%	0.00%
Support	**2**	Emergency Financial Assistance	4.29%	0.00%
Support	**7**	Nutrition Support (Food Bank/Home-delivered Meals)	8.27%	0.00%
Support	**5**	Non-Medical Case Management	12.56%	0.00%
Support	**10**	Medical Transportation	1.86%	0.00%
Support	**23**	Legal Services	2.68%	0.00%
Support	**1**	Housing	11.75%	100.00%
Core	**3**	Mental Health Services	3.64%	0.00%
Support	**4**	Psychosocial Support Services	0.00%	0.00%
		Overall Total	**100.00%**	**100.00%**

The FY 2026 service rankings were determined under the following key realities: 1) lack of affordable housing and increased risk for homelessness will remain a significant challenge for PLWH; 2) financial instability will persist due to inflation, high cost of living and unlivable wages; and 3) ongoing demand for culturally competent medical and mental health services. Concerns for meeting the necessities of life, such as shelter, food, and healthcare remain as the key overarching needs of PLWH in LAC.

b) i.b. The allocations approved by the Commission, support the needs of the priority populations identified in the CHP. According to the 2022 DHSP Annual Surveillance Report, HIV diagnosis rates remain substantially higher among Black and Latinx males compared with females. Certain subpopulations have higher HIV positivity and diagnosis rates compared to other subpopulations. In 2021, molecular HIV surveillance identified clusters where recent and rapid HIV transmission could be occurring (high priority clusters). Persons in these clusters were more likely to be men, aged 20-29 years, non-White, and have MSM transmission risk compared with persons newly diagnosed with HIV who were not associated with a priority cluster.

Between 2020-2021, 95% of HIV-positive pregnant women living with diagnosed HIV received at least one arm of ART during pregnancy and/or at labor and delivery. Among the four infants that had perinatal infection in 2020, all were born to mothers who were not confirmed to have received ART during pregnancy and/or delivery. Persons living with HIV who are unhoused continue to experience suboptimal outcomes along the HIV care continuum. Compared with housed persons, unhoused persons had lower rates of receiving HIV care, retention in care, and achieving viral suppression in 2021. A major driver for the low viral suppression rates among PLWDH is delayed treatment among PLWDH and low adherence to ART among those on treatment. In a representative sample of PLWDH, only 8 in 10 were on ART, and 100% adherence to ART doses in the past 30 days was low at 54%. ART adherence was lower among non-White and lower among those aged 18-29 years (29%) than other age groups. The Commission increased allocations to key services that address barriers to care instigated by social determinants of health, support engagement and retention in care and, to ultimately improve health outcomes (medical case management, emergency financial assistance, legal, and non-medical case management services). Resources allocated are supportive of the needs of women, infants, children, and youth and leverages local Part D funding and programs. Women, infants, and children are primarily served through Part D and Medi-Cal providers in LAC.

b.ii People living with HIV represent over 40% of the Commission with several unaffiliated consumers serving in leadership positions in committees and subgroups. Thirty-three percent of the planning council meet HRSA's definition of "unaffiliated consumer." The strong representation of PLWH on the Commission lends to a process and outcome that is driven by their lived experience, strengths, and vision for optimal health. For the FY 2026 PSRA process, representatives from various caucuses participated in the service ranking and allocation deliberations. The Commission's various caucuses (including the Consumer Caucus) routinely discuss the needs of PLWH and their experience with the local RWP service delivery system at their meetings. Economic inflation and financial hardships have led to a greater need for housing, food bank/nutrition services, and emergency financial services. The caucuses play a critical role in designing the local HIV care system and serve as promoters of services to their peers. The Consumer Caucus ranked the RWP services prior to the PP&A Committee deliberations to ensure that discussions are centered around the needs of consumers.

b.iii The Commission attests that the FY 2025 budget period formula, supplemental, and MAI funds were expended according to the allocated priorities approved by the Commission. The PP&A Committee approved the FY 2025 reallocations for RWP core and support services on August 19, 2025. The Executive Committee subsequently approved the reallocations on August 28, 2025. The FY 2025 reallocations aimed to align contractual obligations with the total amount of funding received from HRSA.

b.iv The Commission confirms that all RWHAP HIV core and support services were prioritized during the FY 2025 and FY 2026 PSRA process per sections 2602(b)(4)(C) and 2602(d)(1) of the Public Health Service Act.

c) Training

The Commission established a series of virtual trainings for PC members and the public from February 26, 2025 to July 23, 2025. The topics and dates for the trainings are as follows: General Orientation and PC Overview (2/26/24); Ryan White CARE Act Legislative Overview and Membership Structure and Responsibilities (4/2/25); Priority Setting and Resource Allocation Process (4/23/25); Service Standards Development (5/1/25); Policy Priorities and Legislative Docket Development Process (6/25/25); and Bylaws Review (7/23/25). As a standing practice, the first meeting of each year includes a training on the Brown Act and parliamentary procedures. In addition to these formal trainings, staff provide onboarding sessions for newly appointed members and ongoing coaching and support for PC members. Slides and video recordings are available on the Commission website so that PC members and interested applicants can access training materials online.

d) Assessment of the Efficiency Administrative Mechanism (AEAM)

The PY 33 and PY 34 Assessment of the Efficiency of the Administrative Mechanism (AEAM) Report was completed and approved by the Commission on July 10, 2025. The AEAM covered 1) feedback from contracted agencies on the efficiency of Los Angeles County's administrative mechanisms (such as contracts, procurement, solicitations) to rapidly disburse funds to support HIV services in the community; and 2) survey and key informant interviews with key recipient staff to integrate their insights regarding the County's solicitations, contracting, and invoicing processes.

The PY 33 and PY 34 AEAM highlighted key suggestions for improvement based on provider and recipient survey responses and interviews:

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

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

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

The Commission remains firmly committed to staying the course to end the HIV epidemic in Los Angeles County and beyond. The disparities in access to care, the worsening economic divide, and the dismantling of safety net services will further strain the local RWP system and exacerbate the challenges faced by PLWH in LAC and across the country. The Commission will work closely with DHSP in monitoring service needs and making funding allocations as appropriate to ensure continuity of care for PLWH.

If you have any questions or need further assistance, please do not hesitate to contact us at 213.738.2816.

Sincerely,

Danielle Campbell

Danielle Campbell, Co-Chair
Los Angeles County Commission on HIV

Joseph Green

Joseph Green, Co-Chair
Los Angeles County Commission on HIV

Service Standard Development

LOS ANGELES COUNTY COMMISSION ON HIV

KEYWORDS AND ACRONYMS

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

WHAT ARE SERVICE STANDARDS?

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

WHAT ARE SERVICE CATEGORIES?

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

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

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

HRSA/HAB GUIDANCE FOR SERVICE STANDARDS

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

COH SERVICE STANDARDS

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

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

REMINDER

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

DEVELOPING SERVICE STANDARDS

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

SERVICE STANDARD DEVELOPMENT PROCESS

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

together.

WE CAN END HIV IN OUR COMMUNITY ONCE AND FOR ALL

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

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

SERVICE STANDARDS REVISION DATE TRACKER FOR PLANNING PURPOSES

Last updated: 10/01/25

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

*** SERVICES IN BLUE ARE CURRENTLY FUNDED ***

HRSA Service Category	COH Standard Title	DHSP Service	Description	Notes
N/A	AIDS Drug Assistance Program (ADAP) Enrollment	N/A	State program that provides medications that prolong quality of life and delay health deterioration to people living with HIV who cannot afford them.	ADAP contracts directly with agencies. Administered by the California Department of Public Health, Office of AIDS.
Child Care Services	Child Care Services	Child Care Services	Childcare services for the children of clients living with HIV, provided intermittently, only while the client attends in person, telehealth, or other appointments and/or RWHAP related meetings, groups, or training sessions.	**Last approved by COH: 7/8/2021**
Early Intervention Services	Early Intervention Program (EIS) Services	Testing Services	Targeted testing to identify HIV+ individuals.	**Last approved by COH: 5/2/2017**
Emergency Financial Assistance	Emergency Financial Assistance (EFA)	Emergency Rental Assistance	Pay assistance for rent, utilities, and food and transportation for PLWH experiencing emergency circumstances.	**Last approved by COH: 2/13/2025** **Updates from DHSP:** Clients must be facing eviction to qualify, the limit is $5,000 per year, per client, and applications are through Benefits Specialists.
Food Bank/Home Delivered Meals	Nutrition Support Services	Nutrition Support Services	Home-delivered meals and food bank/pantry services programs.	**Last approved by COH: 8/10/2023**
N/A	HIV/STI Prevention Services	Prevention Services	Services used alone or in combination to prevent the transmission of HIV and STIs.	**Last approved by COH: 4/11/2024** *Not a program- Standards apply to prevention services.*

*** SERVICES IN BLUE ARE CURRENTLY FUNDED ***

LOS ANGELES COUNTY COMMISSION ON HIV

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

*** SERVICES IN BLUE ARE CURRENTLY FUNDED ***

HRSA Service Category	COH Standard Title	DHSP Service	Description	Notes
			status and self-management skills to help treat HIV disease.	
Medical Transportation	Transportation Services	Medical Transportation	Ride services to medical and social services appointments.	**Last approved by COH: 2/13/2025**
Mental Health Services	Mental Health Services	Mental Health Services	Psychiatry, psychotherapy, and counseling services.	**Last approved by COH: 5/2/2017** *Committee will continue review on 10/7/25.*
Non-Medical Case Management	Benefits Specialty Services (BSS)	Benefits Specialty Services	Assistance navigating public and/or private benefits and programs.	**Last approved by COH: 9/8/2022**
	Patient Support Services (PSS)	Patient Support Services	Provide interventions that target behavioral, emotional, social, or environmental factors that negatively affect health outcomes with the aim of improving an individual's health functioning and overall well-being.	New service standard currently under development. *Committee will review public comments received and hold vote to approve on 10/7/25.*
	Transitional Case Management: Justice-Involved Individuals	Transitional Case Management- Jails	Support for post-release linkage and engagement in HIV care.	**Last approved by COH: 12/8/2022** *COH will review and hold vote to approval on 10/9/25*
	Transitional Case Management: Youth	Transitional Case Management- Youth	Coordinates services designed to promote access to and utilization of HIV care by identifying and linking youth living with HIV/AIDS to HIV medical and supportive services.	**Last approved by COH: 12/8/2022** *COH will review and hold vote to approval on 10/9/25*
	Transitional Case Management: Older Adults 50+	N/A	Coordinate transition between systems of care for older adults 50+ living with HIV/AIDS.	*COH will review and hold vote to approval on 10/9/25*
Oral Health Care	Oral Health Care Services	Oral Health Services	General and specialty dental care services.	**Last approved by COH: 4/13/2023**
Outpatient/Ambulatory Health Services	Ambulatory Outpatient Medical (AOM)	Ambulatory Outpatient Medical	HIV medical care accessed through a medical provider.	**Last approved by COH: 2/13/2025**
Outreach Services	Outreach Services	Linkage and Retention Program	Promote access to and engagement in appropriate services for people newly diagnosed or identified as	**Last approved by COH: 5/2/2017**

*** SERVICES IN BLUE ARE CURRENTLY FUNDED ***

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

LOS ANGELES COUNTY
COMMISSION ON HIV

TRANSITIONAL CASE MANAGEMENT SERVICES: JUSTICE-INVOLVED INDIVIDUALS

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

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

Contents

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

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

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

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

Service Standards: Ryan White HIV/AIDS Programs

Introduction

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

Service Description

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

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

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

HRSA Guidance for Non-Medical Case Management

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

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

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

General Eligibility Requirements for Ryan White Services

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

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

Transitional Case Management for Justice-Involved Individuals

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

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

SERVICE STANDARDS

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

IN-REACH AND OUTREACH

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

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

COMPREHENSIVE ASSESSMENT

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

Comprehensive assessment is conducted to determine the:

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

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

INDIVIDUAL RELEASE PLAN (IRP)

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

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

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

IMPLEMENTATION, MONITORING, AND FOLLOW-UP OF IRP

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

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

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

STAFFING REQUIREMENTS AND QUALIFICATIONS

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

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

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

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

Recommended Training Topics

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

TRANSITIONAL CASE MANAGEMENT SERVICES: OLDER ADULTS 50+

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

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

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

Contents

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

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

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

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

Service Standards: Ryan White HIV/AIDS Programs

Introduction

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

Service Description

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

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

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

HRSA Guidance for Non-Medical Case Management

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

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

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

General Eligibility Requirements for Ryan White Services

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

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

TCM for Older Adults 50+: Service Compoments

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

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

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

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

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

Care Planning

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

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

Resource Navigation

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

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

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

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

Recommended Training Topics for Transitional Case Management Staff

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

TRANSITIONAL CASE MANAGEMENT SERVICES: YOUTH

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

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

Contents

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

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

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

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

Service Standards: Ryan White HIV/AIDS Programs

Introduction

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

Service Description

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

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

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

HRSA Guidance for Non-Medical Case Management

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

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

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

General Eligibility Requirements for Ryan White Services

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

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

Transitional Case Management for Youth

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

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

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

SERVICE STANDARDS

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

OUTREACH

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

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

COMPREHENSIVE ASSESSMENT AND REASSESSMENT

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

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

Comprehensive assessment is conducted to determine the following:

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

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

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

INDVIDUAL SERVICE PLAN (ISP)

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

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

BRIEF INTERVENTIONS

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

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

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

IMPLEMENTATION, MONITORING, AND FOLLOW-UP OF ISP

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

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

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

STAFFING REQUIREMENTS AND QUALIFICATIONS

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

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

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

Recommended Training Topics and Additional Resources

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

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

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

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

We're Listening

share your concerns with us.

HIV + STD Services Customer Support Line

(800) 260-8787

Why should I call?

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

Will I be denied services for reporting a problem?

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

Can I call anonymously?

Yes.

Can I contact you through other ways?

Yes.

By Email:
dhspsupport@ph.lacounty.gov

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

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

Estamos Escuchando

Comparta sus inquietudes con nosotros.

Servicios de VIH + ETS
Línea de Atención al Cliente

(800) 260-8787

¿Por qué debería llamar?

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

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

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

¿Puedo llamar de forma anónima?

Si.

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

Si.

Por correo electronico:
dhspsupport@ph.lacounty.gov

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

County of Los Angeles
Public Health
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