To: City of Los Angeles, Budget And Finance Committee:
Mandy Morales, Legislative Assistant: Clerk.BudgetandFinanceCommittee@lacity.org
Councilmember Katy Yaroslavsky, Chair, Katy.Yaroslavsky@Lacity.Org
City of Los Angeles, Office of the City Clerk, Cityclerk@Lacity.Org

April 27, 2025

Re: Public Comment: Council File 25-0600, City of Los Angeles FY 2025–26 Budget

Dear Chair Yaroslavsky and Councilmembers,

Please accept this email as my official public comment for inclusion in the record for Council File 25-0600 regarding the Fiscal Year 2025–26 City of Los Angeles Budget.

In the context of a projected $1 billion City budget shortfall, it is more important than ever to act strategically and protect against escalating fiscal liabilities. **Restoring the $1.075 million cut to the Department on Disability and allocating a modest $5 million Long COVID Response line-item is a critical cost-containment measure and fiscal stabilization strategy.**

Extrapolating Harvard economist estimates, **Long COVID will cost Los Angeles over $3 billion in five years[1].** Globally, Long COVID is already costing more than $1 trillion per year[4], and U.S. losses exceeded $152.6 billion in 2024 alone[5]. **With 268,000 adults in Los Angeles now living with Long COVID[2], the projected local economic impact exceeds $11,000 per person in lost productivity, healthcare needs, and reduced quality of life.**

Long COVID is a CDC- and WHO-recognized **disabling condition that impacts over 400 million people worldwide[4]**. Without intervention, Long COVID will continue to drive housing instability, workforce attrition, rising emergency service costs, and long-term erosion of the City's tax base and economic resilience. **Proactive investment now, representing less than 0.2% of the projected loss, is fiscally prudent and essential to mitigating broader systemic risks.**

Los Angeles first allocated funding to the AIDS crisis in 1987, six years into the epidemic. The City's first independent general fund allocation came in 1990, amounting to $55k[3]. By 1992, AIDS cases in LA County peaked at roughly 4k annually, and there were fewer than 10k PWA in LA. Adjusted for inflation, that allocation equals approximately $132k today. **Today, the number of Angelenos with Long COVID is more than 20 times the peak AIDS caseload.** Yet, the timeframe that Los Angeles funded AIDS programs, **there is no effective treatment, dedicated services, or public health infrastructure for Long COVID.**

If we apply the same per-person investment as we did for AIDS, the commensurate ask would be approximately $8.8 million. However, acknowledging the City's fiscal constraints, **I am not asking for that full amount**. Instead, I respectfully request a **$5 million starter allocation** to launch a targeted Long COVID response and restore core disability services. **This is a modest, strategic investment that will help prevent far higher costs later while laying the groundwork for future state and federal funding.**

Key Facts:

- $1.075 million cut to the Department on Disability proposed
- $5 million requested for Long COVID response efforts
- $3 billion in projected economic losses over five years if unaddressed[1]
- Less than 0.2% of projected losses represented by this $5M ask
- 268,000+ Angelenos living with Long COVID[2]
- 20× the scale of the population impacted when AIDS services were first funded[3]
- Creates avenue to leverage future related State and Federal funds

A humble but historic line item for Long Covid is the fiscally sound, economically responsible, and morally necessary action. **Please act to reverse the proposed Department on Disability cuts and fund a dedicated $5 million Long COVID Response line-item under Council File 25-0600.**

Thank you for your leadership and for considering this critical measure.

Respectfully,

Sara L. Johnson
Los Angeles, CA 90026

References:

1. Cutler, D. (2022). *The Economic Impact of Long COVID*. Harvard Kennedy School.
2. CDC Household Pulse Survey. (September 2024). *Long COVID Prevalence Estimates*.
3. Los Angeles Times. (1990). *Los Angeles Takes a Big Lead : Is First in Area to OK Funds for AIDS Outreach Efforts*
4. Nature Medicine. (2024). *Long COVID Science, Research and Policy*.
5. Economist Impact. (2024). *Incomplete Picture: Understanding the Burden of Long COVID*.

CC :

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The Economic Cost of Long COVID: An Update

David M. Cutler

Harvard University

In a 2020 JAMA Viewpoint, Lawrence Summers and I guessed at the possible economic costs of long COVID.[1] At the time, we thought the cost might be $2.6 trillion. With more data, that estimate can be updated. I do so here.

Background

Many survivors of SARS-CoV-2 infection suffer "long COVID," formally termed Post-Acute Sequelae of SARS-CoV-2 infection (PASC). Data suggest that 22-38% of people with COVID will have at least one symptom 12 weeks after initial onset, and 12-17% will have three or more symptoms. With 80.5 million confirmed COVID cases in the United States, this implies at least 9.6 million people with three or more symptoms of long COVID. The most common symptom of long COVID is fatigue, but every organ system has been implicated.

Three Economic Costs

Three economic costs of long COVID were estimated. The first is the lost quality of life. Economists value lost quality of life by estimating the reduction in quality adjusted years of life due to long COVID (QALY) and multiplying that by the value of a year of good health. To estimate the QALY disutility of long COVID, I assume that cases with three or more symptoms experience the same disutility as people with myalgic encephalomyelitis (ME)/chronic fatigue syndrome

(CFS), which has been estimated at -0.29.[2] Cases with one or two symptoms were assumed to have a disutility of -0.1.[3] I assume that long COVID lasts 5 years on average, consistent with the slow rate of recovery observed to date.[4] I assume a year in good health is worth $100,000. The first row of the table shows the resulting implied cost of reduced health, estimated to be $2.2 trillion.

The second economic cost is lost earnings. Based the prevalence rates above, there are an estimated 8.4 million adults with three or more symptoms of long COVID. The labor force participation rate for adults is about 60 percent, which I assume applies to this population. I assume no labor supply consequences for people with <3 symptoms. Surveys of people with long COVID suggest that the reduction in labor supply for those with significant impairment is about 70 percent.[5] I assume this persists for five years and that people out of work lose the average amount earned, roughly $1,100 per person. The net loss in income, shown in the second row of the table, is $1 trillion.

The third economic cost is higher spending on medical care. I again use ME/CFS as a guide. Costs for these conditions rage between $3,712 to $13,750.[6] I assume the midpoint of $8,731 for people with three or more symptoms and one-third that amount for cases with <3 symptoms, consistent with the roughly two-thirds reduction in quality of life. The additional medical spending totals $528 billion, shown in the last row of the table.

Adding across the three areas, Table 1 shows the total cost of long COVID is $3.7 trillion. 59% of the cost is lost quality of life; the remainder is reduced earnings and greater medical spending. The total amount is roughly $11,000 per person, or about 17% of pre-COVID US GDP. By another metric, the cost of long COVID rivals in aggregate the cost of the Great Recession.[1]

Discussion

Relative to my earlier estimate with Lawrence Summers of the cost of long COVID of $2.6 trillion, the higher number here is higher: $3.7 trillion in total. The higher estimate is largely a result of the greater prevalence of long COVID than we had guessed at the time. There are about 10 times the number of people with long COVID as have died of COVID.

Because long COVID is so new, there is uncertainty about all of the numbers involved in the calculations. Still, the costs here are conservative, based on only cases to date.

The enormity of these costs implies that policy to address long COVID are urgently needed. With costs this high, virtually any amount spent on long COVID detection, treatment, and control would result in benefits far above what it costs.

Table 1: The Economic Cost of Long COVID

Impact	Value ($ billion)
Reduced quality of life	$2,195
Reduced earnings	$997
Increased medical spending	$528
Total cost	$3,719
Cost per capita	$11,189
Percent of 2019 GDP	17%

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[1] Cutler DM, Summers LH. The COVID-19 Pandemic and the $16 Trillion Virus. *JAMA.* 2020;324(15):1495–1496. doi:10.1001/jama.2020.19759.

[2] Falk Hvidberg M, Brinth LS, Olesen AV, Petersen KD, Ehlers L. The Health-Related Quality of Life for Patients with Myalgic Encephalomyelitis / Chronic Fatigue Syndrome (ME/CFS). PLoS One. 2015 Jul 6;10(7):e0132421.

[3] Martin C, Luteijn M, Letton W, Robertson J, McDonald S. A model framework for projecting the prevalence and impact of Long-COVID in the UK. *PLoS One*. 2021;16(12):e0260843. Published 2021 Dec 2. doi:10.1371/journal.pone.0260843

[4] Davis, H, et al., Characterizing Long COVID in an International Cohort: 7 Months of Symptoms and Their Impact, medRxiv 2020.12.24.20248802;

[5] COVID-19 Longhauler Advocacy Project, An Open Letter to President Biden, Cabinet and Congressional Leadership, and Key Governmental Agencies, January 10, 2022.

[6] Jason LA, Mirin, AA. Updating the National Academy of Medicine ME/CFS prevalence and economic impact figures to account for population growth and inflation, *Fatigue: Biomedicine, Health & Behavior*, 2021; DOI: 10.1080/21641846.2021.1878716

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March 24, 2025

The Honorable Jesse Gabriel
Assembly Budget Committee
1021 O Street
Sacramento, CA 95814

The Honorable Sharon Quirk Silva
Assembly Budget SubCommittee 5
1021 O Street
Sacramento, CA 95814

Re: California State Budget – Request for $1.893 Billion to Support City of Los Angeles Fire Recovery and Resilience

Dear Chair Gabriel and Sub Chair Quirk Silva:

We, the below signed legislators, are writing to respectfully request that the 2025-26 State Budget include the following funding priorities to address the City of Los Angeles' urgent disaster recovery efforts following the devastating fires this past January, which displaced thousands, destroyed businesses and damaged critical infrastructure.

Protecting City Services Under Budgetary Strain & Addressing Liability Costs – $638M

● Request: Funding to enhance and make access improvements to streets, sidewalks, and street lights ($250M), to help address an extraordinary spike in liability payouts ($200M), replenish the City's reserves ($150M) and to make up for lost revenues from the Palisades fire ($38M).

Ensuring the City's Cash Flow for Recovery during Federal Uncertainty - $301M

● Request: Provide a loan to support disaster recovery expenses pending FEMA reimbursement ($291M, e.g. debris removal, emergency protective measures, repairs to damaged City property) and funding for disaster response contract services ($10M).

Investing in Mitigation and Resilience for City Residents – $750M

● Request: Provide a loan to support upgrades to the electric power grid in Pacific Palisades for resiliency, reliability and capacity ($700M) and funds to incentivize electric upgrades and appliances (e.g., heat pumps, induction cooktops, battery storage) that increase reliability during outages ($40M) and upgrade the Advanced Transportation System and Coordination (ATSAC) traffic signal system ($10M).

Enhancing Fire Safety and Fire Suppression – $56.5M

● Request: Funding for brush fire equipment caches in high fire severity zones ($1.5M), new Fast Response Vehicles/brush control units and accompanying staff for fire suppression ($15M), and to reconstruct the decommissioned Palisades Reservoir to address structural issues ($40M).

Supporting Workers and Residents – $72.8M+

● Request: Funding to operate a One-Stop Rebuilding Center ($12-15M); waive certain permitting fees for property owners to rebuild ($38M+); employ Angelenos to perform fire clean-up, remediation, and other recovery work ($3.8M); provide interim library services and recreation/park activities to the community ($3M); support Disaster Recovery Center operations ($1M); and support displaced renters with emergency housing vouchers ($15M).

Expediting Public Assistance – $75.5M

● Request: Expedite CalOES processing of FEMA Public Assistance from previous emergencies, particularly COVID-19 (Project Roomkey/Non-Congregate Shelter and Continuity of Operations).

These amounts reflect the City's ongoing need for support in the areas of site cleanup, housing assistance, public safety, infrastructure restoration, and economic support for impacted communities. These investments are essential not only for immediate relief but also for fostering the City's long-term stability and preparedness.

We appreciate your consideration of these requests and look forward to working with you to secure the necessary resources for our communities impacted by this devastating natural disaster.

Thank you for your attention to this matter.

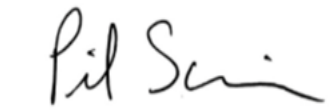
Sincerely,

TINA McKINNOR
61st Assembly District
Chair, LA County Legislative Delegation

MARIA ELENA DURAZO
26th Senate District
Vice Chair, LA County Legislative Delegation

SADE ELHAWARY
57th Assembly District

JOSE LUIS SOLACHE
62nd Assembly District



PILAR SCHIAVO
40th Assembly District

MIKE FONG
49th Assembly District

JESSICA CALOZA
52nd Assembly District

ISAAC BRYAN
55th Assembly District

LAURA RICHARDSON
35th Senate District

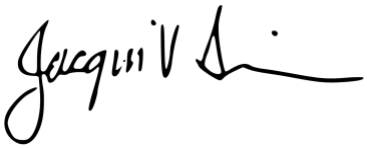
BEN ALLEN
24th Senate District

AL MURATSUCHI
66th Assembly District

JOSH LOWENTHAL
69th Assembly District

NICK SCHULTZ
44th Assembly District

MARK GONZALEZ
54th Assembly District



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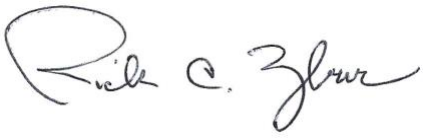

RICK CHAVEZ ZBUR
51st Assembly District

HENRY STERN
27th Senate District

CAROLINE MENJIVAR
20th Senate District

LENA GONZALEZ
33rd Senate District

LOLA SMALLWOOD-CUEVAS
28th Senate District

MARK GONZALEZ
54th Assembly District

MIKE GIPSON
65th Assembly District

First They Got Long Covid. Then, It Made Them Homeless

rollingstone.com/culture/culture-features/long-covid-homeless-chronic-illness-gig-economy-1312460

Elizabeth Yuko February 25, 2022

People ride their bikes past a homeless encampment set up along the boardwalk in the Venice neighborhood of Los Angeles on June 29, 2021 *Jae C. Hong/AP*

Cold weather is brutal for Wendi Taylor. After living with long Covid for two years, she knows that when the temperature drops, the pain and discomfort increases. This is especially true because of the severe arthritis in her hands, which only developed following her initial Covid-19 infection.

Taylor, who lives in Houston and is among the estimated millions of Americans living with long Covid, says that doing dishes during cold weather is probably the hardest part about living in the makeshift cabin she built from tarps and an 8×8 metal pop-up awning frame she found in the garbage.

“I heat water on the stove, but when it’s below freezing, it cools down quickly, and contact with the water causes extreme pain in my hands,” says Taylor. “It feels like being burned and smashed with a sledgehammer at the same time, and takes a long time for the pain to stop.

Even just going outside can cause my hands to turn red and swell and have pain like that. It has made me curl up on my bed and cry more than once."

At the foot of her twin mattress, atop a small table, sits a small green camping stove she uses both to cook and heat her 64-square-foot living space. A row of plastic storage cabinets is situated at the head of her bed. "Arranging it this way leaves room in the center to sit in a folding chair, or stand up to change clothes, or set groceries down when I come in from the store," Taylor explains.

After riding out last year's historic ice storm — which left at least 246 Texas residents dead — in a previous camp, when Taylor found out about the major winter storm at the beginning of this month, she went in prepared. She reinforced the tarps that function as the walls of her cabin, and ensured that the poles of its frame were firmly anchored into the ground.

One of Taylor's biggest concerns this time was having the propane she needed to operate her stove. "Power outages matter little to me, but 'they' will buy all the propane if their electric heat goes off," Taylor, 41, tells *Rolling Stone*, referring to housed individuals. "This is one of the biggest issues we face: Supplies we depend on daily become unavailable when they're hoarded for emergencies."

Fortunately, 2022's storm ended up being far less severe than the one in 2021. Instead of having to go weeks without propane, stores near Taylor's camp in Houston were restocked within days. "That made it far easier to stay warm," she explains. "I could just hole up inside and avoid opening the door at all, for the most part."

This isn't what Taylor's life was like prior to Covid-19. In fact, things were starting to look up during the first week of March 2020. She was working steadily as a day laborer in construction and landscaping in the Houston area, and was living in an extended-stay motel, saving up to get an apartment. "I was one paycheck away from being able to do so when I got sick," Taylor says, noting that her first Covid-19 symptoms (a sore throat, fever, and hacking cough) began on March 7.

Although Taylor still felt run-down weeks later, she wasn't initially alarmed by her lengthy convalescence: After all, it took her several months to recover after she contracted the H1N1 flu in 2009. "I figured this would be the same kind of thing," she says. "Lots of comparisons were being made to that pandemic." But nearly two years later, Taylor is still sick.

"One day I saw a list of 'common' long Covid symptoms that numbered over 200 — and I've had most of them," she says, noting that like many people living with long Covid, her symptoms are neither consistent nor constant, varying in combination and intensity over days and weeks.

And while fatigue, rashes, and neurocognitive issues are among her most persistent and disruptive symptoms, it's the severe, sudden-onset arthritis that makes coping with daily life the hardest. "Because my hands are particularly affected, I had to learn new ways of doing simple tasks like tying my shoes or buttoning clothes," she explains. "And since [getting Covid], I haven't been able to work for more than a day or two at a time."

Without an income, Taylor had no choice but to move out of the motel and into a tent behind the dumpster of the local doughnut shop. She estimates that over the course of the spring and summer of 2020 she stayed in at least two-dozen different places, ranging from a cardboard box to friends' couches to motel rooms.

By the fall of 2020, the constant moving was too much for Taylor, so she built the first of her longer-term camps. "At that point, my neurological symptoms were getting progressively worse and, in retrospect, I think I was subconsciously building a place to die," she says.

Taylor has spent the past year living in her makeshift cabin under a sprawling oak tree on a dead-end street near the Astrodome. "I'm basically a hermit these days," she says. "Covid trashed my immune system, so I mostly keep to myself and stay at my camp as much as possible."

But Taylor is one of many people whose Covid-19 infection morphed into a chronic illness that unraveled their lives: first taking their health, then their financial stability. For some, the multiple burdens of living with long Covid resulted in losing their housing. And for at least one person, long Covid was the first in a series of events that ended in their death.

"We are only beginning to scratch the surface of [understanding] the effects of long Covid on folks' financial well-being — including their housing security, or lack thereof," says Megan Ranney, M.D., the associate dean for strategy and innovation at Brown University, and co-leader of the School of Public Health's Long Covid Initiative. "Unfortunately, for much of America, living with long Covid is enough to put folks over the edge financially, with very limited safety nets."

One thing we do know about long Covid is that it encompasses a wide range of symptoms and severity. So while some people living with long Covid are able to continue working without a problem, others — especially those with physically demanding gig-economy jobs — don't have that option.

"Our country does not do a great job of supporting people in ways that allow them to continue to work and take care of their families while living with chronic medical conditions," Ranney explains. "There's obviously a knock-on effect: If you can't work and can't get disability, at some point you're going to lose your house."

Last August, in a Missouri state park about an hour north of Kansas City, Amanda Finley was starting a campfire, getting ready to heat a frozen meal for a late dinner, when her phone buzzed around 9 p.m. It was a text from her friend Ashlee Bryant, who went by Jake. “I’m about to break,” he wrote. “Broke, homeless, I weigh 92 lbs, in more pain than I thought was possible. My life’s ruined.”

Though she was keenly aware of the severity of his condition, this update hit Finley hard. They had both been living with long Covid for more than a year, but his health began to rapidly decline when he developed pneumonia in May 2021, and spent most of the month on a ventilator. His clothing — purchased when he was at his normal weight of 170 pounds — no longer fit his emaciated frame. “It was like watching a train wreck in very slow motion,” Finley says. “And this was preventable.”

Less than three weeks after sending that text, Bryant died in a Beaumont, Texas, hospital at the age of 40, with his fiancee, Carrie Savage, by his side.

“It wasn’t supposed to be like this,” Savage, 40, tells *Rolling Stone.* “That day [he died] he told me he wasn’t ready to leave me. We were supposed to spend the rest of our lives together. I hate Covid. I hate what it took from me.”

Prior to the pandemic, Bryant and Savage were living in a comfortable two-bedroom trailer in Vidor, Texas. He worked as a bartender, and took side jobs installing flooring. She worked as a server at a local restaurant. When he wasn’t on the clock, Bryant always managed to find people who needed help — whether it was a neighbor whose car wouldn’t start, or communities on the Gulf Coast cleaning up after the most recent hurricane. Savage often joined him. “Jake was very active, and liked fishing,” Savage says. “He always had this goofy-ass smile on his face, and loved making people laugh. Anybody who met him liked him.”

Then in March 2020, Bryant and Savage both lost their jobs. A month later, Bryant tested positive for Covid-19. Initially, they lived off their unemployment benefits and savings, but by October 2020, they could no longer pay their rent. To make ends meet, Bryant worked odd jobs in construction, and they took out a small loan on their car. That still wasn’t quite enough, so they both did some landscaping work in Louisiana — that is, until Bryant contracted Covid again in November 2020. And this case was more severe than his first.

With Bryant now physically unable to work, and no money for rent, he and Savage moved out of their trailer and into their car — a 20-year-old four-door Chevy Impala — at the end of November. “Jake would say things like, ‘You know, it’s not going to be that bad,’ because he was always trying to be optimistic,” says Savage. “Every time I felt like we had no options, he would always say, ‘It’ll work out somehow.’”

But by Jan. 1, 2021, Bryant had developed pneumonia and his health began declining fast. ”Having to stay in our car — that’s what really made him go downhill,” Savage explains. “Last year, Texas had a very hardcore winter. And it just happened to happen when we were staying in our freaking car. I could not believe how cold it got.”

With Bryant’s health worsening, and some financial help from family and friends, the couple lived in a series of hotels from mid-February until they received some long-overdue unemployment back-payments in April. “We also had a little help that allowed us to get into housing again,” Savage notes, “but by April, Jake was in very, very bad shape.”

Prior to the pandemic, Nathan Barse was a preschool teacher in Seattle. But after Covid-19 infections in March and November 2020 left him with long Covid — including debilitating exhaustion, pain and pressure in his ears, and constant tinnitus — he no longer had the stamina required to return to teaching. Unable to pay his rent in Seattle, Barse moved back to his home state of Idaho, and has been staying with different friends and family members until they tell him that it’s time to move on. “I have until the first of March to find a place to live,” Barse, 45, tells *Rolling Stone.* “So again, [I’m] on the verge of being homeless.”

And though Barse is eager to find at least part-time work, he’s concerned that his lack of endurance and frequent long-Covid symptom relapses may make it difficult, or even impossible, to hold onto a job. “I have a lot of anxiety about that,” he says. “One of my worst fears is that I will go through the effort of getting a job, and end up liking it just in time to get sick again with Covid or another relapse, be out of work for a week or two, and then get fired from a job that I actually wanted.”

Others living with long Covid share Barse’s concerns about returning to work — also questioning whether they have the stamina to make it through a day at the office, and worried about living up to their manager’s expectations. And it doesn’t help that it’s still unclear how employers will handle requests for reasonable accommodations through the Americans with Disabilities Act (ADA).

Although long Covid can qualify as a disability under the ADA, the application of the law and its protections are determined on a case-by-case basis by a person’s employer. “Employers may have more leeway here, as they traditionally have been given discretion to determine which job functions are essential,” Elizabeth Pendo, JD, a professor of law at St. Louis University and an expert on employment-and-disability law, told *Rolling Stone* in October.

But if the challenges people living with other chronic conditions — like myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS), fibromyalgia, and chronic lyme disease — have faced attempting to get workplace accommodations are any indication, those living with long Covid are in for a bumpy ride. “The disability system in this country has been slowly eroding for a long time now,” says Emily Taylor, vice president of advocacy and

community engagement for #SolveME — a research and advocacy organization focused on ME/CFS and other long-term chronic illnesses — and a senior staffer at the Long Covid Alliance. “I, as an ME/CFS advocate, want to apologize to all the long-Covid folks and say, ‘If we had made more progress, you would be in a better place right now.’ ”

Unaccommodating employers aside, the underlying problem is that people with long Covid and other chronic conditions have no choice but to navigate a system that wasn’t designed to include them. “Some of the [existing] disability structures have been helpful, but the challenge is kind of like a square-peg-round-hole situation,” she explains. “You’re trying to squeeze a person with ME/CFS, long Covid, or other invisible illnesses into the disability holes that are defined for people with more visible disabilities.”

And with an estimated 56 percent of Americans living paycheck to paycheck, and 47 percent having no formal savings plan, experiencing a loss of income without personal or social safety nets can be financially devastating. This is especially evident among workers in the gig economy.

While it’s unclear exactly how many Americans depend on these short-term contracts and/or freelance jobs to make a living, according to a December 2021 report from MBO Partners, the overall number of independent workers increased by 34 percent during the first year of the pandemic, jumping from 38.2 million in 2020 to 51.1 million in 2021.

Those numbers didn’t include Bryant’s friend Amanda Finley, who made the decision to stop taking delivery-gig jobs after she got Covid-19 in March 2020. “I know this was a personal choice, but I thought, ‘Oh, my god, I can’t work if I’m dead, [or] if I get something else on top of this,’ ” she explains. “Plus, I didn’t know how long I’d be contagious, and I wasn’t going to give [Covid-19] to someone else.”

An anthropologist with training in archeology — and a former life as an opera singer with the St. Louis Symphony Orchestra — Finley, 45, tried to find a way to make a living without exposing herself, or anyone else, to Covid. “I started teaching online STEM classes for kids, but it wasn’t enough,” she says. “And this really gets to the crux of why long Covid has impacted so many people: When you are working in a gig position, you don’t have benefits. You work, or you go homeless and you go hungry. It’s almost predatory the way that we rely on these people to literally put their lives on the line.”

Researchers have come to similar conclusions about the gig economy. For example, a paper published in *JAMA Cardiology* in February 2022 argues that working in the gig economy should be considered a social determinant of health. Along the same lines, a report by the Robert Wood Johnson Foundation and the Urban Institute, also published this month, found that because gig workers lack the benefits and protections associated with traditional full-time jobs, it could put their health and well-being — as well as their family’s — at risk.

This was the case for Finley, who lost her home on July 31, 2020. “It wasn’t an eviction,” Finley explains. “They didn’t renew my lease. And there’s no way you can fight that: It’s the end of a business contract.” She temporarily moved into a friend’s basement, and continued to bounce between friends’ houses until May 2021, when she got Covid for the second time. At that point, she was staying with a friend who had four children — all unvaccinated — and grew increasingly fearful of getting sick again, or making anyone else sick. That’s when Finley started camping as much as possible.

By August 2021, she was camping full time, living in a tent at Weston Bend State Park. Finley had been going on camping trips there for 26 years, and refers to the park — with its sweeping views of the Missouri River — as her “happy place.” “Even though [moving into a tent] sounds like a rather ridiculous option, I just couldn’t keep getting sick again and again,” she explains. “I didn’t want anybody breathing my air. And actually, I quite like camping. I’ll gladly take the turkeys over the humans.”

But as the leaves turned, so did Finley’s health. “It just got too cold,” she says. “It started snowing in October, and by the end of the month I had pneumonia again. And that’s when the campground’s bathrooms are locked until they open again in the spring. It got to the point where camping was no longer a feasible option.”

So starting in November, Finley embarked on another leg of her tour of friends’ couches, spare rooms, and basements, while applying for spots in different apartments. But if it gets to the point where she no longer thinks this living arrangement is safe, she hasn’t ruled out a return to her tent. “If I had to, I would,” she says. “I would polarize up, but what a terrible choice: Do I freeze to death? Or do I get Covid again?”

For the past eight years, Bilal Qizilbash of Jackson, Mississippi, has served free hot meals to local residents in need through his nonprofit organization R U Hungry? Working primarily with unhoused individuals, Qizilbash has seen the toll the Covid-19 pandemic has had on the community — including those now living with long Covid. In addition to the usual barriers to health care, most unhoused people have no evidence of their initial Covid infection.

“That’s where it gets a little challenging,” says Qizilbash, who is living with long Covid himself. “A lot of homeless people are experiencing long-Covid symptoms, but no one’s taking them seriously because they don’t have insurance or proof of infection. Several of them told me that they went to get tested but were turned away because they couldn’t pay.”

On occasion, Qizilbash will notice that unhoused individuals living with long Covid or other illnesses stop showing up for the meals he serves each Friday, and it can be hard not to assume the worst. “They’re basically the invisible people,” he tells *Rolling Stone.* “When

you're poor and you don't really have a track record, you just go missing. And no one's going to notice unless you've left the state or you end up dying on the streets and someone finds your body."

That feeling of invisibility is something Taylor has experienced firsthand, as a result of both living with long Covid and being unhoused. "Medical care for long Covid is nearly nonexistent, and symptoms are often dismissed as mental illness," she explains. "Medical care for the homeless is also nearly nonexistent, and homelessness itself is too often treated as a mental illness."

When unhoused individuals do have the chance to see a doctor, instead of appropriate medical attention and care, Taylor says, they're given an unsolicited, uninformed lecture. "We're told to try harder, patronizingly 'educated,' referred to mental health services, and given unhelpful advice to make lifestyle changes — which are often the result rather than the cause of our position," she explains. "And then, when all that fails? [We're] written off as choosing to be in this situation."

Bryant's attempts to get medical care in Texas were also futile. Though his health got progressively worse throughout 2021, Savage says that the doctors wouldn't take him seriously — especially when he said he had long Covid. "Every time he went to the doctor, he'd have to explain why he was there," she recalls. "It was so frustrating. Couldn't they look at his records and see that it was something he had been dealing with for the past year? But since it was a 40-year-old guy coming in, they'd just assume it was another [opioid] overdose."

When Bryant came in with severe pneumonia — or, in one case, carbon-monoxide poisoning — the hospital would keep him overnight and release him the following day. "He didn't have insurance, so he didn't matter," Savage says. "They could have taken better care of him. They had every opportunity. But I feel like unless you're an unborn fetus, they don't give a shit about you."

While Medicaid would eventually become an option for Bryant, in order to be eligible for coverage in Texas, he first had to qualify for disability benefits: a process Savage knew would take several months. "I wonder all the time, if we had moved, would Jake still be here? Could I have gotten him better care?" she says. "I know at least in West Virginia, there are a lot of poor people, and that if you're poor, they take care of you. But you can't be poor in Texas. If you're poor in Texas, you have no worth."

For Savage, Bryant's last few months were a blur, between caring for him both in and out of the hospital, dealing with dismissive doctors, and trying to scrape together the money to buy a few days' worth of his medication at a time — or whatever she was able to afford. And after back-to-back bouts of double pneumonia, "his lungs filled up with so much fluid that it started getting hard on his heart, and he went into heart failure," she explains.

Bryant died before sunrise on Sept. 4, 2021. Later that day, Savage got the call saying he was approved for disability benefits.

Living with long Covid while dealing with housing insecurity is a “vicious cycle,” says Taylor. “The most mundane daily tasks you take for granted — like washing your face or drinking a glass of water — become major chores when you are homeless, requiring effort and planning,” she says. “This is completely at odds with the need to rest and pace yourself [when living with long Covid]. You are constantly forced to push yourself too hard, which makes you sicker, which makes it even more difficult just to exist, which causes you to have to push yourself even harder. And it’s never enough.”

While it’s no secret that the American health care system is broken, many people are still unable to let go of the toxic “bootstrapping” mentality: that anyone who works hard enough and sufficiently contributes to society is able to access the medical care they need.

And, in addition to the disbelief that people living with long Covid continue to face from those who don’t acknowledge they’re actually sick, people who are also unhoused have to deal with endless judgment from others questioning how it’s possible to end up in that position when there are places like shelters, food banks, and free clinics providing assistance.

“You’re constantly bombarded by advice to go to a shelter — which, even in the best of circumstances, can’t adequately meet the needs of people living with long Covid,” Taylor says. This is especially true for people like Taylor and Finley, who are immunocompromised. Crowded indoor spaces — including tightly packed rows of occupied cots in emergency shelters — put them at high risk of contracting another illness, and therefore are not a viable option.

Finley has received similarly well-intentioned but misguided unsolicited advice from people who think that there are an abundance of safety nets in place for someone in her position, which are easily accessible and adequately meet their needs. “People think all these resources are available,” she says. “And yes, there are some, but they’re also very strapped. Everyone is hurting right now.”

She also points to Bryant’s death as an example of what can happen when long Covid leads to a loss of income, then housing. “It was a snowball effect from lack of access to health care [and] lack of access to basic necessities,” Finley says. “People just assume, ‘Oh, you can go to a shelter and get that.’ Well, if it were that easy, he wouldn’t be dead.”

The continued lack of understanding and awareness of the devastating and wide-reaching impacts of long Covid is why Savage decided to share her and Bryant’s story. “I don’t want anyone to have to go through what we did,” she explains. “And I want people to know that

long Covid is real, and it's changing a lot about people's lives. Sometimes, it's so overwhelming that you can't bounce back from it, especially when it all comes at once. You can lose your job, your health, your sanity, your social life — and your dignity."

And though there's still a lot to learn about what causes long Covid and how to treat it, Ranney says that those currently living with it need — and deserve — support right now. "We can't wait for all the information to be accumulated [from studies] before we do something to help people who are experiencing its financial impact," she says. "And it's going to require some leadership on the part of the government, insurers, and forward-thinking employers to get there."

In the meantime, Taylor is working through a list of life goals she made before the pandemic, then adjusted to reflect the realities of living with long Covid. Despite everything that's happened since she first made that list, she's still on track for accomplishing her goal of building good credit. "But the best credit score in the world is useless if you have no income and are unable to work," she says.

More than anything else, Taylor knows that what happens next will largely depend on her health. "I want to have a place to live, a car to drive," she says. "I want to work. I want to live. Getting well — or at least knowing what's wrong with me so it can be managed — is step one."

- Culture
- (Sub)Culture Features

PATIENT-LED RESEARCH COLLABORATIVE

2025 Long Covid Fact Sheet

Version 1
March 2025

1. **Long COVID is a global public health crisis.** Over 400 million people worldwide have been impacted by Long COVID[1].

2. **Long COVID is common.** As of fall 2024, at least 1 in 19 US adults are currently living with Long COVID[2] - similar to the rate of diabetes - with many additional cases likely going undiagnosed or misdiagnosed.

3. **The vast majority of Long COVID cases happen after a mild acute infection.** Studies show between 76%[3] to 90%[4] of Long COVID cases happen after a mild infection.

4. **Recovery from Long COVID is rare.** Only 6-9% of people with Long COVID are recovered at 2-3 years.[5] [6] [7]

5. **Long COVID incidence remains high, even among those fully vaccinated and with more recent variant strains.**

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[1] https://www.nature.com/articles/s41591-024-03173-6
[2] https://www.cdc.gov/nchs/covid19/pulse/long-covid.htm
[3] https://s3.amazonaws.com/media2.fairhealth.org/whitepaper/asset/Patients%20Diagnosed%20with%20Post-COVID%20Conditions%20-%20A%20FAIR%20Health%20White%20Paper.pdf
[4] https://jamanetwork.com/journals/jama/fullarticle/2797443 (eTable 16 in Supplement 1)
[5] https://www.thelancet.com/journals/lanepe/article/PIIS2666-7762(23)00143-6/fulltext
[6] https://www.thelancet.com/journals/lanam/article/PIIS2667-193X(25)00036-5/fulltext
[7] https://www.mdpi.com/2077-0383/12/3/741

a. The incidence of people currently living with Long COVID has remained between 5.3-6.1% of the US adult population from December 2022 to September 2024.[8]
b. 17% of study participants developed Long COVID after Omicron infection, compared to 23% after pre-Omicron variants.[9]

6. **Each additional COVID infection increases the risk of developing Long COVID, even in those fully vaccinated.** Studies on reinfection show:
    a. People are 1.7x more likely to develop Long COVID after 2 infections, and 2.6x more likely to develop Long COVID after 3 infections.[10]
    b. Long COVID occurred in 24% of reinfections.[11]
    c. Reinfections lead to higher incidence and severity of Long COVID.[12]
    d. Reinfections increase the rates of long-term health problems including heart, lung, and brain issues.[13]
    e. Reinfections are associated with increased chance of getting Long COVID, and worsened existing Long COVID.[14]

7. **People infected with COVID are more susceptible to other infections.**
    a. Those infected with COVID had higher rates of bacterial, mycoplasma, and influenza infections.[15]
    b. Children aged 0-5 who had COVID were 1.4x more likely to get RSV that required medical attention.[16]
    c. Reinfections increased the odds of reporting poor immune health, including having many other infections and taking longer to recover from common infections.[17]

8. **Common new-onset conditions in Long COVID include serious and lifelong disorders.**
    a. This includes vascular events like heart attacks and strokes, as well as permanent conditions like dysautonomia, myalgic encephalomyelitis, and diabetes[18].
    b. In non-hospitalized people, COVID increases the risk of 30 neurological disorders for at least a year, including Alzheimer's, ischemic stroke and TIA, memory problems, peripheral neuropathy, migraine, epilepsy, and hearing and vision abnormalities.[19]

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[8] https://www.cdc.gov/nchs/covid19/pulse/long-covid.htm
[9] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2820087
[10] https://www150.statcan.gc.ca/n1/pub/75-006-x/2023001/article/00015-eng.htm
[11] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2820087
[12] https://www.thelancet.com/journals/lanwpc/article/PIIS2666-6065(24)00212-8/fulltext
[13] https://www.nature.com/articles/s41591-022-02051-3
[14] https://www.researchsquare.com/article/rs-4909082/v1
[15] https://www.thelancet.com/journals/lanwpc/article/PIIS2666-6065(24)00212-8/fulltext
[16] https://pubmed.ncbi.nlm.nih.gov/37292931/
[17] https://www.researchsquare.com/article/rs-4909082/v1
[18] https://www.nature.com/articles/s41579-022-00846-2
[19] https://www.nature.com/articles/s41591-022-02001-z

c. In non-hospitalized people, COVID increases the risk of 18 cardiovascular conditions for at least a year, including myocarditis, pulmonary embolism, and heart failure.[20]

9. **Long COVID has caused the highest rates of serious, persistent cognitive problems in the US population than any time in the last 15 years[21].**
    a. The cognitive impairment includes problems with memory, reasoning, executive functioning, language, and processing speed, and younger people may have worse and more marked impairment.[22]

10. **Long COVID patients experience severe functional limitations, poor quality of life, and extreme fatigue at least as detrimental as many serious illnesses, including Parkinson's disease and certain cancers.**
    a. Long COVID patients' functional ability scores ranked lower than stroke and were on par with those found in Parkinson's disease on a scale measuring ability to work, manage the household, engage in leisure, and maintain social relationships.[23]
    b. Long COVID patients' quality of life scores ranked lower than those in advanced/metastatic cancers.[24]
    c. Long COVID patients' fatigue scores were worse than those in end stage renal failure.[25]

11. **Long COVID substantially impacts patients' livelihoods and ability to work, with most being unable to work or needing reduced hours.**
    a. At 2 years, only 40% of Long COVID patients could work full-time.[26]
    b. 52% had reduced work hours and lost an average of 25% of their monthly income.[27]
    c. People with Long COVID are nearly twice as likely to report housing insecurity.[28]
    d. People with Long COVID report high rates of food insecurity[29] [30] and difficulty paying utility bills.[31]

12. **COVID increases risks during pregnancy and childbirth, and is associated with reproductive health issues like altered menstruation and erectile dysfunction.**

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[20] https://www.nature.com/articles/s41591-022-01689-3
[21] https://www.nytimes.com/2023/11/13/upshot/long-covid-disability.html
[22] https://www.nature.com/articles/s41598-023-32939-0
[23] https://bmjopen.bmj.com/content/13/6/e069217
[24] https://bmjopen.bmj.com/content/13/6/e069217
[25] https://bmjopen.bmj.com/content/13/6/e069217
[26] https://www.mdpi.com/2077-0383/12/3/741
[27] https://pmc.ncbi.nlm.nih.gov/articles/PMC11377524/
[28] https://www.sciencedirect.com/science/article/pii/S2352827323002513
[29] https://www.jandonline.org/article/S2212-2672(24)00731-7/abstract
[30] https://www.urban.org/research/publication/employment-and-material-hardship-among-adults-long-covid-december-2022
[31] https://www.urban.org/research/publication/employment-and-material-hardship-among-adults-long-covid-december-2022

a. COVID infections are associated with early miscarriages[32], stillbirths[33], preterm births and cesarean deliveries[34], and preeclampsia and maternal mortality.[35]
b. Long COVID is associated with many reproductive health disorders including menstrual issues, endometriosis, erectile dysfunction, and others.[36] [37]

13. Long COVID disproportionately impacts people from already marginalized groups.

a. Rates of Long COVID are higher in Hispanic/Latine and Black people, trans people, disabled people, and women.[38] [39] [40]

14. Children are greatly impacted by Long COVID.

a. An estimated 6 million children are estimated to have Long COVID as of early 2024.[41] [42]
b. Children have similar rates of Long COVID to adults, as well as similar findings regarding organ system complications, new-onset conditions, and biological mechanisms.[43] [44]
c. Many pathological findings in adults, such as impaired function on a CPET, have also been found in children.[45] [46]

15. Long COVID has a highly destructive impact on the economy.

a. The global economic cost of Long COVID is estimated at $1 trillion per year.[47]
b. In 2024, 1.5 billion work hours were lost in the US due to Long COVID corresponding to a potential cost of more than US $152.6 billion.[48]
c. Long COVID is responsible for massive GDP losses worldwide – including $24.4 billion in Saudi Arabia, $12.3 billion in Taiwan, and $11 billion in Brazil.[49]
d. Five years of Long COVID burden is projected to cost $3.7 trillion to the US economy in reduced quality of life, lost earnings, and increased medical spending.[50]

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[32] https://academic.oup.com/humrep/article/37/6/1126/6564665
[33] https://www.cdc.gov/mmwr/volumes/70/wr/mm7047e1.htm
[34] https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-024-06767-7
[35] https://jamanetwork.com/journals/jamapediatrics/fullarticle/2779182
[36] https://www.frontiersin.org/journals/rehabilitation-sciences/articles/10.3389/fresc.2023.1122673/full
[37] https://www.nature.com/articles/s41579-022-00846-2
[38] https://link.springer.com/article/10.1007/s11606-022-07997-1
[39] https://www.census.gov/library/stories/2023/05/long-covid-19-symptoms-reported.html
[40] https://www.cdc.gov/nchs/covid19/pulse/long-covid.htm
[41] https://jamanetwork.com/journals/jama/article-abstract/2815350
[42] https://publications.aap.org/pediatrics/article/153/3/e2023062570/196606/Postacute-Sequelae-of-SARS-CoV-2-in-Children
[43] https://publications.aap.org/pediatrics/article/153/3/e2023062570/196606/Postacute-Sequelae-of-SARS-CoV-2-in-Children
[44] https://www.nature.com/articles/s41579-022-00846-2
[45] https://journals.lww.com/pidj/fulltext/2024/08000/cardiopulmonary_exercise_testing_in_children_with.17.aspx
[46] https://www.nature.com/articles/s41579-022-00846-2
[47] https://www.nature.com/articles/s41591-024-03173-6
[48] https://impact.economist.com/perspectives/health/incomplete-picture-understanding-burden-long-covid
[49] https://impact.economist.com/perspectives/health/incomplete-picture-understanding-burden-long-covid
[50] https://scholar.harvard.edu/files/cutler/files/long_covid_update_7-22.pdf

e. Long COVID disproportionately impacts certain labor sectors, particularly those with high exposure to COVID infections, like low-wage workers, farm workers, and those in education and the service industry.[51] [52] [53]
f. A quarter of US Marines who had COVID developed Long COVID, with long-term decrease in functional performance.[54]
g. Lost productivity of caretakers in the UK was estimated at £4.8 billion.[55]

16. Medical provider education about Long COVID is inadequate.

a. Only 7% of physicians are very confident diagnosing Long COVID and only 4% are very confident treating it.[56]
b. A majority of Long COVID patients have experienced a negative experience with a healthcare provider.[57]

17. Lack of public awareness is causing crucial delays in care and support.

a. Over ⅓ of people have still not heard of Long COVID despite its wide impact.[58]
b. Communities of color are particularly affected.[59] [60]

18. There is a significant amount of Long COVID research.

a. Over 86,000 research papers have demonstrated wide-ranging biological abnormalities in Long COVID.[61]
b. Up-to-date review papers include the scope of mechanisms and possible therapeutics[62] [63], viral persistence[64] and mechanisms to target persisting reservoirs[65], designing and optimizing clinical trials[66], and roadmaps for Long COVID research and policy.[67]
c. An incredible breadth of biological mechanisms have been found in Long COVID, including reduced cerebral blood flow[68] [69] and disrupted neurovascular function[70],

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[51] https://labor.ucla.edu/wp-content/uploads/2022/01/Fast-Food-Frontline-Report-1-13-22.pdf
[52] https://environmentalhealth.ucdavis.edu/research/covid-19/domestic-workers-survey
[53] https://academic.oup.com/eurpub/article/34/3/489/7616634
[54] https://www.thelancet.com/pdfs/journals/lanam/PIIS2667-193X(24)00236-9.pdf
[55] https://pmc.ncbi.nlm.nih.gov/articles/PMC11377524/
[56] https://debeaumont.org/wp-content/uploads/2023/03/Long-COVID-Brief.pdf
[57] https://www.nature.com/articles/s44220-023-00064-6
[58] https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2024.1360341/full
[59] https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2024.1360341/full
[60] https://pubmed.ncbi.nlm.nih.gov/39090366/
[61] https://scholar.google.com/scholar?as_vis=1&q=%22long+covid%22&hl=en&as_sdt=0,33&as_ylo=2020
[62] https://www.sciencedirect.com/science/article/pii/S0092867424008869
[63] https://www.nature.com/articles/s41579-022-00846-2
[64] https://www.nature.com/articles/s41590-023-01601-2
[65] https://www.sciencedirect.com/science/article/abs/pii/S1473309924007692
[66] https://www.sciencedirect.com/science/article/pii/S0024320524005605
[67] https://www.nature.com/articles/s41591-024-03173-6
[68] https://www.ahajournals.org/doi/10.1161/JAHA.124.036752
[69] https://www.mdpi.com/2227-9032/10/10/2105
[70] https://journals.sagepub.com/doi/full/10.1177/10738584231194927

fibrin microclots and their downstream impacts[71] [72], tissue damage and skeletal muscle necrosis after exercise[73], changes to the brainstem[74] and hippocampus[75], viral persistence[76] and persisting antigen[77], induced Long COVID in mice by transferring IgG from Long COVID patients[78] [79], and innumerable more.

19. **The vast majority of the public and physicians believe Long COVID needs more research funding.** 82% of physicians and 76% of the public believe it is important to increase research funding for Long COVID.[80]

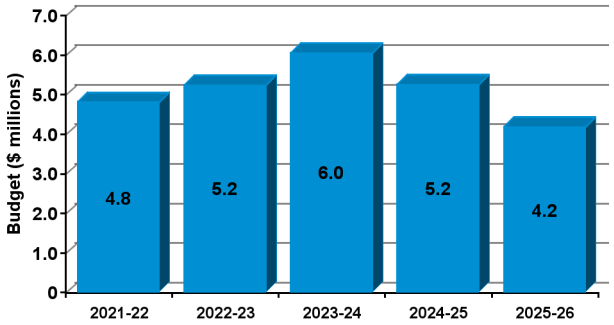
[71] https://www.nature.com/articles/s41586-024-07873-4
[72] https://pmc.ncbi.nlm.nih.gov/articles/PMC11491705/
[73] https://www.nature.com/articles/s41467-023-44432-3
[74] https://academic.oup.com/brain/article/147/12/4121/7811070
[75] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0316625
[76] https://www.science.org/doi/10.1126/scitranslmed.adk3295
[77] https://www.clinicalmicrobiologyandinfection.com/article/S1198-743X(24)00432-4/abstract
[78] https://www.medrxiv.org/content/10.1101/2024.06.18.24309100v1
[79] https://www.biorxiv.org/content/10.1101/2024.05.30.596590v1
[80] https://debeaumont.org/wp-content/uploads/2023/03/Long-COVID-Brief.pdf

DISABILITY

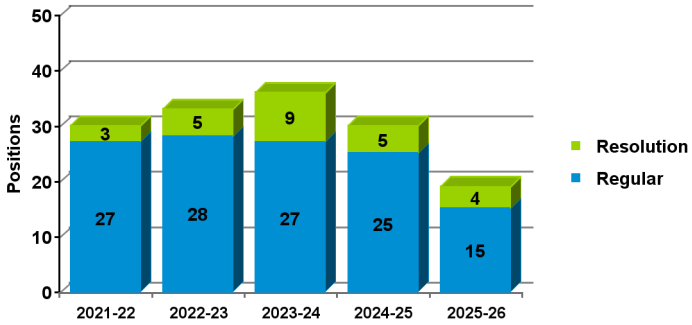
2025-26 Proposed Budget

FIVE-YEAR HISTORY OF BUDGET AND POSITION AUTHORITIES

FIVE-YEAR BUDGET HISTORY



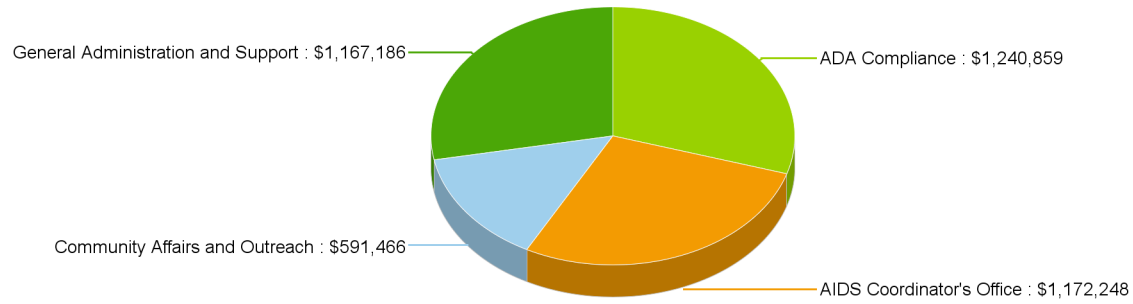
FIVE-YEAR POSITION AUTHORITY HISTORY



SUMMARY OF 2025-26 PROPOSED BUDGET CHANGES

	Total Budget			General Fund			Special Fund		
		Regular	Resolution		Regular	Resolution		Regular	Resolution
2024-25 Adopted	$5,247,119	25	5	$5,208,281 99.3%	25	5	$38,838 0.7%	-	-
2025-26 Proposed	$4,171,759	15	4	$4,132,901 99.1%	15	4	$38,858 0.9%	-	-
Change from Prior Year	**($1,075,360)**	**(10)**	**(1)**	**($1,075,380)**	**(10)**	**(1)**	**$20**	**-**	**-**

2025-26 FUNDING DISTRIBUTION BY PROGRAM



MAIN BUDGET ITEMS

		Funding	Positions
*	Student Workers and Student Professional Workers	$37,770	-
*	Community Affairs and Outreach Director	$153,890	-
*	Durable Medical Equipment	$40,000	-
*	AIDS Coordinator's Office Director	$153,890	-

Recapitulation of Changes

	Adopted Budget 2024-25	Total Budget Changes	Total Budget 2025-26
EXPENDITURES AND APPROPRIATIONS			
Salaries			
Salaries General	3,489,018	(518,507)	2,970,511
Salaries, As-Needed	80,112	(47,636)	32,476
Overtime General	14,330	-	14,330
Total Salaries	3,583,460	(566,143)	3,017,317
Expense			
Printing and Binding	4,000	2,000	6,000
Travel	-	-	-
Contractual Services	1,516,311	(502,100)	1,014,211
Transportation	6,000	-	6,000
Office and Administrative	44,827	3,404	48,231
Total Expense	1,571,138	(496,696)	1,074,442
Special			
AIDS Prevention Policy	92,521	(12,521)	80,000
Total Special	92,521	(12,521)	80,000
Total Disability	**5,247,119**	**(1,075,360)**	**4,171,759**

	Adopted Budget 2024-25	Total Budget Changes	Total Budget 2025-26
SOURCES OF FUNDS			
General Fund	5,208,281	(1,075,380)	4,132,901
Sidewalk Repair Fund (Sch. 51)	38,838	20	38,858
Total Funds	**5,247,119**	**(1,075,360)**	**4,171,759**
Percentage Change			(20.49)%
Positions	25	(10)	15

Changes Applicable to Various Programs

The following changes involve two or more budgetary programs. These changes are explained below and apportioned as single entries in the affected programs. Single-program changes are shown only in the programs involved.

Program Changes	Direct Cost	Positions	Total Cost
Changes in Salaries, Expense, Equipment, and Special			
Obligatory Changes			
1. **2024-25 Employee Compensation Adjustment** Related costs consist of employee benefits. *SG: $87,933* *Related Costs: $30,591*	87,933	-	118,524
2. **2025-26 Employee Compensation Adjustment** Related costs consist of employee benefits. *SG: $21,246* *Related Costs: $7,391*	21,246	-	28,637
3. **Salary Step and Turnover Effect** Related costs consist of employee benefits. *SG: $112,118* *Related Costs: $39,006*	112,118	-	151,124

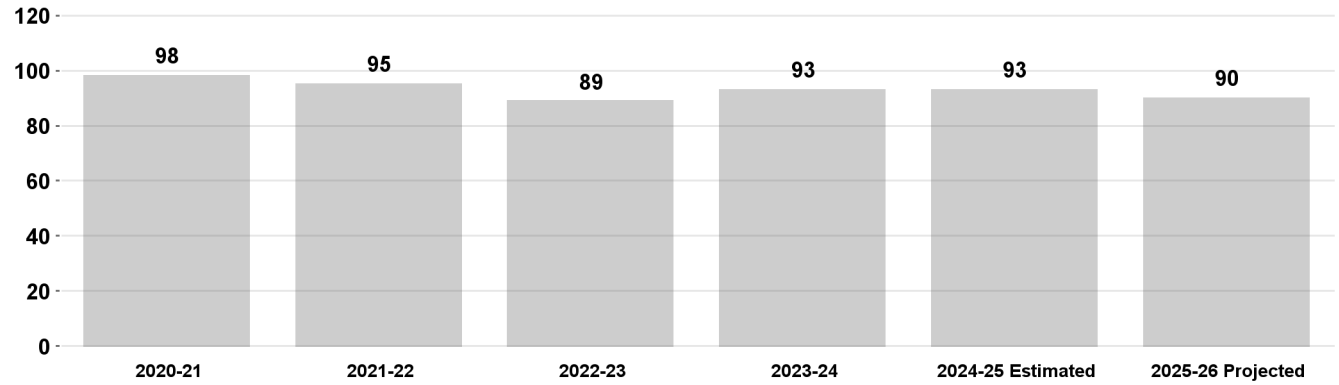
Program Changes	Direct Cost	Positions	Total Cost
Changes in Salaries, Expense, Equipment, and Special			
Deletion of One-Time Services			
4. **Deletion of One-Time Expense Funding** Delete one-time Salaries, As-Needed and expense funding. *SAN: ($42,882) EX: ($59,000)*	(101,882)	-	(101,882)
5. **Deletion of Funding for Resolution Authorities** Delete funding for five resolution authority positions. Resolution authorities are reviewed annually and continued only if sufficient funding is available to maintain the current service level. Related costs consist of employee benefits. Four positions are continued: ADA Compliance Administration (One position) Deaf Services and Accessible Communications (One position) Community Affairs and Outreach Director (One position) AIDS Coordinator's Office Director (One position) One position is not continued: Administrative Support for Commission on Disability (One position) *SG: ($494,238)* *Related Costs: ($242,749)*	(494,238)	-	(736,987)
6. **Deletion of One-Time Salary Funding** Delete one-time Salaries General funding. *SG: ($62,878)* *Related Costs: ($21,875)*	(62,878)	-	(84,753)
Continuation of Services			
7. **Student Workers and Student Professional Workers** Continue funding in the Salaries, As-Needed Account to provide part-time employment opportunities for students with disabilities. *SAN: $37,770*	37,770	-	37,770
Restoration of Services			
8. **Restoration of One-Time Reductions** Restore funding in the Printing and Binding, Travel, Contractual Services, and Office and Administrative accounts that was reduced on a one-time basis in the 2024-25 Budget. *EX: $168,359*	168,359	-	168,359

Program Changes	Direct Cost	Positions	Total Cost
Changes in Salaries, Expense, Equipment, and Special			
Efficiencies to Services			
9. **Expense Account Reduction** Reduce funding in the Salaries, As-Needed, Printing and Binding ($18,000), Travel ($20,000), Contractual Services ($540,000), Office and Administrative ($71,355), and AIDS Prevention Policy ($12,521) accounts on a one-time basis to reflect anticipated expenditures, which include savings achieved due to Departmental efficiencies and expenditure reductions. *SAN: ($42,524) EX: ($649,355) SP: ($12,521)*	(704,400)	-	(704,400)
Reduced Services			
10. **Elimination of Filled Positions** Delete funding and regular authority for 10 positions consisting of one Senior Administrative Clerk, one Senior Accountant I, three Project Coordinators, one Community Program Assistant II, and four Management Analysts as a result of the elimination of filled positions. Related costs consist of employee benefits. *SG: ($1,137,563)* *Related Costs: ($553,243)*	(1,137,563)	(10)	(1,690,806)
11. **One-Time Salary for Eliminated Filled Positions** Add one-time funding in the Salaries General Account to provide four-months funding for positions deleted as a result of the elimination of filled positions. Related costs consist of employee benefits. *SG: $396,340* *Related Costs: $130,554*	396,340	-	526,894
TOTAL CHANGES APPLICABLE TO VARIOUS PROGRAMS	**(1,677,195)**	**(10)**	

ADA Compliance

This program oversees the City's compliance with the Americans with Disabilities Act (ADA) and provides training and technical assistance for compliance with disability law through its Community Outreach Resource Center, Braille and sign language interpretation (SLI) services, computer assistance real-time transcription (CART), Section 504 of the Rehabilitation Act on the rights of people with disabilities assistance, and management of federal and state grants.

Percentage of SLI and CART Requests Filled



Program Changes	Direct Cost	Positions	Total Cost
Changes in Salaries, Expense, Equipment, and Special			
Apportionment of Changes Applicable to Various Programs	(431,406)	(4)	(666,827)

Related costs consist of employee benefits.

SG: ($430,744) SAN: ($4,250) EX: $3,588

Related Costs: ($235,421)

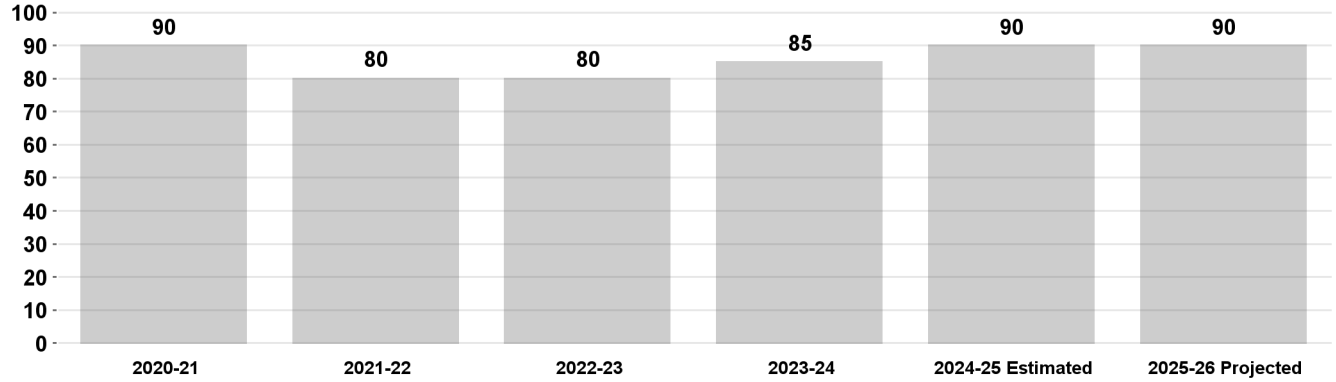
ADA Compliance

Program Changes	Direct Cost	Positions	Total Cost
Changes in Salaries, Expense, Equipment, and Special			
Continuation of Services			
12. **ADA Compliance Administration** Continue funding and resolution authority for one Senior Management Analyst I to support the ADA Compliance Program. Related costs consist of employee benefits. *SG: $128,333* *Related Costs: $60,126*	128,333	-	188,459
13. **Deaf Services and Accessible Communications** Continue funding and resolution authority for one Management Analyst to provide deaf services and accessible communications. Related costs consist of employee benefits. *SG: $122,422* *Related Costs: $58,179*	122,422	-	180,601
14. **Lead CASp** Continue one-time funding for contractual services for a lead Certified Access Specialist (CASp) position. This position will directly support the City's ADA Compliance Officer and address possible Americans with Disabilities Act violations at City facilities. Funding will be transferred from the CASp Certification and Training Fund to the Department's Contractual Services Account during the year.	-	-	-
15. **Self Evaluation/Transition Plan CASp Assistance** Continue one-time funding for contractual services to assess City facilities for Americans with Disabilities Act compliance. The assessments will be performed by service providers who are Certified Access Specialist (CASp), as defined in the California Senate Bill 1186. Funding will be transferred from the CASp Certification and Training Fund to the Department's Contractual Services Account during the year.	-	-	-
TOTAL ADA Compliance	**(180,651)**	**(4)**	
2024-25 Program Budget	1,421,510	8	
Changes in Salaries, Expense, Equipment, and Special	(180,651)	(4)	
2025-26 PROGRAM BUDGET	**1,240,859**	**4**	

Community Affairs and Outreach

This program conducts the Department's community outreach and education functions, coordinates the City's disability-related events, provides information and referrals, supports the Department's emergency management operations, and provides training and technical assistance on digital accessibility, assistive technologies, and telecommunications to City departments as required by the Americans with Disabilities Act.

Percentage of Resource Center Inquiries Filled

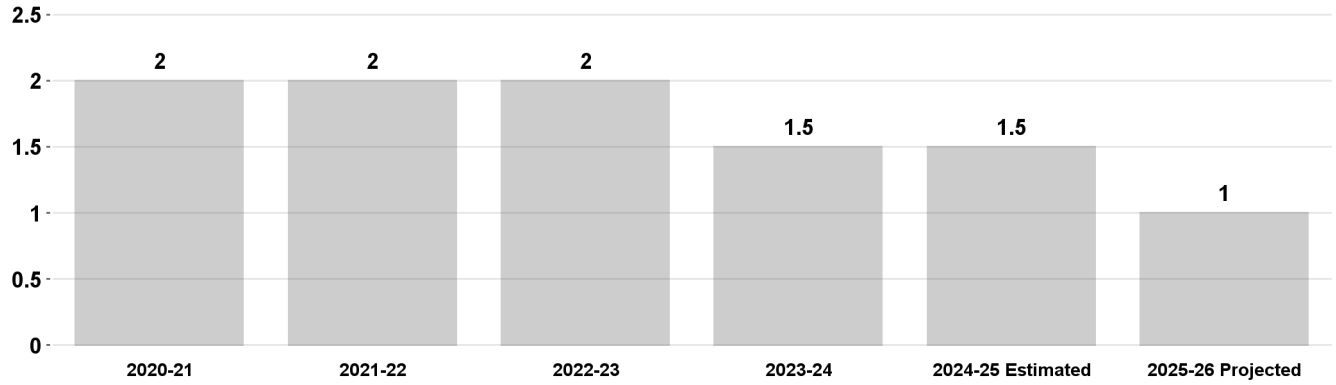


Program Changes	Direct Cost	Positions	Total Cost
Changes in Salaries, Expense, Equipment, and Special			
Apportionment of Changes Applicable to Various Programs Related costs consist of employee benefits. *SG: ($261,578) SAN: ($30,637) EX: ($19,367)* *Related Costs: ($141,128)*	(311,582)	(2)	(452,710)
Continuation of Services			
16. **Community Affairs and Outreach Director** Continue funding and resolution authority for one Principal Project Coordinator to lead the Community Affairs and Outreach Program. Related costs consist of employee benefits. *SG: $153,890* *Related Costs: $68,544*	153,890	-	222,434
17. **Durable Medical Equipment** Continue funding in the Contractual Services Account for the Durable Medical Equipment Program. *EX: $40,000*	40,000	-	40,000
TOTAL Community Affairs and Outreach	**(117,692)**	**(2)**	
2024-25 Program Budget	709,158	4	
Changes in Salaries, Expense, Equipment, and Special	(117,692)	(2)	
2025-26 PROGRAM BUDGET	**591,466**	**2**	

AIDS Coordinator's Office

This program develops and supports programs and policies that prevent the transmission of HIV, and improves the quality of life for people living with HIV/AIDS through HIV testing, outreach, health education, risk reduction, and syringe collection and disposal services.

Number of Syringes Removed (in millions)



Program Changes	Direct Cost	Positions	Total Cost
Changes in Salaries, Expense, Equipment, and Special			
Apportionment of Changes Applicable to Various Programs Related costs consist of employee benefits. *SG: ($294,312) SAN: ($4,250) EX: ($520,000)* *SP: ($12,521)* *Related Costs: ($151,957)*	(831,083)	(2)	(983,040)
Continuation of Services			
18. **AIDS Coordinator's Office Director** Continue funding and resolution authority for one Principal Project Coordinator to lead the AIDS Coordinator's Office Program. Related costs consist of employee benefits. *SG: $153,890* *Related Costs: $68,544*	153,890	-	222,434
TOTAL AIDS Coordinator's Office	**(677,193)**	**(2)**	
2024-25 Program Budget	1,849,441	4	
Changes in Salaries, Expense, Equipment, and Special	(677,193)	(2)	
2025-26 PROGRAM BUDGET	**1,172,248**	**2**	

General Administration and Support

This program performs management and administrative support including policy development, implementation and control; budget; and operational planning.

Program Changes	Direct Cost	Positions	Total Cost
Changes in Salaries, Expense, Equipment, and Special			
Apportionment of Changes Applicable to Various Programs Related costs consist of employee benefits. *SG: ($90,408) SAN: ($8,499) EX: ($4,217)* *Related Costs: ($81,819)*	(103,124)	(2)	(184,943)
Transfer of Services			
19. **Mobile Worker Program** Transfer funding from the Information Technology Agency to the Office and Administrative Account for mobile phone usage costs. The Department has fully transitioned from traditional desk phones, which were funded by the Information Technology Agency, to the Mobile Worker Program and will pay for departmental mobile phone costs on an ongoing basis. See related Information Technology Agency item. *EX: $3,300*	3,300	-	3,300
TOTAL General Administration and Support	**(99,824)**	**(2)**	
2024-25 Program Budget	1,267,010	9	
Changes in Salaries, Expense, Equipment, and Special	(99,824)	(2)	
2025-26 PROGRAM BUDGET	**1,167,186**	**7**	

DEPARTMENT ON DISABILITY
DETAIL OF CONTRACTUAL SERVICES ACCOUNT

2023-24 Actual Expenditures	2024-25 Adopted Budget	2024-25 Estimated Expenditures	Program/Code/Description	2025-26 Contract Amount
			ADA Compliance - EG6501	
$ 102,959	$ 197,506	$ 198,000	1. Disabled employee assistance	$ 197,506
-	23,100	5,000	2. Americans with Disabilities Act (ADA) assistants	25,000
20,300	22,000	43,000	3. ADA inspection and compliance software	22,000
517,326	-	435,000	4. Certified access specialists - lead and on-call pool	-
$ 640,585	$ 242,606	$ 681,000	**ADA Compliance Total**	$ 244,506
			Community Affairs and Outreach - EG6503	
$ 1,123	$ 9,000	$ 8,000	5. Section 508 online training platform and remediation	$ 35,000
-	50,000	50,000	6. Durable medical equipment	40,000
$ 1,123	$ 59,000	$ 58,000	**Community Affairs and Outreach Total**	$ 75,000
			AIDS Coordinator's Office - EG6504	
$ 1,215,686	$ 994,305	$ 994,000	7. Acquired immunodeficiency syndrome prevention programs	$ 514,305
-	190,000	16,000	8. Expansion of human immunodeficiency virus prevention services	150,000
$ 1,215,686	$ 1,184,305	$ 1,010,000	**AIDS Coordinator's Office Total**	$ 664,305
			General Administration and Support - EG6550	
$ 42,322	$ 28,000	$ 2,000	9. Case management system	$ 28,000
2,109	2,400	2,000	10. Heavy-duty copier	2,400
$ 44,431	$ 30,400	$ 4,000	**General Administration and Support Total**	$ 30,400
$ 1,901,825	$ 1,516,311	$ 1,753,000	**TOTAL CONTRACTUAL SERVICES ACCOUNT**	$ 1,014,211

Disability

Position Counts						
2024-25	Change	2025-26	Code	Title	2025-26 Salary Range and Annual Salary	
GENERAL						
Regular Positions						
2	-	2	1358	Administrative Clerk	1989(2)	(41,530 - 62,431)
1	(1)	-	1368	Senior Administrative Clerk	2451(2)	(51,176 - 76,880)
1	-	1	1513	Accountant	2951(2)	(61,616 - 92,581)
1	(1)	-	1523-1	Senior Accountant I	3426(2)	(71,534 - 107,490)
3	(3)	-	1537	Project Coordinator	3523(2)	(73,560 - 110,496)
1	-	1	1538	Senior Project Coordinator	4187(2)	(87,424 - 131,293)
1	-	1	1702-1	Emergency Management Coordinator I	4440(2)	(92,707 - 139,290)
1	-	1	1786	Principal Public Relations Representative	3651(2)	(76,232 - 114,547)
1	(1)	-	2501-2	Community Program Assistant II	2931(2)	(61,199 - 91,913)
1	-	1	2501-3	Community Program Assistant III	3523(2)	(73,560 - 110,496)
1	-	1	9134	Principal Project Coordinator	5135(2)	(107,218 - 161,047)
1	-	1	9171-2	Senior Management Analyst II	5732(2)	(119,684 - 179,776)
8	(4)	4	9184	Management Analyst	3762(2)	(78,550 - 117,992)
1	-	1	9720	Executive Director Department on Disability		(240,621)
1	-	1	9722	Assistant Executive Director - Department on Disability	5947(2)	(124,173 - 186,541)
25	(10)	15				
Commissioner Positions						
9	-	9	0101-2	Commissioner	$50/mtg	
9	-	9				
AS NEEDED						
To be Employed As Needed in Such Numbers as Required						
			1501	Student Worker	$17/hr	
			1502	Student Professional Worker	1471(7)	(30,714 - 46,165)
			1550	Program Aide	2045(2)	(42,699 - 64,143)

	Regular Positions	Commissioner Positions
Total	15	9

CALIFORNIA

County to Get AIDS Grant of $2.6 Million

L.A. Times Archives

Oct. 2, 1986 12 AM PT

Los Angeles County will receive $2.6 million in federal funds over the next three years to improve health care for patients with AIDS and related illnesses, the U.S. Department of Health and Human Services announced Wednesday.

In total, $15.3 million in federal funds were awarded to Los Angeles, New York, San Francisco and Miami, the four metropolitan areas with the highest concentration of acquired immune deficiency syndrome patients.

The funds, allocated according to the percentage of AIDS cases in the four areas, are designed to improve the coordination of patient services. In Los Angeles, attention will be focused on black and Latino AIDS patients.

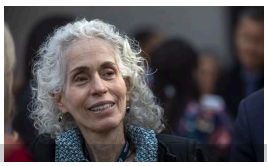
More to Read

CDC to slash infectious-disease funding for states; California impact uncertain

March 26, 2025

Q&A with Barbara Ferrer: L.A. County Public Health braces for impact under Trump

Feb. 27, 2025



COLUMN ONE : Aids in L.A. : AIDS Fight in L.A. at Key Point : A decade into the disease, L.A. County cases are still on the rise. Decisions made this year could be crucial to containing--or losing control of--the epidemic.

CALIFORNIA

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By VICTOR F. ZONANA

Dec. 31, 1989 12 AM PT

TIMES STAFF WRITER

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Dec. 31, 1989 12 AM PT
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Not long ago, AIDS Project Los Angeles took an unusual step in its campaign to prevent people in the county from becoming infected with the human immunodeficiency virus.

The agency asked government funders to reduce its allocation for educational efforts by $100,000--and to redirect the money to agencies that tailor their educational programs specifically for black and Latino gay and bisexual men.

“That’s the top priority in terms of primary prevention,” explained Stephen Bennett, chief executive officer of APLA, which is rooted in the Anglo gay community.

The group’s decision to spread its money around is a hopeful sign that the attempt to forge a countywide partnership among local AIDS organizations and county health officials, launched earlier this year amid great skepticism, is beginning to bear fruit.

Another promising indicator is that county health officials, after months of input from community-based organizations, are putting the finishing touches on a plan that is designed to plug the gaps in the county’s response to the HIV epidemic for the 1990s.

The plan urges expanded educational efforts among minority gays; new programs to prevent the spread of the virus among needle-sharing addicts; better outpatient care at county facilities, and a drive to provide early medical intervention for the already-infected to delay the onset of full-blown AIDS, which without treatment develops an average of 11 years after infection.

“It is a shared vision,” said Torie Osborn, director of the Gay and Lesbian Community Services Center, the county’s second-largest AIDS-services organization. “In order for things to work, we have got to work together,” added John Schunhoff, assistant director of the Department of Health Service’s AIDS Program Office.

The new atmosphere couldn’t be more timely, for health experts say that Los Angeles is at a turning point. The decisions its leaders make in coming months will help determine whether the county’s path in the 1990s resembles San Francisco’s, a model of comprehensive prevention efforts and compassionate, cost-effective care, or New York’s, where the epidemic rages out of control among IV drug abusers.

Though the new cooperative spirit provides reason for optimism, there is a major caveat: Key elements of the plan are dependent upon the approval of the county Board of Supervisors, whose conservative majority has blocked previous AIDS initiatives proposed by county health officials.

“We have an outstanding work plan,” said city of Los Angeles AIDS Coordinator Dave Johnson. “The key issues, come this spring, will be getting it funded and getting it through the Board of Supervisors without impediment.”

At a time when state and federal officials are reining in AIDS spending, the estimated public and private cost of early medical intervention alone for the 112,000 county residents believed to be infected totals $500 million a year.

Whatever the supervisors decide, the board’s response will be critical in determining the course of the epidemic: not only how many will get sick and how many will die, but also whether the crisis-plagued public health system can continue to deliver even minimal levels

of care to huge segments of the population.

Despite earlier hopes, the AIDS epidemic has not leveled off or peaked. Between January and November, 1989, the latest period for which figures are available, new cases of full-blown AIDS in the county totaled 2,274, up 28% from the comparable period a year earlier.

Even if the spread of HIV were halted tomorrow, cases of full-blown AIDS would continue as people infected years ago became sick. County planning documents estimate that, within two years, the cumulative total number of cases will more than double, to at least 19,000. The total could rise to as high as 44,000, based on infections in past years.

Despite the grim projections, Los Angeles has a choice. Will it go the way of San Francisco, widely praised as a model of compassionate and cost-effective AIDS care? Or will Los Angeles resemble New York City, the third major center of the epidemic, where people are dying in the streets as the unchecked spread of the virus among drug addicts fills public and private hospitals beyond capacity?

While some credible voices suggest that the same forces that unleashed disaster on New York--poverty, drug addiction, racism, denial and homophobia--are poised to strike here, others believe that AIDS in Los Angeles will follow its own course somewhere between the New York and San Francisco experiences.

“Comparisons among cities are fraught with variables that can confound analysis,” said George Ersek, who oversees AIDS programs for the Health Resources and Services Administration in Rockville, Md.

The geographic, political and ethnic contours of Los Angeles County present opportunities for containing the epidemic--as well as obstacles. The county’s vast sprawl and poor public transit system, for example, are believed to have slowed the spread of the virus among needle-using drug addicts.

On the other hand, that same sprawl has made AIDS invisible to large segments of the county’s diffuse population. That, critics charge, has led to complacency in the overall community’s response.

“There is a continuing sense in Los Angeles that AIDS is somebody else’s problem,” said David E. Gooding, executive vice president of Transamerica Life Insurance. Gooding, one of the few ranking downtown officials to take a high-profile role in the AIDS struggle, is a board member of AIDS Project Los Angeles.

The contrast with other big cities is stark. Despite New York’s problems containing the disease, top corporate executives there staff AIDS task forces and open their coffers to local AIDS charities. In contrast, business leaders in Los Angeles--with the primary exception of those in the entertainment industry--have remained comparatively aloof.

To cite just one comparison, Chevron, based in San Francisco, donated $125,000 for Project Open Hand to buy a new kitchen for its meals-on-wheels program for AIDS patients. Arco, based in Los Angeles, has given from $3,000 to $4,000 to AIDS causes since the epidemic began--an average of $500 a year.

Other unique aspects of Los Angeles are its rich ethnic mix and a population that includes more than 1 million undocumented immigrants--many of them poor, uneducated and hard to reach with AIDS-prevention messages.

AIDS educators fear that their task has been complicated by the Roman Catholic Church's unyielding stand against the use of condoms, and that Latinos are suffering disproportionately as a result.

"In the past two months, our clinic has found 45% (infection rates) among gay and bisexual Latinos," said Osborn, compared to 17% among Anglo gays. "The figure just leaps out at you. . . . It is really alarming."

"The gay white male experience, horrible as it has been, will look like a walk in the sun compared to what is coming in the ghettos and barrios of Los Angeles," added Dr. German Maisonet, a private physician who treats AIDS-infected intravenous drug abusers.

Despite efforts to educate the black community by such groups as the Minority AIDS Project, denial remains a powerful force. Dr. Wilbert Jordan, a black physician who directs the AIDS clinic at Martin Luther King Jr./Drew Medical Center, said that fewer than 10% of black ministers responded to his letter inviting their congregations to "adopt" an AIDS patient to raise awareness about the disease.

And when county health officers sponsored a forum for Latino doctors on treating AIDS and HIV infection, only three showed up. "We invited over 1,000, and 75 to 150 would have been a good showing," said Dr. Martin Finn, the county's top AIDS health officer.

Finally, the political contours of Los Angeles County may hamper the response to the epidemic. Supervisors, for example, have twice spurned recommendations to fund programs that would distribute bleach to IV drug users--steps New York and San Francisco instituted years ago.

"Under the present political philosophy of the board, we will never have an effective battle against AIDS in Los Angeles," said Michael Weinstein, president of the AIDS Hospice Foundation and a frequent critic of the county's response to the epidemic.

"There's a definite lack of leadership--and, I would add, a lack of will," said Mary Nalick, director of the City of Angels Hospice in Hollywood. Although the facility is widely admired for providing excellent care to end-stage patients, to date it has received no government funding because of one bureaucratic obstacle after another.

“We’ve managed to exist with no public money and no client money for a year,” said Nalick, who has been forced to rely on an unsteady stream of foundation grants and private donations. “Basically, I beg.”

Dr. Neil Schram, former head of the City-County Task Force on AIDS, still seethes when he thinks back to his first visit to the Los Angeles Board of Supervisors in 1985 to warn of a killer that would wipe out tens of thousands of county residents.

Schram had waited four years since AIDS first appeared to sound the alarm. Here at last was his chance to urge leaders to mount aggressive educational efforts to stem the spread of the fatal disease, to avert panic and to shore up a sagging health-care system to cope with the tidal wave of patients to come.

“As I delivered my testimony, Pete Schabarum stood in a corner and talked to a friend,” Schram recalled. “Ken Hahn and Deane Dana were absent. Ed Edelman listened. And Mike Antonovich sat there and watched me, watching him, while he made calls on his portable telephone.”

Schram, a South Bay physician, was not mollified when people more familiar with the ways of local government assured him that such inattention from supervisors was typical for hearings. To Schram, the episode drove home “the egregious and shameful leadership vacuum” that has characterized the county’s response to AIDS.

County supervisors insist that they have taken the epidemic seriously all along. But Edelman, the only supervisor who consented to an interview, said he feels “lonely and frustrated” when supporting AIDS issues on the board.

Despite years of urging from public health officials, for example, Los Angeles County did not adopt legislation barring discrimination against people with AIDS until February, 1989--after the cities of Los Angeles, Santa Monica, Berkeley, Riverside and Pasadena and various California counties enacted similar measures.

The civil rights legislation was hotly contested and was approved by the Los Angeles County Board of Supervisors by a 3-2 vote.

Many people within county government believe that Schabarum was betraying his own feelings when he said at a board meeting earlier this year that “the man on the street . . . could care less about funding” AIDS care. Last year, alone among supervisors, Schabarum refused a special briefing on AIDS by county health officers.

Judy Hammond, an aide to Schabarum, said the supervisor reflects his “conservative, working-class district,” which includes such cities as Pomona, Arcadia and Whittier.

“We get all the extremes, including mail that says, ‘Let them die, they brought it on themselves,’ ” she said.

Antonovich aide Dawson Oppenheimer said the board's conservative majority has refused to approve bleach distribution to needle-using addicts because it is "very concerned about sending out the wrong message to young people."

"AIDS kills, but drugs kill too," he added. "There is no safe way to take drugs."

Many county health officials, especially in the AIDS office, say they are demoralized, caught between the increasingly noisy demands of AIDS activists and the truculence of top officials and supervisors.

Finn, formerly the county's top medical officer and now medical director of the AIDS Program Office, recalls testifying at a 1984 state legislative hearing that Los Angeles needed a three-fold increase in AIDS prevention education funds. "I was called on the carpet by (County Health Department Director Robert C.) Gates," he said, and admonished for speaking out.

Gates, in an interview, said he does not recall the incident.

The health chief defends the department's response to AIDS, given the political and economic realities in the county. This year's county AIDS budget, including state and federal funds, will climb to $60.4 million from $51 million a year ago and $30 million a year before.

"I work for the board," Gates said. "The fact that I am not visibly and vocally standing up to the Board of Supervisors does not mean that I am not expressing to the board what needs to be done to deal with AIDS. . . . My style is to convince people privately, rather than to engage in public confrontations."

Gates takes pride in the new 20-bed inpatient AIDS ward at County-USC Medical Center. The facility, opened in September and long a priority of AIDS activists, is modeled on one opened at San Francisco General Hospital six years earlier.

But outpatient care at County-USC remains "a scandal," said Mark Kostopoulos of ACT UP, the AIDS Coalition to Unleash Power, and some county health officials privately agree.

Consider 40-year-old Ernesto Oliva, who had to wait six weeks to get an appointment after he tested positive for HIV. When he was finally seen, doctors found that his immune system had deteriorated so badly that he might have been struck by deadly pneumonia while he waited; doctors immediately instituted preventive treatments.

The outpatient facility at County-USC, known as ward 5P21, is so crowded that patients like Bill Oxendine must take intravenous chemotherapy treatments on a bench in a public hallway due to the shortage of infusion rooms.

"You get the drugs, but in a way that robs you of your human dignity," said Oxendine, 44, who was diagnosed as having Kaposi's sarcoma six months ago.

County officials originally intended to open a new outpatient clinic at the hospital this year, but funding delays and red tape have delayed that until next September, at the earliest.

County health department's response to the epidemic is its establishment of an HIV clinic in West Hollywood. The facility formerly housed a clinic that catered mostly to gay men with sexually transmitted diseases.

"Somewhere in 1984, the numbers of clients began to drop as gays adopted safe-sex practices," said Dr. David Dassey, the clinic's director. "By 1986 and 1987, they were off precipitously."

So, in conjunction with the city of West Hollywood, county officials converted the under utilized clinic into what they hope will be a model for providing outpatient care for patients infected with the virus.

Since March, the clinic has been monitoring HIV-positive patients. Within a few months, it will open a treatment room in an effort to forestall the development of full-blown AIDS.

"My crude guess is that we'll be able to enroll 750 patients and take some of the burden off of County-USC," Dassey said. But he fears that the clinic, which has already evaluated 550 patients, will itself be overwhelmed when it begins offering treatment. And, already, the facility is suffering from staffing problems and a high turnover rate.

"If we are going to advise people to get tested for HIV, we need to have services ready for them if they test positive," he said.

Although there are common elements in the responses of the gay communities of the three cities hardest hit by AIDS, there are also important distinctions.

New York, for example, was the birthplace of ACT UP.

San Francisco is the home of Project Inform, a clearinghouse for information on experimental medical treatments. Although ACT UP and Project Inform have taken root in Los Angeles, the primary route to "self-empowerment" here has been markedly different.

It can be seen every Wednesday evening at West Hollywood Park, in an auditorium a few hundred feet away from the HIV clinic, where about 500 people touched by the AIDS epidemic gather in a spiritual response to the disease personified by the self-proclaimed metaphysical counselor Louise L. Hay.

Every week, the sick, the dying and the worried-but-well gather to hear the blond and personable Hay dispense her New Age bromides.

Hay's basic message can be summarized in two words: "Love yourself." She peddles variations on the theme in books, meditation tapes, videos and personal appearances throughout the country. "Go up to a mirror, look into your eyes, and say, 'I love you, I love you, I love you," Hay told her rapt audience at one of her "Hay Rides" (suggested donation: $10) one recent evening.

The meeting concluded with a group meditation and the singing of her trademark song: "I Love Myself the Way I Am."

"Southern California is the seed bed where all sorts of new religious expressions take root and bloom," said the Rt. Rev. Oliver Garver, Episcopal bishop of Los Angeles. "It doesn't surprise me at all that new organizations would grow up seeking to address, in spiritual ways, this painful and personal tragedy."

Garver, a board member of AIDS Project Los Angeles, suspects that more people with AIDS in Los Angeles resort to such groups than in New York or San Francisco because they feel politically disenfranchised. "Even in 1989, we are still knocking on doors and confronting deaf ears," he said.

Some gay leaders were slow to mobilize against AIDS in Los Angeles. When Sheldon Andelson died of AIDS in December, 1987, obituaries noted his distinguished career as a gay leader, lawyer, banker and member of UC Board of Regents. Most obituaries did not mention, or glossed over, Andelson's part-ownership of Los Angeles County's biggest gay bathhouse during the 1970s and early 1980s, the 8709 on West Third Street.

Some people charge that the influential gay leader's involvement in the commercial-sex industry seriously hampered the battle against AIDS here. When AIDS first burst onto the scene in 1981, gay doctors like Neil Schram repeatedly beseeched Andelson to take a leadership role in combatting the epidemic. His requests, Schram said, were ignored.

"He wasn't the only one," Schram recalls. "During the early years, gay newspapers wanted nothing to do with AIDS." One newspaper that featured AIDS on its cover was banished from several gay bars.

Municipal Judge Rand Schrader, head of the County AIDS Commission and an old friend of Andelson, said that for Andelson, the bathhouse was more than a money-making business.

"To him, it represented our hard-won sexual freedom," said Schrader, noting that Andelson began his legal career defending consenting adults against charges of sodomy before the act was decriminalized in California.

Andelson finally shut down the bathhouse in 1984.

But although gay leaders may have been slow to act, many gay men and lesbians at the grass-roots level reacted heroically during the early years of the epidemic. Gays, for example, largely founded and staffed AIDS Project Los Angeles, which provides food, shelter, case management, dental services and transportation to people with symptomatic HIV disease.

After several rocky years when it was threatened with insolvency, APLA is returning to financial and operational health under Stephen Bennett, its new chief executive.

There are other success stories, powered largely by an extraordinary volunteer effort. Gay men and women continue to pour hours into volunteer work at AIDS Project Los Angeles, the Shanti Project, the Gay and Lesbian Community Services Center, the AIDS Hospice Foundation, Minority AIDS Project and dozens of other community-based organizations that battle the epidemic.

Take Phill Wilson, whose lover died of AIDS last month. Working with a group called Black and White Men Together, Wilson--who is infected with HIV--runs workshops designed to reinforce safe-sex practices among blacks.

Certainly, gays have been generous financially. With Hollywood donating the talent, gays in Los Angeles have opened their coffers to support star-studded benefits for a host of AIDS-related causes. They have also organized politically, though not nearly as effectively as in San Francisco, where gays have much more political clout.

Some people believe the reason has to do with the socioeconomic structure of Los Angeles's gay community.

Indeed, there appear to be two AIDS epidemics among gays: one for those who can afford private medical care, and a second for those who must rely on county health facilities. While those with insurance are able to fight for access to experimental drugs, the poor must struggle for basic medical services.

Torie Osborn of the Gay and Lesbian Community Services Center believes that gay clout in Los Angeles also is weakened because so many more gay people remain closeted here compared to San Francisco.

"There are a lot of powerful gay people--in corporations, in government, in the professions--who could have made a difference but didn't dare to because they were in the closet," she said.

Even though gays account for 89% of the AIDS cases in Los Angeles, nine years into the epidemic they are finding it difficult to maintain a wartime footing.

“You can walk down (the gay strip on) Santa Monica Avenue in West Hollywood and not even realize there’s an epidemic going on,” said Paul Monette, author of “Borrowed Time: An AIDS Memoir,” a searing account of his lover’s struggle with AIDS.

Partly, this reflects what psychologists call “healthy denial” as the epidemic’s dreary role call of death drones on. But Monette believes the reasons go deeper. “Los Angeles is fantasyland,” he said. “Maybe our capacity for denial is greater.”

Now that the epidemic has lost its novelty, “there’s a sense out there that AIDS is all over now,” he said. And, with current and expected treatment advances, “it seems like the light at the end of the tunnel is no longer an onrushing freight train.”

But AIDS is far from over. “I recently came back from Europe and found out that four friends had died,” Monette said. “Whatever the perceptions, the death and the suffering are not stopping.”

AIDS in Three Major Cities

The following are selected AIDS statistics through Sept. 30, 1989, for New York, Los Angeles and San Francisco, the three major centers of the epidemic which together accounted for 34.5% of the nation’s AIDS cases. The data shows that Los Angeles has more than twice as many female cases and three times as many pediatric cases as San Francisco, even though its total caseload is only 11% higher.

New York Los Angeles San Francisco Total cases 22,571 8,063 7,277 Total deaths 12,246 5,306 4,706 Children under 13 536 70 22 Adult women 2,934 244 91 Gay/bisexual contact 10,916 6,474 6,164 Heterosexual IV drug use 6,166 325 159 Reported new cases, 4,081 1,928 1,458 year to date Total cases White 39% 65% 82% Black 33% 16% 7% Latino 27% 18% 8% Projected net municipal outlay $229.6 $20.5 $19.9 (millions) for AIDS prevention and care, current fiscal year*

* Does not include private contributions, state and federal expenditures or payments from private insurers. Aids Cases Per Census Tract in Los Angeles Metro Area Census tracts are based on population and range in size in the Los Angeles Basin from very largest-about 72 square miles-to the smallest-less than a mile square.)

No. of cases Map area No. of tracts per tract White 1,312 0 to4 Gray 159 5 to 9 Dark gray 78 10 to 24 Striped 11 25 to 49 Black 14 50 to 124

Map shows reported AIDS cases between January, 1983, and December, 1988 Source: Department of Geography, California State University, Northridge and Los Angeles County Department of Health Services

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Los Angeles Takes a Big Lead : Is First in Area to OK Funds for AIDS Outreach Efforts

L.A. Times Archives

April 7, 1990 12 AM PT

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Mayor Tom Bradley and the Los Angeles City Council, with its unanimous vote appropriating emergency funds for special AIDS education and outreach service programs, are providing welcome leadership in controlling the AIDS epidemic.

The council is the first government body in Southern California to establish outreach with bleach and condoms to intravenous drug users, the group that poses the greatest threat of expanding the epidemic. The condoms serve as a reminder of the dangers of sexual transmission of AIDS. The bleach, effective in cleaning needles, can reduce the risk of transmission when needles are shared. Community-based groups will

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Council members also voted $30,000 for an outreach education program aimed at minority populations to increase their awareness of the efficacy of early intervention with persons infected with the human immunodeficiency virus (HIV) that causes AIDS. A new city study found that HIV infection is progressing to full-blown AIDS more rapidly among poor people, including ethnic minorities, because they are not receiving early intervention care as are the more affluent. Hundreds are being denied life-extending therapies through ignorance or inadequate public services.

Los Angeles County Supervisors earlier had rejected a recommendation from their own AIDS Commission to undertake the condom and bleach distribution. There has been similar resistance in Orange and San Diego counties. Federal funding has underwritten two demonstration outreach programs in the area, however. Horizontes targets Latino intravenous drug users in San Diego, and the AIDS Research and Education Project based at Cal State Long Beach works with drug users in that city. Both projects have reported positive results. Funding is being sought to perpetuate Horizontes when its three-year federal funding runs out in August. The Long Beach program, in its second year, already has reported evidence of behavior change among the more than 1,000 persons interviewed.

Critics have argued that bleach distribution could be seen as official approval of drug use, and that condom distribution could encourage promiscuity and exaggerated confidence in the limited protection it provides. Analysis of the programs in place, however, has found no such negative consequences. Most public-health officials remain convinced that it is an effective way to reach drug-dependent persons and educate them on the dangers of AIDS while opening the door to rehabilitation. In fact, some public-health officials believe the effort would be even more effective if it included a needle-exchange program.

HIV infection rates remain relatively low among intravenous drug users in Southern California, ranging from 5% to 8%. By comparison, New York’s rate is an appalling 50% to 60%. But New York’s experience could be repeated in Southern California unless outreach programs to high-risk populations prove more effective, according to public-health officials.

The commitment of Bradley and the council responds appropriately to that risk. And it responds to the study by Dave Johnson, city AIDS coordinator, charting the inadequacy of early treatment programs among the poor, including minority populations. The study has inspired not only the emergency funding but also plans to appropriate an additional $500,000 for the fiscal year commencing July 1. Unfortunately, no similar response has been forthcoming from the county governments of the region which are, in fact, the responsible public-health agencies and should be taking the lead. That makes the city’s leadership all the more important, all the more welcome.

More to Read

Mandy Morales <mandy.morales@lacity.org>

Public Comment: $5M Long COVID Line-Item to Prevent $3B in Losses (CF 25-0600)

1 message

Anita <anita@crotty.net> Tue, Apr 29, 2025 at 10:10 PM
To: katy.yaroslavsky@lacity.org, CityClerk@lacity.org, Clerk.BudgetandFinanceCommittee@lacity.org
Cc: Councilmember.Blumenfield@lacity.org, heather.hutt@lacity.org, councilmember.mcosker@lacity.org, councilmember.hernandez@lacity.org, DOD.Contact@lacity.org, controller.mejia@lacity.org

Dear Budget and Finance Committee Members,

I am a constituent, residing in Highland Park, in CD1. Please accept this email as my official public comment for inclusion in the record for Council File 25-0600 regarding the Fiscal Year 2025–26 City of Los Angeles Budget.

In the face of a $1 billion budget shortfall, it is essential to act strategically. I urge you to reverse the proposed $1.075 million cut to the Department on Disability and to allocate a $5 million Long COVID Response line-item as a critical fiscal stabilization and cost-containment measure.

Key facts:
• $1.075 million cut to the Department on Disability proposed
• $5 million requested dedicated for Long COVID case management, benefits navigation, public outreach, prevention, and more
• $3 billion in projected five-year economic losses if Long COVID is ignored[1]
• $5 million investment now is less than 0.2% of projected losses over the next five years
• 268,000 Angelenos living with Long COVID (and growing)[2]
• Over 20× the number impacted when the City first funded AIDS services[3]

By Harvard economists estimations, Long COVID will cost Los Angeles over $3 billion in five years[1]. Globally, Long COVID is already costing more than $1 trillion per year[4], and U.S. losses exceeded $152.6 billion in 2024 alone[5]. Without intervention, these costs will continue to rise and directly undermine the City's tax base and services.

For comparison, during the AIDS crisis, Los Angeles began allocating dedicated funding in 1987, and by 1990 independently invested from its general fund—even though annual AIDS diagnoses in the County peaked at roughly 4,000 cases in 1992. Today, over 267,000 adults in Los Angeles are living with Long COVID, which is more than twenty times the peak impact of AIDS. Targeted investment at scale is again urgently needed.

A $5 million starter investment today would stabilize residents, reverse critical service cuts, prevent escalating liabilities, and position Los Angeles to leverage future State and Federal pandemic recovery funds. This small, targeted investment today is a cost-saving, revenue-protecting action for the City's future. It strengthens our workforce, protects public health infrastructure, and positions Los Angeles to leverage additional State and Federal recovery funding. And, it's the right thing to do.

Investing now is responsible governance. Thank you for your leadership and for considering this critical measure.

Respectfully,
Anita Crotty
Highland Park (CD1)

References:
[1] Cutler, D. (2022). The Economic Impact of Long COVID. Harvard Kennedy School.
[2] CDC Household Pulse Survey. (September 2024). Long COVID Prevalence Estimates.
[3] Los Angeles Times. (1990). City Council Approves Funds for AIDS Prevention.
[4] Nature Medicine. (2024). Global Economic Cost of Long COVID Estimated at $1 Trillion Annually.
[5] Economist Impact. (2024). Incomplete Picture: Understanding the Burden of Long COVID.

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Anita Epler Crotty (she/her)
anita@crotty.net

Mandy Morales <mandy.morales@lacity.org>

STOP the Slaughter: Restore L.A. Animal Services Funding

1 message

Jonathan Lazar <jlazar13@mac.com> Tue, Apr 29, 2025 at 10:42 PM
To: Clerk.BudgetandFinanceCommittee@lacity.org
Cc: mayor.helpdesk@lacity.org, mandy.morales@lacity.org, katy.yaroslavsky@lacity.org, bob.blumenfield@lacity.org, heather.hutt@lacity.org, tim.mcosker@lacity.org, eunisses.hernandez@lacity.org

Dear Mayor Bass, Chair Yaroslavsky, and Committee Members Blumenfield, Hutt, McOsker, and Hernandez,

As an outraged and heartbroken Los Angeles resident, I am demanding that you immediately reverse the dangerous and disproportionate 33% budget cut proposed for L.A. Animal Services in the FY25/26 budget.

We are already in a crisis.
Shelters are overrun. Staff is stretched beyond human limits. Healthy, adoptable animals—including puppies—are being euthanized because there's no space, no resources, and no support. These are not rare cases—they're happening every day. I see the last-minute rescue pleas constantly on social media: "24 hours left," "Final call," "Will be killed tomorrow."

These cuts will eliminate 122 critical positions, risk shelter closures, and accelerate the collapse of an already overwhelmed system. The rescues trying to keep these animals alive are operating on fumes. I donate. I follow. I support. But they cannot keep up—and now you're asking them to do even more while the city pulls the floor out from under them.

This is not just bad policy. It's a death sentence for thousands of voiceless lives. It's cruel, and it's cowardly.

There is no excuse when $5 million remains unappropriated in the budget. That money should be immediately allocated to restore critical Animal Services funding.

And if the city can't advocate, then let the people help. I urge you to create a public donation fund or matching grant program so residents who care deeply about our animals—as family—can directly support them. Angelenos are ready to step up. But we need the city to lead, not abandon its responsibilities.

Do better. We're not just watching. We're grieving. We're angry. And we're not going away.

With Urgency,
Jonathan Lazar
Los Angeles Resident

Mandy Morales <mandy.morales@lacity.org>

Public Comment: $5M Long COVID Line-Item to Prevent $3B in Losses (CF 25-0600)

1 message

Alexis Silva <alex_silva08@outlook.com> Tue, Apr 29, 2025 at 11:39 PM
To: "katy.yaroslavsky@lacity.org" <katy.yaroslavsky@lacity.org>, "CityClerk@lacity.org" <CityClerk@lacity.org>, "Clerk.BudgetandFinanceCommittee@lacity.org" <Clerk.BudgetandFinanceCommittee@lacity.org>
Cc: "Councilmember.Blumenfield@lacity.org" <Councilmember.Blumenfield@lacity.org>, "heather.hutt@lacity.org" <heather.hutt@lacity.org>, "councilmember.mcosker@lacity.org" <councilmember.mcosker@lacity.org>, "councilmember.hernandez@lacity.org" <councilmember.hernandez@lacity.org>, "DOD.Contact@lacity.org" <DOD.Contact@lacity.org>, "controller.mejia@lacity.org" <controller.mejia@lacity.org>

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Investing now is responsible governance. Thank you for your leadership and for considering this critical measure.

Respectfully,
Alexis Silva
90033

References:
[1] Cutler, D. (2022). The Economic Impact of Long COVID. Harvard Kennedy School.
[2] CDC Household Pulse Survey. (September 2024). Long COVID Prevalence Estimates.
[3] Los Angeles Times. (1990). City Council Approves Funds for AIDS Prevention.
[4] Nature Medicine. (2024). Global Economic Cost of Long COVID Estimated at $1 Trillion Annually.
[5] Economist Impact. (2024). Incomplete Picture: Understanding the Burden of Long COVID.