LOS ANGELES COUNTY
COMMISSION ON HIV

Visit us online: http:/ / hiv.lacounty.gov
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Consumer Caucus
Virtual Meeting

Be a part of the HIV movement

Thursday, October 14, 2021
3:00-4:30PM (PST)

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

REGISTRATION NOT REQUIRED + SIMUTANEOUS TRANSLATION IN SPANISH AND OTHER LANGUAGES NOW AVAILABLE VIA CLOSED CAPTION FEATURE WHEN JOINING VIA WEBEX. CLICK HERE FOR MORE INFO.

TO JOIN BY COMPUTER: **registration is not required*

https://tinyurl.com/6tvfs6h9

Meeting password: CAUCUS

TO JOIN BY PHONE:

+1-213-306-3065

Access Code/Event #: 2595 033 3015

For a brief tutorial on how to use WebEx, please check out this video: https://www.youtube.com/watch?v=iQSSJYcrgIk

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Apply to become a Commissioner at http:/ / tinyurl.com/ HIVCommApplication

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LOS ANGELES COUNTY
COMMISSION ON HIV

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CONSUMER CAUCUS (CC)

VIRTUAL MEETING AGENDA

THURSDAY, OCTOBER 14, 2021
3:00 PM – 4:30 PM

TO JOIN BY COMPUTER
https://lacountyboardofsupervisors.webex.com/lacountyboardofsupervisors/j.php?MTID=mafb9c31d7eea20697db19ebe04192aaf
MEETING PASSWORD: CAUCUS
TO JOIN BY PHONE: +1-213-306-3065 **MEETING #/ACCESS CODE:** 2595 033 3015

I.	Welcome & Introductions (Co-Chairs)	3:00pm - 3:05pm
II.	COH Meeting Debrief	3:05pm – 3:10pm
III.	Staff Report/Commission Updates	3:10pm - 3:15pm
IV.	Co-Chair Report • NMAC Building Leaders of Color (BLOC) Training Feedback • STD Letter Update • Legal Services Focus Group • Holiday Meeting Schedule	3:15pm - 3:30pm
V.	Presentation: • DHSP Clinical Quality Management (CQM) Program Newsletter & Dashboard Updates | Becca Cohen, MPH, MD & Lisa Klein RN, MSN, CPHQ – Division of HIV and STD Programs (DHSP)	3:30pm – 4:25pm
VI.	Announcements	4:25pm-4:30pm
VII.	Adjourn	4:30pm

LOS ANGELES COUNTY
COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-6748
HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov

CODE OF CONDUCT

We welcome commissioners, guests, and the public into a space where people of all opinions and backgrounds are able to contribute. We create a safe environment that celebrates differences while striving for consensus and is characterized by consistent, professional, and respectful behavior. Our common enemies are HIV and STDs. We strive to be introspective and understand and clarify our assumptions, while appreciating the complex intersectionality of the lives we live. We challenge ourselves to be self-reflective and committed to an ongoing understanding. As a result, the Commission has adopted and is consistently committed to implementing the following guidelines for Commission, committee, and associated meetings.

All participants and stakeholders should adhere to the following:

1) **We strive for consensus and compassion in all our interactions.**
2) **We respect others' time by starting and ending meetings on time, being punctual, and staying present.**
3) **We listen, don't repeat what has already been stated, avoid interrupting others, and allow others to be heard.**
4) **We encourage all to bring forth ideas for discussion, community planning, and consensus.**
5) **We focus on the issue, not the person raising the issue.**
6) **We give and accept respectful and constructive feedback.**
7) **We keep all issues on the table (no "hidden agendas"), avoid monopolizing discussions and minimize side conversations.**
8) **We have no place in our deliberations for homophobic, racist, sexist, and other discriminatory statements and "-isms" (including transphobia, ableism, and ageism).**
9) **We give ourselves permission to learn from our mistakes.**

Approved (11/12/1998); Revised (2/10/2005; 9/6/2005); **Revised (4/11/19)**

POSITIVE WOMEN'S NETWORK USA
pwn-usa.org

Unpacking the Process:

How to Engage in Federal Administrative Advocacy

The executive branch of the federal government can often be a confusing space for both new and experienced advocates. Both the ways to participate in the regulatory process and the agencies making decisions about the lives of people living with HIV are complicated, making the process hard to navigate.

This fact sheet will provide a primer on what the executive branch and administrative agencies do, what the main agencies and policies affecting the lives of people living with HIV are, and what steps advocates can take to influence executive agency decision making.

Background: The Executive Branch

What does it do?

The executive branch "executes" the laws: putting what Congress passes into action. This includes enforcement.

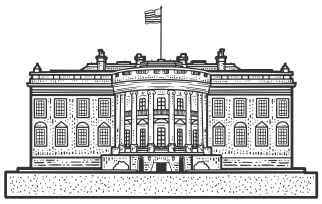
Who's in charge?

The President is the head of the executive branch and the Vice President (VP) is second in command.

Below the President and VP are the Cabinet officials who serve as advisors to the president and the heads of the 15 main executive (or administrative) agencies. The executive branch is made up of various departments, independent agencies, boards, commissions and committees.

A few administrative agencies that affect HIV policy are the Department of Health and Human Services which is in charge of the Centers for Disease Prevention and Control and the Health and Human Services Administration, which manages the Ryan White HIV/AIDS Program.

President of the U.S.



Vice President of the U.S.

Cabinet (advisors to the President; heads of executive agencies)

Secretary of Agriculture	**Secretary of Commerce**
Secretary of Defense	**Secretary of Education**
Secretary of Energy	**Secretary of Health & Human Services**
Secretary of Homeland Security	**Secretary of Housing & Urban Development**
Secretary of the Interior	**Secretary of Labor**
Secretary of State	**Secretary of Transportation**
Secretary of the Treasury	**Secretary of Veterans Affairs**

Attorney General

How do agencies make policies?

Rules

Rules are generally applicable, meaning they apply to everyone, and have a future effect.

They are designed to implement or interpret law or policy.

Orders

Orders are final dispositions in any matter other than rule-making and usually affect individual rights or the rights of very small groups.

They are created by a process called adjudication.

Guidance

Also called "interpretive rules," these are intended to help the public understand how a rule applies to them.

They may explain how an agency interprets a rule or a law, how a rule may apply in a given instance, and what a person or organization must do to comply.

Guidance cannot set new legal standards or impose new requirements.

HIV and the Executive Branch

White House Domestic Policy Council

Office of National AIDS Policy (ONAP)

This office has provided overall guidance and coordination of the domestic HIV response. ONAP is situated on the White House Domestic Policy Council, which advises the President on all domestic policy matters. ONAP became defunct under the Trump administration, but was reestablished by the Biden administration in 2021. Harold Phillips currently serves as director of ONAP.

Executive agencies that create or influence policies that affect people living with HIV

Department of Health & Human Services

Social Security Administration

Department of Housing and Urban Development

Department of Justice

Department of Agriculture

Advisory bodies

The Presidential Advisory Council on HIV/AIDS (PACHA) and the CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (CHAC) are both governed by a charter.

The charter mandates everything about the advisory body, from who is included on the body (like if people living with HIV must be included) to how many times it meets per year.

PACHA is rechartered by each new presidential administration. At the time of publication of this fact sheet, President Biden has not yet rechartered PACHA.

Presidential Advisory Council on HIV/AIDS (PACHA)

Advises HHS on programs, policies, and research on the treatment, prevention, and cure of HIV, including comment and advice on the EHE and HNSP programs.

- The current PACHA charter specifies a maximum of 25 members who serve for 4-year terms and meet 3 times per fiscal year. There is no requirement that any of these members be people living with HIV.
- For example, following its last meeting in March 2021, PACHA recommended that HHS eliminate administrative barriers to eligibility and recertification process for services that could be creating and perpetuating systemic racism and to examine additional incentives to encourage states that have not expanded Medicaid to do so, among other things.

CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (CHAC)

Advises HHS, the CDC, and HRSA on objectives, strategies, policies, and priorities for HIV, viral hepatitis, and STD prevention and treatment efforts.

- Comprised of 18 members, at least 4 of which must be people living with HIV, and meets about 2 times per year. As it is currently chartered, members can serve for up to 4 years and can serve for an additional 180 days until their successor takes office. Their terms overlap with one another, so not all members terms will expire at one time.
- For example, CHAC will write letters to the heads of HHS, the CDC, and HRSA, like one it wrote to the Secretary of HHS in June 2020 asking HHS to prioritize young people in the Ending the Epidemic Plan and activities that are known to be linked to prevention of HIV in young people.

Government-wide HIV policies

Ending the HIV Epidemic (EHE): A Plan for America

An operational plan developed by U.S. Department of Health and Human Services (HHS) agencies which aims to end the HIV epidemic by 2030.

It focuses on prevention, diagnosis, treatment, and outbreak response.

Opportunities to influence the implementation of EHE exist at the state & local level, when budgets are being developed, and at PACHA and CHAC meetings.

HIV National Strategic Plan (HNSP)

A road map for ending the HIV epidemic in the United States by 2030.

The current iteration covers 2021-2025.

Opportunities to influence the HNSP implementation exist when budgets are being developed, and at PACHA and CHAC meetings.

Executive agencies, cont.

Department of Health & Human Services

The Office of Assistant Secretary for Health (OASH)

Manages HHS's response to HIV

Minority HIV/AIDS Fund

Funds different programs and activities designed to improve prevention, care, and treatment for racial and ethnic minorities.

Centers for Disease Control and Prevention (CDC)

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)

Department of HIV/AIDS Prevention (DHAP)

Focuses on prevention through public health surveillance, scientific research, prevention public education campaigns, programs to prevent and control HIV/AIDS and promoting school-based health and disease prevention among youth.

Office of Infectious Disease and HIV/AIDS Policy (OIDP)

Formerly known as the HIV/AIDS and Infectious Disease Policy (OHAIDP) before it was combined with the National Vaccine Program Office in April 2019.

- Leads EHE project coordination and management;
- Monitors EHE progress;
- Delivers information through hiv.gov.

Office of AIDS Research (OAR)

Coordinates HIV/AIDS research across National Institutes of Health (NIH), which provides the largest public investment in HIV/AIDS research globally.

Health Resources and Services Administration (HRSA)

Health Center Program

- Grant program in which grants are given to health centers which deliver primary health services to low-income and underserved communities
- Health centers often test for and treat HIV and increase access to PrEP and PEP

HIV/AIDS Bureau (HAB)

AIDS Drug Assistance Programs (ADAP)

- Funds are managed by states and territories, but the programs are intended to provide certain approved medications to low-income people living with HIV who have limited or no health coverage from private insurance, Medicaid, or Medicare.
- Funds may also be used to purchase health insurance for clients and for services that enhance access to, adherence to, and monitoring of drug treatments.

Ryan White HIV/AIDS Program

- A funded initiative to provide healthcare, treatment, and related services to people living with HIV. Focuses on linking people living with HIV who are either newly diagnosed or are not in care, to the HIV care, treatment, and support services by granting funds to states, cities, counties, and local community-based organizations.
- Jurisdictional planning councils are supposed to be comprised of at least 33% people living with HIV and decide how to allocate these resources at the local level.

Executive agencies, cont.

Department of Health & Human Services, cont.

Centers for Medicare and Medicaid Services (CMS)

Medicaid

Single largest source of health care for U.S. people living with HIV; represents 30% of all federal spending on HIV care.

It is the second largest source of public financing for HIV care in the U.S.

Medicare

Federal health insurance program for people age 65 and older and younger adults with permanent disabilities.

About ¼ of people living with HIV get their healthcare through Medicare.

The primary pathway to get onto Medicare is through Social Security Disability Insurance (SSDI).

Administration for Children and Families (ACF)

Temporary Assistance for Needy Families (TANF)

Time-limited program that assists families with children when the parents or other guardians cannot provide for the family's basic needs.

Department of Housing and Urban Development

Housing Opportunities for Persons with AIDS (HOPWA)

Grants to local communities, states, and nonprofit organizations for projects that provide housing for low-income persons living with HIV/AIDS and their families.

Social Security Administration

Supplemental Security Income (SSI)

Financial support for people with disabilities and low income and resources.

Social Security Disability Insurance (SSDI)

Provides benefits for people with disabilities, including HIV.

Department of Agriculture

Supplemental Nutrition Assistance Program (SNAP)

Federal program helping low- and no-income people, those receiving public benefits, the elderly or disabled, or unhoused people purchase food.

Department of Justice

Conducts new investigations of HIV/AIDS discrimination under the Barrier-Free Health Care Initiative, the Fair Housing Act, and the Americans with Disabilities Act.

Released the Best Practices Guide to Reform HIV-Specific Criminal Laws to Align with Scientifically Supported Factors in 2014.

How Do You Make Changes in Administrative Policies?

Join and/or attend the meeting of state or local working groups (Ryan White, Ending the Epidemic, ADAPs).

Join an advisory body, attend the meetings, and submit comments.

Join Positive Women's Network - USA or another network of people living with HIV.

Disrupt by contacting the media, rallies, direct actions, and demonstrations. You can be creative with how you disrupt the process and different actions are better suited for different issues.

Submit public comments on rules and regulations.

How to find policies and other agency actions

- Rules and Regulations: FederalRegister.gov OR Regulations.gov
- Calendar of planned and ongoing rulemaking: RegInfo.gov

How to Write an Effective Comment

1. Read the Rule or at least the summary.
2. Outline the questions being asked from the agency and other areas where comment will be useful.
3. Give yourself time to write, and to review.
4. Submit comment online by the deadline.

TIPS:

- Share personal stories and/or stories of how the proposed rule will impact you and/or your community.
- Can address all of the proposed rule or only a part.
- Can be as simple as a sentence or as many pages and points as you want to make.
- Constructive comments hold more weight.
- If you have particular expertise because of your work or life experience, make sure to put that up front.
- Support your comment with facts and data if you have it; you may be considered an expert, and your opinion matters.
- If you can think of an alternative to the rule, include it!
- **Form letters:** Many organizations create form letters - if you don't personalize them up front or add your opinion, it is not taken as seriously.

Want to learn more? Or ready to get started?

Go to pwn-usa.org/advocacy-guide

Claim Your Seat at the Table: A How-To Guide to Advocacy for People Living with HIV has tons of multimedia resources for advocates, from the newest to the most seasoned, to give you the knowledge, skills, tools and templates, and pro tips you need to make a difference for people living with HIV and our communities.

LOS ANGELES COUNTY COMMISSION ON HIV

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HIVCOMM@LACHIV.ORG • https://hiv.lacounty.gov

CONSUMER CAUCUS

9.9.21 Meeting Summary

Attendance may be verified with Commission staff

1. **Welcome + Introductions + Check In**
   Co-Chairs Jayda Arrington, Alasdair Burton and Ish Herrera opened the meeting and led introductions.

2. **COH Meeting Debrief** Members shared their complements around the HIV and Aging presentation and requested to stay updated on the Aging Task Force's progress on its recommendations.

   Members also expressed its continued appreciation for the reading activity, "So You Want to Talk About Race" particularly as it related to today's presentation around microaggressions.

   Lastly, the Caucus shared its condolences regarding the passing of a HIV advocate icon – Bishop Carl Bean.

3. **Staff Report/Commission Updates**
   Chery Barrit, Executive Director, reminded the Caucus that effective October 1, 2021, all Brown Act meetings will be held in person for Commission members and a virtual option for members of the public. Although the Consumer Caucus is not Brown Act governed, it immediately follows the Commission meeting necessitating an option for those to attend in person as well as virtually.

   For those attending the meeting in person, please bring your smart device and earphones to allow for a pleasant experience and to access meeting materials via the Commission's website. Hard copies of materials will not be provided, and Wi-Fi information will be shared at the meeting.

   C. Barrit noted that because of COVID, safer food handling practices will be enforced thus providing boxed lunches versus a buffet for those who attend Caucus meetings in person.

4. **Co-Chair Report**
   <u>2021 Priorities/Workplan Updates + Review</u>
   Recenter & Streamline Activities for Planning Effectiveness
   It was discussed that given the enormous amount of work, competing priorities and overload of information, it is essential to streamline the work plan for 2022 and master fundamental and key pieces of information necessary to be effective and efficient planners.

Members expressed the need to simply information to do better work and noted that it is not necessary to fully understand everything that comes across your desk because it is almost impossible. Rather, simplify information and convert into a more digestible format, i.e., infographics.

Recommendations for upcoming meetings:

- Prioritize ongoing training
- Keep hybrid meetings light for initial meetings to allow for adjustments
- For October's in-person meeting, re-introduce the framework and the objective of the Caucus by asking, (1) Who are We, (2) What is Our Charge, and (3) How Do We Meet it? Also, begin developing priorities for 2022.

Caucus decided to cancel its November meeting in lieu of the all-day Annual Meeting on November 18, 2021.

NMAC Building Leaders of Color (BLOC) Training – September 13-17

A reminder was made that the NMAC BLOC training orientation is tomorrow, September 10, followed by the actual training on September 13-17. There are still open seats available. For those who did not receive confirmation upon registering, staff will follow up.

5. Discussion

Commission's Response to STD Crisis in Los Angeles County (STD Letter)

Supporting/Championing Commission Initiatives via Public Comment and Other Outreach Efforts in Your Communities

Katja Nelson, Public Policy Co-Chair, led the Caucus in a review of the Commission's letter in response to the STD crisis in LA County. *(See Commission's STD letter in meeting packet.)*

K. Nelson provided recommendations on how Caucus members can champion initiatives impacting people living with HIV to include providing e-Public Comment at the Board of Supervisor's (BOS) meetings via https://publiccomment.bos.lacounty.gov/ as well as calling in; BOS meetings are held every Tuesday at 9am. Public Comment can also be made at the Health and Mental Health Services (HMHS) cluster meetings (aka Health Deputy meetings) which take place each Wednesday and discuss health-related matters ahead of the BOS meetings.

K. Nelson noted there is no cap on how many Public Comments can be made and that it is an ongoing effort by constituents to champion initiatives, i.e., STD letter, that are important to their health and wellbeing.

K. Nelson agreed to assist Caucus members and the entire Commission membership in supporting the STD letter by drafting an email to include a Public Comment template/script for members to use to make Public Comment at the upcoming Health Deputy and BOS meetings.

6. Announcements.

C. Barrit reminded the Caucus of the webinar offered by Positive Women's Network on how to engage in federal administrative advocacy by unpacking: What are the federal agencies and offices, such as PACHA and ONAP, affecting HIV law and policy; the main laws and regulations impacting people living with HIV; and how to get involved and impact the process yourself. An infographic on this topic has been included as a standing item in Caucus meeting packets.

Carlos Moreno shared a new program, B3, at Children's Hospital Los Angeles for queer men of color living with HIV/AIDS ages 16-29. B3 is an individualized program where skilled peer facilitators create a space for informative and supportive discussions, focuses on youth empowerment and development, and covers topics that promote growth and healing, such as HIV status disclosure, medication adherence, media navigation and healthy relationships. For more information, contact Carlos at B3@chla.usc.edu.

LOS ANGELES COUNTY
COMMISSION ON HIV

Consumer Caucus Workplan 2021
(October 14, 2021)

PURPOSE OF THIS DOCUMENT: To identify activities and priorities the Consumer Caucus will lead and advance throughout 2021.
PRIORITIZATION CRITERIA: Select activities that 1) represent the core functions of the COH and Caucus, 2) advance the goals of the local Ending the HIV (EHE) Plan, and 3) align with COH staff and member capacities and time commitment.
CAUCUS RESPONSIBILITIES: 1) Facilitate dialogue among caucus members, 2) develop caucus voice at the Commission and in the community, 3) provide the caucus perspective on various Commission issues, and 4) cultivate leadership within the caucus membership and consumer community.

#	Activities & Lead/Champion(s)	Priority Level (High, Medium, Low)	Approach/Comments/Target Deadline
1	Foster and nurture consumer (both PLWH and HIV-negative) leadership and empowerment in COH and community	High	• Trainings, meeting debriefs and Q&As to be determined by Consumer Caucus and weaved into Consumer Caucus meetings. • NMAC BLOC training completed.
2	Increase consumer participation at Consumer Caucus/COH meetings, especially individuals from the Black/African American, Latinx, youth, and indigenous communities.	High	• Work with community advisory boards. Explore follow-up opportunities to the CAB conference held in 2019. • Use testimonials from members and use in social media-based recruitment. Staff emailed Commissioners on 2/2/21 to solicit testimonials. No replies received as of 2/18/21. • Encourage consumers to attend caucuses and task forces first as those meetings may be less intimidating than full body or Committee level meetings. • Develop outreach tracking form that Commissioners will use to what events they attended to promote the COH and consumer participation. C. Moreno to share draft template for consideration. ➢ Partner with the Operations Committee to develop strategies and best practices to engage and retain consumer members.
3	Increase integration of consumer voice into all COH Committees	High	• Encourage consumers (including non-COH members) to attend COH Committee meetings. Attendance at meetings may incite consumers to apply to the COH or as Committee members. *Ask Committee and other subgroups to attend Consumer Caucus meetings.* • Encourage at least two consumers attend each Committee and subordinate work group meetings as champions and representatives for CC and report back to CC. • Encourage more consumers to apply to the COH. • Consumer voices should drive the COH agenda. • Provide feedback on updated membership application to create a more

			consumer friendly format and use as a recruitment tool for consumers • Encourage providers to support and promote consumer participation at COH meetings. ➢ Develop list of consumer-focused priorities/recommendation for Commission consideration/implementation - ongoing.
4	Support/partner with Black/African American Community Task Force (BAAC TF), Women's Caucus, Transgender Caucus and Aging Task Force to develop a more coordinated and collaborative planning agenda for consumers from all priority communities on the COH.	Low	• Host an "all Caucus/Task Force" meeting to combine planning efforts for consumers from all priority communities. o Schedule an "all Co-Chair" meeting to brainstorm and develop agenda. Meeting took place on March 9. Follow up/next steps to be determined. • Help implement BAAC TF, WC and ATF recommendations. • Work with ATF *and Women's Caucus* to coordinate an activity for Long Term Survivors Day (June 5); activity can be leveraged to build consumer-led coalitions. ➢ "All Caucus" Co-Chairs met and determined that "All Caucus" efforts be placed on hold until LAC Human Relations Commission training has concluded

STATEMENT OF PROCEEDINGS FOR THE

REGULAR MEETING OF THE BOARD OF SUPERVISORS

OF THE COUNTY OF LOS ANGELES HELD VIRTUALLY IN

ROOM 381B OF THE KENNETH HAHN HALL OF ADMINISTRATION

500 WEST TEMPLE STREET, LOS ANGELES, CALIFORNIA 90012

Tuesday, September 28, 2021

9:30 AM

14. Addressing the Sexually Transmitted Disease (STD) Crisis in Los Angeles County

Recommendation as submitted by Supervisor Solis: Instruct the Director of Public Health, in collaboration with the Directors of Health Services, Mental Health, the Alliance for Health Integration, and the Chief Executive Officer through the Anti-Racism, Diversity and Inclusion Initiative, to report back to the Board within 120 days with an updated plan of action to address the STD crisis, incorporating progress and ongoing challenges outlined in the quarterly STD reports and progress to date on goals included in the Center for Health Equity's STD focus area, with considerations to the plan to include, but not be limited to:

Analysis of all existing funding streams, including Federal, State and local resources currently utilized or available for STD response;

Establishing a planning process to ensure coordination of efforts with the Alliance for Health Integration and relevant County Departments, community partners, including community-based organizations and advocates, Federally-qualified health centers, hospitals, and health plans, to support shared goals around reducing STD rates, including sharing best practices and reducing redundant efforts and squarely addressing the inequities in race that prevent accesses to compassionate, basic health care as defined in the "social determinants of health" that continue to exponentially propel this preventable epidemic;

Analysis of community capacity and infrastructure needs to respond to the STD crisis, including identifying key populations that are disproportionately impacted and least resourced, and an outline of key steps to build capacity for communities to respond, as well as strategies for working with the Anti-Racism, Diversity and Inclusion Initiative to address the intersection of racism, stigma and sexual health;

Training opportunities to develop skills to provide culturally humble and linguistically appropriate outreach, education and marketing; and

A framework and timeline, including key metrics and milestone goals, for ending the STD crisis in Los Angeles County;

Instruct the Director of Public Health to create a public-facing STD dashboard to track the County's progress towards reducing STD rates; and

Direct the Chief Executive Officer through the Legislative Affairs and Intergovernmental Relations Division, and County advocates in Sacramento and Washington, D.C. to coordinate with the Directors of Public Health, Health Services and Mental Health to advocate with Governor Gavin Newsom, the State Legislature, the California Department of Public Health, the California Department of Health and Human Services, and Congress for additional Federal and State resources to combat the STD crisis, support the initiatives detailed in the Director of Public Health's report back, and identify STD-related legislative and budget proposals to help alleviate the crisis, build and support the County's STD public health infrastructure, expand access to STD testing and treatment and improve community education. (21-3445)

Bridget Gordon, Katja Nelson, Sylvia Castillo, Eric Preven, Dr. Genevieve Clavreul and Rolando Chavez addressed the Board. Interested person(s) also submitted written testimony.

Supervisor Hahn made a motion to amend Supervisor Solis' motion to instruct the Director of Public Health to include in the report back to the Board a plan for fully utilizing the County's public health clinics to provide Sexually Transmitted Disease (STD) testing and treatment; and a strategy for deploying mobile teams to test people, particularly those who are experiencing homelessness.

After discussion, on motion of Supervisor Solis, seconded by Supervisor Kuehl, this item, as amended, was duly carried by the following vote; and the Director of Public Health was instructed to include in the report back to the Board a plan for fully utilizing the County's public health clinics to provide STD testing and treatment; and a strategy for deploying mobile teams to test people, particularly those who are experiencing homelessness:

Ayes: 5 - Supervisor Mitchell, Supervisor Kuehl, Supervisor Hahn, Supervisor Barger and Supervisor Solis

Attachments:
Motion by Supervisor Solis
Report
Public Comment/Correspondence
Audio I
Audio II

The foregoing is a fair statement of the proceedings of the regular meeting held September 28, 2021, by the Board of Supervisors of the County of Los Angeles and ex officio the governing body of all other special assessment and taxing districts, agencies and authorities for which said Board so acts.

Celia Zavala, Executive Officer
Executive Officer-Clerk
of the Board of Supervisors

By 

Celia Zavala
Executive Officer

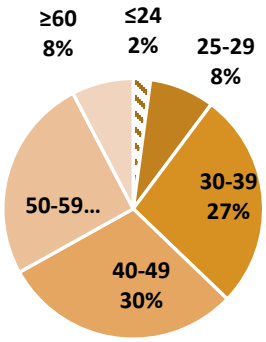
Clinical Quality Management Program Performance Measure Dashboard

Ambulatory Outpatient Medical (AOM) Services

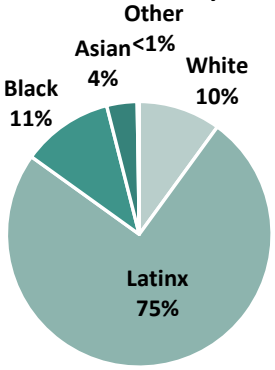
Client Demographics

5,653 clients had at least one Medical Outpatient service between March 1, 2020 - February 28, 2021 (RW Year 30)

Age Group (In Years)

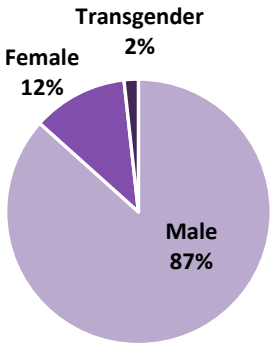


Race/Ethnicity



Other includes 10 Native Hawaiian/ Pacific Islander and 4 Native American/Alaskan Native

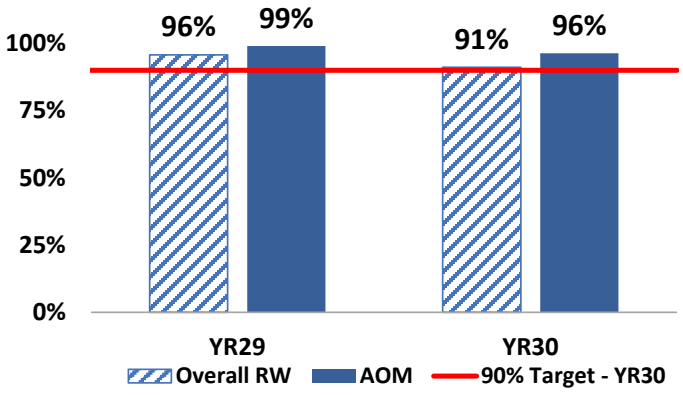
Gender



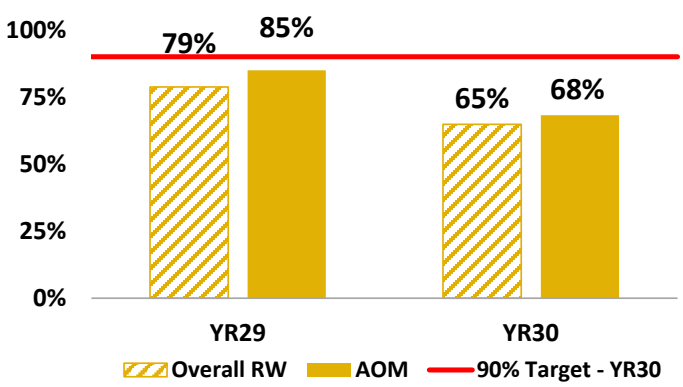
- 56% were living at or below the Federal Poverty Level (FPL)
- 5% experienced homelessness
- 3% were incarcerated within the past 24 months
- 71% were men who have sex with men
- 2% reported past injection drug use

Engagement & Retention

Engaged in Care

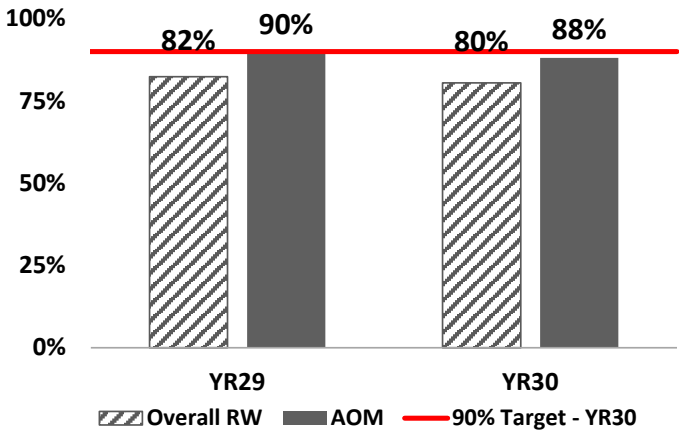


Retained in Care

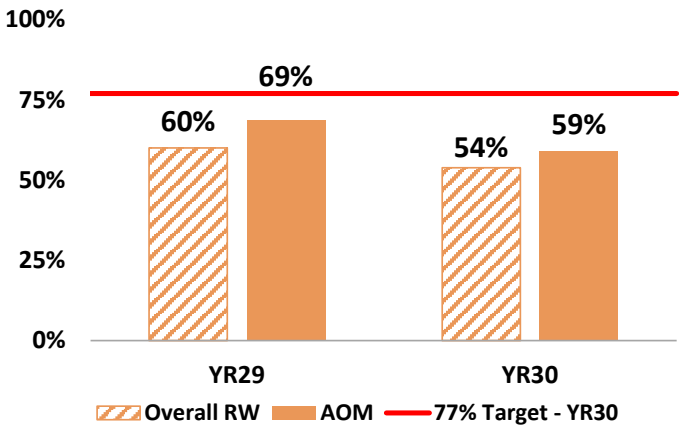


Viral Suppression (VS)

Viral Suppression



Sustained Viral Suppression



Ambulatory Outpatient Medical (AOM) Services

About

The Clinical Quality Management (CQM) Program Performance Measure Dashboards are intended to inform DHSP's quality improvement (QI) efforts and to be used to determine the efficacy and progress of quality improvement activities. Our hope is that consumers of HIV services and our subrecipient network providing these services will also benefit from these Dashboards and be able to use them to guide improvement efforts as well.

Ambulatory Outpatient Medical (AOM) Services

AOM services provide evidenced-based preventive, diagnostic, and therapeutic HIV medical services through outpatient medical visits to Ryan White Program (RWP) eligible people living with HIV. AOM services are expected to interrupt or delay the progression of HIV disease; prevent and treat opportunistic infections; promote optimal health and quality of life; and reduce further HIV transmission through education and support for appropriate risk reduction strategies.

Data Methodology

These dashboards were developed with data reported in the HIV Casewatch system by Ryan White-funded agencies in Los Angeles County. This report reflects outcomes for clients who utilized Ryan White (RW) AOM services during the reporting period from March 1, 2020 to February 28, 2021. This service category was selected based on the Health Resources and Services Administration's (HRSA) criteria to monitor performance measures for services that are used by at least 16% of all RW clients.

In order to estimate outcomes, HIV laboratory data (viral load, CD4, and genotype tests) were obtained for RW clients from the Los Angeles County HIV Surveillance system. The HIV-related outcomes and their definitions are based on HRSA HIV/AIDS Bureau recommendations and the U.S. Department of Health and Human Services guidelines.

● Engagement in HIV Care: ≥1 viral load, CD4 or genotype test reported in the 12 months before the end of the reporting period.

● Retention in HIV Care: ≥2 viral load, CD4 or genotype tests reported at >90 days apart in the 12 months before the end of the reporting period.

● Viral Suppression: viral load of <200 copies/ml at most recent test reported in the 12 months before the end of the reporting period. Clients with missing viral load tests are considered to have unsuppressed viral load in the time period.

● Sustained Viral Suppression: of clients with at least two viral load tests, all viral load test results are <200 copies/ml in the 12 months before the end of the reporting period. Clients with missing results or with less than two viral load tests are considered to have non-sustained viral suppression in the time period.

Summary and Analysis

● 5,653 clients, or 33%, of the 16,960 RWP clients received AOM services in YR 30.

● Compared to RWP clients overall, the percentage of Latinx clients receiving AOM services was much higher at 75% (53% overall).

● Engagement and viral suppression outcomes did not change substantially compared to YR 29; retention and sustained viral suppression decreased.

● Compared to RWP clients overall served in YR 30, AOM clients had higher engagement in care, retention in care, viral suppression and sustained viral suppression.

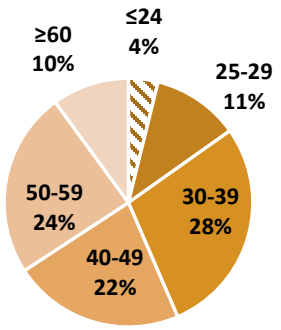
Clinical Quality Management Program Performance Measure Dashboard

Medical Care Coordination (MCC) Services

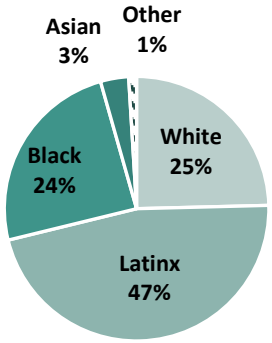
Client Demographics

8,350 clients had at least one Medical Care Coordination service between March 1, 2020 - February 28, 2021 (RW Year 30)

Age Group (In Years)

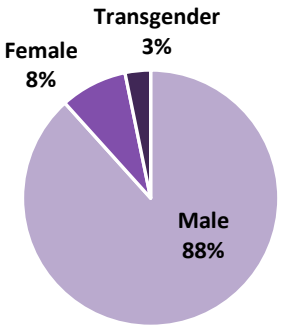


Race/Ethnicity



Other includes 44 Native Hawaiian/Pacific Islander and 26 Native American/Alaskan Native

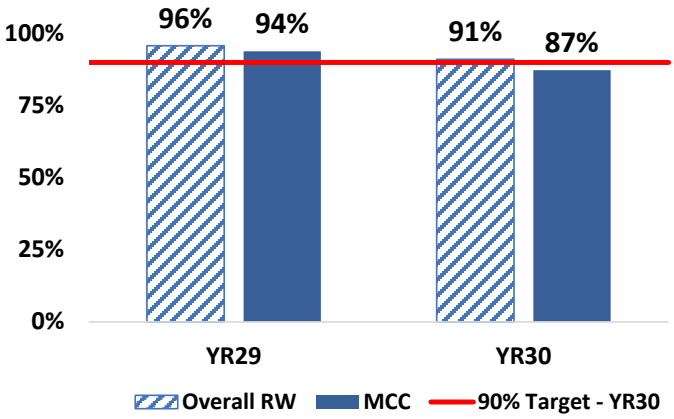
Gender



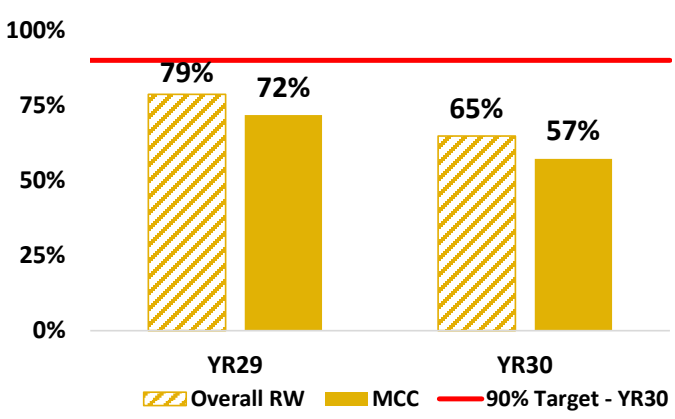
- 67% lived at or below the Federal Poverty Level (FPL)
- 15% experienced homelessness
- 10% were incarcerated within the past 24 months
- 77% were men who have sex with men
- 5% reported past injection drug use

Engagement & Retention

Engaged in Care

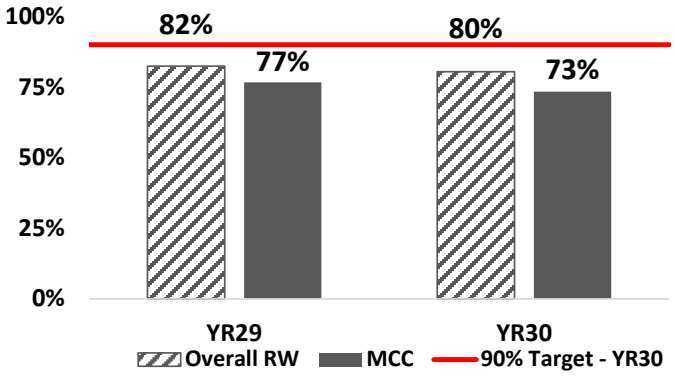


Retained In Care

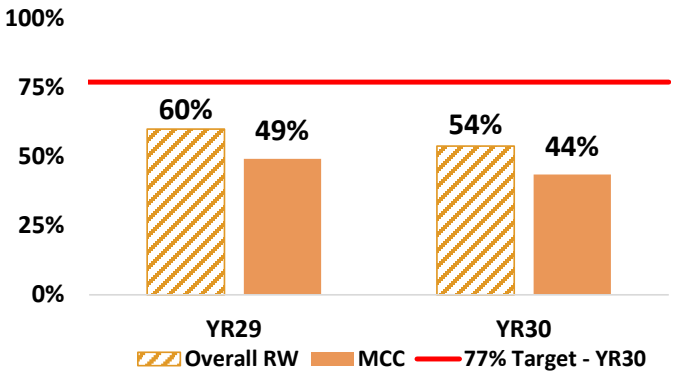


Viral Suppression (VS)

Viral Suppression



Sustained Viral Suppression



Medical Care Coordination (MCC) Services

About

The Clinical Quality Management (CQM) Program Performance Measure Dashboards are intended to inform DHSP's quality improvement (QI) efforts and to be used to determine the efficacy and progress of quality improvement activities. Our hope is that consumers of HIV services and our subrecipient network providing these services will also benefit from these Dashboards and be able to use them to guide improvement efforts as well.

Medical Care Coordination (MCC) Services

MCC is a model of care designed to provide behavioral interventions and support services in coordination with medical care to fully respond to patients' needs, and to promote treatment adherence and health outcomes. The primary goals of the MCC program are to increase retention in HIV care; improve adherence to antiretroviral therapy (ART); link patients to mental health, substance abuse and housing support services; and reduce HIV transmission through sexual risk reduction counseling and education.

Data Methodology

The Quality Improvement dashboards were developed with data reported in the HIV Casewatch system by Ryan White-funded agencies in Los Angeles County. This report reflects outcomes for clients who utilized Ryan White (RW) MCC services during the reporting period from March 1, 2020 to February 28, 2021. This service category was selected based on Health Resources and Services Administration (HRSA) criteria to monitor performance measures for services that are used by at least 16% of all RW clients.

In order to estimate outcomes, HIV laboratory data (viral load, CD4, and genotype tests) were obtained for RW clients from the Los Angeles County HIV Surveillance system. The HIV-related outcomes and their definitions are based on HRSA HIV/AIDS Bureau recommendations and the U.S. Department of Health and Human Services guidelines.

● Engagement in HIV Care: ≥1 viral load, CD4 or genotype test reported in the 12 months before the end of the reporting period.

● Retention in HIV Care: ≥2 viral load, CD4 or genotype tests reported at >90 days apart in the 12 months before the end of the reporting period.

● Viral Suppression: viral load of <200 copies/ml at most recent test reported in the 12 months before the end of the reporting period. Clients with missing viral load tests are considered to have unsuppressed viral load in the time period.

● Sustained Viral Suppression: of clients with at least two viral load tests, all viral load test results are <200 copies/ml in the 12 months before the end of the reporting period. Clients with missing results or with less than two viral load tests are considered to have non-sustained viral suppression in the time period.

Summary and Analysis

● 8,350 clients, or 49%, of the 16,960 RWP clients received MCC services in YR 30.

● There were more White and Black clients (25% and 24% respectively) receiving MCC services compared to overall RWP clients (21% White and 22% Black). 47% of MCC patients served were Latinx while they made up 53% of overall RWP clients.

● More MCC clients were younger than age 40 (44%) than overall RWP clients (35%).

● MCC clients had lower percentages of engagement in care, retention in care, viral suppression, and sustained viral suppression compared to overall RWP clients in YR 30.

● Engagement in care, retention in care, and viral suppression outcomes decreased among MCC clients in YR 30 compared to clients who received MCC services in YR 29.

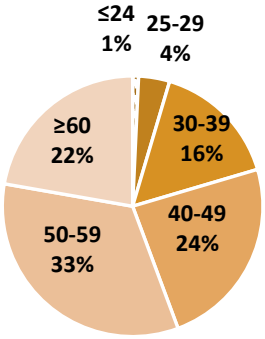
Clinical Quality Management Program Performance Measure Dashboard

Oral Health (General and Specialty)

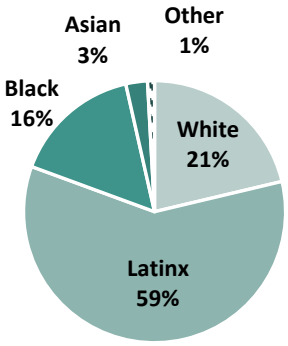
Client Demographics

3,377 clients received at least one Oral Health service between March 1, 2020 - February 28, 2021 (RW Year 30)

Age Group (In Years)

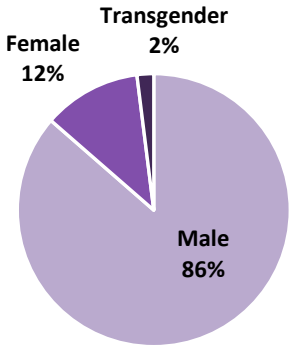


Race/Ethnicity



Other includes 19 Native Hawaiian/Pacific Islander and 9 Native American/Alaskan Native

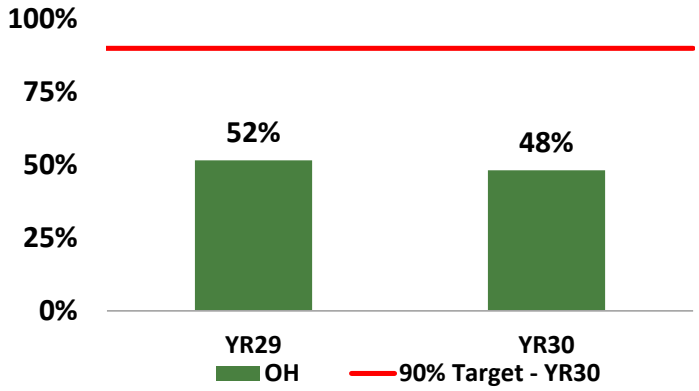
Gender



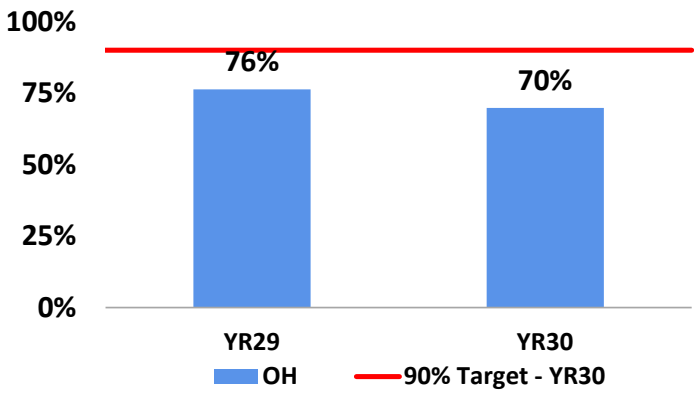
- 54% were living at or below the Federal Poverty Level (FPL)
- 5% experienced homelessness
- 4% were incarcerated within the past 24 months
- 75% were men who have sex with men
- 3% reported past injection drug use

Performance Measures

Received Periodontal Services

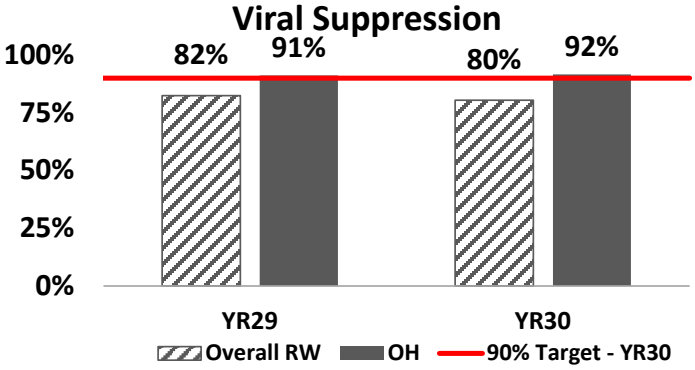


Received Oral Health Education

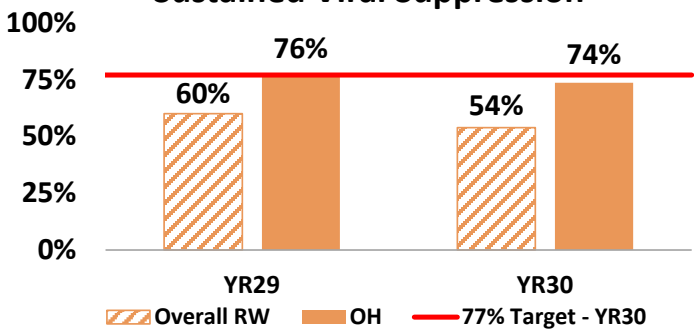


Viral Suppression

Viral Suppression



Sustained Viral Suppression



Oral Health (General and Specialty)

About

The Clinical Quality Management (CQM) Program Performance Measure Dashboards are intended to inform DHSP's quality improvement (QI) efforts and to be used to determine the efficacy and progress of quality improvement activities. Our hope is that consumers of HIV services and our subrecipient network providing these services will also benefit from these Dashboards and be able to use them to guide improvement efforts as well.

Oral Health (OH) Services

Oral health is an integral part of primary medical care for all people living with HIV (PLWH). The data included in this report represents data from both the General and Specialty Dental Services.

General Dentistry Services (GOS) includes diagnostic, prophylactic, and therapeutic dentistry services rendered by licensed dentists, registered dental hygienists, registered dental assistants, and other similarly trained professional practitioners. Specialty Dentistry Services (SOS) are those oral health care services beyond the scope of GOS, where advanced knowledge and skills are essential to maintain or restore oral function and healing.

Data Methodology

These dashboards were developed with data reported in the HIV Casewatch system by Ryan White-funded agencies in Los Angeles County (LAC). This report reflects outcomes for clients who utilized Ryan White (RW) OH services during the reporting period from March 1, 2020 to February 28, 2021. This service category was selected based on Health Resources and Services Administration's (HRSA) criteria to monitor performance measures for services that are used by at least 16% of all RW clients.

In order to estimate outcomes, HIV laboratory data (viral load, CD4, and genotype tests) were obtained for RW clients from the Los Angeles County HIV Surveillance system. The HIV-related outcomes and their definitions are based on HRSA HIV/AIDS Bureau recommendations and the U.S. Department of Health and Human Services guidelines. Targets for OH specific measures are based on LAC Commission on HIV's Oral Health Care Standards of Care.

● Received Periodontal Services: Percentage of OH clients who had a periodontal screening, examination and treatment at least once in the measurement year.

● Received Oral Health Education: Percentage of OH clients who received oral health education at least once in the measurement year.

● Viral Suppression: viral load of <200 copies/ml at most recent test reported in the 12 months before the end of the reporting period. Clients with missing viral load tests are considered to have unsuppressed viral load in the time period.

● Sustained Viral Suppression: of clients with at least two viral load tests, all viral load test results are <200 copies/ml in the 12 months before the end of the reporting period. Clients with missing results or with less than two viral load tests are considered to have non-sustained viral suppression in the time period.

Summary and Analysis

● 3,377 clients, or 20%, of the 16,960 RWP clients received OH services in YR 30.

● There was a slightly higher proportion of Latinx clients receiving OH services (59%) compared to the proportion of overall RWP Latinx clients (53%).

● The proportion of older clients (over age 40) receiving OH services (80%) was higher compared to that of overall RWP clients (65%).

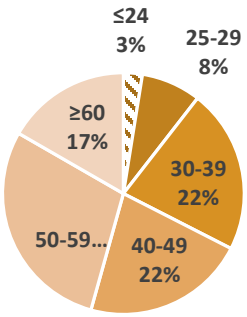
Clinical Quality Management Program Performance Measure Dashboard

Benefit Specialty Services (BSS)

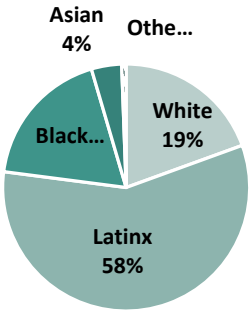
Client Demographics

4,542 clients had at least one Benefits Specialty Services between March 1, 2020 - February 28, 2021 (RW Year 30)

Age Group (In Years)

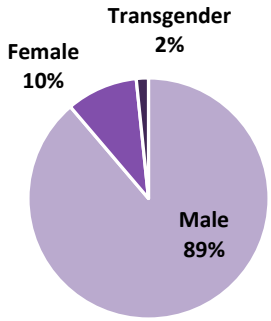


Race/Ethnicity



Other includes 13 Native Hawaiian/Pacific Islander and 13 Native Hawaiian/Alaskan Native

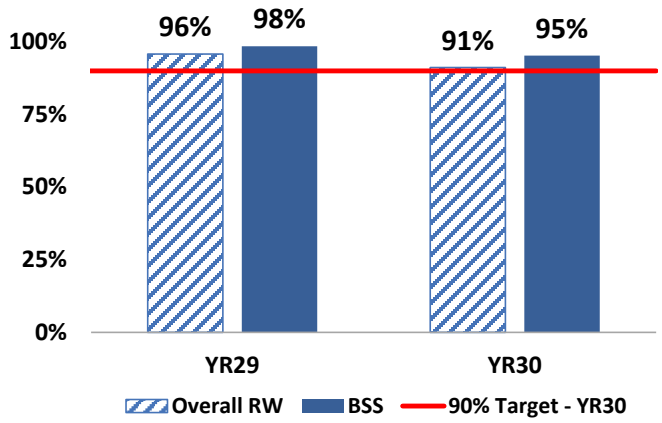
Gender



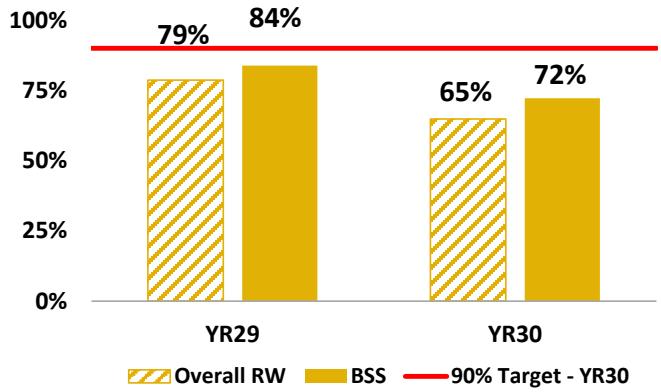
- 53% were living at or below the Federal Poverty Level (FPL)
- 6% experienced homelessness
- 5% were incarcerated within the past 24 months
- 75% were men who have sex with men
- 4% reported past injection drug

Engagement & Retention

Engaged in Care

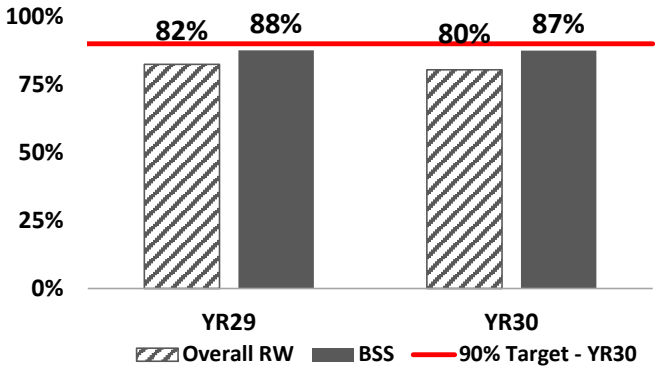


Retained In Care

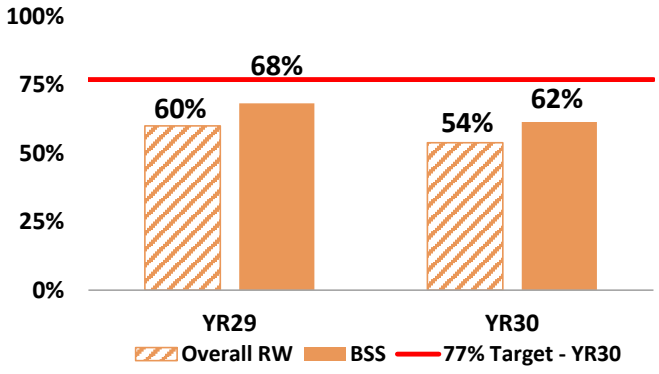


Viral Suppression (VS)

Viral Suppression



Sustained Viral Suppression



Clinical Quality Management Program Performance Measure Dashboard

Benefit Specialty Services (BSS)

About

The Clinical Quality Management (CQM) Program Performance Measure Dashboards are intended to inform DHSP's quality improvement (QI) efforts and to be used to determine the efficacy and progress of quality improvement activities. Our hope is that consumers of HIV services and our subrecipient network providing these services will also benefit from these Dashboards and be able to use them to guide improvement efforts as well.

Benefit Specialty Services (BSS)

BSS facilitate a client's access to public/private health and disability benefits and programs. Benefits specialty services work to maximize public funding by helping clients identify all available health and disability benefits supported by funding streams other than the Ryan White Part A funds.

Data Methodology

The Quality Improvement dashboards were developed with data reported in the HIV Casewatch system by Ryan White-funded agencies in Los Angeles County. This report reflects outcomes for clients who utilized Ryan White (RW) BSS services during the reporting period from March 1, 2020 to February 28, 2021. This service category was selected based on Health Resources and Services Administration (HRSA) criteria to monitor performance measures for services that are used by at least 16% of all RW clients.

In order to estimate outcomes, HIV laboratory data (viral load, CD4, and genotype tests) were obtained for RW clients from the Los Angeles County HIV Surveillance system. The HIV-related outcomes and their definitions are based on HRSA HIV/AIDS Bureau recommendations and the U.S. Department of Health and Human Services guidelines.

● Engagement in HIV Care: ≥1 viral load, CD4 or genotype test reported in the 12 months before the end of the reporting period.

● Retention in HIV Care: ≥2 viral load, CD4 or genotype tests reported at >90 days apart in the 12 months before the end of the reporting period.

● Viral Suppression: viral load of <200 copies/ml at most recent test reported in the 12 months before the end of the reporting period. Clients with missing viral load tests are considered to have unsuppressed viral load in the time period.

● Sustained Viral Suppression: of clients with at least two viral load tests, all viral load test results are <200 copies/ml in the 12 months before the end of the reporting period. Clients with missing results or with less than two viral load tests are considered to have non-sustained viral suppression in the time period.

Summary

● 4,542 clients, or 27%, of the 16,960 clients received RW funded BSS in RW YR 30.

● The percentage of Latinx clients receiving BSS was higher (58%) compared to the percentage of overall Latinx RW clients (53%).

● Engagement and suppression outcomes did not change substantially between YR29 and YR30 among BSS clients; retention and sustained viral suppression decreased.

● The proportion of BSS clients engaged and retained in care, virally suppressed and with sustained viral suppression was higher than the respective proportions of RW clients overall.

Division of HIV and STD Programs (DHSP)

July 2021

Volume 1, Issue 2

WELCOME TO ISSUE #2

THE DHSP CLINICAL QUALITY MANAGEMENT (CQM) PROGRAM NEWSLETTER

IN THIS ISSUE: CQM Program News || Performance Measures || CQII Create+ Equity || HIV Continuum

CQM PERFORMANCE MEASURES

Performance measurement is a vital part of quality improvement and allows DHSP to determine whether the care that clients receive meets or exceeds the desired quality as stipulated in contracts and established by local and national benchmarks. Performance measures provide the data necessary to identify opportunities for improvement and guide progress through tests of change. Consistent with HRSA/HAB recommendations, the CQM performance measures should reflect the impact of HIV intervention strategies outlined in the Los Angeles County (LAC) HIV/AIDS Strategy for 2020 and Beyond (LACHAS) and the LAC Ending the HIV Epidemic (EHE) plan.

As noted in the following graphs, performance in all measures saw a brief decline, particularly in engagement and retention in care, during the initial period of the COVID-19 pandemic (March – May 2020). Although most services recovered quickly, the client's served by Medical Care Coordination (MCC) services appear to have been most negatively affected by the COVID-19 pandemic's impact on in-person care services and the inability of clients to access clinical or laboratory services across LAC. Viral suppression rates remained relatively stable throughout this time.

CQM PROGRAM
QUARTERLY PERFORMANCE MEASURES

PERFORMANCE MEASURES METRICS AND DEFINITIONS

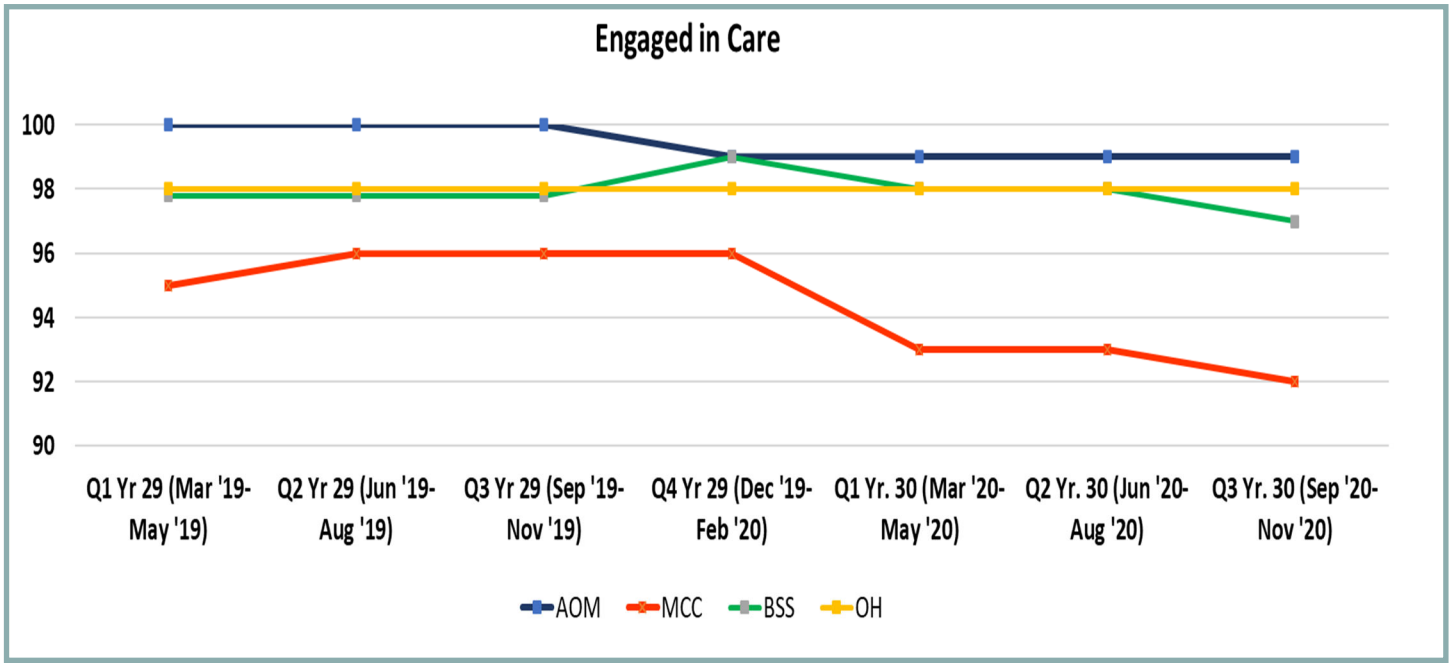
Engagement in Care: ≥ 1 VL, CD4 or genotype test reported in the 12 months prior to quarters end.

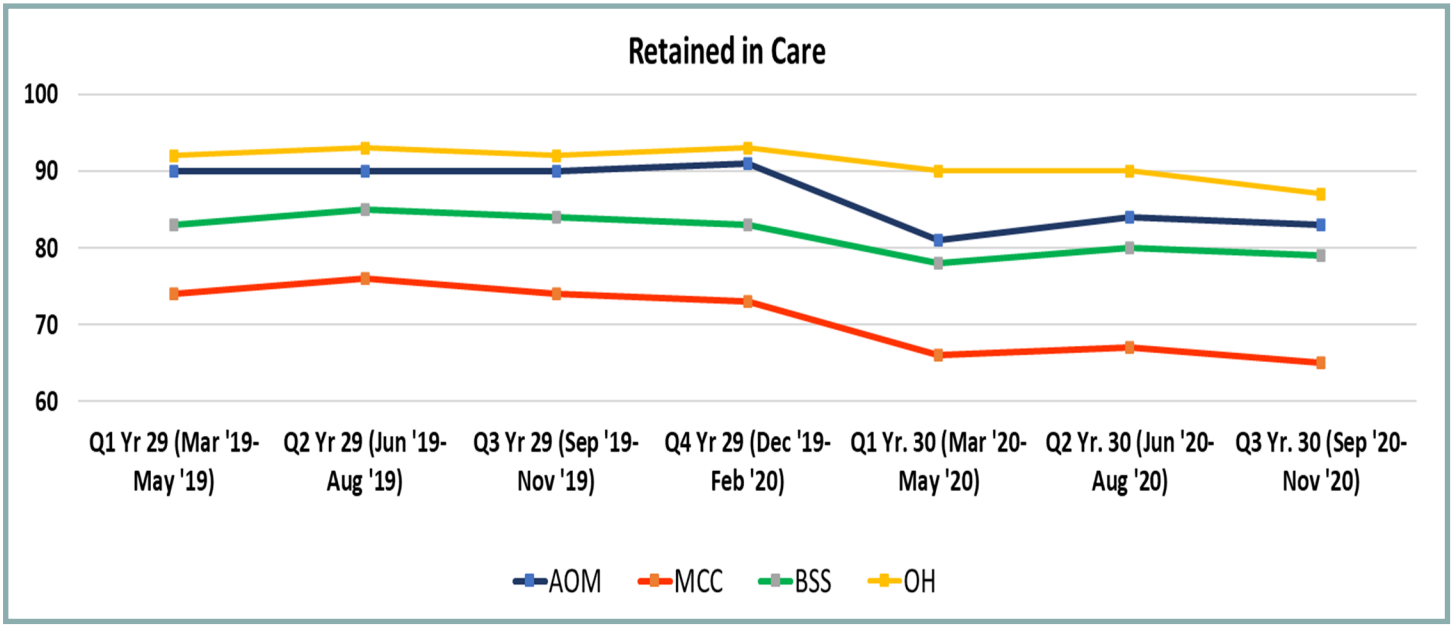
Retention in Care: ≥ 2 VL, CD4 or genotype test reported (> 90 day apart) in the 12 months prior to quarters end.

Viral Load Suppression: VL < 200 copies/ml at most recent test reported in the 12 months prior to quarters end.

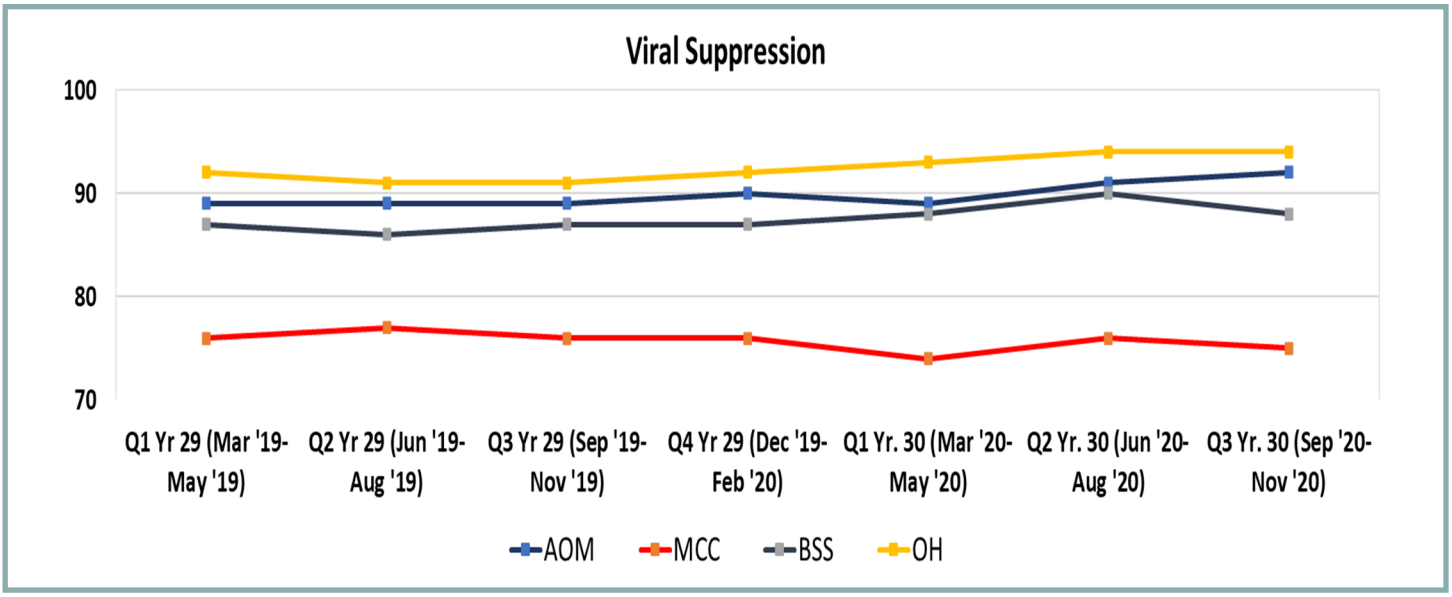
Durable Viral Load Suppression: HIV VL of < 200 copies/ml at all tests in the measurement period.

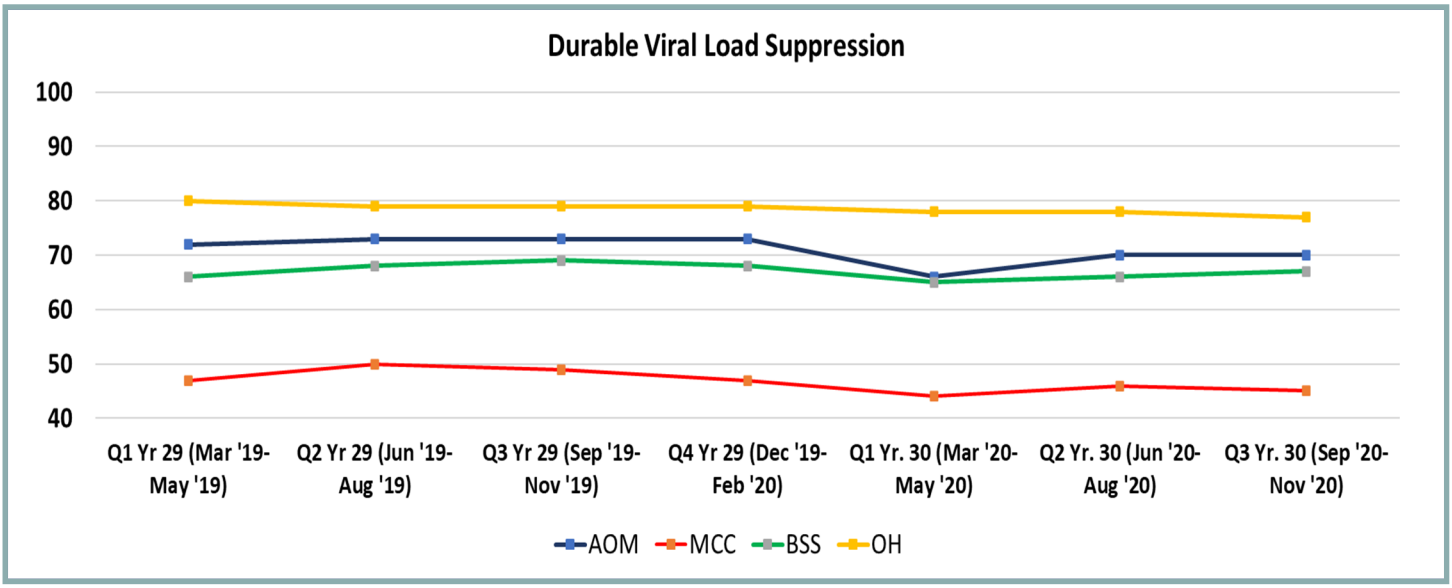
Periodontal Screening/Treatment (Oral Health Only): Percentage of clients who had ≥ 1 periodontal screening or treatment in the measurement period.

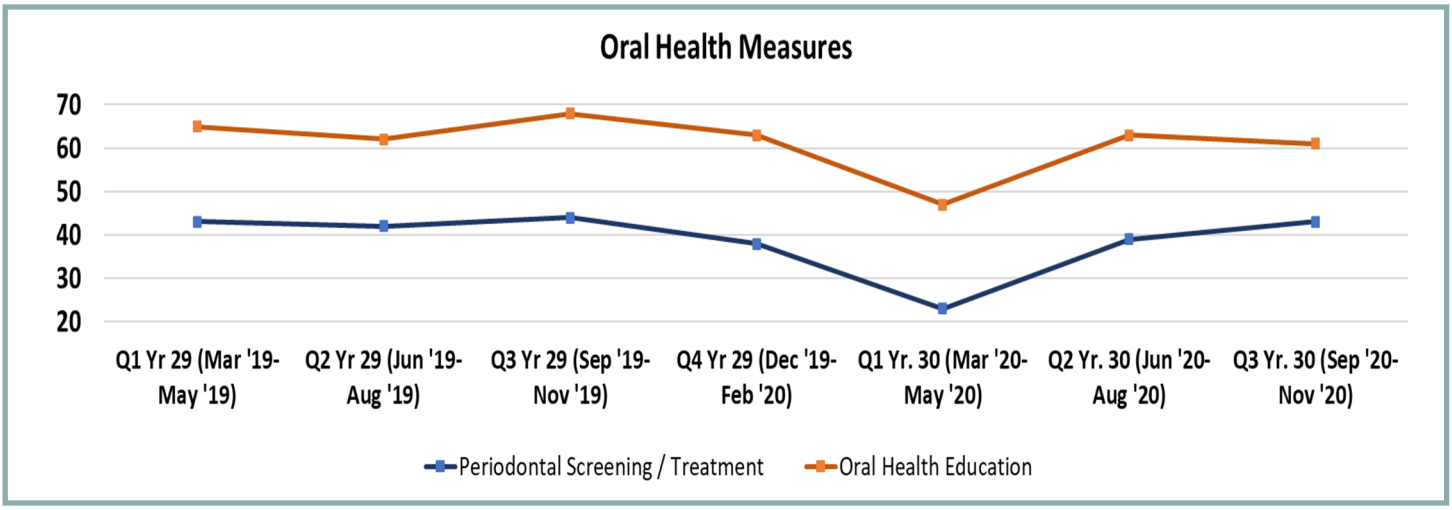




CQM PROGRAM
QUARTERLY PERFORMANCE MEASURES







CREATE+EQUITY
QUALITY COLLABORATIVE
NOV. 2020—MAY 2022

The ***Create+Equity Collaborative*** is a national quality improvement initiative designed to mitigate barriers associated with the social determinants of health that are experienced by people with HIV. The focus is on improving the viral suppression of patients experiencing unstable housing, substance use, mental health issues, and barriers associated with their age. The 18-month collaborative aims to improve health outcomes and advance local quality improvement capacities. The ***Create+Equity Collaborative*** managed by the HRSA Ryan White HIV/AIDS Program Center for Quality Improvement & Innovation (CQII) and is supported by the HRSA HIV/AIDS Bureau.

PROJECT AIM: By July 2022, LAC MCC Program Team will increase viral load suppression by 5 percentage points from a baseline of 83% to 88% for persons with HIV experiencing homelessness, or temporarily or unstably housed at last MCC assessment.

DHSP has partnered with **AIDS Healthcare Foundation (AHF)** to form the ***LAC MCC Program Team*** and will be focused on eliminating disparities in viral suppression rates for Medical Care Coordination (MCC) clients experiencing housing instability and homelessness.

Mar 21 (Baseline)	May 21	Jul 21	Sept 21	Nov 21	Jan 22	Mar 22
83%	80%	83%	TBD	TBD	TBD	TBD

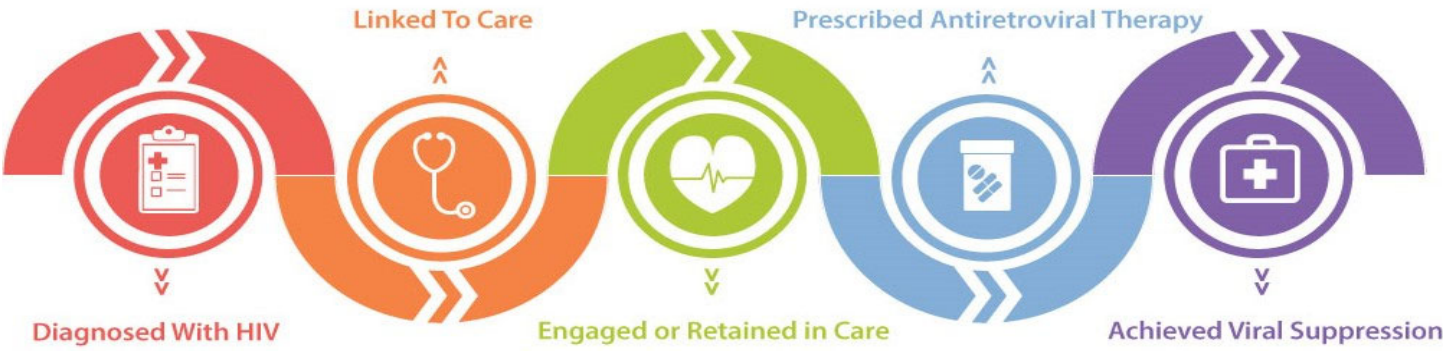
Participation benefits include:

- Improved viral suppression rates
- Alignment with HRSA HIV/AIDS Bureau clinical quality management expectations
- Access to nationally recognized content experts
- Routine access to benchmarking data on key social determinants of health barriers
- Access to evidence-informed interventions that address social determinants of health
- Strengthened partnerships with other HIV providers locally and across the country
- Increased quality improvement capacity of HIV providers and consumers

….Stay Tuned for Updates

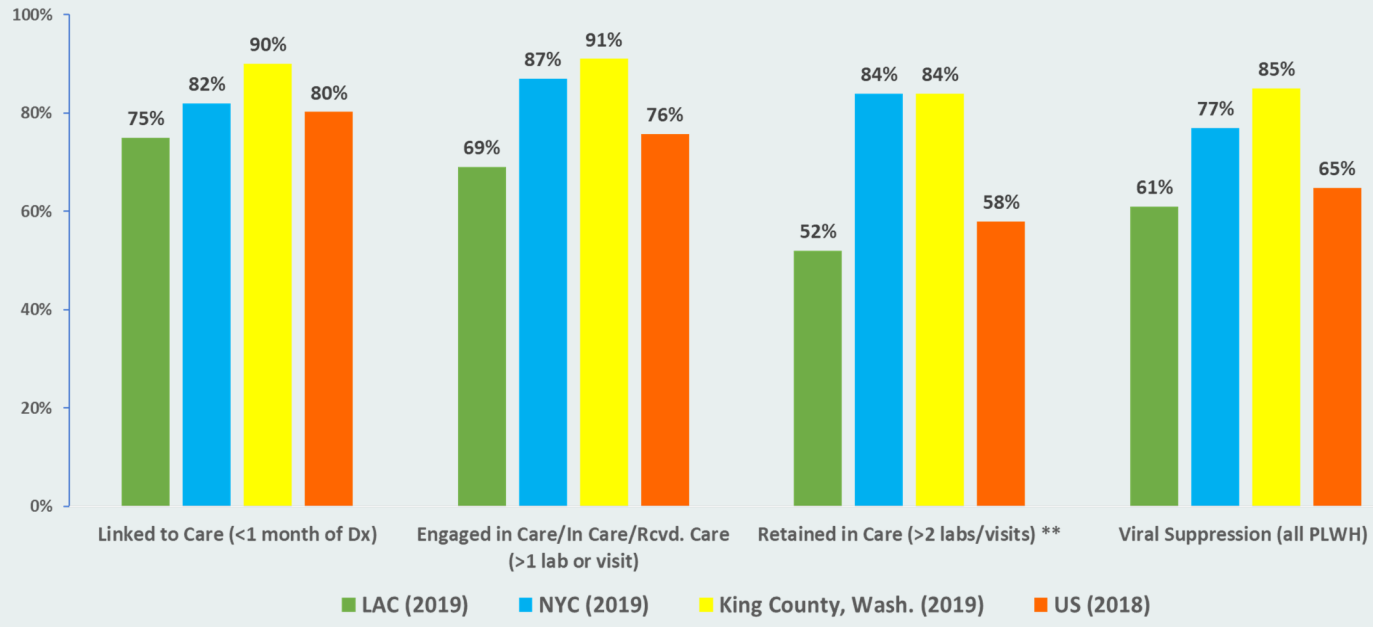
HIV CARE CONTINUUM

"The HIV care continuum is a representation of the extent to which individuals living with HIV are diagnosed, engaged in care and benefiting from antiretroviral therapy in terms of full viral suppression (undetectable lab values). The value of the continuum in managing the HIV epidemic is compelling: individuals engaged in care can manage HIV as a chronic condition and simultaneously reduce the risk of transmitting the virus to others." - TargetHIV.org



Based on feedback from the Commission on HIV, the following is presented to demonstrate how the HIV epidemic in LAC varies in comparison to other jurisdictions and the US overall. While metrics vary slightly based on location, the below graph identifies the improvement opportunities and gaps in care that persist in LAC.

HIV Continuum comparing Los Angeles County (LAC) to NYC, King County, WA, and the US

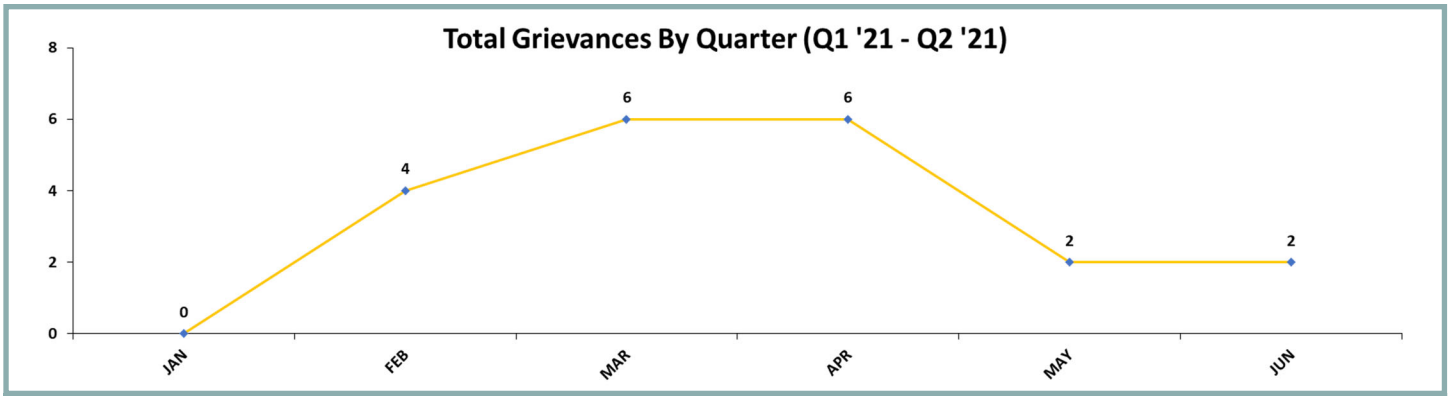


Data Sources: LAC - 2019 Annual HIV Surveillance Report, US – CDC HIV Surveillance Report; Supplemental Report Vol. 25, No.2 (2018), NYC – HIV Surveillance Annual Report (2019), King County, Wash. – HIV/AIDS Epidemiology Report, 2020.

** NYC: Prescribed ART is used for retained in care metric. Defined/calculated as # of PLWH retained in care multiplied by estimated proportion of PLWH prescribed ART in prior 12 months.

GRIEVANCE MANAGEMENT PROGRAM

The DHSP Grievance Management Program aims to resolve grievances and/or quality of care issues identified at DHSP funded agencies. Grievances are received by DHSP's Grievance Management Unit (GMU) via the warmline, referral, or through other agency oversight activities (e.g., contract monitoring) and may include grievances reported by clients, client representatives, agency or DHSP staff, community partners and other stakeholders. GMU staff work directly with the agencies to resolve the grievance through a variety of communication and investigation activities including the development of corrective actions, as appropriate. Every effort is made to resolve grievances within 60 days of receipt.



Grievances Received by Service Category	Q1 '21	Q2 '21
Ambulatory Outpatient Medical (AOM)	1	2
Substance Abuse		
RCFCI/TCRF		1
Mental Health		
Oral Health	1	1
Vulnerable Populations	1	
Nutritional Support		
Unknown/Unstated, Non-jurisdictional, Non-Grievance Related (i.e., Request for Resources)	7	6
Total	**10**	**10**
Grievances Received by Complaint Category		
Inappropriate/Unprofessional Behavior	1	1
Substandard Care/Service or Facility/Accommodations	4	3
Delayed Care or Service		2
Denial of Service		
Excessive Wait Time	1	
Request for Resources, Unknown (i.e. No response from Complainant)	4	4
Total	**10**	**10**

In 2011, in keeping with National efforts to better integrate HIV and STD public health efforts, the Department of Public Health combined the HIV Epidemiology Program, the Office of AIDS Programs and Policy, and the Sexually Transmitted Disease Program to form the Division of HIV and STD Programs (DHSP). DHSP continues to work closely and collaboratively with community-based organizations, other governmental offices, advocates, and people living with HIV/AIDS as it seeks to control the spread of HIV and sexually transmitted diseases, monitor HIV/AIDS and STD morbidity and mortality, increase access to care for those in need, and eliminate HIV-related health inequalities.

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COUNTY OF LOS ANGELES
Public Health

REGIONAL QUALITY UPDATES

California Regional Group - As part of CQII's End+Disparities ECHO Collaborative, LAC RWP recipients and subrecipients demonstrated strong involvement in the collaborative designed to eliminate disparities among highly affected subpopulations: MSM of Color, Youth, Women of Color, and Transgender Persons. The Collaborative officially ended in 2019 but California participants including DHSP have continued meeting as the California Regional Group or CARG, to continue working toward the viral suppression goals established during the Collaborative. The original CARG included HIV provider agencies from the California Department of Public Health Office of AIDS as well as Los Angeles, Riverside, San Bernardino and Orange counties.

In 2020, CARG developed a plan for sustainability, inviting additional counties (Alameda, San Francisco, and San Diego) to join the fight to End the HIV Epidemic. The new plan consists of monthly zoom calls, restructuring of member roles and responsibilities, and quarterly in-person meetings to share data, successes and lessons learned. Since early 2020, participating agencies continue to submit bi-monthly viral load suppression data related to one of the following priority populations: MSM of Color, Women of Color, Women of Color 18-30 years, Youth and Persons Experiencing Homelessness (PEH).

Table 1—Viral Load Suppression Rates by CARG Priority Population

Priority Population	March 2020	Nov 2020
MSM of Color	83%	89%
Youth	25%	33%
Persons Experiencing Homelessness	76%	83%
Women of Color (all ages)	92%	91%
Women of Color (18-30 yrs.)	53%	72% (Sept. 2020)

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