LOS ANGELES COUNTY
COMMISSION ON HIV

Visit us online: http://hiv.lacounty.gov
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PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
Virtual Meeting
Tuesday, December 15, 2020
1:00PM-3:00PM (PST)

Agenda + Meeting Packet will be available on the Commission's website at:
http://hiv.lacounty.gov/Planning-Priorities-and-Allocations-Committee

REGISTER VIA WEBEX ON YOUR COMPUTER OR SMART PHONE:

https://tinyurl.com/yxfrpdmz

**Link is for non-Committee members only*

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LOS ANGELES COUNTY
COMMISSION ON HIV

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

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

TUESDAY, December 15, 2020|1:00 PM – 3:00 PM

To Join by Computer: https://tinyurl.com/yxfrpdmz

To Join by Phone: 1-415-655-0001
Access code: 145 534 3119

Planning, Priorities and Allocations Committee Members:			
Al Ballesteros, Acting Co-Chair	Raquel Cataldo, Co-Chair	Everardo Alvizo	Frankie Darling Palacios
Joseph Green	Karl T. Halfman	Diamante Johnson (Alt. Kayla Walker-Heltzel)	William King, MD, JD
Miguel Martinez, MPH, MSW	Anthony M. Mills, MD	Derek Murray	LaShonda Spencer, MD
Maribel Ulloa	DHSP Staff		
QUORUM:	8		

Due to COVID-19, quorum requirement suspended for teleconference meetings per Governor Newsom's Executive Order N-25-20

AGENDA POSTED December 10, 2020 *Second Co-Chair seat currently vacant.

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

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

Los servicios de interpretación para personas con impedimento auditivo y traducción para personas que no hablan Inglés están disponibles sin costo. Para pedir estos servicios, póngase en contacto con Comisión en HIV al (213) 738-2816 (teléfono), o por correo electrónico á hivcomm@lachiv.org, por lo menos 72 horas antes de la junta.

SUPPORTING DOCUMENTATION can be obtained at the Commission on HIV Website at: http://hiv.lacounty.gov. The Commission Offices are located in Metroplex Wilshire, one building west of the southwest corner of Wilshire and Normandie. Validated parking is available in the parking lot behind Metroplex, just south of Wilshire, on the west side of Normandie.

NOTES on AGENDA SCHEDULING, TIMING, POSTED and ACTUAL TIMES, TIME ALLOTMENTS, and AGENDA ORDER: Because time allotments for discussions and decision-making regarding business before the Commission's standing committees cannot always be predicted precisely, posted times for items on the meeting agenda may vary significantly from either the actual time devoted to the item or the actual, ultimate order in which it was addressed on the agenda. Likewise, stakeholders may propose adjusting the order of various items at the commencement of the committee meeting (Approval of the Agenda), or times may be adjusted and/or modified, at the co-chairs' discretion, during the course of the meeting.
If a stakeholder is interested in joining the meeting to keep abreast of or participate in consideration of a specific agenda item, the Commission suggests that the stakeholder plan on attending the full meeting in case the agenda

order is modified or timing of the items is altered. All Commission committees make every effort to place items that they are aware involve external stakeholders at the top of the agenda in order to address and resolve those issues more quickly and release visiting participants from the obligation of staying for the full meeting.

External stakeholders who would like to participate in the deliberation of discussion of an a posted agenda item, but who may only be able to attend for a short time during a limited window of opportunity, may call the Commission's Executive Director in advance of the meeting to see if the scheduled agenda order can be adjusted accordingly. Committee leadership and staff will make every effort to accommodate reasonable scheduling and timing requests—from members or other stakeholders—within the limitations and requirements of other possible constraints.

Call to Order | Introductions | Statement – Conflict of Interest 1:00 P.M. – 1:02 P.M.

I. ADMINISTRATIVE MATTERS 1:02 P.M. – 1:04 P.M.

1. Approval of Agenda **MOTION #1**

2. Approval of Meeting Minutes **MOTION #2**

II. PUBLIC COMMENT 1:04 P.M – 1:06 P.M.

3. Opportunity for members of the public to address the Committee on items of interest that is within the jurisdiction of the Committee.

III. COMMITTEE NEW BUSINESS 1:06 P.M. – 1:10 P.M.

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

IV. REPORTS 1:10 P.M. – 1:20 P.M.

5. **EXECUTIVE DIRECTOR'S/STAFF REPORT**

a. Committee, Caucus, Task Force Updates

6. **CO-CHAIR REPORT** 1:20 P.M. – 1:30 P.M.

a. Committee Co-Chair Nominations/Elections

7. **DIVISION OF HIV AND STD PROGRAMS (DHSP)** 1:30 P.M. – 2:05 P.M.

a. Fiscal Update

b. Contracts and Procurement Update

V. DISCUSSION 2:05 P.M. – 2:35 P.M.

8. Prevention Planning

a. Workgroup Update

i. Structure and Membership
ii. Review Ending the HIV Epidemic (EHE) Plan | Prevention Pillars
iii. Prevention-focused Community Forums among Priority Populations

VI. Discussion

9. Operating Paradigms and Values Review 2:35 P.M. – 2:55 P.M

VI. NEXT STEPS 2:55 P.M. – 2:58 P.M.

10. Task/Assignments Recap

11. Agenda Development for the Next Meeting

VII. ANNOUNCEMENTS 2:58 P.M. – 3:00 P.M.

12. Opportunity for Members of the Public and the Committee to Make Announcements

VIII. ADJOURNMENT 3:00 P.M.

13. Adjournment for the Meeting of December 15, 2020.

PROPOSED MOTION(s)/ACTION(s):	
MOTION #1:	**Approve the Agenda Order, as presented or revised.**
MOTION #2:	**Approve Meeting Minutes as presented.**

LOS ANGELES COUNTY COMMISSION ON HIV

Ending the HIV Epidemic Awards (EHE)| Financial Resources Inventory (created 12/2/20)

Division of HIV and STD Programs, Department of Public Health	
HRSA 20-078	**CDC 20-2010**
Award |$3,083,808 Year 1 (carry over allowable)	**Award | $3,360,658 Year 1**
Contract Term: March 1, 2020-February 28, 2025	**Contract Term**: August 1, 2020-July 31, 2025
Purpose: To link people with HIV who are either newly diagnosed, or are diagnosed but not currently in care, to essential HIV care and treatment and support services, as well as to provide workforce training and technical assistance.	**Purpose:** To implement comprehensive HIV programs, that complement programs, such as the Ryan White program and other HHS programs, designed to support ending the HIV epidemic in America by leveraging powerful data, tools and resources to reduce new HIV infections by 75% in 5 years.

HRSA Primary Care HIV Prevention (PCHP) Awards (1)			
ORGANIZATION NAME	**AWARD AMOUNT**	**RYAN WHITE/DHSP FUNDED SERVICES**	**LOCATION (2)**
AltaMed Health Services Corporation	$417,912	Ambulatory Outpatient Medical (AOM) Benefits Specialty Case Management, Home-Based HIV Testing Storefront Biomedical HIV Prevention Medical Care Coordination (MCC) Mental Health Oral Healthcare Services Transitional Case Management Promoting Healthcare Engagement Among Vulnerable Populations Transportation Services	Los Angeles
APLA Health & Wellness	$261,233	Benefits Specialty Nutrition Support HIV Testing Storefront HIV Testing Social & Sexual Networks STD Screening, Diagnosis and Treatment	

HRSA Primary Care HIV Prevention (PCHP) Awards (1)			
ORGANIZATION NAME	**AWARD AMOUNT**	**RYAN WHITE/DHSP FUNDED SERVICES**	**LOCATION (2)**
		Sexual Health Express Clinics (SHEx-C) Health Education/Risk Reduction Health Education/Risk Reduction, Native American Biomedical HIV Prevention Oral Healthcare Services Ambulatory Outpatient Medical (AOM) Medical Care Coordination (MCC) HIV and STD Prevention Services in Long Beach Transportation Services	
Bartz-Altadonna Community Health Center	$256,071	NOT RYAN WHITE/DHSP FUNDED	Lancaster
Behavioral Health Services Inc	$252,468	NOT RYAN WHITE/DHSP FUNDED	Gardena
Central City Community Health Center Inc	$268,231	STD Screening, Diagnosis and Treatment	Rosemead
T.H.E Clinic	$263,355	Ambulatory Outpatient Medical (AOM) Medical Care Coordination (MCC) Transportation Services	Los Angeles
East Valley Community Health Center, Inc.	$264,715	Ambulatory Outpatient Medical (AOM) Benefits Specialty HIV Testing Storefront Medical Care Coordination (MCC) Oral Healthcare Services	West Covina
El Proyecto Del Barrio, Inc	$268,099	Ambulatory Outpatient Medical (AOM) HIV Testing Storefront Medical Care Coordination (MCC) Oral Healthcare Services	Arleta

HRSA Primary Care HIV Prevention (PCHP) Awards (1)			
ORGANIZATION NAME	**AWARD AMOUNT**	**RYAN WHITE/DHSP FUNDED SERVICES**	**LOCATION (2)**
JWCH Institute, Inc	$289,548	HIV Testing Storefront HIV Testing & Syphilis Screening, Diagnosis, & inked Referral for Treatment Services in Commercial Sex Venues (CSV) STD Screening, Diagnosis and Treatment Health Education/Risk Reduction Mental Health Oral Healthcare Services Transitional Case Management Ambulatory Outpatient Medical (AOM) Benefits Specialty Biomedical HIV Prevention Medical Care Coordination (MCC) Transportation Services	Commerce
Los Angeles LGBT Center	$278,196	Ambulatory Outpatient Medical (AOM) HIV Testing Storefront HIV Testing Social & Sexual Networks STD Screening, Diagnosis and Treatment Health Education/Risk Reduction Biomedical HIV Prevention Medical Care Coordination (MCC) Promoting Healthcare Engagement Among Vulnerable Populations Transportation Services	Los Angeles
Northeast Valley Health Corporation	$329,066	Ambulatory Outpatient Medical (AOM) Benefits Specialty Medical Care Coordination (MCC) Oral Healthcare Services Mental Health Biomedical HIV Prevention STD Screening, Diagnosis and Treatment Transportation Services	San Fernando
St. John's Well Child and Family Center, Inc	$305,039	Ambulatory Outpatient Medical (AOM) Oral Healthcare Services Medical Care Coordination (MCC) Mental Health HIV Testing Social & Sexual Networks Transportation Services	Los Angeles

HRSA Primary Care HIV Prevention (PCHP) Awards (1)			
ORGANIZATION NAME	**AWARD AMOUNT**	**RYAN WHITE/DHSP FUNDED SERVICES**	**LOCATION (2)**
Valley Community Healthcare	$274,893	NOT RYAN WHITE/DHSP FUNDED	N. Hollywood
Venice Family Clinic	$264,541	Ambulatory Outpatient Medical (AOM) Benefits Specialty HIV Testing Storefront Medical Care Coordination (MCC) Mental Health	Venice
Watts Healthcare Corporation	$270,534	Transportation Services Ambulatory Outpatient Medical (AOM) Medical Care Coordination (MCC) Oral Healthcare Services Biomedical HIV Prevention STD Screening, Diagnosis and Treatment	Los Angeles

Footnote:

(1) **HRSA EHE Primary Care HIV Prevention (PCHP) Awards: Purpose-** to expand HIV prevention services that decrease the risk of HIV transmission in geographic locations identified by Ending the HIV Epidemic: A Plan for America, focusing on supporting access to and use of pre-exposure prophylaxis (PrEP). HRSA identified eligible health centers based on service delivery site location, and either existing Ryan White HIV/AIDS Program (RWHAP) funding or proximity to a RWHAP-funded organization. Award recipients will achieve the following objectives: **Outreach:** Engage new and existing patients in HIV prevention services, identifying those at risk for HIV using validated screening tools; **HIV Testing:** Increase the number of new and existing patients tested for HIV; **PrEP Prescriptions:** For persons who test negative, provide HIV prevention education, and prescribe and support the use of clinically indicated PrEP; **Linkage to Treatment:** For persons who test positive, link them to HIV treatment; **Partnerships:** Establish new and/or enhance existing partnerships with health departments, and community and faith-based organizations to support identification of at-risk individuals, testing, linkage to treatment, and other activities that will help achieve the PCHP purpose and objectives; **Personnel:** Within eight months of award, add at least 0.5 FTE personnel who will identify individuals for whom PrEP is clinically indicated and support their access to and use of PrEP.

(2) Organization may have additional locations.

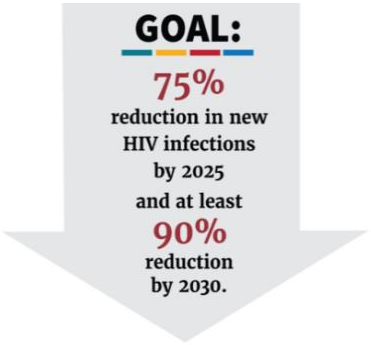
County of Los Angeles - Department of Public Health
Division of HIV and STD Programs

Ending the HIV Epidemic in Los Angeles County
Executive Summary

December 1, 2020

What is Ending the HIV Epidemic?

Ending the HIV Epidemic: A Plan for America (EHE) is a national initiative which focuses on four key pillars of interventions designed to help us reach the goal of reducing new HIV transmissions and acquisitions in the United States by 75 percent in five years (by 2025) and by 90 percent in ten years (by 2030).[i] The four EHE Pillars are: (1) **Diagnose** people living with HIV as early as possible, (2) **Treat** people living with HIV rapidly and effectively to achieve viral suppression, (3) **Prevent** new HIV transmissions using proven interventions, and (4) **Respond** quickly to HIV outbreaks and deliver prevention and treatment services to people who need them. A network of federal partners, including the Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), Indian Health Service (HIS), Substance Abuse and Mental Health Services Administration (SAMHSA), and the Region IX Prevention through Active Community Engagement (PACE) Program, have collaborated to fund and support 57 EHE Phase I priority jurisdictions across the United States to develop and implement strategies that will move us towards an AIDS-free generation. Los Angeles County is one of the 57 priority jurisdictions.



What does HIV look like in Los Angeles County?

In Los Angeles County (LA County) there are approximately 58,000 people living with HIV (PLWH), the majority of these persons are male (90%), a smaller fraction are female (9%) and a smaller number (but highly disproportionate compared to their share of the LA County population) are transgender (either male to female or female to male). The majority of PLWH in LA County are treating their HIV with highly active antiretroviral therapy (ART) and effectively managing HIV as evidenced by their achievement of sustained viral suppression – a level of HIV in the bloodstream that is so low that it is undetectable. While some people living with HIV can achieve viral suppression through the routine and consistent access to their health care delivery system, many other persons living with HIV depend on access to a broader menu of medical and support services to achieve viral suppression. These services include but are not limited to medical care coordination services that improve health system navigation, housing support, mental health, oral health food and nutrition services, substance use treatment, and transportation services.

In Los Angeles County, there are nearly 1,700 new HIV infections each year and separately there are more than 6,000 undiagnosed people living with HIV. For people living with HIV, adherence to ART and achieving viral suppression is critical to promoting health and to ensuring that HIV is not sexually transmitted to others.[ii] For persons who have HIV but are not yet diagnosed (e.g. unaware of their HIV infection) or for persons who have been diagnosed but are experiencing challenges with both adherence to ART and maintaining viral load suppression, the scale up of existing effective interventions and the adoption of new interventions are necessary to achieve our Ending the HIV Epidemic goals. It has been well established that broad scale testing that allows persons with HIV to be diagnosed as close to the period of infection as possible and promptly linking newly HIV diagnosed persons to care and treatment services will not only improve overall individual health outcomes but will also have broad public health benefits. The support and access of new biomedical HIV prevention tools like PrEP (pre-exposure prophylaxis or a daily pill that prevents HIV transmission) for HIV-negative persons at elevated risk for HIV continues to be uneven across Los Angeles County.

Ending the HIV Epidemic in Los Angeles County
Executive Summary
December 1, 2020

The underutilization of these low-cost or no-cost prevention tools in the most impacted areas of our County will require a renewed commitment of education, awareness and mobilization if we are to realize the full potential of this science, and end the HIV epidemic, once and for all.

At the end of 2018, approximately 0.6% of the 10.3 million LA County residents were living with HIV. The group with the plurality of PLWH are Latinx cisgender men who have sex with men (~40%), followed by White cisgender men who have sex with men (26%), followed by Black/African-American cisgender men who have sex with men (23%).[iii] The balance of males with HIV are injection drug users of multiple racial/ethnic groups as well as cisgender American Indian/Alaskan Native, Asian or Pacific Islander men who have sex with men.

Separately, Latinx and Black/African American cisgender heterosexual females each represent approximately 40% of the cases among females while White cisgender heterosexual females represent nearly 19% of female cases. Approximately 1% of female cases are among cisgender heterosexual females who identify as American Indian/Alaskan Native, Asian or Pacific Islander.

Transgender persons continue to be the most disproportionately impacted gender group compared to their share of the LA County population with HIV positivity rates exceeding 30%. The disproportionate impact is evident across all racial/ethnic groups.

Black/African American males, female and transgender persons and American Indian/Alaskan Native males are disproportionately impacted with HIV compared to their share of the LA County population.

How will we end the HIV epidemic in Los Angeles County?

Ending the HIV epidemic locally requires the significant scale up and expanded reach of proven and new interventions that work towards overarching goals and are undergirded by overarching strategies.

Overarching Goal: Reduce new HIV transmissions and acquisitions in the United States by 75% in five years and by 90% in ten years.

Overarching Strategy: Ensure that Los Angeles County Ending the HIV Epidemic pillars of interventions address and eliminate health inequities, address and dismantle racial inequities that are at the root of HIV and related syndemics, focus on the communities most impacted by HIV, and adopts a client-centered, people first approach.

Priority Populations: Based on the most recent LA County epidemiologic profile and other key local data, the priority populations include: Black/African-American men who have sex with men (MSM), Latinx MSM, women of color, people who inject drugs, transgender persons, and persons under 30 years of age.

Ending the HIV Epidemic in Los Angeles County
Executive Summary
December 1, 2020

Diagnose people living with HIV as early as possible.

Why is early diagnosis important? An HIV diagnosis as close to the period of infection as possible is a crucial first step to achieving good HIV-related health outcomes and reducing the likelihood of HIV transmission to others. In LA County in 2019, 1,660 people aged 13 years or older were newly diagnosed with HIV. While HIV diagnoses rates have declined in general and across all most racial and gender groups, Black/African American cisgender men and cisgender women continue to have the highest rates of new diagnoses (number per 100,000 residents.) In 2017, 6,400 people in LA County were unaware of their HIV-positive status and the greatest disparities in awareness were among young people living with HIV (PLWH). In 2017, only 48% of PLWH aged 13-24 years and 66% of PLWH aged 25-34 years were aware of their HIV status, falling short of the 95% local and national target. Disparities in status awareness also persist among persons who inject drugs (PWID), with over one-third of PWID with HIV unaware of their HIV-positive status and only 55% having been tested for HIV in the past 12 months.

What will be measured as part of this pillar of EHE?

- Increase the percentage of people living with HIV (PLWH) who are aware of their HIV status to 95%
- Reduce annual number of HIV diagnoses

What strategies will be implemented?

Strategy 1A: Expand or implement routine opt-out HIV screening in healthcare and other settings (such as emergency departments and community health centers) in high prevalence communities. Identify additional opportunities in healthcare and non-healthcare settings where HIV testing can be included, including as part of the delivery of STD screening, substance use treatment, and syringe service program services, among others.

Strategy 1B: Develop locally tailored HIV testing programs to reach persons in non-healthcare settings including home and/or self-testing.

Strategy 1C: Increase the rate of annual HIV re-screening among persons at elevated risk for HIV in both healthcare and non-healthcare settings. Implement technology to help providers identify clients due for HIV re-screening and increase ways of maintaining communication with clients.

Pillar 2: Treat people rapidly and effectively to achieve viral suppression.

Why is this important? People diagnosed with HIV should be linked to medical care within days of diagnosis to ensure optimal treatment for the individual and reduce transmission to others. In LA County, HIV testing providers are responsible for linking people who are newly diagnosed with HIV to a specialty care provider. In many instances, due to a combination of factors, including denial of the diagnosis, competing life demands, health care access barriers, necessary but cumbersome financial screening requirements, among others, access to HIV is delayed or halted. In response to these barriers, we must insist on the universal availability of rapid initiation of antiretroviral therapy (ART), an intervention that has been shown to shorten the time to viral suppression. Our current approach to linkage to care must be restructured to promote and incentivize the prompt linkage to care of newly diagnosed persons and coupled with building the capacity among HIV specialty providers to receive same day referrals.
In 2018, 75% of people aged 13 and older newly diagnosed with HIV in LA County were linked to care within one month of diagnosis. The lowest levels of prompt linkage to care were noted among cisgender

women, Black/African-American persons, young persons aged 13-19, persons over age 60, and individuals whose mode of HIV transmission was heterosexual sex or injection drug use, persons who were unhoused at the time of HIV diagnosis, and those who report injection drug use as the transmission risk.

What will we measure to determine if we are making progress in this area?

- The proportion of people diagnosed with HIV who are linked to HIV care within 1 month of diagnosis to 95%
- The proportion of diagnosed people living with HIV (PLWH) who are virally suppressed to 95%

What strategies will be implemented?

Strategy 2A: Ensure rapid linkage to HIV care and ART initiation for all persons newly diagnosed with HIV by developing a network of specialty care providers who offer same day appointments with rapid ART disbursement.

Strategy 2B: Support re-engagement and retention in HIV care and treatment adherence, especially for persons who are not eligible for Ryan White Program-supported services, persons with mental illness and persons with substance use disorders.

Strategy 2C: Expand promotion of Ryan White Program services to increase awareness, access to and utilization of available medical care and support services for PLWH.

Strategy 2D: Develop and implement an emergency financial assistance program that supports PLWH experiencing financial hardship to allow for better treatment adherence or engagement in medical care and/or supportive services.

Strategy 2E: Improve the delivery of HIV services and client satisfaction rates by supporting strategies to address workforce burnout, improve staff capacity to better meet the needs of PLWH, and expand the availability of staff training tied to trauma informed care, stigma reduction, implicit bias, and medical mistrust.

Strategy 2F: Develop and fund a housing service portfolio that provide rental subsidies to prevent homelessness among PLWH.

Strategy 2G: Explore the impact of conditional financial incentives to increase adherence to treatment for high acuity out-of-care PLWH. Implement and evaluate a pilot program to determine continued use of financial incentives and potential for expansion to disproportionately impacted populations.

Pillar 3: Prevent new HIV transmissions by using proven interventions, including PrEP and syringe services programs.

Why is this important? PrEP will be a cornerstone to our efforts to end the HIV epidemic because it reduces the risk of getting HIV through sex by about 99% and reduces the risk of getting HIV among people who share and inject drugs by at least 74%, when the medication is taken as prescribed.[iv] In 2018, an estimated 72,700 Los Angeles County residents had an indication for PrEP and approximately 25,500 had

been prescribed PrEP; despite widely available PrEP resources and providers, fewer than a third of people with an indication for PrEP report taking it. Interventions to address suboptimal PrEP coverage, particularly among Black/African American men who have sex with men (MSM) and cisgender women of color, are critically needed.

Historical LA County HIV transmission data reveals that injection drug use (IDU) is a consistent, but less common risk factor for HIV transmission, accounting for less than 5% of HIV cases annually. However, across the United States and the west coast, IDU-based HIV outbreaks have occurred, even in areas where syringe support programs are available. The rise of conditions and co-morbidities that contribute to drug use and are associated with HIV risk, such as economic inequality, homelessness, untreated mental illness, and opioid and methamphetamine use, are becoming more pervasive in LA County. These trends increase our local susceptibility to an HIV outbreak among persons who inject drugs and demands that we expand the reach of syringe service programs. Of the six agencies funded by the LA County Substance Abuse and Prevention Control (SAPC) Program to deliver syringe service programs, only three are funded to deliver HIV, STD, and hepatitis C (HCV) testing, revealing a critical service gap.

What will we do as a sign of progress in this area?

- Increase the number of people prescribed PrEP in priority populations to at least 70,000 persons in a 12-month period.
- Increase the number of syringe service programs by 50% by 2025 and expand the menu of services available at syringe service programs.

What strategies will be implemented?

Strategy 3A: Accelerate efforts to increase PrEP use (particularly for populations with the highest rates of new HIV diagnoses and lowest PrEP coverage rates) by adopting new strategies at LA County funded PrEP Centers of Excellence tied to client retention, PrEP navigation, community education related to cost, effectiveness and availability, supporting alternatives to daily PrEP and expanding PrEP support groups.

Strategy 3B: Increase availability, use, and access to comprehensive syringe services programs in collaboration with LA County Substance Abuse and Prevention Control (SAPC) Program and other partners and identify opportunities to improve the delivery of linkage to care services for client accessing syringe service programs to HIV prevention and other services. As part of service expansion efforts, explore alternate models of prevention service delivery (e.g., syringe exchange vouchers for use at pharmacies in exchange for clean syringes and home HIV test kits.)

Pillar 4: Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

Why is this important? In 2018, LA County adopted the use of the CDC's HIV TRACE program to identify priority molecular clusters (defined as a group of 5 or more persons whose HIV genotype is identified as being highly similar and a transmission cluster requiring additional review and intervention.) Because HIV has a high mutation frequency, individuals whose HIV genotypes are highly similar are likely connected through recent sexual or social networks where there is ongoing HIV transmission. In addition, there is a high likelihood that persons who may be part of new cluster are unaware of their HIV status or know their

status but are not virally suppressed. LA County staff perform molecular cluster analysis of available surveillance and programmatic data to determine if the individuals are in care, virally suppressed, and if they need contact and engagement from linkage to care, re-engagement or partner services/notification teams.

All persons newly diagnosed with HIV should receive a partner services interview to help them engage in HIV care and ensure that any sex or needle-sharing partner is tested for HIV and linked to PrEP or Syringe Service Programs as a strategy to prevent the forward transmission of HIV. Current data suggests that only two-thirds of persons newly diagnosed with HIV infection in LAC receive an offer of Partner Services around the time of their new diagnosis.

What will we accomplish as a sign of progress in this area?

- Develop and maintain capacity for cluster and outbreak detection and response.
- Increase the number of people newly diagnosed with HIV that are interviewed for partner services within 7 days of diagnosis to at least 85%.

What strategies will be implemented?

Strategy 4A: Refine processes, data systems, and policies for robust, real-time cluster detection, time-space analysis within DHSP to help identify hot-spot locations and sub-populations where rapid investigation and response is needed.

Strategy 4B: Refine current processes to increase capacity of Partner Services to ensure people newly diagnosed are interviewed and close partners are identified and offered services in a timely and effective manner.

Ending the HIV Epidemic in Los Angeles County Next Steps

In this unprecedented era of COVID-19, it is imperative now more than ever that the strategies and activities tied to the Ending the HIV Epidemic (EHE) Plan be adopted by a broad cross-section of organizations and that we all work in a concerted fashion towards the goals of the EHE plan.

The full EHE Plan for Los Angeles County can be accessed here. The proposed strategies are complementary to the existing LAC HIV service portfolio and strives to further expand existing prevention and care services available to persons living with HIV or at elevated risk for HIV in our County. The proposed strategies and activities will be implemented starting in 2021 and further expanded over the course of the next five years.

[i] https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview
[ii] https://getprotectedla.com/uu/what-is-uu/
[iii] https://www.cdc.gov/healthyyouth/terminology/sexual-and-gender-identity-terms.htm
[iv] https://www.cdc.gov/hiv/basics/prep/prep-effectiveness.html

INTEGRATED PREVENTION AND CARE PLANNING PROPOSED SHORT-TERM ACTION STEPS

Planning, Priorities and Allocations Committee
Prevention Planning Workgroup
December 15, 2020

Miguel Martinez, Maribel Ulloa, Luckie Alexander, Pamela Ogata, Dr. Michael Green

LOS ANGELES COUNTY
COMMISSION ON HIV

Pre-Integration | Refresher

- Separate Prevention Planning Committee (PPC)
- Clear community planning requirement from the Centers for Disease Control and Prevention
- Developed Countywide Risk Assessment Survey
- Developed Los Angeles Coordinated Needs Assessment, focus groups and listening sessions
- Developed allocation models
  - Behavioral Risk Groups (BRGs)
  - Hot spots
- Developed inventory of interventions in Los Angeles County

Integrated HIV, STD Prevention and Care Planning Council | Refresher

- Merged in 2013
- New bylaws and ordinance to reflect broader membership with prevention stakeholders
- Formed Comprehensive HIV Plan (CHP) Workgroup
- Conducted listening sessions to help develop CHP
- Completed CHP in 2016
- Developed prevention service standards

LOS ANGELES COUNTY
COMMISSION ON HIV

Integrated HIV, STD Prevention and Care Planning Council | Refresher

- Discussed how to improve and fully integrate prevention in planning, priority setting and resource allocation process
- Formed Prevention Planning Workgroup in October 2020 to lead process
- Presented initial set of ideas to PP&A on November 17, 2020
- Met on December 3, 2020 to review suggestions from PP&A and develop action steps

LOS ANGELES COUNTY
COMMISSION ON HIV

Integrated HIV, STD Prevention and Care Planning Council | Refresher

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LOS ANGELES COUNTY
COMMISSION ON HIV

PROPOSED SHORT-TERM ACTION STEPS

LOS ANGELES COUNTY
COMMISSION ON HIV

1. Structure

- Maintain Prevention Planning Workgroup to lead, facilitate and engage members and community in integrated planning
- Determine meeting dates and time
- Recruit other Commissioners and members of the public to the workgroup
- Ensure active participation from youth groups and other highly impacted populations
- Keep workgroup reports and prevention planning as a standing item on the PP&A agenda

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2. Ending the HIV Epidemic (EHE) Plan

- Review Los Angeles County (LAC) EHE Plan, with a special focus on prevention pillars and activities
- Analyze plan from priority setting and resource allocations (PSRA) lenses
- Schedule DHSP presentation on all services and financial investments available to support EHE goals and objectives
  - Clarify grant terms for federal funding
  - Clarify timing for Commission input on prevention grant proposals
- December 2020-February 2021

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3. Data Needs

- Identify types of prevention and care data needed to help inform and drive integrated prevention and care planning and PSRA
- Clarify data report cycles and months from DHSP
- Review and prioritize data requests from various Commission Committees and subgroups
- January-March 2021

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4. Prevention Focused Community Forums

- Convene prevention focused community forums in highly impacted populations identified in the EHE plan
- Use feedback from the community to help inform PSRA process and deliberations
- March-May 2021

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5. PAUSE, REFLECT, ASSESS

- May-June 2021
- Review and reflect on steps taken
- Get ready for data summit
  - Review and rethink approach to data summit
- Discuss next action steps towards full integration

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Other Considerations

- Evening or weekend meetings
- Partner and recruit from existing community advisory board
- Staff and Commissioner time commitments and capacity
- Thoughtfulness and critical attention to data requests
  - Needs vs wants
  - How will PP&A and COH use the data?
  - Identify other data sources outside of DHSP

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Q & A

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Integrating Prevention in Multiyear Planning and Commission on HIV Functions
Ideas and Recommendations
(Miguel Martinez, Maribel Ulloa and Luckie Alexander)
FOR DISCUSSION ONLY

Planning, Priorities and Allocations Committee and Division of HIV and STD Programs:

- Start gathering prevention related data in April and dedicate May and June Planning, Priorities and Allocations (PP&A) meetings for prevention-focused discussions on identifying priority populations and services. Work with the Division of HIV and STD Programs (DHSP) to gather HIV testing, prevention services utilization, populations served by demographic groups, and other relevant data to understand HIV and STD prevention needs, gaps and opportunities in Los Angeles County.

- Identify other partners who may be able to provide relevant prevention data and invite them to present information to PP&A and full Commission.

- Similar to the HRSA Part A application process, collaborate with the Commission to help inform the development of CDC grant applications and have Commissioners review the grant proposal. Review CDC/prevention annual plans with the PP&A Committee and full body. Commission leadership should submit a letter of concurrence for CDC grant applications even if the letter is not required.

Full Council:

- Agendize prevention focused discussions and planning with Commission caucuses and task forces and submit their ideas/recommendations to the PP&A Committee.

- Discuss how the Commission can support the “Prevent” pillar of the local Ending the HIV plan.

- Consider adding the word “Prevention” in PP&A Committee’s name.

- Work with Commission staff to develop prevention focused training for Commissioners. Integrate prevention concepts in ongoing training for all Committees. Expand the Consumer Caucus membership to include individuals who are HIV-negative.

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PARADIGMS (Decision-Making)

- Compassion: response to suffering of others that motivates a desire to help
- Equity: allocating levels of investments and commitment that meaningfully address the needs of populations disproportionately impacted by HIV/STIs and social determinants of health

OPERATING VALUES

- Efficiency: accomplishing the desired operational outcomes with the least use of resources
- Quality: the highest level of competence in the decision-making process
- Advocacy: addressing the asymmetrical power relationships of stakeholders in the process
- Representation: ensuring that all relevant stakeholders/constituencies are adequately represented in the decision-making process

Health Care in Motion

Timely, Substantive Updates on Policy Shifts · Actionable Advocacy to Protect Health Care

November 3, 2020

What's at Stake in the Courtroom?: Health Care Litigation Round-Up

Today, voters across the country are casting their ballots—many with the future of health care on their minds. The election will not only determine the ways in which health care laws, like the Affordable Care Act (ACA), will be interpreted over the next four years, but it will also determine the approach our federal government takes in addressing public health emergencies, rising health care costs, and discrimination in our health care system.

Much of recent health care litigation has been tied to executive action in the last four years. In this installment of *Health Care in Motion*, we provide a round-up of current litigation efforts in the health care space – both cases that threaten our health care system and cases that try to protect it. This broad range of health care-related cases underscores not only the importance of the courts, but of the executive and legislative branches that are all too often implicated in these cases.

The Affordable Care Act Reaches the Supreme Court (Once Again)

Over ten years and many attempts by state and federal officials to undercut the health care law later, the ACA has returned to the Supreme Court and oral argument will be held next week on November 10, 2020 in *California v. Texas*.

California v. Texas follows a landmark decision from 2012: *NFIB v. Sebelius*. In this contentious 5-4 decision, Chief Justice Roberts, writing for the majority, held the ACA's individual mandate (requiring individuals to purchase minimum essential coverage) was constitutional as a tax, in line with the federal government's power of taxation set forth in the U.S. Constitution. Because the Court determined the individual mandate to be constitutional, it did not reach the question of severability—whether the entire health care law would have to be struck down if the individual mandate was ruled unconstitutional.

Notably, the composition of the Supreme Court has changed dramatically since 2012 and the issue of severability has now taken center stage. A group of Republican state attorneys general filed a complaint arguing that the Tax Cuts and Jobs Act (TCJA) of 2017 rendered the individual mandate unconstitutional. Congress had reduced the tax of the individual mandate to zero, meaning that the individual mandate no longer raises revenue and can no longer be protected as a tax.[1] The complaint then goes on to argue that the individual mandate is "the heart of the ACA" and inseverable from the rest of the law, thus the entire ACA must be declared unconstitutional.

[1] Brief of Petitioner at 2, Texas, et al., v. U.S. et al., 352 F.Supp.3d 665(2018) (4:18CV00167).

The case went up to the Fifth Circuit before a panel of three judges. The Fifth Circuit affirmed the lower court's holding that the ACA, as amended by the TCJA, was no longer a legitimate exercise of Congress' taxing power when the penalty was reduced to zero. Although the Fifth Circuit held the individual mandate was now unconstitutional, it remanded the case to the district court on the issue of severability, imploring the district court "to employ a finer-toothed comb on remand and conduct a more searching inquiry into which provisions of the ACA Congress intended to be inseverable from the individual mandate." In January of 2020 the Fifth Circuit denied a request for a larger hearing with the entire Fifth Circuit and on March 2, 2020 the Supreme Court agreed to hear the case.[2]

What Can We Expect from a Changed Court?

With Justices Kennedy, Scalia, and Ginsburg no longer on the Supreme Court, the fate of the ACA is difficult to predict. One vote (Justice Ginsburg) from the ACA-saving majority is gone. Justice Ginsburg's replacement, Justice Amy Coney Barrett, wrote in 2017 that "Chief Justice Roberts pushed the Affordable Care Act beyond its plausible meaning to save the statute." Also worth nothing, however, is that Justice Kavanaugh recently authored a majority opinion in which he embraced the "strong presumption of severability" when one portion of a law is held unconstitutional. Another clue as to Justice Kavanaugh? In 2011, when he sat on the D.C. Circuit, Justice Kavanaugh authored a dissent to a challenge to the Affordable Care Act's individual mandate arguing that the federal courts did not have jurisdiction to hear the case. Although his dissent turned on an analysis of the Anti-Injunction Act (noting that the court would have jurisdiction after the mandate went into effect), it hints that Justice Kavanaugh may be more reluctant than some of his conservative colleagues to strike the law down.

California v. Texas: What's at Stake?

With three new justices on the Court, *California v. Texas* hangs in the balance and is one of the most important cases on the docket. The ACA insures more than 22 million Americans and with an ongoing pandemic reliable health insurance is more important than ever. States that have expanded Medicaid (an option provided by the ACA) have been better equipped to address COVID-19, especially among essential workers. The pandemic has exacerbated health disparities especially among low income workers and recent data indicates "the uninsured rate for low-income people with these [essential worker] jobs was about twice as high in non-expansion states than in expansion states."

The Election Implicates Health Care Litigation in More Ways than One

While President Trump has indicated he will go to court to contest the election, the upcoming presidential election will likely have other effects on the Supreme Court's docket. Many cases seeking *cert.* could be rendered moot if there is a change in administration because there is a lot of Trump-centric litigation right now. For example, one petition that could be rendered moot by the election is *Azar v. Gresham*, a case concerning work requirements for Medicaid recipients in Arkansas. The D.C. Circuit invalidated the Department

[2] The Supreme Court will consolidate petitions and cases for oral argument when they are related or touch on the same issue. Here, the federal defendants of the original lawsuit agreed with the plaintiffs that the ACA was unconstitutional. In 2018, the California Attorney General and sixteen other attorneys general filed a motion to intervene in the lawsuit and defend the ACA. Their appeal of the Fifth Circuit's decision regarding the constitutionality of the individual mandate has been consolidated with the Texas Attorney General's appeal of the severability decision. Documents filed in these cases are filed under "California v. Texas" and the appeals will be heard in one oral argument.

of Health and Human Services' (HHS) approval of the work requirements and a new administration could simply rescind this approval, rendering the case moot.

The Rollback of Nondiscrimination Protections

In addition to *California v. Texas*, the Affordable Care Act is embroiled in federal litigation surrounding the Trump administration's "Rollback Rule" which revised HHS' prior interpretation of the nondiscrimination provision of the ACA (Section 1557). As we discussed in June, this rollback poses a significant threat to the health care rights of transgender and gender non-conforming people. Section 1557 prohibits health care discrimination on the basis of race, color, national origin, sex, age, or disability. The Obama administration had interpreted Section 1557's incorporation of Title IX, which prohibits sex-based discrimination, to extend protections against discrimination on the basis of sex stereotyping or gender identity.

In line with a number of other Trump-era rules repealing protections for transgender and gender non-conforming people, the Trump administration rolled back the Obama-era rule in June 2020 and removed explicit protections against discrimination on the basis of gender identity and sex stereotyping (among other protections). Ignoring the Supreme Court's recent ruling in *Bostock v. Clayton County* which held that a sister non-discrimination statute (Title VII of the Civil Rights Act) protects individuals from workplace discrimination on the basis of sexual orientation and gender identity, the Trump administration promptly issued this Rollback Rule, interpreting Section 1557 to not extend protections to those who are discriminated against due to sex stereotyping, their gender identity, or their sexual orientation. Advocacy groups around the country filed suit.

- In *Walker v. Azar*, Judge Block of the United States District Court for the Eastern District of New York issued a stay on the 2020 repeal of the 2016 definition of discrimination on the basis of sex. Judge Block requested further briefing from the parties to determine how much of the Rollback Rule should be stayed. Last week, he ruled that the stay applied to (1) the repeal of definitions for "on the basis of sex", "gender identity", and "sex stereotyping" and (2) the repeal of a particular section that requires health care providers to treat individuals consistent with their gender identities and to not deny or limit a patient's access to sex-specific care because they are transgender. The government is set to appeal.
- The plaintiffs in *BAGLY v. HHS* (supported by CHLPI) filed an amended complaint in September, arguing that the Rollback Rule "manifests a disregard for the intent of the law and the weight of contrary legal authority." The Trump administration has filed a motion to dismiss and Judge Saris of the United States District Court for the District of Massachusetts is set to hear arguments on January 26, 2021 at a virtual hearing.
- In *Whitman-Walker Clinic v. HHS*, Judge Boasberg of the United States District Court for the District of Columbia issued a preliminary injunction on some of the Rollback Rule's provisions, including the enforcement of the "repeal of the 2016 Rule's definition of discrimination '[o]n the basis of sex'" and the enforcement of incorporating religious exemptions from Title IX. The government is set to appeal.

Other Cases to Keep an Eye On

SCOTUS Justices Threaten Obergefell on Second Day of October Term

At the beginning of this October term, the Supreme Court declined to hear a case involving Kim Davis, the former Kentucky county clerk who refused to issue marriage licenses in the wake of *Obergefell v. Hodges*, the 2015 case that recognized the right to same-sex marriage. Published alongside the denial to hear the case was a concerning

opinion from Justice Thomas, joined by Justice Alito. In it, Justice Thomas criticizes the *Obergefell* precedent, writing that in recognizing the constitutional right to same-sex marriage "the Court has created a problem that only it can fix."

Discriminatory Adoption Agencies Get New Day in Court

A Christian adoption agency in New York sued the New York Office of Children and Family Services (OCFS), alleging a regulation prohibiting adoption agencies from discriminating on the basis of sexual orientation and marital status violated the Free Exercise, Free Speech, and Equal Protection Clauses of the Constitution. The district court dismissed the case, but in July the Second Circuit reversed and remanded the case back to the district court, concluding that the adoption agency had raised plausible claims under the Free Exercise and Free Speech clauses. A similar case, *Fulton v. City of Philadelphia, Pennsylvania*, came out differently in the Third Circuit and was appealed up to the Supreme Court. The Supreme Court will hear oral argument for *Fulton* tomorrow on November 4th.

Next Steps

Vote!

If you are a registered voter and haven't already voted in today's election, make a plan to vote! Make sure you leave yourself enough time to safely vote at your polling location and consider how your vote can impact the future of health care rights in this country.

Listen to Oral Arguments!

The COVID-19 pandemic caused the Supreme Court to begin hearing oral arguments by telephone conference for the first time back in March. The Court recently announced it will continue to hear oral arguments via telephone through November and December. The Court has been livestreaming these oral arguments, giving advocates unique access to the process. Make sure to tune in on November 4 for *Fulton v. City of Philadelphia* and November 10 for *Texas v. California*.

Engage on Social Media!

If the Supreme Court takes this opportunity to strike down the Affordable Care Act, it would be a devastating blow to health care. Over 20 million Americans would likely be uninsured. The Supreme Court needs to know exactly what is at stake. Take this opportunity to encourage your coalitions and stakeholders to take to social media and share what the ACA means to them.

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Health Care in Motion is written by Robert Greenwald, Faculty Director; Kevin Costello, Litigation Director and Associate Director; Phil Waters, Staff Attorney; Maryanne Tomazic, Staff Attorney; and Rachel Landauer, Senior Clinical Fellow. This issue was also authored by Abbey Bowe, an advanced clinical student of the Health Law and Policy Clinic of Harvard Law School.

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