LOS ANGELES COUNTY
COMMISSION ON HIV

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WOMEN'S CAUCUS
Virtual Meeting

Monday, March 21, 2022

2:00PM-4:00PM (PST)

***Meeting Agenda + Packet will be available on our website at:**
http://hiv.lacounty.gov/Meetings

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All Public Comments will be made part of the official record.

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WOMEN'S CAUCUS

Virtual Meeting Agenda

Monday, March 21, 2022 @ 2:00PM – 4:00PM

To Join by Computer:
https://lacountyboardofsupervisors.webex.com/lacountyboardofsupervisors/j.php?MTID=ma15db23d8b4c9954252ed2cdedac27e0
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1. Welcome + Introductions + Check-In — 2:00 PM – 2:05 PM
2. Executive Director/Staff Report — 2:05 PM – 2:10 PM
   Operational and Programmatic Updates
3. Co-Chairs' Report — 2:10 PM – 2:15 PM
4. PRESENTATION: — 2:15 PM – 3:00 PM
   - Perinatal Syphilis and HIV Transmission | Dr. Mikhaela Cielo
5. DISCUSSION: — 3:00 PM – 3:30 PM
   - Ideas for Directives
6. Meeting Recap + Agenda — 3:30 PM – 3:45 PM
7. Public Comment + Announcements — 3:45 PM – 4:00 PM
8. Adjournment — 4:00 PM

USC University of Southern California

MATERNAL CHILD AND ADOLESCENT/ADULT CENTER
FOR INFECTIOUS DISEASES & VIROLOGY

Perinatal Syphilis and HIV

Mikhaela Cielo, MD
Pediatric Infectious Disease
LAC+USC Medical Center
Maternal, Child, Adolescent/Adult Clinic

Objectives

- Current rates of HIV and syphilis infection in CA and LA County
- Modes of transmission of HIV infection to babies
  - Relationship to syphilis infections
- Neonatal treatment for HIV exposure and infection
- Neonatal management of syphilis infection
- Prevention of perinatal syphilis & HIV infection

National Women and Girls HIV/AIDS Awareness Day

March 10, 2022

Drew C.A.R.E.S

National Women and Girls HIV/AIDS Awareness Day increases awareness, sparks conversations, and highlights the work being done to reduce HIV among women and girls in the United States while showing support for those living with HIV.

23% of people living with HIV are women.[1]

Adult and adolescent women accounted for **19%** of new HIV diagnoses in 2018.[1]

1 in 9 women with HIV are unaware of their HIV status.[1]

Despite significant progress towards Ending the HIV Epidemic, women and girls remain vulnerable to HIV, especially transgender women, African American women, and Latina women.

In Los Angeles County,
the rate of new HIV diagnoses among Black women and girls ≥ 13 years is
5 times the rate of white women and girls ≥ 13 years.

However, WE ARE MAKING PROGRESS

between 2006 and 2018, HIV diagnoses rates declined by 48% and 60% among Black and Latina women and girls ≥ 13 years, respectively.[2]

Black and Latina transgender women made up **51%** and **29%** of new HIV diagnoses among transgender women from 2009-2014, respectively.[3]

Transgender women face stigma and discrimination which makes access to healthcare, education, employment, and housing a challenge and impacts their health, well-being, and HIV risk.

Together we can offer support to women and girls living with HIV, share information, and reduce stigma to empower women and girls and improve HIV prevention, care, and treatment among these communities.

CDC. Diagnoses of HIV infection in the United States and dependent areas, 2018. HIV Surveillance Report 2019;30.
Division of HIV and STD Programs, Department of PublicHealth, County of Los Angeles. HIV Surveillance Annual Report, 2019 Published May 2020.
Clark H, Babu AS, Wiewel EW, Opoku J, Crepaz N. Diagnosed HIV Infection in Transgender Adults and Adolescents: Results from the National HIV Surveillance System, 2009-2014external icon. AIDS Behav 2017;21(9):2774-2783.

Contact Information: BreannMcAndrew1@cdrewu.edu or (323) 563-5815

Cisgender Women with HIV in LAC

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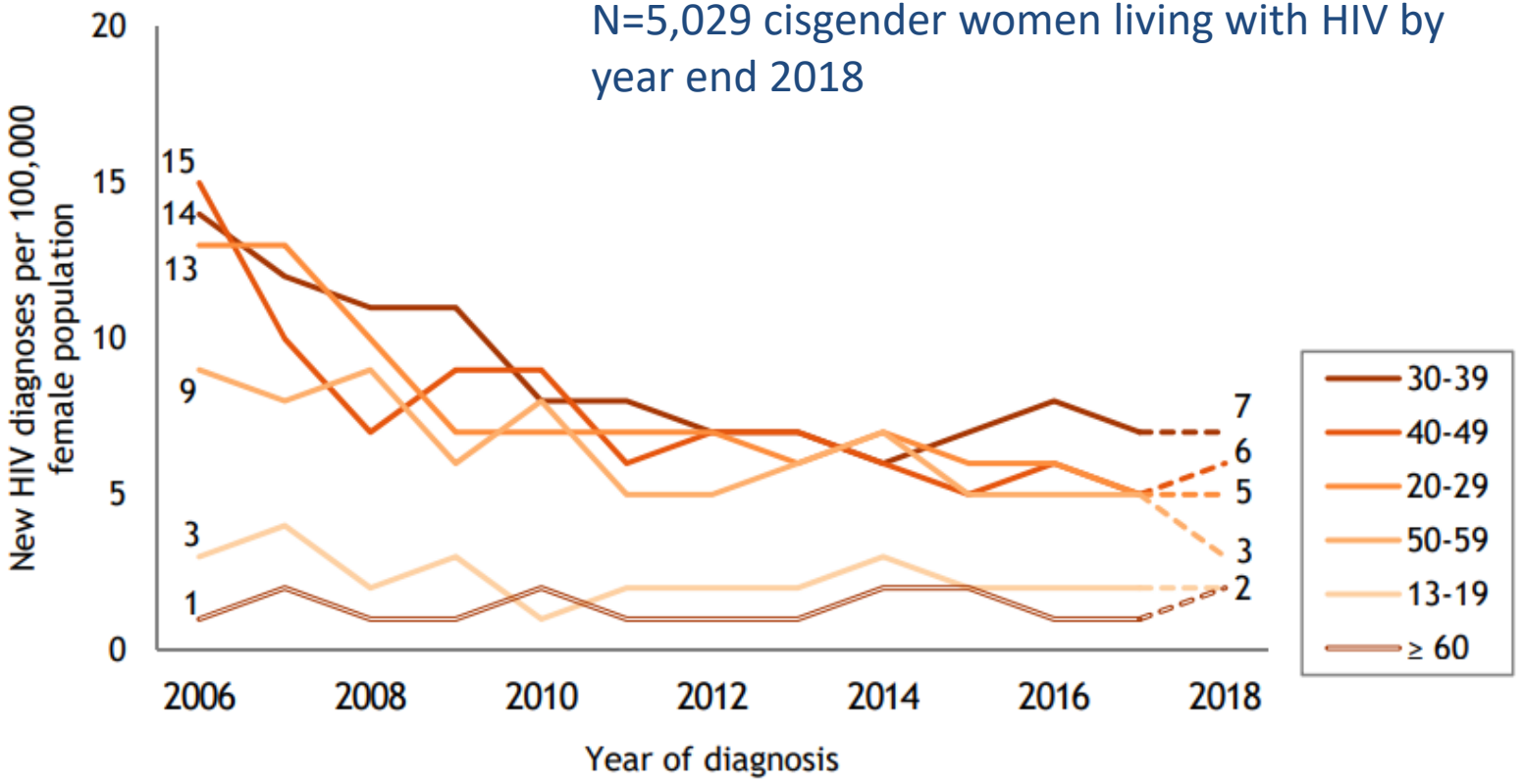
Figure 10: HIV diagnoses rates among females aged ≥ 13 years by age group, LAC 2006-2018



MATERNAL CHILD AND ADOLESCENT/ADULT CENTER FOR INFECTIOUS DISEASES & VIROLOGY

Cisgender Women with HIV in LAC

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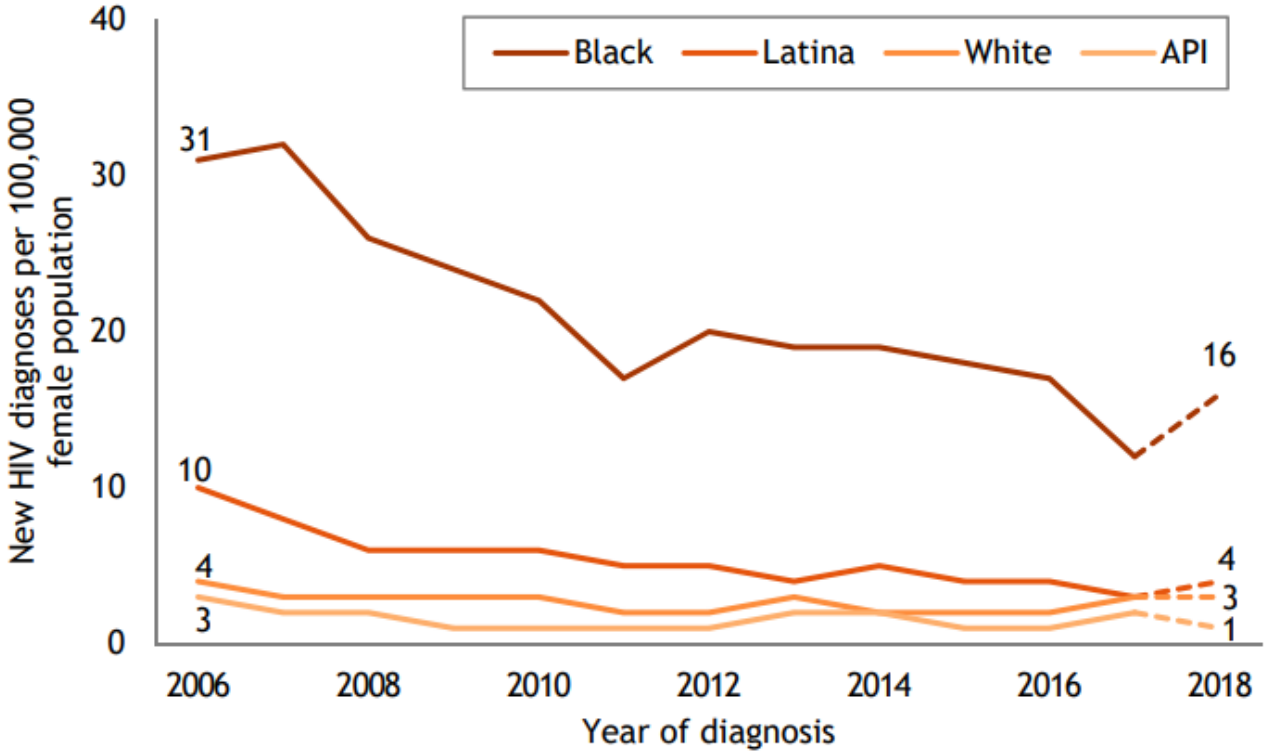
Figure 11: HIV diagnoses rates among females aged ≥ 13 years by race/ethnicity[1], LAC 2006-2018



Data in context: HIV diagnoses rates among American Indian/Alaskan Native (AI/AN) and persons with multiple race/ethnicity are not included due to small numbers. In 2018, AI/AN and multi-racial persons represented <1% of females newly diagnosed with HIV.

Source: LAC DPH Division of HIV and STD Programs

MATERNAL CHILD AND ADOLESCENT/ADULT CENTER FOR INFECTIOUS DISEASES & VIROLOGY

Cisgender Women with HIV in LAC

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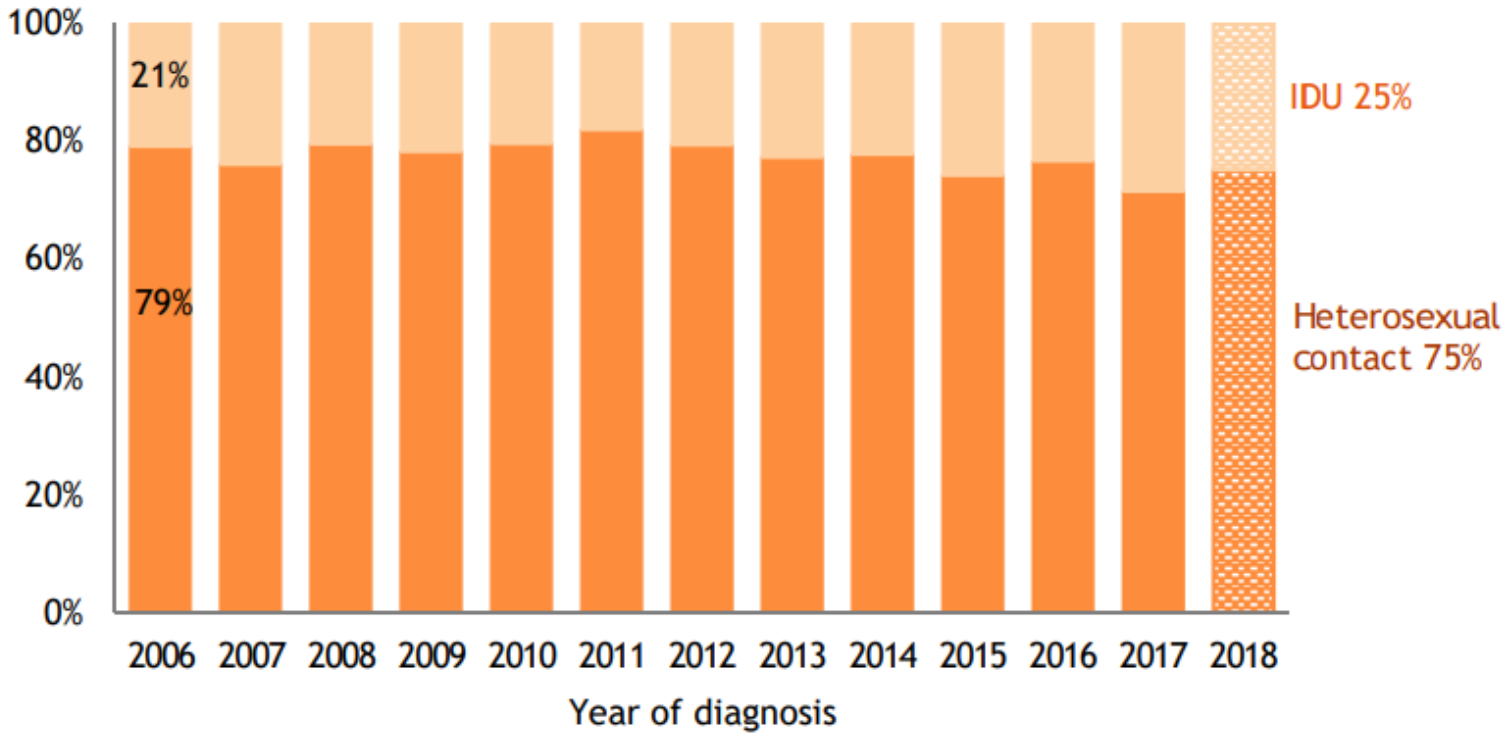
Figure 12: Transmission risk among females newly diagnosed with HIV, LAC 2006-2018[2]

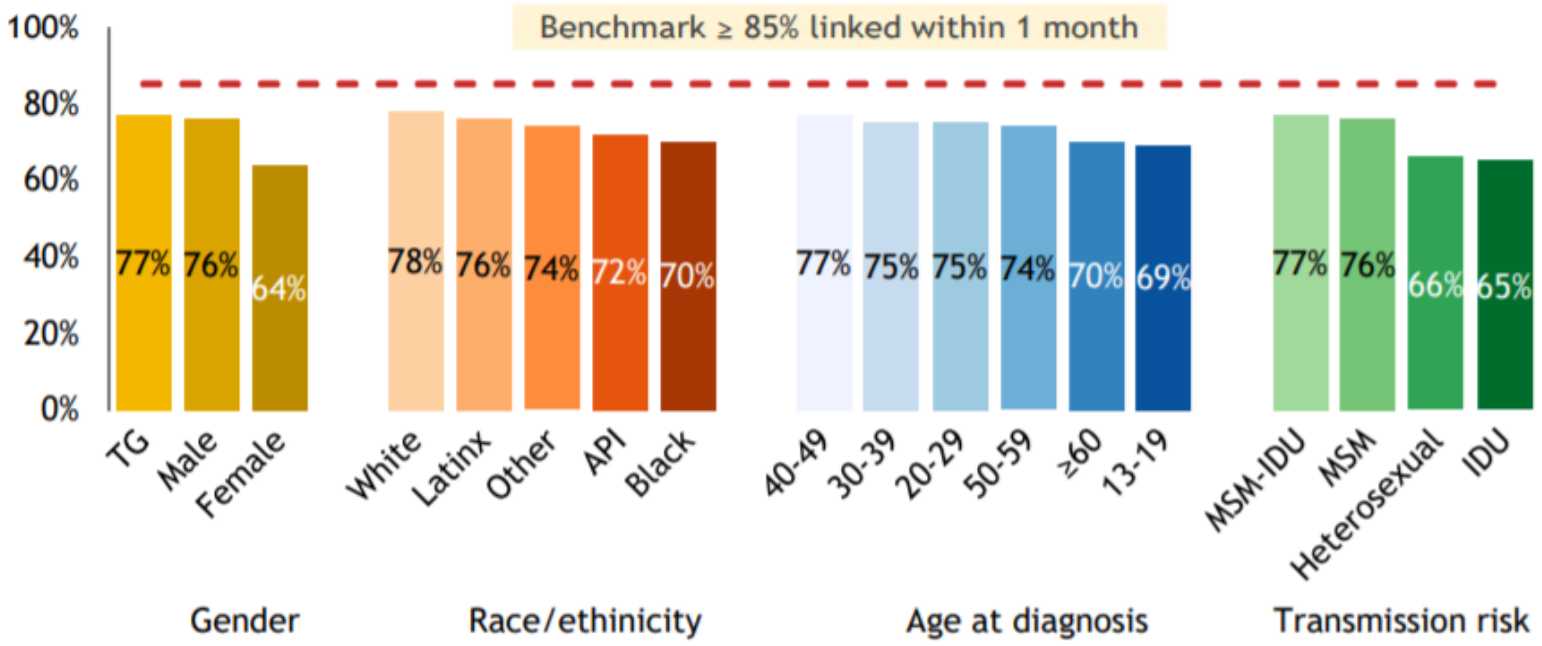


Source: LAC DPH Division of HIV and STD Programs

MATERNAL CHILD AND ADOLESCENT/ADULT CENTER FOR INFECTIOUS DISEASES & VIROLOGY

Cisgender Women with HIV in LAC

Figure 28: Linkage to care[1] within 1 month of HIV diagnosis among persons aged ≥ 13 years newly diagnosed with HIV by selected demographics[2] and risk characteristics, LAC 2018[1,2]

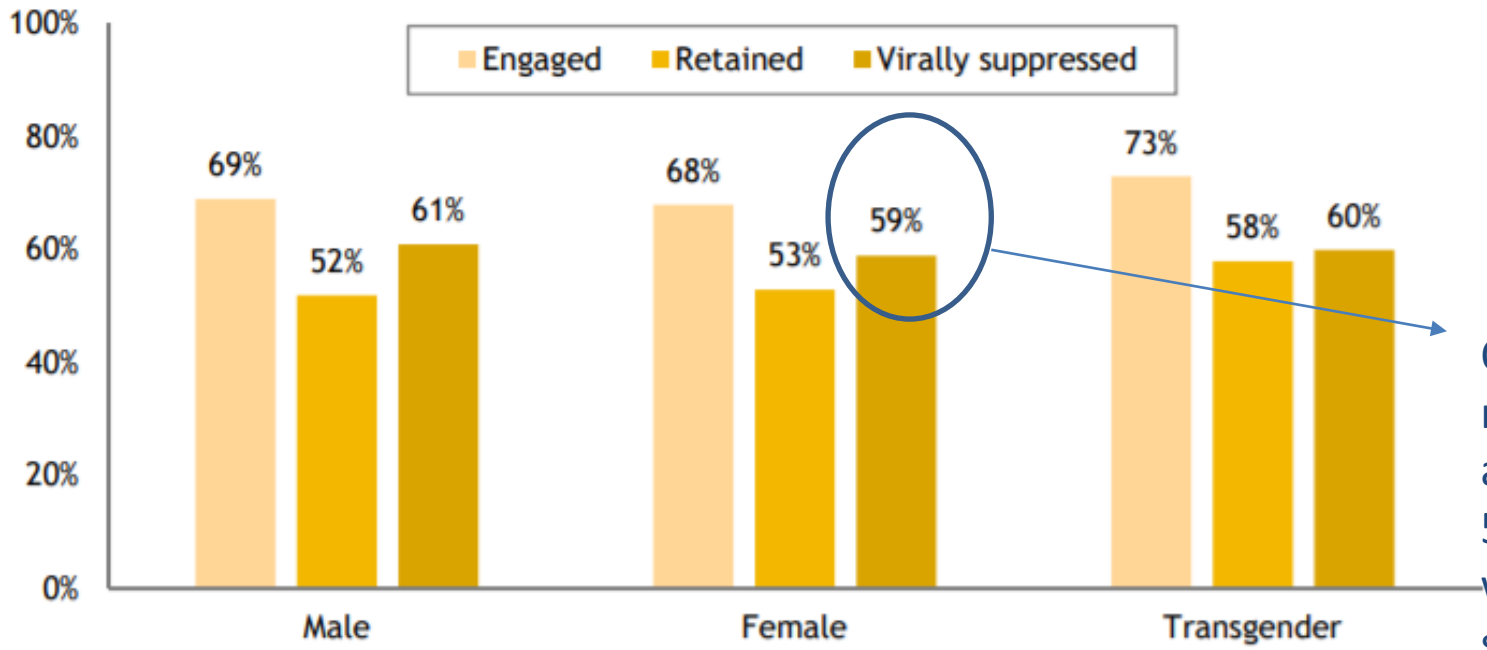


Source: LAC DPH Division of HIV and STD Programs

Cisgender Women with HIV in LAC

USC University of Southern California

Figure 30: Engagement, retention, and viral suppression by gender among persons aged ≥ 13 years diagnosed through 2018 and living in LAC at year-end 2019[1]

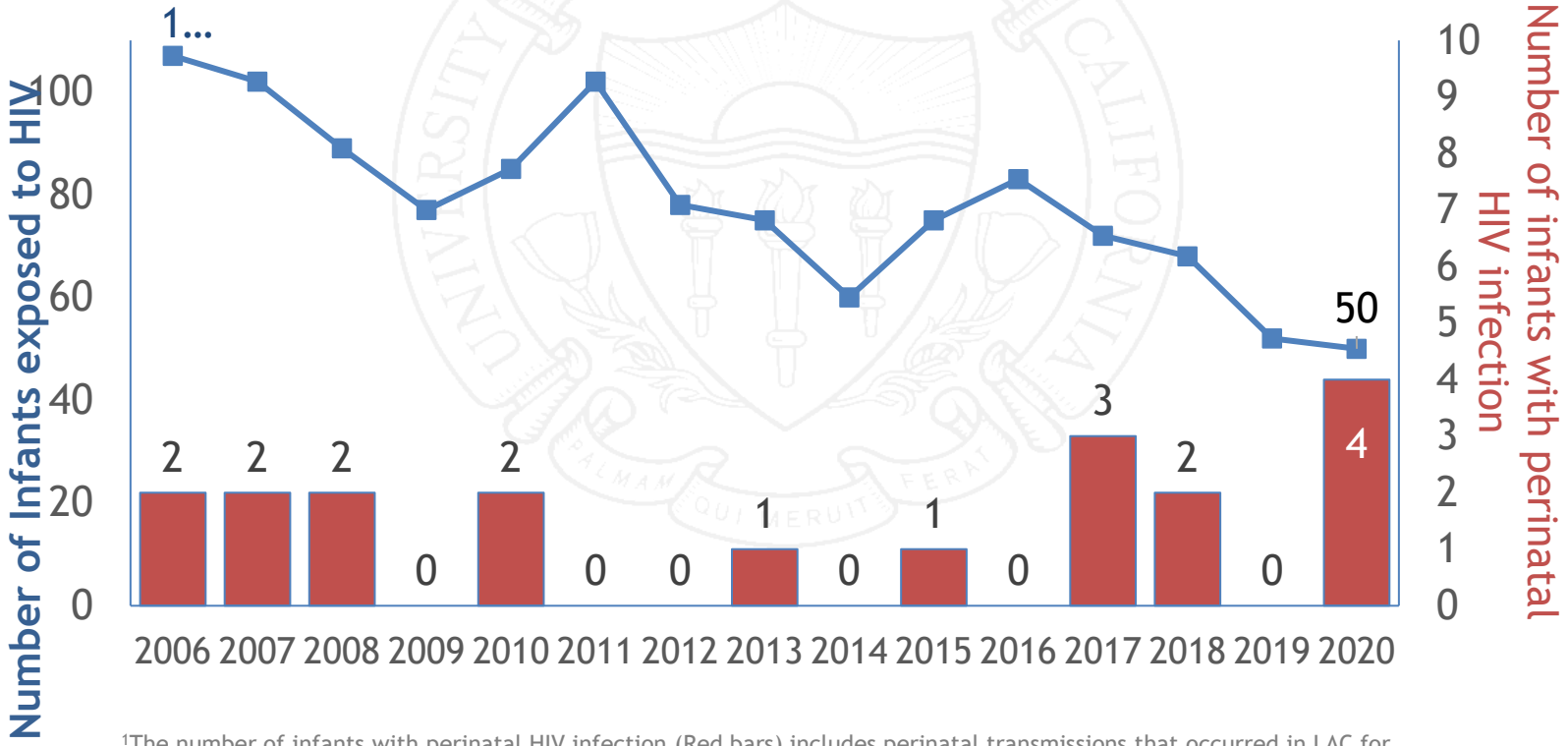


Of women of reproductive age (15-44), 52% (1,089) were virally suppressed

Source: LAC DPH Division of HIV and STD Programs

MATERNAL CHILD AND ADOLESCENT/ADULT CENTER FOR INFECTIOUS DISEASES & VIROLOGY

Trends in Perinatal HIV, 2006 to 2020[1]



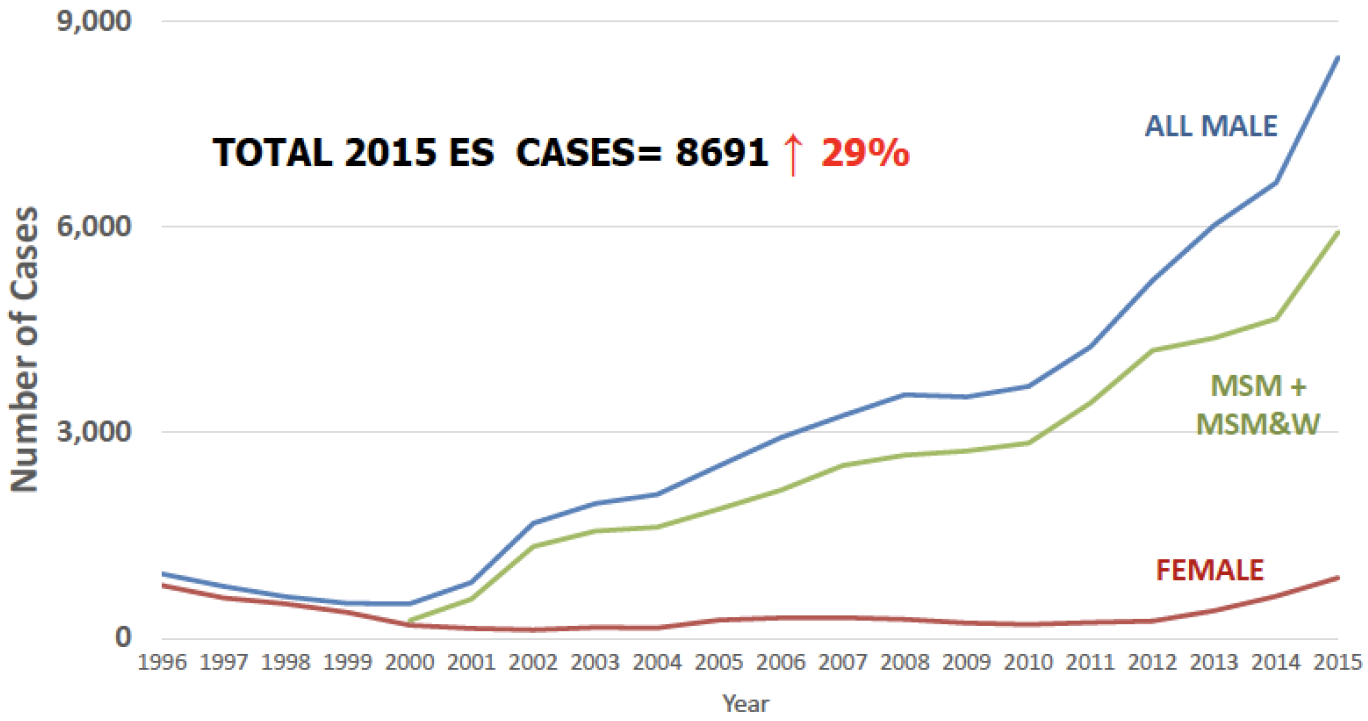
[1]The number of infants with perinatal HIV infection (Red bars) includes perinatal transmissions that occurred in LAC for a given birth year. The number of HIV-exposed infants was derived from 7 pediatric HIV-specialty sites which serve over 90% of HIV-positive pregnant women who seek care in Los Angeles County and is an underestimate of the total number of HIV-exposed infants in the County. Data for 2019 and 2020 are provisional due to reporting delay.

Table 1b. Persons newly diagnosed with HIV infection, by year of diagnosis and transmission category, 2013–2017 — California

Demographic group	Transmission category	2013 N	2013 %	2014 N	2014 %	2015 N	2015 %	2016 N	2016 %	2017 N	2017 %
Male adult or adolescent											
(≥12 years old at diagnosis)	Male-to-male sexual contact (MMSC)	3,247	77.0%	3,497	76.0%	3,490	75.8%	3,355	73.6%	3,039	71.4%
	Injection drug use (IDU)	141	3.3%	156	3.4%	141	3.1%	140	3.1%	146	3.4%
	MMSCIDU	179	4.2%	185	4.0%	169	3.7%	172	3.8%	177	4.2%
	High-risk heterosexual contact	141	3.3%	143	3.1%	107	2.3%	133	2.9%	109	2.6%
	Heterosexual contact (non-high-risk)	263	6.2%	286	6.2%	323	7.0%	360	7.9%	324	7.6%
	Perinatal	0	0.0%	2	0.0%	1	0.0%	0	0.0%	0	0.0%
	Unknown risk	246	5.8%	334	7.3%	375	8.1%	401	8.8%	461	10.8%
	Other	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.0%
	Subtotal	**4,217**	**88.7%**	**4,603**	**88.2%**	**4,606**	**89.3%**	**4,561**	**88.0%**	**4,257**	**88.9%**
Female adult or adolescent											
(≥12 years old at diagnosis)	Injection drug use	58	11.3%	65	10.9%	63	11.7%	62	10.2%	77	14.6%
	High-risk heterosexual contact	223	43.3%	234	39.1%	201	37.2%	197	32.3%	177	33.5%
	Heterosexual contact (non-high-risk)	170	33.0%	240	40.1%	220	40.7%	270	44.3%	211	39.9%
	Perinatal	1	0.2%	2	0.3%	0	0.0%	2	0.3%	1	0.2%
	Unknown risk	63	12.2%	57	9.5%	56	10.4%	79	13.0%	63	11.9%
	Subtotal	**515**	**10.8%**	**598**	**11.5%**	**540**	**10.5%**	**610**	**11.8%**	**529**	**11.0%**
Child											
(<12 years old at diagnosis)	Perinatal (Born in CA)	2	10.0%	4	25.0%	3	30.0%	4	36.4%	4	80.0%
	Perinatal (Born in other US States)	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	Perinatal (Foreign-born)	11	55.0%	7	43.8%	4	40.0%	3	27.3%	1	20.0%
	Perinatal (Unrecorded birth country)	1	5.0%	1	6.3%	0	0.0%	1	9.1%	0	0.0%
	Unknown risk	6	30.0%	4	25.0%	3	30.0%	2	18.2%	0	0.0%
	Other	0	0.0%	0	0.0%	0	0.0%	1	9.1%	0	0.0%
	Subtotal	**20**	**0.4%**	**16**	**0.3%**	**10**	**0.2%**	**11**	**0.2%**	**5**	**0.1%**
	Total	**4,752**		**5,217**		**5,156**		**5,182**		**4,791**	

Note: Transmission category classified by sex-at-birth. High-risk heterosexual contact: heterosexual intercourse with a person of the opposite sex-at-birth who has a high risk of HIV (e.g., MMSC, IDU). Heterosexual contact (non-high-risk): heterosexual intercourse with a person of the opposite sex-at-birth who does not have a high risk for HIV. Other includes hemophilia, blood transfusion, and risk factor not reported or not identified. The number of perinatal diagnoses in a given year do not reflect the number of transmissions during that year since some cases are not diagnosed at birth. Perinatal children who were less than 12 years old at diagnosis and were exposed to HIV perinatally are further categorized by the country of birth.

Early Syphilis*, Number of Cases by Gender & Gender of Sex Partners, California, 1996–2015

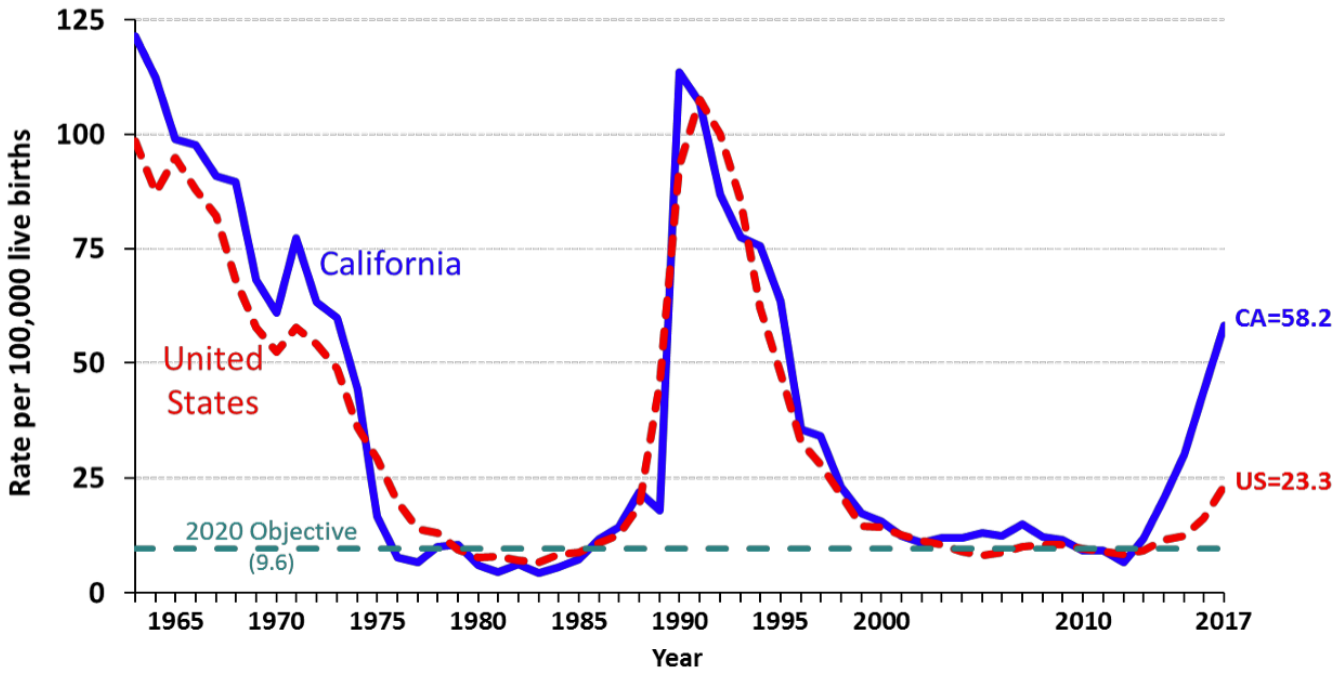


In 2015, MSM made of 70% of MALE early syphilis cases; 56% of MSM were HIV+

CDPH California Department of Public Health

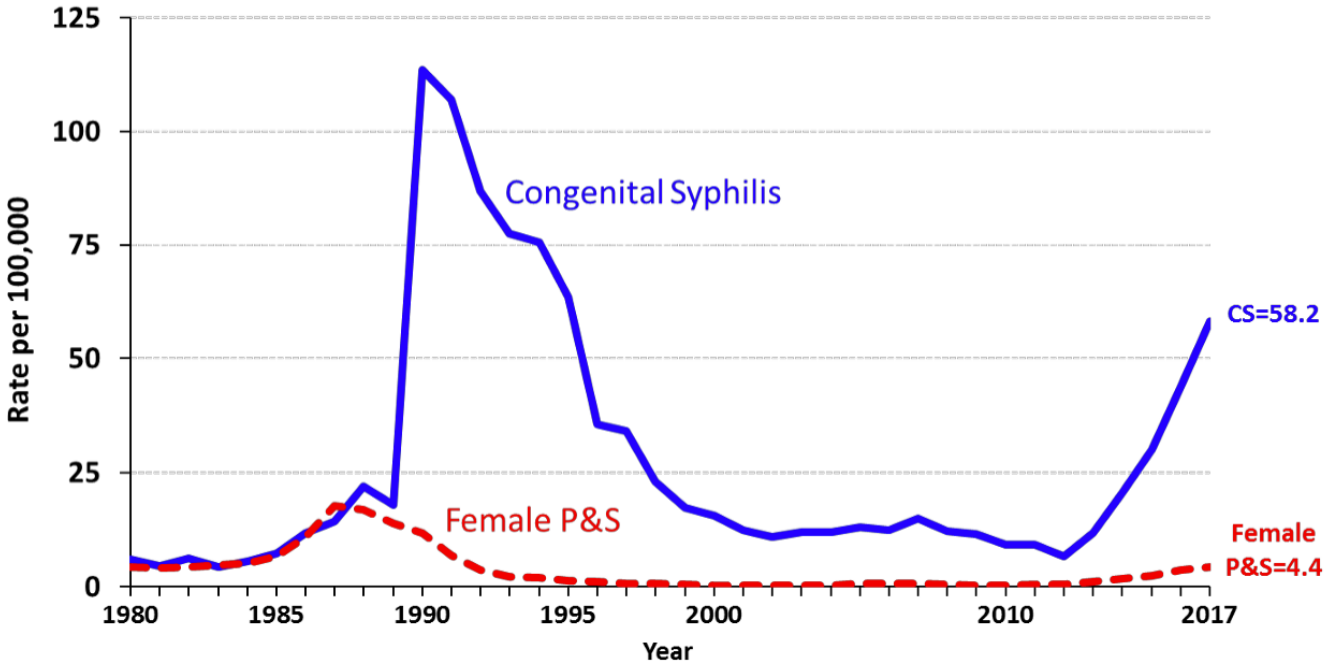
* Early syphilis includes primary, secondary, and early latent syphilis.

Congenital Syphilis, California versus United States Incidence Rates, 1963–2017



Note: The Modified Kaufman Criteria were used through 1989. The CDC Case Definition (MMWR 1989; 48: 828) was used effective January 1, 1990. California data prior to 1985 include all cases of congenital syphilis, regardless of age.

Congenital Syphilis versus Female Primary & Secondary Syphilis Incidence Rates, 1980–2017

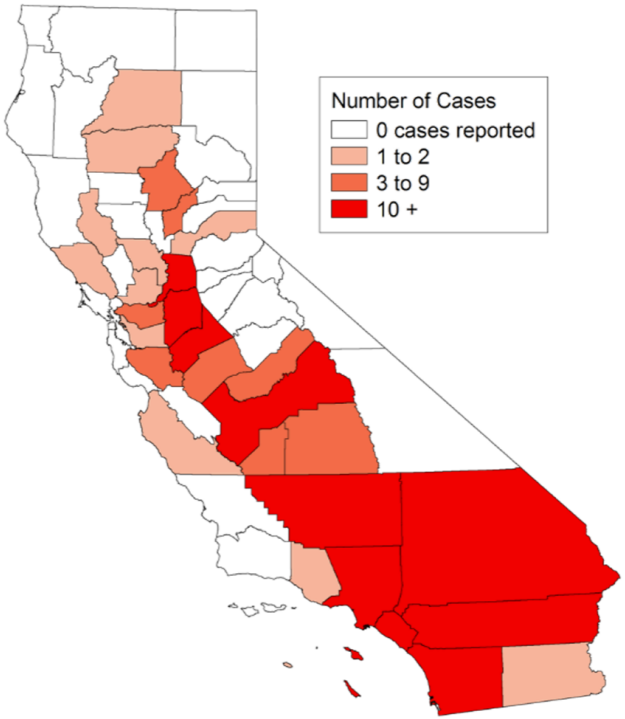


Note: Congenital syphilis rates are per 100,000 live births; female P&S rates are per 100,000 female population.

- General trend of increasing syphilis cases, congenital syphilis in Western US.
- Highest rates in CA are in Southern CA and Central Valley
- In 2018, 329 babies with congenital syphilis (CS) were reported in California, representing a 900% increase from 2012, and a magnitude of CS burden not observed since 1995.

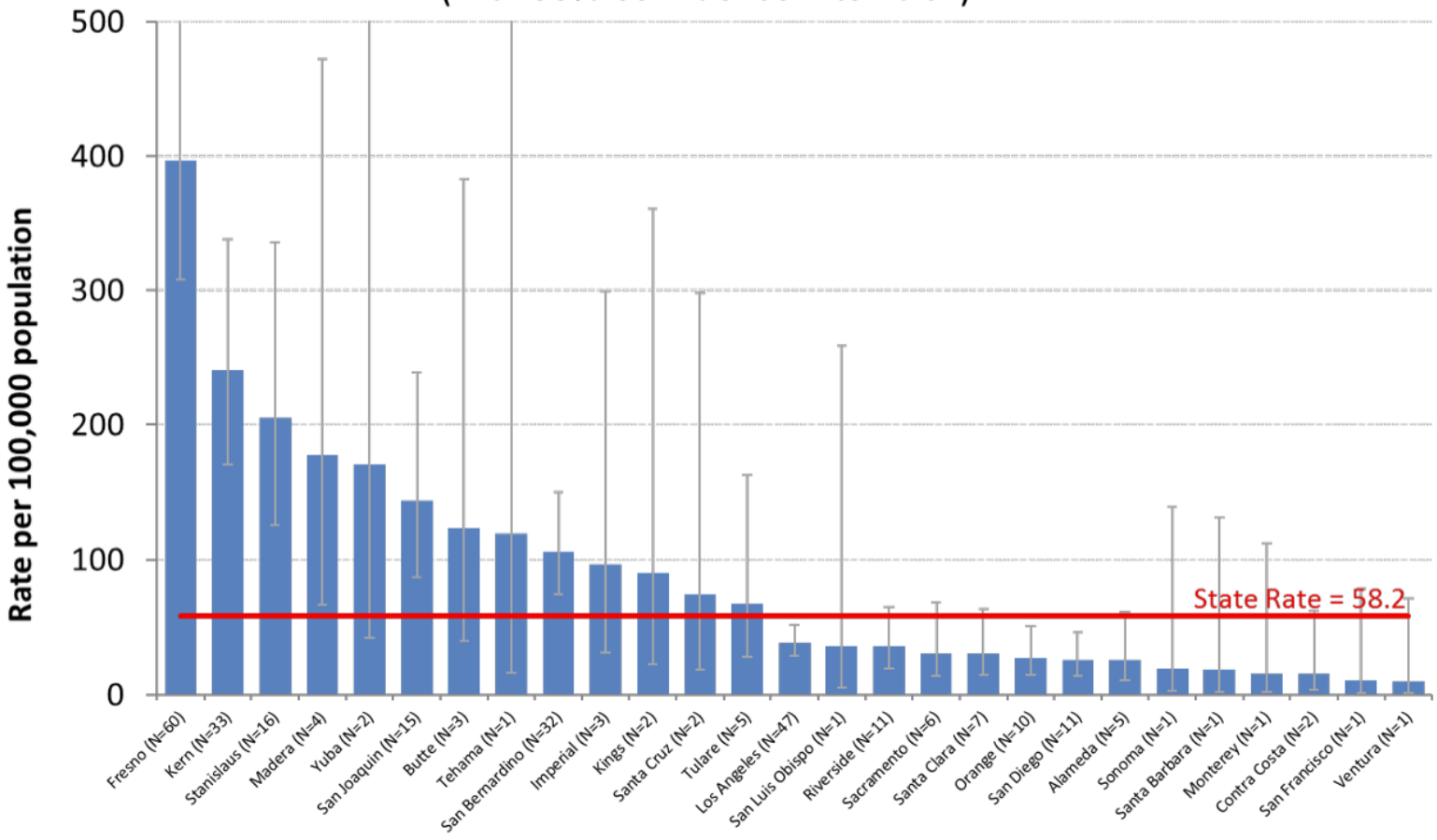
The number of California local health jurisdictions reporting CS cases continues to increase. In 2
30 out of 61 local health jurisdictions reported at least one case of CS (Figure 2).

Figure 2: Congenital Syphilis: Number of Cases by County, California 2018



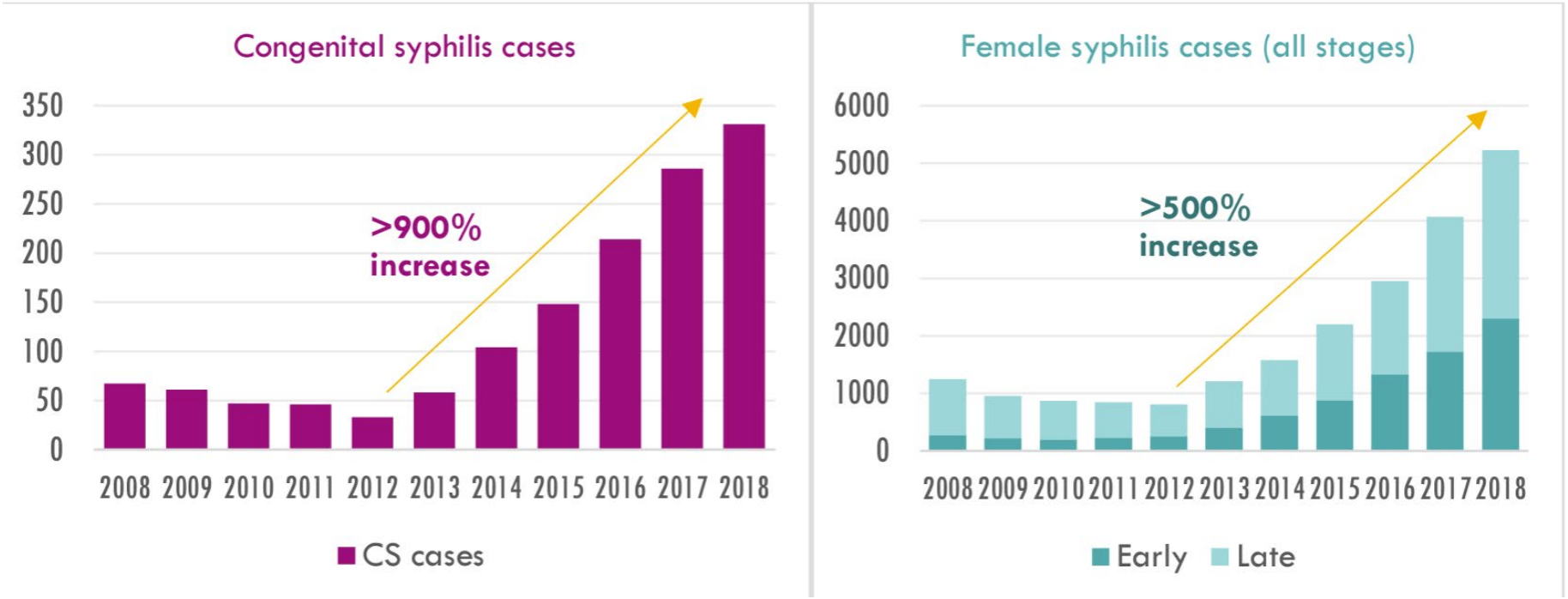
Ranking of County Congenital Syphilis Rates California, 2017

(with 95% Confidence Intervals*)

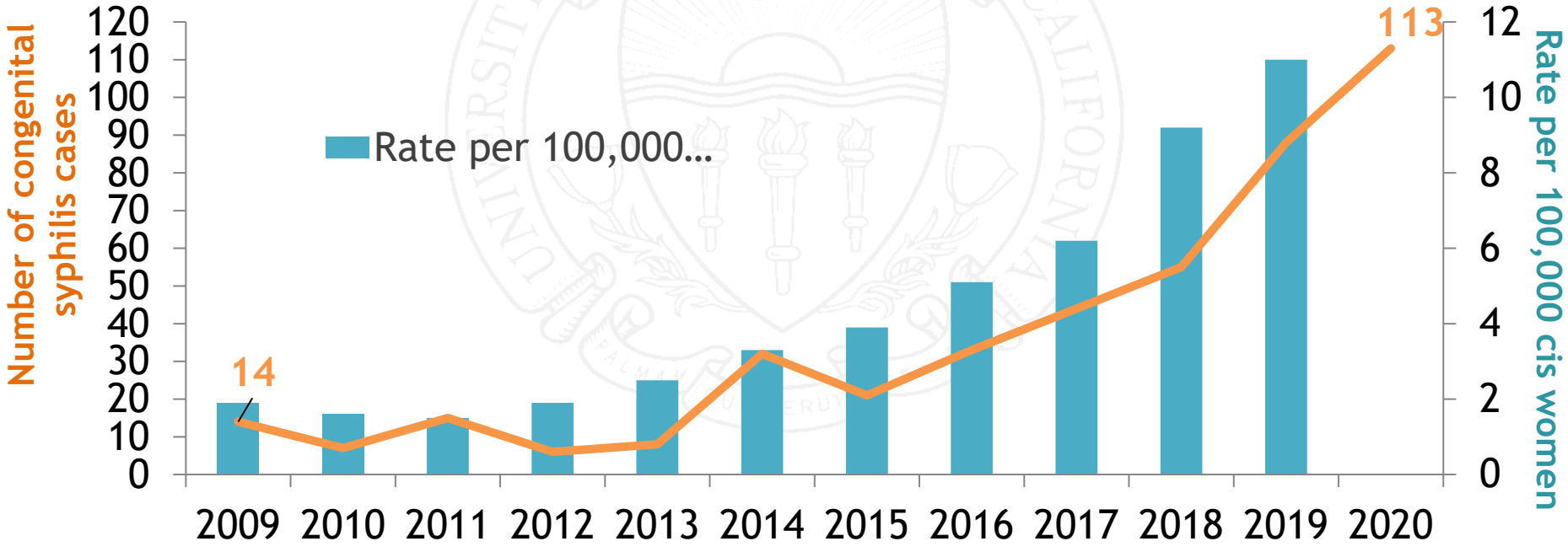


* Confidence intervals were calculated using Poisson exact method; excludes counties with no cases.
Note: Rates are per 100,000 live births.
Source: California Department of Public Health, STD Control Branch

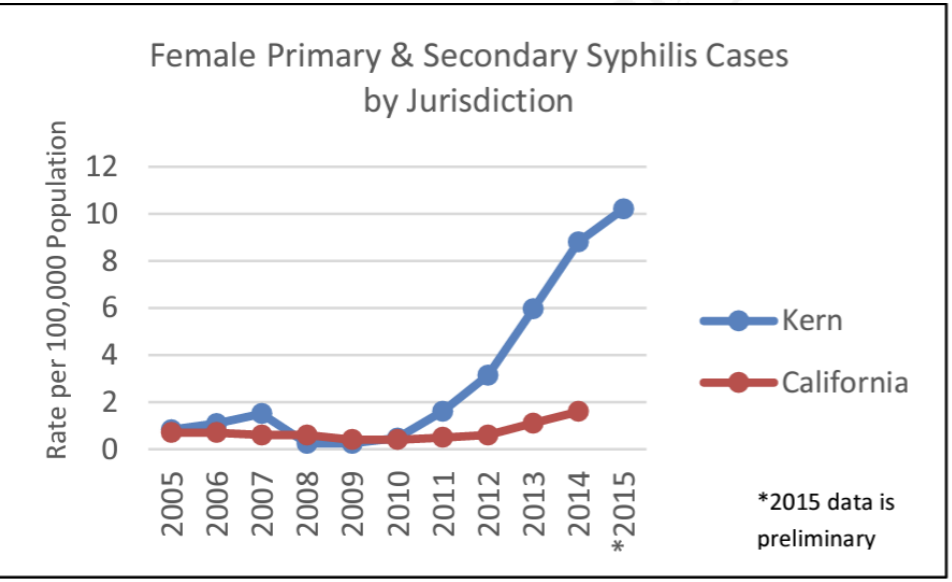
Figure 1: Congenital Syphilis and Female Syphilis, California 2008 – 2018

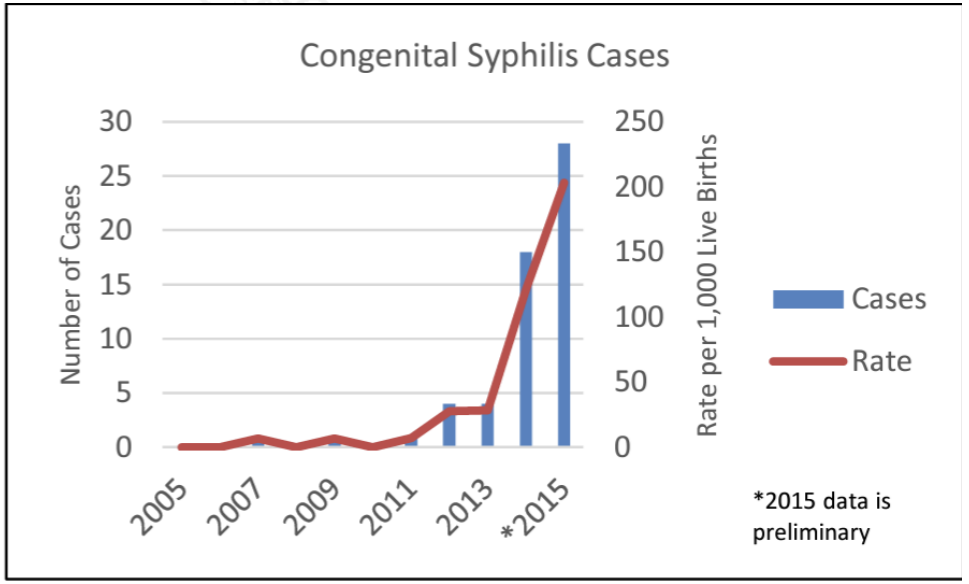


Early syphilis in cisgender women and newborns, Los Angeles County, 2009-2019[1]



[1] Data as of 03/14/2021. Early syphilis includes all cases staged as primary, secondary, or early non-primary non-secondary (previously early latent); cases from Long Beach and Pasadena are excluded. 2018, 2019, and 2020 data are provisional due to reporting delay

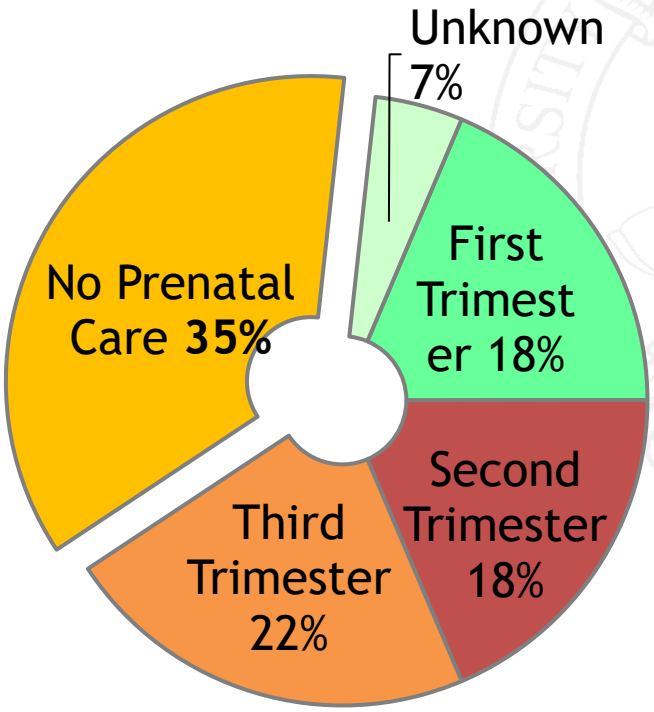

Female Primary & Secondary Syphilis Cases by Jurisdiction
Rate per 100,000 Population
12
10
8
6
4
2
0
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
*2015
Kern
California
*2015 data is preliminary


Congenital Syphilis Cases
Number of Cases
30
25
20
15
10
5
0
250
200
150
100
50
0
Rate per 1,000 Live Births
2005
2007
2009
2011
2013
*2015
Cases
Rate
*2015 data is preliminary

- 2019: 446 Congenital Syphilis cases in CA, highest number since 1993
- 2020: 6 perinatal HIV transmissions in CA
  - Most mothers had syphilis infection, not on PrEP

Maternal Characteristics of 88 Congenital Syphilis Cases, Los Angeles County, 2019

Entry into Prenatal Care



36% had a history of incarceration

40% had unstable housing

68% had a substance use disorder

49% were using meth or a drug combination with meth

80% of deliveries resulted in DCFS/Foster Care Referral

Maternal Characteristics of 4 Perinatal Transmission Cases, Los Angeles County, 2020

Common maternal risk factors

- No PNC (N=3) or Late PNC (N=1)
- Meth use (N=3)
- Unhoused (N=3)
- Mental illness (N=3)
- STDs (N=4)
  - **Syphilis** (N=3), Gonorrhea (N=1)
- History of incarceration (N=2) and partner incarceration (N=1)

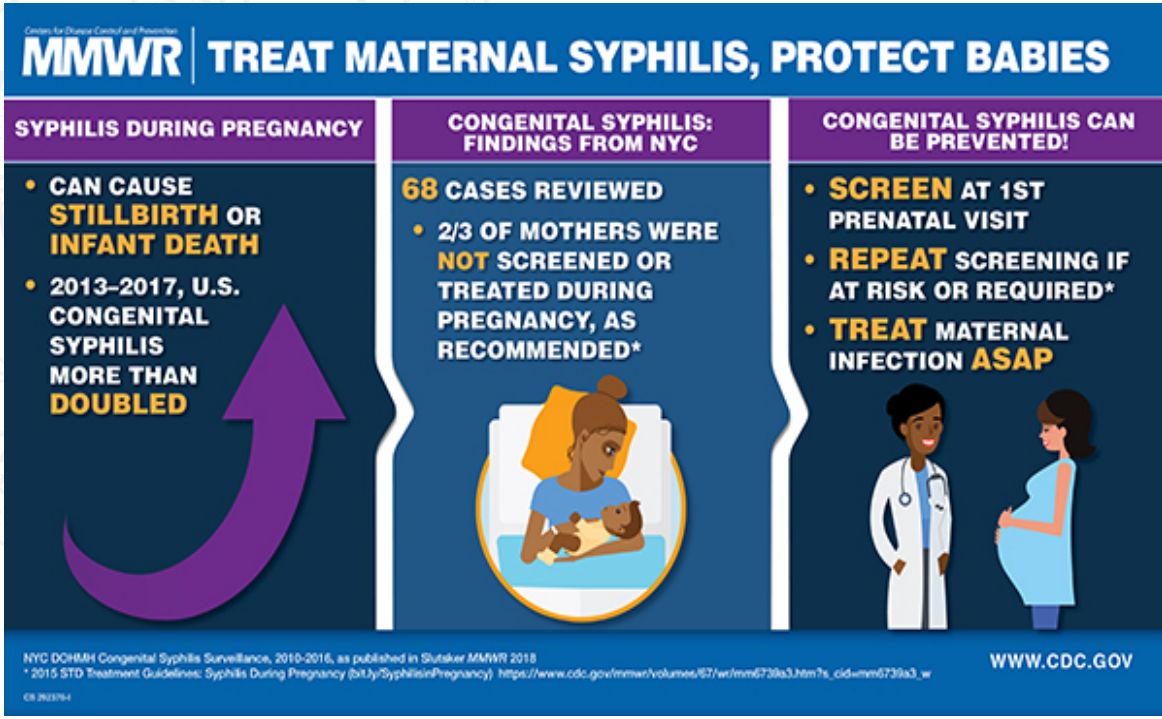
Neonate information

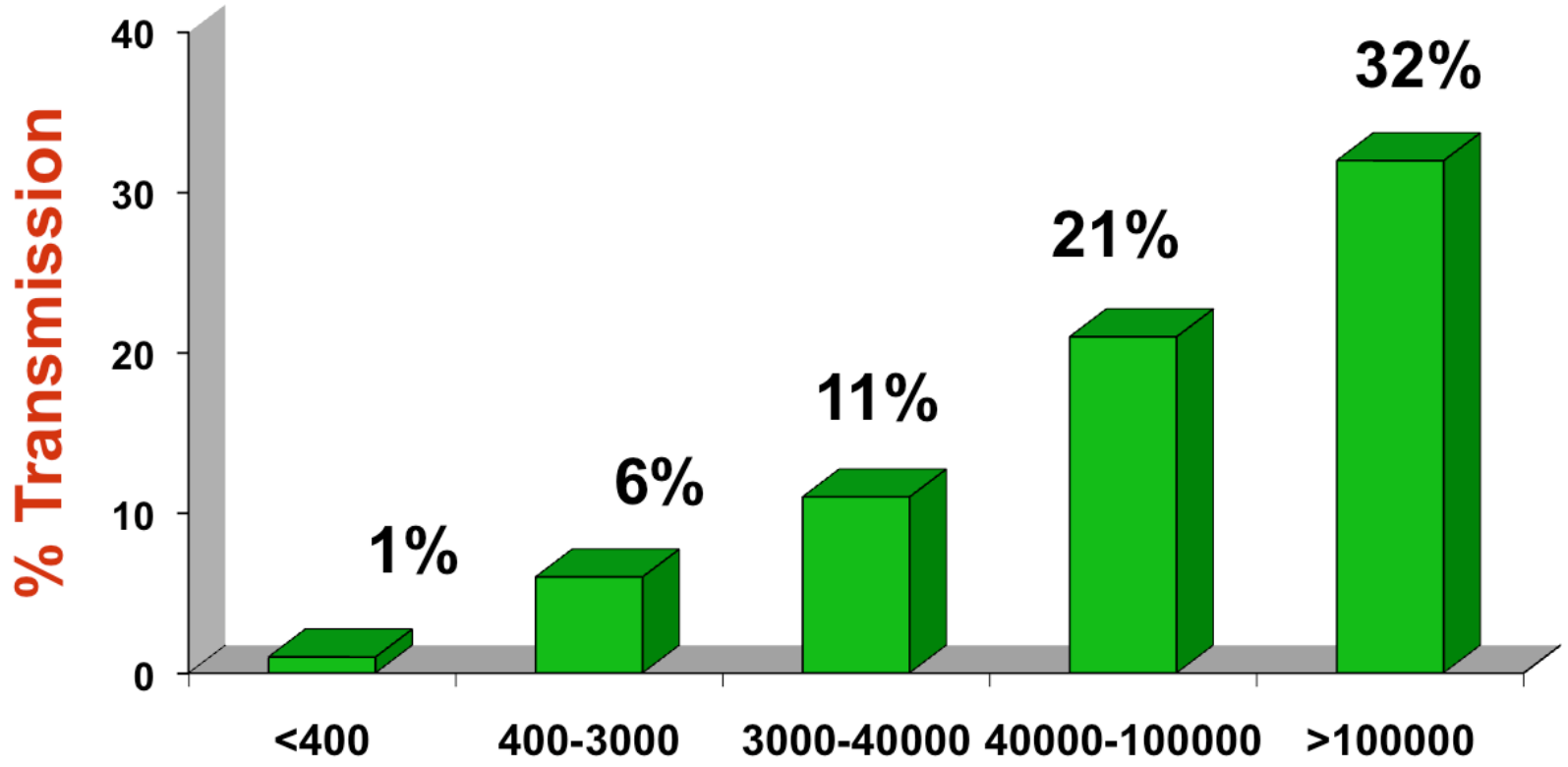
Congenital syphilis (N=3)

- Mothers co-infected with HIV and syphilis had 2-2.5 increased risk of transmitting HIV infection to their babies, when controlled for other factors.
- Inflammation and maceration of placental tissue
- Immune phenomena leading to decreased protection of maternal-fetal barrier, possibly increased viral load and decreased CD4

Testing guidelines

- Screen all pregnant patients for HIV at least once
- Repeat 3rd trimester HIV testing recommended for those receiving care in high incidence area or other risk factors
- Birth testing for those with no 3rd trimester testing
- Screen all pregnant patients for syphilis 3 times; first trimester, 3rd trimester and delivery





Delivery Plasma HIV RNA

Protecting Baby from HIV:

Steps to Prevent Transmission of HIV from Mother to Baby

Women with HIV take HIV medicines during pregnancy and childbirth. Their babies are given HIV medicine for 4 to 6 weeks after birth.

Women with a high or unknown level of HIV in their blood may have a C-section to reduce the risk of HIV transmission during delivery.

HIV can spread through breast milk. Women with HIV give their babies formula instead of breastfeeding.

For more information, visit HIVinfo.NIH.gov

Prophylaxis for baby

- **Standard risk**
  - Mother continues ARVs during delivery
  - IV zidovudine during delivery
  - Baby receives 4-6 weeks of oral AZT
- **More than standard risk**
  - Prolonged rupture
  - Exchange of maternal/fetal blood
  - Add 3 doses of nevirapine at birth, 48h later, and 96h after that

Prophylaxis for baby

- **High risk**
  - Viral load greater than >1000
  - Not in care
  - Newly diagnosed
  - Non-compliant with recent elevated viral loads
  - Coinfected with syphilis or other STI
  - Social risk factors: homeless, no PNC, +drug screen
- **3-4 drug regimen**
  - Zidovudine
  - Lamivudine
  - Nevirapine
  - Raltegravir

Table 6. **Perinatal Guidelines: Management of Infants Born to Women with HIV Infection**

Neonatal Antiretroviral Management According to Risk of HIV Infection in the Newborn

Category	Description	Neonatal Antiretroviral Management
Low Risk of Perinatal HIV Transmission	Mothers who received antiretroviral (ARV) therapy during pregnancy with sustained viral suppression (defined as a confirmed HIV RNA level less than 50 copies/mL) near delivery and no concerns related to adherence	Zidovudine for 4 weeks
Higher Risk of Perinatal HIV Transmission[a,b]	Mothers who received neither antepartum nor intrapartum ARV drugs Mothers who received only intrapartum ARV drugs Mothers who received antepartum and intrapartum ARV drugs but who have detectable viral loads near delivery, particularly if delivery was vaginal Mothers with acute or primary HIV infection during pregnancy or breastfeeding (in which case, the mother **should discontinue breastfeeding**)[c]	Presumptive HIV therapy using either: • Zidovudine, lamivudine, and nevirapine (treatment dose) from birth to age 6 weeks[d] *or* • Zidovudine, lamivudine, and raltegravir administered from birth to age 6 weeks[d]
Presumed Newborn HIV Exposure	Mothers with unconfirmed HIV status who have at least one positive HIV test at delivery or postpartum *or* Whose newborns have a positive HIV antibody test	ARV management as above for newborns with a higher risk of perinatal HIV transmission Infant ARV drugs should be discontinued immediately if supplemental testing confirms that the mother does not have HIV
Newborn with Confirmed HIV[e]	Positive newborn HIV virologic test/nucleic acid test (NAT)	Three-drug ARV regimen using treatment doses

[a] See text for evidence supporting combination ARV prophylaxis and empiric HIV therapy.
[b] See the Intrapartum Care section for guidance on indications for scheduled cesarean delivery and intrapartum intravenous zidovudine to reduce the risk of perinatal HIV transmission for mothers with elevated viral load at delivery.
[c] Most Panel members would opt to administer empiric HIV therapy to infants whose mothers had acute HIV during pregnancy because of the high risk for *in utero* transmission. If acute HIV is diagnosed during breastfeeding, the mother should stop breastfeeding.
[d] The optimal duration of presumptive HIV therapy in newborns who are at higher risk of perinatal HIV transmission is unknown. If possible, newborns who are at a higher risk of HIV acquisition should receive ZDV for 6 weeks. Additional medications, such as 3TC, raltegravir, or nevirapine, may need to administered for 2 to 6 weeks; the recommended durations for these drugs vary

Testing Algorithm

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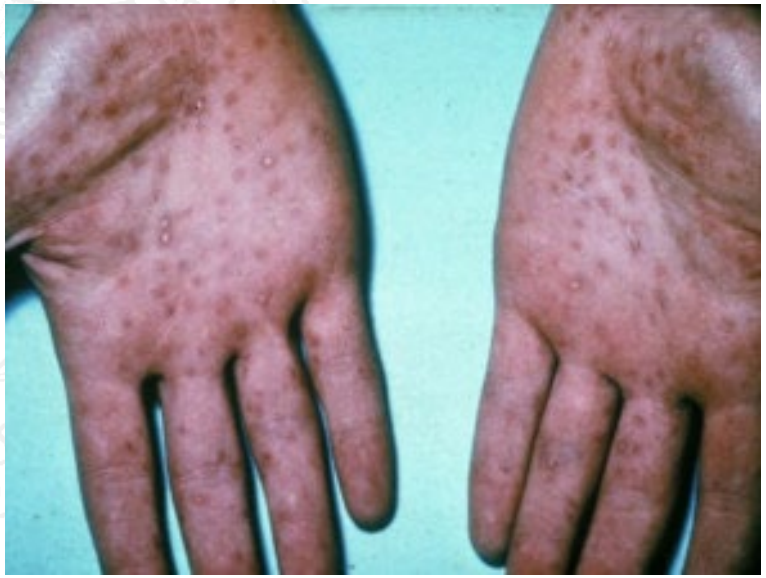
- HIV DNA PCR performed at birth, 2 weeks, 2 months, 4 months
- HIV Ab performed at 18mo-2yo

- Birth PCR positive= congenital infection
  - Peripartum interventions cannot mitigate infection
- Later PCR positive= peripartum infection
  - Peripartum interventions can prevent

MATERNAL CHILD AND ADOLESCENT/ADULT CENTER
FOR INFECTIOUS DISEASES & VIROLOGY

Risk factors syphilis transmission

- Highest risk with primary & secondary syphilis (60-100% transmission)
- Next highest risk early latent syphilis (40%)
- Latent syphilis still with risk of ~8%



Congenital Syphilis Follow-up

- Routine well-child care
- Monitor development
- Repeat testing at 3-6mo to ensure non-reactive
- If persistently abnormal after 6mo, then retreatment and repeat evaluation is mandated

Prevention Strategies Perinatal HIV and Syphilis

- Prioritization of cisgender women with HIV of childbearing age and those who are pregnant for HIV-related services
  - Offer case management for pregnant clients with HIV
  - If client appears out of care or in need of assistance, offer to assist with range of services
  - Post-partum follow-up is important
- Prioritization of cisgender women with syphilis of childbearing age and those already pregnant
- Routine case conferences: root cause analysis
- Incentives and transportation available
- Street medicine—reaching patients where they are
- Partner/contact tracing and treatment, linkage to care

Prevention Strategies Perinatal HIV and Syphilis

USC University of Southern California

MATERNAL CHILD AND ADOLESCENT/ADULT CENTER FOR INFECTIOUS DISEASES & VIROLOGY

- Strengthening County-wide partnerships
  - State and neighboring LHDs, includes cluster-related activities
  - Other DPH departments: Syphilis and HIV need to work more closely
  - Homeless services providers, street medicine
- Established a weekly huddle and case review
- Reestablishing the Perinatal HIV Stakeholder Workgroup
  - Goals include updating LAC Standards for Perinatal HIV Prevention and Care and creating coordination of care guidelines and a resource guide for LAC providers
- Provider outreach and TA to high priority clinics and hospitals
  - Enhanced messaging re: HIV and syphilis/STI testing recommendations during pregnancy
  - Pregnancy reporting processes and expectations
  - Working with L+Ds and NICUs
- Increased provision of PrEP and PEP through ED, UCC, VIP, juvenile hall/jails, ACT Clinic, street medicine

Women's Caucus-Key Highlights and Ideas for Directives

Top services identified by MCA and UCLA Clients: 1) family housing; 2) transportation; 3) benefits specialty; 4) mental health and substance use services

Directives ideas:

1. Augment contracts to add childcare and transportation to facilitate consistent engagement in care; this strategy would avoid releasing a stand alone RFP for childcare and transportation; service providers should be given the flexibility to provide these services to all female or (or male clients with children) and get reimbursed for the services; could be a budget line item.

2. Fund more family housing for women and men with children.

3. Expand flexibility to provide emergency financial support for women and families. This too could be a contract augmentation. This is a strategy to keep people housed and prevent homelessness.

4. Fund women and family focused housing specialist

5. Advertise services; create resource directories for women. Women simply do not know where to go for services; make it available in print, online, and apps.

6. Provide comprehensive care including mental health at women-friendly clinics so that they don't have to travel to another location.

7. Fee for service is a barrier for agencies—assess the impact of the fee for service structure service delivery and quality of care

8. Fund mobile teams or mobile care units to serve women. Mobile teams would be available for all agencies and can link women to services; mobile teams would go to where women are at instead of expecting them to travel to multiple sites. Study Max-Plus model from Seattle

9. Support one stop care sites for women and families.

10. Fund psychosocial services and support groups for women

11. Prevention services are typically male centric; need to create women-centered prevention services; many do not see them as "at-risk"

12. Have DHSP assess how funded agencies are addressing the needs of women; offer training for those requiring support and coaching.

13. Require that all contracted agencies create community advisory boards with women and/or give them meaningful roles in quality improvement committees.

14. Embed women-centered prevention services outside of usual HIV service agencies, such as domestic violence shelters and family planning clinics.

15. DHSP work with AETC to build upon public health detailing and train providers on what women-centered services look like (specific skill sets and service outcomes)

Other issues:
Some providers do not refer clients to other agencies for fear of losing that client/revenue. Address territorialism.

LOS ANGELES COUNTY
COMMISSION ON HIV

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October 9, 2020

To: Mario J. Perez, Director of HIV and STD Programs (DHSP), Department of Public Health

From: Alvaro Ballesteros and Bridget Gordon, Co-Chairs, Commission on HIV

Re: Program Directives for Maximizing Ryan White Part A and MAI Funds for Program Years 30, 31, 32

In keeping with the Commission on HIV's commitment to engage in multi-year priority setting and resource allocation planning for the next three years, the PP&A Committee has developed a set of program directives for program years (PY) 30, 31, and 32. The multi-year service rankings and allocations aim to assist DHSP in your programmatic planning and initiating the solicitations process so that services are in place by the start of the upcoming Ryan White program years.

Part A Planning Councils are required to "establish priorities for the allocation of funds within the eligible area, including how best to meet each such priority and additional factors that a Recipient should consider in allocating funds under a grant based on numerous factors including: "size and demographics of the population of individuals with HIV disease;" "priorities of the communities with HIV disease;" and "capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities."

Along with service priorities, the Planning Council (i.e., Commission on HIV) gives the Recipient (i.e., Division of HIV and STD Programs) directives for how to best meet the priorities. Directives are instructions that the Recipient must follow in developing requirements for providers for use in procurement and contracting. While the Planning Council has no involvement in the procurement process, it is responsible for providing guidance on service models or strategies, population priorities, and methods for overcoming barriers to care. (Mosaica for the HRSA/HAB TAC – 2007 – TARGET Center – http://careacttarget.org)
This document is a comprehensive list of program directives for the Division of HIV and STD Programs (DHSP) aimed at informing the design and implementation of HIV/STD program and service delivery in Los Angeles County (LAC). The Commission on HIV will review the document at least annually to ensure

alignment with funding, priorities, service needs and opportunities to advance the goals of ending the HIV epidemic in Los Angeles County.

Based on epidemiological data, the disproportionately impacted populations in Los Angeles County are **young MSM (YMSM), African American MSM, Latino MSM, and transgender persons**. Given the physiologic role that sexually transmitted diseases (STDs) play in HIV transmission, it is recognized that maximizing HIV prevention will require significant reduction in syphilis and gonorrhea cases, among these aforementioned groups and **women of color** (LACHAS, pg. 14).

The 2019 HIV Surveillance Report notes following areas of disparities:

- Largest gaps in awareness of HIV-positive status existed for persons aged <35 years, where over 50% of HIV-infected persons aged 13-24 years and one third of HIV-infected persons aged 25-34 years were unaware of their infection. Disparities also existed for persons who inject drugs (PWID), with over one-third of HIV-infected PWID unaware of their HIV-positive status and only 55% having been tested for HIV in the past 12 months.

- There are continued disparities in HIV diagnosis by population and geographic location. Rates of new HIV diagnosis are higher among men than women. Across age groups, young men aged 20-29 years and women aged 30- 39 years had highest HIV diagnosis rates. Black men and women had higher rates of HIV diagnosis compared with other race/ethnicity groups. Among men the highest rates of diagnoses were seen in the Central, South, and Hollywood-Wilshire Health Districts, and the highest rates for women were seen in the Central, South, and Southeast Health Districts.

- Populations with lowest achievements in linkage to care were females, Blacks, adolescents, persons aged ≥ 60 years, and persons with injection drug use (IDU) or heterosexual transmission risk. Health Districts with greatest need for interventions to improve linkage to HIV care services were Antelope Valley, El Monte, and South Health Districts where linkage rates were ≤ 70%.

- Approximately 9 in 10 people living with diagnosed HIV were on HIV treatment. Of those, 8 in 10 had adhered to their drugs in the past 3 days. Treatment coverage was lowest for Black populations and persons aged < 40 years, while adherence was lowest for younger persons aged <30 years and the Latinx population.

- Greatest disparities in viral suppression were among Black populations, females, persons aged 30-49 years, and persons whose transmission risk included injection drug use. Geographically, unsuppressed viral load was highest in the Central Health District, followed by South, Southeast, Hollywood-Wilshire, and West Health Districts.

With the unprecedented opportunity and infusion of additional resources to end the HIV epidemic in the next 10 years, we recommend that Ryan White funded services be expanded to address the unacceptable disparities in HIV health outcomes (both prevention and care) that continue to persist for African Americans, Latinos, transgender individuals and youth. Furthermore, funds released under the HRSA NOFO 20-078, should be used to overcome income

and service standards restrictions set forth under the Ryan White Part A requirements. Given the more flexible nature of the HRSA Ending the HIV Epidemic dollars, every effort should be made to fund previously prohibited items that would help achieve optimal health for PLWH. These items include but are not limited to, refrigerators for food, ability for providers to procure dental chairs, computers, and other equipment necessary to expand access to services.

It is important to note that during the Committee's service ranking deliberations, the consumers, ranked housing as their number one service need for PY 31 and 32. This speaks to the need for keeping PLWH stably housed to support their retention to care, viral suppression and overall health. Medical/outpatient care also remains a top priority for consumers.

The program directives below expand on the directives sent to DHSP on April 23, 2019:

1. Across all funding sources, prioritize investments in populations most disproportionately affected and in health districts with the highest disease burden and prevalence, where service gaps and needs are most severe.

2. Implement the recommendations developed by the Black/African Community (BAAC) Task Force (TF) which set a progressive and inclusive agenda to eliminate the disproportionate impact of HIV/AIDS/STDs in all subsets of the African American/Black diaspora. PP&A is calling special attention to the following recommendations from the BAAC TF as key priorities for RFP development, funding, and service implementation starting in 2020:

    - Require contracted agencies to complete training for staff on cultural competency and sensitivity, implicit bias, medical mistrust and cultural humility. DHSP should work with the Black/African American community as subject matter experts in developing training materials and curriculum.
    - In collaboration with the Black/African American community, conduct a comprehensive needs assessment specific to all subsets of the Black/African American population with a larger sample size. Subgroups include MSM, transgender masculine and feminine communities, and women.
    - Assess available resources by health districts by order of high prevalence areas.
    - Conduct a study to identify out of care individuals, and populations who do not access local services and why they do not.
    - Fund mental health services for Black/African American women that are responsive to their needs and strengths.
    - Ear mark funds for peer support and psychosocial services for Black gay and bisexual men.
    - It is recommended that DHSP collaborate with SBP to convene subject matter experts from the African American community to ensure that mental health and psychosocial support services are culturally tailored to the needs of the community.

3. Provide Non-Medical Case Management services in non-traditional and traditional

locations to support improved service referrals and access points to Ryan White services for identified priority populations, such as young men who have sex with men (YMSM), African American men and women, Latinx communities, transgender individuals, and older adults.[1]

4. Continue to enhance Foodbank and Home Delivered Meals services to include dietary guidance, better quality foods (specifically more high quality nutrient rich fruits, vegetables and lean proteins), and increase the amount of food available for clients based on their individual needs or by gaps observed or reported by agencies and clients; cover essential non-food items such as personal hygiene products (to include feminine hygiene items), household cleaning supplies, and personal protective equipment (PPE). Permit contracted agencies to provide grocery, gas, and transportation support (e.g., Metro Tap cards, ride share services) to clients to facilitate expanded access to food.

5. Support intensive case management services for people living with HIV served in Ryan White HIV housing programs and increase target number of clients served during the reallocation process. Funds should also be used to support additional training for housing specialists to serve the housing needs of families.

6. Continue to support the expansion of medical transportation services.

7. Continue efforts to develop Ryan White client eligibility cards and welcome packets, with information on Ryan White-funded services in Los Angeles County; train providers on the use of eligibility cards to reduce paperwork burden on clients. Develop and implement eligibility cards without the need to issue a Request for Proposals (RFP) to hasten distribution of eligibility cards as stated by DHSP representatives.

8. Augment contracts to permit agencies to have an operational line item budget for childcare and transportation to facilitate consistent engagement in care and support services. This strategy would avoid releasing a stand-alone RFP for childcare and transportation and give service providers the flexibility to provide these services to all clients with children.

   Expand flexibility to provide emergency financial support for PLWH. Augment Medical Case Management/Medical Care Coordination services to include Emergency Financial Assistance (EFA) and Childcare services. Priority populations such as women and their families, YMSM and transgender women, may have unique needs for emergency financial assistance due to domestic and intimate partner, or community violence.

9. Fund mobile care teams or clinics that provide holistic care for women. Mobile teams should be available for all agencies and link women to services where they reside, congregate, or prefer to be engaged.

10. Fund psychosocial services and support groups for women. Psychosocial support services must

[1] The Aging Task Force will provide further guidance on the age parameters for "older adults."

include peer support in order to build a stronger sense of community, empowerment and resilience among women living with HIV.

In order to inform the Commission's planning efforts around HIV/STD prevention and care services, we direct DHSP to provide written fiscal reports and status updates on these directives to the PP&A Committee and full Commission on a regular basis.

In support of the recommendations from the PP&A Committee, Standards and Best Practices (SBP) will continue updating and/or developing service standards for the following service categories. These service categories were prioritized by the PP&A Committee as recommended by DHSP and because of the feasibility of releasing solicitations in 2020-2022. Status updates on the development of service standards are noted below.

1. **Universal Service Standards -**Completed; updated and approved on 9/12/19
2. **Non-Medical Case Management –** Completed; updated and approved on December 12, 2019
3. **Psychosocial Support -**in progress and on the 9/10/20 Commission agenda for approval
4. **Emergency Financial Assistance –** Completed; approved by the Commission on 6/11/20
5. **Childcare** - in progress; public comment period 9/11-9/23; target month for Commission approval is October/November

The Commission is committed to ongoing collaborations with DHSP and we seek your feedback on how we can work together to implement these directives. We thank DHSP for ongoing regular progress reports on implementing directives and efforts to maximize Ryan White funds and activities to end the HIV epidemic. Furthermore, we appreciate feedback from DHSP in updating service standards. Thank you, we appreciate the ongoing partnership and support from you and your staff.

cc: Raquel Cataldo, PP&A Co-Chair
Kevin Stalter and Erika Davies, SBP Committee Co-Chairs
Miguel Martinez and Jason Brown, 2019 PP&A Committee Co-Chairs

ATTACHMENT: Black/African American Task Force Recommendations

Attachment

(REVISED) Black/African American Community (BAAC) Task Force Recommendations

October 10, 2019

Introduction

The BAAC Task Force was formed in response to the Commission on HIV's (COH) February 14, 2019 National Black HIV/AIDS Awareness Day (NBHAAD) Panel discussion in an effort to address the disproportionate impact of HIV/AIDS in the Black/African American (AA) communities of Los Angeles County.

The BAAC Task Force convened on April 30, 2019 to develop a progressive and inclusive agenda to address and provide recommendations to the COH on how to reduce and ultimately eliminate the disproportionate impact of HIV/AIDS and STIs in all subsets of the Black/AA community utilizing a community-wide mobilization effort.

Healthcare Disparities in the Black/AA Community

The United States Census Bureau estimates Black/AA living in Los Angeles County (LAC) at 9% or approximately 909,500 as of 2018.(1) In 2017, there were 51,438 persons living with diagnosed HIV (PLWH) in LAC. **Twenty percent (20%) were Black/AA.**(2)

In 2016, **the highest overall rate of HIV diagnoses was among African Americans (56 per 100,000)**, followed by Latinos (19 per 100,000), whites (12 per 100,000), and Asians (6 per 100,000). These differences in rates were also observed by sex, most notably among **African American females (17 per 100,000) where the rate of HIV diagnoses** was 8 times higher than that of white females (2 per 100,000) and 5 times higher than the rate for Latinas (3 per 100,000). Among **males**, the rate of HIV diagnoses among **African Americans (101 per 100,000)** was 5 times higher than among whites (22 per 100,000) and 3 times higher than the rate for Latinos (34 per 100,000).(2)

The highest rate of stage 3 diagnoses (Acquired Immunodeficiency Syndrome) (AIDS) **was among African Americans (18 per 100,000).** The rate of stage 3 diagnoses for **African American females (6 per 100,000)** was 9 times higher than the rate for white females (<1 per 100,000) and 3 times higher than the rate for Latinas (2 per 100,000). Among **males**, the rate of stage 3 diagnoses for **African Americans (32 per 100,000)** was 4 times higher than the rate for whites (9 per 100,000) and 3 times higher than the rate for Latinos (13 per 100,000).(2)

Black/AA Care Continuum as of 2016[3]

Demographic Characteristics	Diagnosed/Living with HIV	Linked to Care ≤30 days	Engaged in Care	Retained in Care	New Unmet Need (Not Retained)	Virally Suppressed
Race/Ethnicity						
African American	**9,962**	**54.2%**	**65.9%**	**49.7%**	**50.3%**	**53.0%**
Latino	21,095	65.4%	68.3%	55.7%	44.3%	59.7%
Asian/Pacific Islander	1,710	80.5%	74.6%	60.5%	39.5%	68.5%
American Indian/Alaskan Native	294	75.0%	70.1%	54.10%	45.9%	52.4%
White	14,778	75.2%	71.6%	54.5%	45.5%	64.9%

The Ryan White (RW) program in LAC served 15,747 individuals between March 1, 2018 and February 28, 2019. Three-thousand three-hundred sixty (3,360) were Black/AA during the same period.[4]

Objectives:

- **Identify** strategies on how the COH can support Black/AA leaders and community stakeholders in an effort to end HIV in the Black/AA community
- **Identify** HIV prevention, care and treatment best practices in the Black/AA community
- **Identify** specific strategies to reduce HIV stigma in the Black/AA community

General/Overall Recommendations:

1. Provide on-site cultural sensitivity and education training – to include addressing implicit bias and medical mistrust within the Black/AA community – for all County-contracted providers and adopt cultural humility into the local HIV provider framework. *Decision makers must realize their own power, privilege and prejudices and be willing to accept that acquired education and credentials alone are insufficient to address the HIV epidemic in the Black/AA community.*

2. Revise messaging County-wide around HIV to be more inclusive, i.e., "If you engage in sexual activity . . . you're at risk of HIV" in an effort to reduce stigma.

3. Incorporate universal marketing strategies for HIV prevention that appeal to all subsets of the Black/AA community in an effort to reduce stigma and increase awareness.

4. Provide resources to Community-Based Organizations (CBOs) to develop, implement and evaluate primary prevention interventions which are culturally appropriate and relevant.

5. Support young people's right to the provision of confidential sexual health care services.

6. Increase Pre-exposure Prophylaxis (PrEP) advertising within the Black/AA community to increase awareness. Marketing materials must depict the very community it is attempting to reach - specifically, Black/AA youth, women, transgender individuals, and gender nonconforming populations.

7. Initiate or partner in culturally informed research that aims to address the needs of the Black/AA communities. Researchers, whenever possible, must mirror the affected community it purports to study. Community reflectiveness in academic and CBO partnerships should include training in instrument development, data interpretation, presentations and publications.

8. Increase use of local statistics regarding new infections and disparities to educate and plan for the community; request Department of Public Health data be organized by Health Districts and zip codes to better target and identify communities in need.

9. Provide technical assistance to aid Black/AA agencies in obtaining funds for culturally sensitive services.

10. Proactively reach out to engage CBOs that are connected to the local Black/AA community.

11. End the practice of releasing Request for Proposals (RFPs) that have narrowly defined "Proposer's Minimum Mandatory Requirements." *This discriminatory practice purposely disqualifies existing relevant CBOs and other agencies that provide intersection health and human services.* When issuing RFAs, RFPs, or RFSQs, establish a demonstration/data pilot by creating a 15% funding carve-out for CBO's/ASO's, whose qualifications are below the "Minimum Mandatory Requirements", but at an agreed upon standard, to identify the proven and effective grassroots/community empowerment efforts that reach specified Black/AA audiences. This will allow DHSP in collaboration with the Commission to determine the efficacy of methodologies for outreach, linkages to care, retention in care, and other sensitive treatment and prevention interventions that are effective in reducing new HIV cases.

12. Continue to evaluate for effectiveness and increase the investment in Vulnerable Populations Grants that target subset populations of the Black/AA community (i.e. Trans men/women, women & girls, MSM) to address barriers and social determinates of health.

13. Engage agencies already funded as well as those not currently funded to focus on a Countywide PrEP Education and Outreach mini-grant process that will target all various subset populations of the Black/AA community, i.e. Trans community, women & girls, MSM.

14. Increase mobilization of community efforts to include:
    a. Increase community awareness fairs and social media campaigns intended to promote health and wellness in the Black/AA community, with concentration in high incidence areas;
    b. Condom distribution in spaces where adults congregate;
    c. HIV education and access to prevention tools in schools, spiritual communities, social clubs, neighborhood associations, etc.;
    d. Fund one social marketing campaign that addresses stigma and internalized homophobia as it relates to health and wellness around HIV;
    e. Support efforts that will ensure additional research and evaluation support be made available to agencies that provide services to the Black/AA community and to increase their capacity to link and collaborate with research institutions; and
    f. Provide training and incentives for CBOs within high incidence areas to prescribe PreP and nPep.

Population-Specific Recommendations:

Black/African American Trans Men:

The Ryan White (RW) program in LAC served 96 Black/AA Transgender persons during the period of March 1, 2018 to February 28, 2019. This was approximately .6% of the total PLWH/A in LAC.(4)

1. Conduct a Countywide needs assessment of the Trans masculine community that focuses on sexual risk behaviors.
2. Use Williams Institutes' research/data using Sexual Orientation Gender identity (SOGI) (method agencies use to collect patient/client data on sexual orientation and gender identity) to develop Trans male-specific programming.
3. Include Trans men in program decision making.
4. Develop a Trans masculine-specific PrEP campaign which will resonate with and reach Trans men in such a way that the message is not convoluted and therefore lost within the overall PrEP messaging. Messaging should include language around safety and gender affirmation - a campaign that says "Trans masculine individuals . . . this is for YOU." Perhaps include a myth buster around the notion that all Trans men are straight and only date and are sexually involved with cis men; a message that says we know sexual appetites are fluid for Trans men and that is why PrEP is important.
5. Educate/train medical and mental health providers to be more inclusive of Trans masculine bodies and its many different nuances.

6. Create a pilot/demonstration project using the information obtained from the various data sources listed above.

Black/African American Trans Women:

The Ryan White (RW) program in LAC served 96 Black/AA Transgender persons during the period of March 1, 2018 to February 28, 2019. This was approximately .6% of the total PLWH/A in LAC.(4)

1. Conduct a Countywide needs assessment of the Trans women community to address barriers and social determinants of health to better provide more targeted programming.
2. Increase efforts in collecting epidemiological data through surveillance on Trans women for purposes of planning more targeted programming.
3. Use William's Institutes' research/data using SOGI (method agencies use to collect patient/client data on sexual orientation and gender identity) to develop Trans women-specific programming.
4. Include and prioritize Trans women in program decision making.
5. Address stigma and the increasing violence against Trans women.

Black/African American Women and Girls: *(DHSP defined Black/AA women and girls as either childbearing women between the ages of 15-44 and those 50 Years and Older)*

The Ryan White (RW) program in LAC served 501 Black/AA women during the period of March 1, 2018 to February 28, 2019. This is approximately 31.82% of those receiving RW services.(4)

1. Evaluate existing PrEP and prevention access and messaging for impact on intervention groups and community health; assess dissemination methodologies and refine outreach and engagement strategies.
2. Allocate resources to create a PrEP Center for Excellence targeting women and their families, sexual and social networks.
3. Conduct an inventory of County-wide HIV/STD interventions and initiatives that target African American women at risk of and living with HIV that focus on education, employment services, empowerment, co-infections, treatment as prevention (TAsP), sexual reproductive health, intimate partner violence, and mental health.
4. Obtain data for all populations of women, especially those who are pregnant or such age groups affected by the high rates of STIs; include women-specific data in summits, reports, and community forums.

5. Reorganize and adopt educational approaches to care and prevention that incorporate information and knowledge on how preventative methods can benefit the woman within the context of her life. Such approaches include but should not be limited to:
   a. Integrate train-the-trainer models for community health outreach workers and testing staff that use motivational and empowerment strategies as a tool for risk reduction. Generating collective approaches and solutions that promote honesty and integrity within self and relationships with others is paramount. Hold agencies accountable to host honest adult conversations and have the courage to meet people where they are and build on what they know.
   b. Generate collective approaches and solutions that promote honesty and integrity of self and relationships with others is paramount; and
   c. Train community health outreach workers in all HIV Testing Sites to have conversations that validate the experience and power dynamics women confront within their relationships. Most often partners are missing from engagement, enrollment, and retention strategies. Include sexual and social networks in education, outreach, testing and other interventions that support family sustainability as a method of retention.

6. Allocate money to partner with institutions to support three demonstration projects at $250,000 each led and facilitated by and for Black women:
   a. Ensure agencies have tools available to demonstrate accountability and cultural competence. Staff should be linguistically and culturally representatives of the community and any intervention include a navigation component to address barriers to recruitment, uptake and retention of prevention and care based programming.
   b. All protocols should explicitly embrace the experience of women who have sex with men of known or unknown status as well as those diagnosed with HIV/AIDS. Further, qualitative interviews or Audio Computer-Assisted Self-Interview (ACASI) instruments should include an assessment of historical care and prevention participation as well as barriers to continuous engagement and participation.

7. Strategically reflect the needs of women in the jurisdictional stigma reduction efforts by funding projects that reduce stigma and increase access to female controlled HIV preventive tools such as Pre-Exposure Prophylaxis (PrEP), Post Exposure Prophylaxis (PEP), and the Female Condom 2 (FC2). Support agencies to integrate comprehensive opportunities for education, research and a complement to other strategies that give women the power to take control of their lives and situations in which have historically had little to no influence.

8. Expand the availability of community-based mental health services as a part of a continuous effort to treat women holistically: HIV and mental health education and awareness should accompany a range of holistic services that recognize that a woman may have multiple traumas that inform her choices. Increased collaborations between community and the private sector which is necessary to build awareness and reduce cultural and social based stigmas associated with mental health care. Increased education and training of non-HIV/AIDS service providers in hopes of offering a full circle of multidisciplinary services to those in need.

9. Develop a standard requiring all contracted organizations offer living wages as an incentive to hiring persons with lived experience. Initiating programming for Black women enables organizations to invest in their peers. Further, increased access to professional development opportunities and resources (ex. Income) enables them to self-sustain and decrease the impact that social correlates of health such as poverty have on informed sexual decision making.

<u>Black/African American Men Who Have Sex with Men (MSM):</u>

The Ryan White (RW) program in LAC served 2,093 Black/AA MSM during the period of March 1, 2018 to February 28, 2019. This was approximately 13.3% of those receiving RW services. (4)

1. Continue to increase the investment in innovative layered interventions that target young MSM and address barriers and social determinates of health like the Vulnerable Populations Grant.

2. Develop and release of Request for Application/Request for Proposal (RFA/RFP) that focuses on HIV positive MSM of all ages who are sexually active and at risk of co-infections.

3. Increase funding and resources in treatment as prevention, social support efforts, housing and mental health services.

4. Address Chemsex within the Black/AA MSM community through CBO led group sessions, evidence-based medicine directed intervention and medication assisted treatment.

Conclusion

Only by genuinely addressing the recommendations as provided above can the Los Angeles County HIV/AID Strategy (LACHAS) goals be met. Many of the recommendations provided are in alignment with the LACHAS and the County's Comprehensive HIV Plan (CHP), however, there must be very intentional and targeted efforts made to address social determinants, primarily stigma and racism, in the Black/AA communities. It is not enough to implore the same strategies of old; we must modernize methodologies in our marketing strategies to reach subpopulations within the Black/AA communities who do not identify according to current messaging. Messaging must be *truly* inclusive – "if you are sexually active, you are at risk".

The adage is true – "to reach them, you have to meet them where they are" - HIV and sexual health education along with HIV prevention interventions must be accessible in schools, jails, churches, barber/beauty shops, and social venues where Black/AA communities gather; while providers must be trained and educated to understand the various cultural nuances that can either stigmatize and subsequently discourage or create a culturally welcoming environment for Black/AA communities to access HIV prevention, care and treatment services.

On behalf of the BAAC Task Force, we thank the Executive Committee for its consideration of the above recommendations and look forward to its plan of action in response.

Special thanks to the following BAAC Task Force members and community stakeholders who volunteered their time and contributed to the development of recommendations: Greg Wilson (COH), Traci Bivens-Davis (COH), Bridget Gordon (COH), Dr. LaShonda Spencer (COH), Danielle Campbell (COH), Yolanda Sumpter (COH), Dr. William King (COH), Cynthia Davis (AHF), Luckie Fuller (COH), Jeffrey King (ITMT), Louis Smith III, Stevie Cole, Ivan Daniel III, Carl Highshaw (AMAAD Institute), Charles McWells (LACADA), Dr. Derrick Butler (THE Clinic), David Lee (CDU), Rev Russell Thornhill (MAPP), Terry Smith (APLA), Doris Reed (COH), Carolyn Echols-Watson (COH) and Dawn Mc Clendon (COH).

Endnotes

1. Census.gov/quickfacts/fact/table/losangelescountycalifornia; RH1225218
2. 2017 Annual HIV Surveillance Report; Ryan White program Clients Living with HIV YR 28 (03/01/2018 – 02/28/19)[i]
3. Los Angeles County HIV/AIDS Strategy (LACHAS) – P26; Table 5
4. Ryan White Program Clients YR 28 (3/1/18-2/28/19) Los Angeles County; Utilization by Service Category among Ryan White Priority Populations in Year 28

Program Directives for Maximizing Ryan White Part A and MAI Funds for Program Years 30, 31, 32
Status Updates from the Division of HIV and STD Programs (DHSP)

DIRECTIVE	DHSP RESPONSE/STATUS UPDATE
1. Across all funding sources, prioritize investments in populations most disproportionately affected and in health districts with the highest disease burden and prevalence, where service gaps and needs are most severe.	Solicitations are composed using the latest data, which reflect the geography and other demographics of target populations
2. Implement the recommendations developed by the Black/African Community (BAAC) Task Force (TF) which set a progressive and inclusive agenda to eliminate the disproportionate impact of HIV/AIDS/STDs in all subsets of the African American/Black diaspora. PP&A is calling special attention to the following recommendations from the BAAC TF as key priorities for RFP development, funding, and service implementation starting in 2020:	
• Require contracted agencies to complete training for staff on cultural competency and sensitivity, implicit bias, medical mistrust and cultural humility. DHSP should work with the Black/African American community as subject matter experts in developing training materials and curriculum.	In progress. Some training resources still need to be identified and tested.
• In collaboration with the Black/African American community, conduct a comprehensive needs assessment specific to all subsets of the Black/AfricanAmerican population with a larger sample size. Subgroups include MSM, transgender masculine and feminine communities, and women.	This should be included in the needs assessments conducted as part of the formative work for the development of the comprehensive plan.
• Assess available resources by health districts by order of high prevalence areas.	
• Conduct a study to identify out of care individuals, and populations who do not access local services and why they do not.	
• Fund mental health services for Black/African American women that are responsive to their needs and strengths.	Is there a different standard of care for these services for this population?

• Earmark funds for peer support and psychosocial services for Black gay and bisexual men. • It is recommended that DHSP collaborate with SBP to convene subject matter experts from the African American community to ensure that mental health and psychosocial support services are culturally tailored to the needs of the community.	Must be allocated by PP&A. DHSP relies on SBP for guidance.
3. Provide Non-Medical Case Management services in non-traditional and traditional locations to support improved service referrals and access points to Ryan White services for identified priority populations, such as young men who have sex with men (YMSM), African American men and women, Latinx communities, transgender individuals, and older adults (over 50 yrs).	Commission must allocate funds for these programs.
4. Continue to enhance Foodbank and Home Delivered Meals services to include dietary guidance, better quality foods (specifically more high quality nutrient rich fruits, vegetables and lean proteins), and increase the amount of food available for clients based on their individual needs or by gaps observed or reported by agencies and clients; cover essential non-food items such as personal hygiene products (to include feminine hygiene items), household cleaning supplies, and personal protective equipment (PPE). Permit contracted agencies to provide grocery, gas, and transportation support (e.g., Metro Tap cards, ride share services) to clients to facilitate expanded access to food.	DHSP has used EHE and HRSA CARES funds to improve capacity to store perishable, nutritious foods, and increase variety and quality of food available consistently.
5. Support intensive case management services for people living with HIV served in Ryan White HIV housing programs and increase target number of clients served during the reallocation process. Funds should also be used to support additional training for housing specialists to serve the housing needs of families.	The entire housing portfolio needs to be examined in order to determine where DHSP's limited housing resources can have the most impact.
6. Continue to support the expansion of medical transportation services.	In progress
7. Continue efforts to develop Ryan White client eligibility cards and welcome packets, with information on Ryan White-funded services in Los Angeles County; train providers on the use of eligibility cards to	In progress

reduce paperwork burden on clients. Develop and implement eligibility cards without the need to issue a Request for Proposals (RFP) to hasten distributionof eligibility cards as stated by DHSP representatives.	
8. Augment contracts to permit agencies to have an operational line item budget for childcare and transportation to facilitate consistent engagement in care and support services. This strategy would avoid releasing a stand-alone RFP for childcare and transportation and give service providers the flexibility to provide these services to all clients with children. Expand flexibility to provide emergency financial support for PLWH. Augment Medical Case Management/Medical Care Coordination services to include Emergency Financial Assistance (EFA) and Childcare services. Priority populations such as women and their families, YMSM andtransgender women, may have unique needs for emergency financial assistance due to domestic and intimate partner, or community violence.	Childcare solicitation is nearly complete. EFA program is in place.
9. Fund mobile care teams or clinics that provide holistic care for women. Mobile teams should be available for all agencies and link women to services where they reside, congregate, or prefer to be engaged.	Need more information on what this would look like.
10. Fund psychosocial services and support groups for women. Psychosocial support services must include peer support in order to build a stronger sense of community, empowerment and resilience among women living with HIV.	Commission should allocate funds accordingly.