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PUBLIC POLICY COMMITTEE

Meeting

Monday, March 4, 2024
1:00pm-3:00pm (PST)

Vermont Corridor
510 S. Vermont Ave. Terrace Conference Room TK05
****Valet Parking: 523 Shatto Place, LA 90020****

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

As a building security protocol, attendees entering the building must notify the parking attendant and security personnel that they are attending a Commission on HIV meeting to access the Terrace Conference Room (9th Floor).

Members of the Public May Join in Person or Virtually.
For Members of the Public Who Wish to Join Virtually, Register Here:
https://events.gcc.teams.microsoft.com/event/e345e98b-8f70-418a-a6bc-13ad0810d44e@7faea798-6ad0-4fc9-b068-fcbcaed341f6
To Join by Telephone: +1-213-204-2512 (285612346#)
Password: WqPYCi **Meeting ID:** 289 154 850 829

Notice of Teleconferencing Sites:
Bartz-Altadonna Community Health Center
43322 Gingham Ave, Lancaster, CA 93535

Scan QR code to download an electronic copy of the meeting agenda and packet on your smart device. Please note that hard copies of materials will not be made available during meetings unless otherwise determined by staff in alignment with the County's green initiative to recycle and reduce waste. **If meeting packet is not yet available, check back 2-3 days prior to meeting; meeting packet subject to change. Agendas will be posted 72 hours prior to meeting per Brown Act.*

together.

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

AGENDA FOR THE REGULAR MEETING OF THE LOS ANGELES COUNTY COMMISSION ON HIV PUBLIC POLICY COMMITTEE

MONDAY, MARCH 4, 2024 | 1:00 PM – 3:00 PM

510 S. Vermont Ave
Terrace Level Conference Room TK05
Los Angeles, CA 90020
Validated Parking: 523 Shatto Place, Los Angeles 90020

For those attending in person, as a building security protocol, attendees entering form the first-floor lobby must notify security personnel that they are attending the Commission on HIV meeting in order to access the Terrace Conference Room (9th floor) where our meetings are held.

NOTICE OF TELECONFERENCING SITE:
Bartz-Altadonna Community Health Center
43322 Gingham Ave, Lancaster, CA 93535

MEMBERS OF THE PUBLIC:
To Register + Join by Computer:
https://events.gcc.teams.microsoft.com/event/e345e98b-8f70-418a-a6bc-13ad0810d44e@7faea798-6ad0-4fc9-b068-fcbcaed341f6
To Join by Telephone: 1-213-204-2512 (285612346#)
Password: WqPYCi Meeting ID: 289 154 850 829

Public Policy Committee Members:			
Katja Nelson, MPP Co-Chair	Lee Kochems, MA Co-Chair	Alasdair Burton	Sandra Cuevas
Mary Cummings	Felipe Findley, PA-C, MPAS, AAHIVS	Bridget Gordon	Paul Nash, PhD, CPsychol, AFBPsS, FHEA
Ricky Rosales	Ronnie Osorio (alternate)		
QUORUM: 6			

AGENDA POSTED: February 29, 2024.

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

PUBLIC COMMENT: Public Comment is an opportunity for members of the public to comment on an agenda item, or any item of interest to the public, before or during the Commission's consideration of the item, that is within the subject matter jurisdiction of the Commission. To submit Public Comment, you may join the virtual meeting via your smart device and post your Public Comment in the Chat box -or- email your Public Comment to hivcomm@lachiv.org -or- submit your Public Comment electronically here. All Public Comments will be made part of the official record.

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 the Commission Office at (213) 738-2816 or via email at HIVComm@lachiv.org.

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

I. ADMINISTRATIVE MATTERS

1.	Call to Order & Meeting Guidelines/Reminders		1:00 PM – 1:03 PM
2.	Introductions, Roll Call, & Conflict of Interest Statements		1:03 PM – 1:05 PM
3.	Approval of Agenda	**MOTION #1**	1:05 PM – 1:07 PM
4.	Approval of Meeting Minutes	**MOTION #2**	1:07 PM – 1:10 PM

II. PUBLIC COMMENT 1:10 PM – 1:15 PM

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

III. COMMITTEE NEW BUSINESS ITEMS

6. 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

7. Executive Director/Staff Report 1:15 PM – 1:25 PM
   a. Operations and Programmatic Updates
8. Co-Chair Report 1:25 PM – 1:40 PM

a. "Commissioner Commitments"
   - How are you fulfilling your role/responsibilities as a commissioner?

b. Draft 2024 Workplan—Review and Adopt
c. Ryan White Care Act Modernization Project—Updates

V. DISCUSSION ITEMS

10. 2024 Legislative Docket—Updates 1:40 PM – 1:55 PM
11. 2023-2024 Policy Priorities—Review 1:55 PM – 2:25 PM
12. State Policy & Budget-- Updates 2:25 PM – 2:30 PM
13. Federal Policy-- Updates 2:30 PM – 2:40 PM
14. County Policy-- Updates 2:40 PM – 2:50 PM
    a. DPH Memo in response to STD Board of Supervisors (BOS) motion

VI. NEXT STEPS 2:50 PM – 2:55 PM

13. Task/Assignments Recap
14. Agenda development for the next meeting

VII. ANNOUNCEMENTS 2:55 PM – 3:00 PM

15. Opportunity for members of the public and the committee to make announcements

VIII. ADJOURNMENT 3:00 PM

16. Adjournment for the meeting of March 4, 2024.

PROPOSED MOTIONS	
MOTION #1	Approve the Agenda Order as presented or revised.
MOTION #2	Approve the Public Policy Committee minutes, as presented or revised.

HYBRID MEETING GUIDELINES, ETTIQUETTE & REMINDERS

(Updated 3.22.23)

☐ This meeting is a **Brown-Act meeting** and is being recorded.

- The conference room speakers are *extremely* sensitive and will pick up even the slightest of sounds, i.e., whispers. If you prefer that your private or side conversations, not be included in the meeting recording which, is accessible to the public, we respectfully request that you step outside of the room to engage in these conversations.
- Turn off your ringers/notifications on your smart devices so as not to disrupt the meeting.
- Your voice is important, and we want to ensure that it is captured accurately on the record. Please be respectful of one another and minimize crosstalk.

☐ The **meeting packet** can be found on the Commission's website at https://hiv.lacounty.gov/meetings/ or accessed via the QR code provided. Hard copies of materials will not be provided in compliance with the County's green initiative to recycle and reduce waste.

☐ Please comply with the **Commission's Code of Conduct** located in the meeting packet

☐ **Public Comment** for members of the public can be submitted in person, electronically @ https://www.surveymonkey.com/r/public_comments or via email at hivcomm@lachiv.org. *For members of the public attending virtually, you may also submit your public comment via the Chat box. Should you wish to speak on the record, please use the "Raised Hand" feature or indicate your request in the Chat Box and staff will call upon and unmute you at the appropriate time. Please note that all attendees are muted unless otherwise unmuted by staff.*

☐ For individuals joining in person, to mitigate any potential streaming interference for those joining virtually, we respectfully ask that you **not simultaneously log into the virtual option of this meeting via WebEx.**

☐ Committee members invoking **AB 2449 for "Just Cause" or "Emergency Circumstances**" must communicate their intentions to staff and/or co-chairs no later than the start of the meeting. Members requesting to join pursuant to AB 2449 must have their audio and video on, at all times, and disclose whether there is a person over the age of 18 in the room in order to be counted toward quorum and have voting privileges. For members joining virtually due to "Emergency Circumstances", a vote will be conducted by the Committee/COH for approval.

☐ Members will be required to explicitly state their agency's **Ryan White Program Part A and/or CDC prevention conflicts of interest** on the record (versus referring to list in the packet). A list of conflicts can be found in the meeting packet and are recorded on the back of members' name plates, courtesy of staff.

LOS ANGELES COUNTY
COMMISSION ON HIV

Approved by COH
6/8/23

510 S. Vermont Ave 14th Floor • Los Angeles, CA 90020 • TEL (213) 738-2816 • FAX (213) 637-6748
HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov

CODE OF CONDUCT

The Commission on HIV welcomes commissioners, guests, and the public into a space where people of all opinions and backgrounds are able to contribute. In this space, we challenge ourselves to be self-reflective and committed to an ongoing understanding of each other and the complex intersectionality of the lives we live. We create a safe environment where we celebrate differences while striving for consensus in the fights against our common enemies: HIV and STDs. We build trust in each other by having honest, respectful, and productive conversations. As a result, the Commission has adopted and is consistently committed to implementing the following guidelines for Commission, committee, and associated meetings.

All participants and stakeholders should adhere to the following:

1) **We approach all our interactions with compassion, respect, and transparency.**
2) **We respect others' time by starting and ending meetings on time, being punctual, and staying present.**
3) **We listen with intent, avoid interrupting others, and elevate each other's voices.**
4) **We encourage all to bring forth ideas for discussion, community planning, and consensus.**
5) **We focus on the issue, not the person raising the issue.**
6) **Be flexible, open-minded, and solution-focused.**
7) **We give and accept respectful and constructive feedback.**
8) **We keep all issues on the table (no "hidden agendas"), avoid monopolizing discussions and minimize side conversations.**
9) **We have no place in our deliberations for racist, sexist, homophobic, transphobic, and other discriminatory statements, and "-isms" including misogyny, ableism, and ageism.**
10) **We give ourselves permission to learn from our mistakes.**

In response to violation of the Code of Conduct which results in meeting disruption, Include provisions of SB 1100 which states in part, ". . . authorize the presiding member of the legislative body conducting a meeting or their designee to remove, or cause the removal of, an individual for disrupting the meeting . . . . Removal to be preceded by a warning to the individual by the presiding member of the legislative body or their designee that the individual's behavior is disrupting the meeting and that the individual's failure to cease their behavior may result in their removal." Complaints related to internal Commission matters such as alleged violation of the Code of Conduct or other disputes among members are addressed and resolved in adherence to Policy/Procedure #08.3302." (Commission Bylaws, Article VII, Section 4.)

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 2/21/24

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ALVAREZ	**Miguel**	No Affiliation	No Ryan White or prevention contracts
ARRINGTON	**Jayda**	Unaffiliated consumer	No Ryan White or prevention contracts
BALLESTEROS	**Al**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis, and Treatment
			Health Education/Risk Reduction (HERR)
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
BURTON	**Alasdair**	No Affiliation	No Ryan White or prevention contracts
CAMPBELL *	**Danielle**	T.H.E. Clinic, Inc.	See attached subcontractor's list
CIELO	**Mikhaela**	LAC & USC MCA Clinic	Biomedical HIV Prevention
CUEVAS	**Sandra**	Pacific AIDS Education and Training - Los Angeles	No Ryan White or prevention contracts
CUMMINGS	**Mary**	Bartz-Altadonna Community Health Center	No Ryan White or prevention contracts
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
FINDLEY	**Felipe**	Watts Healthcare Corporation	Transportation Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Oral Health Care Services
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment
FRAMES	**Arlene**	Unaffiliated consumer	No Ryan White or prevention contracts
FULLER	**Luckie**	Invisible Men	No Ryan White or prevention contracts
GONZALEZ	**Felipe**	Unaffiliated consumer	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated consumer	No Ryan White or prevention contracts
GREEN	**Joseph**	Unaffiliated consumer	No Ryan White or prevention contracts
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
HARDY	**David**	LAC-USC Rand Schrader Clinic	No Ryan White or prevention contracts
HERRERA	**Ismael "Ish"**	Unaffiliated consumer	No Ryan White or prevention contracts
KOCHEMS	**Lee**	Unaffiliated consumer	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
MAGANA	**Jose**	The Wall Las Memorias, Inc.	HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MARTINEZ (PP&A Member)	**Miguel**	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
			Promoting Healthcare Engagement Among Vulnerable Populations
MAULTSBY	**Leon**	Charles R. Drew University	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences (No Affiliation)	No Ryan White or prevention contracts
MURRAY	**Derek**	City of West Hollywood	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
NELSON	**Katja**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			Nutrition Support
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Nutrition Support
OSORIO	**Ronnie**	Center For Health Justice (CHJ)	Transitional Case Management - Jails
			Promoting Healthcare Engagement Among Vulnerable Populations
PATEL	**Byron**	Los Angeles LGBT Center	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
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
RICHARDSON	**Dechelle**	AMAAD Institute	Community Engagement/EHE
ROBINSON	**Erica**	Health Matters Clinic	No Ryan White or prevention contracts
ROBINSON	**Mallery**	No Affiliation	No Ryan White or prevention contracts
ROSALES	**Ricky**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
RUSSEL	**Daryl**	Unaffiliated consumer	No Ryan White or prevention contracts
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SAN AGUSTIN	**Harold**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(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
SOLIS *	**Juan**	UCLA Labor Center	See attached subcontractor's list
SPENCER	**LaShonda**	Oasis Clinic (Charles R. Drew University/Drew CARES)	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
STALTER	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
TALLEY	**Lambert**	Grace Center for Health & Healing (No Affiliation)	No Ryan White or prevention contracts
VALERO	**Justin**	No Affiliation	No Ryan White or prevention contracts
WEEDMAN	**Jonathan**	ViaCare Community Health	Biomedical HIV Prevention
YBARRA	**Russell**	Capitol Drugs	No Ryan White or prevention contracts

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HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov • *VIRTUAL WEBEX MEETING*

Presence at meetings is recorded based on the attendance roll call. Only members of the Commission on HIV are accorded voting privileges and must verbally acknowledge their attendance in order to vote.
Approved meeting minutes are available on the Commission's website; meeting recordings are available upon request.

PUBLIC POLICY COMMITTEE MEETING MINUTES

January 8, 2024

COMMITTEE MEMBERS P = Present | A = Absent |EA = Excused Absence			
Katja Nelson, MPP, Co-Chair	P	Pearl Doan	A
Lee Kochems, MA, Co-Chair	P	Felipe Findley, PA-C, MPAS, AAHIVS	P
Alasdair Burton (Alternate)	P	Paul Nash, PhD, CPsychol, AFBPsS, FHEA	P
Sandra Cuevas	P	Ricky Rosales	P
Mary Cummings	P	Ronnie Osorio	A
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Lizette Martinez, and Jose Rangel-Garibay			

*Some participants may not have been captured. Attendance can be corrected by emailing the Commission.
*Members of the public may confirm their attendance by contacting Commission staff at hivcomm@lachiv.org.
*Meeting minutes may be corrected up to one year from the date of approval.

Meeting and agenda materials can be found on the Commission's website at https://hiv.lacounty.gov/public-policy-committee/

I. ADMINISTRATIVE MATTERS

1. **CALL TO ORDER & MEETING GUIDELINES/REMINDERS**
   The meeting was called to order at 1:45pm.
2. **INTRODUCTIONS, ROLL CALL, & CONFLICTS OF INTEREST STATEMENTS**
   L. Kochems led introductions and asked attendees to state their conflicts of interest.
3. **APPROVAL OF AGENDA**
   MOTION #1: Approve the Agenda Order as presented or revised. ***(Passed by consensus).***
4. **APPROVAL OF MEETING MINUTES**
   MOTION #2: Approve the December 4, 2023 Public Policy Committee minutes, as presented or revised. ***(Passed by consensus).***

II. PUBLIC COMMENT

5. **OPPORTUNITY FOR MEMBERS OF THE PUBLIC TO ADDRESS THE COMMITTEE ON ITEMS OF INTEREST THAT ARE WITHIN THE JURISDICTION OF THE COMMITTEE. FOR THOSE WHO**

WISH TO PROVIDE PUBLIC COMMENT MAY DO SO IN PERSON, ELECTRONICALLY BY CLICKING HERE, OR BY EMAILING HIVCOMM@LACHIV.ORG.
There were no public comments.

III. COMMITTEE NEW BUSINESS ITEMS

6. OPPORTUNITY FOR COMMISSION MEMBERS TO RECOMMEND NEW BUSINESS ITEMS FOR THE FULL BODY OR A COMMITTEE LEVEL DISCUSSION ON NON-AGENDIZED MATTERS NOT POSTED ON THE AGENDA, TO BE DISCUSSED AND (IF REQUESTED) PLACED ON THE AGENDA FOR ACTION AT A FUTURE MEETING, OR MATTERS REQUIRING IMMEDIATE ACTION BECAUSE OF AN EMERGENCY SITUATION, OR WHERE THE NEED TO TAKE ACTION AROSE SUBSEQUENT TO THE POSTING OF THE AGENDA.
There were no committee new business items.

IV. REPORTS

7. EXECUTIVE DIRECTOR/STAFF REPORT

- Jose Rangel-Garibay, COH staff, reported that the Bylaws Review Taskforce (BRT) last met on October 18, 2023 and completed their review of the by-laws. COH staff have prepared a summary of the proposed changes. This document was presented to Executive Committee at their December 12, 2023 meeting. A more comprehensive review is scheduled for January 2024. Once approved, the revisions will be posted for a public comment period then presented to the full COH body for approval.

8. CO-CHAIR REPORT

a. Draft 2024 Workplan and Meeting Calendar

K. Nelson provided an overview of the draft 2024 Committee Workplan and meeting calendar. She noted that the Ryan White Care Act (RWCA) Modernization project will be postponed to a later date and added that the Committee co-chairs will meet with COH staff to review current documents and develop a strategy for crafting a white paper on the topic of RWCA modernization.

The Committee also decided to discuss the updates to the Policy Priorities document at the February meeting. Additionally, the Committee will monitor bill statuses and update the Legislative docket as needed; the Committee will review the updated docket at their February and March meetings.

Ricky Rosales suggested to expand the last item on the workplan to include "harm reduction efforts" across Los Angeles County as well as Los Angeles City. This would afford the Committee the opportunity to monitor harm reduction activities taking place throughout the County and expand the scope of the item beyond "safe consumption sites."

Felipe Findley recommended adding an item related to housing to the workplan. COH

staff reminded the Committee that based on the discussions that took place at the COH 2023 Annual Conference in November, the COH leadership has decided to focus the first quarter of the year on housing-related activities. The Committee co-chairs recommended that the Committee revisit Policy Priorities document to determine if the existing language related to Housing suffices. L. Martinez noted that the Planning, Priorities, and Allocations (PP&A) Committee has previously requested presentations and data from the Los Angeles Housing Services Authority (LAHSA) but has not been successful in securing a presenter. K. Nelson added that the Committee can also consider identifying a potential housing-related activity that can be aligned with the COH's greater effort. F. Findley added that the Committee should consider tracking street-medicine efforts in the County and follow-up with past presenter Bret Feldman to gain insight on any changes in the street-medicine landscape since they last presented to the COH.

F. Findley noted that national and international health and public health organizations such as the American Public Health Association (APHA) and the World Health Organization (WHO) have made ceasefire statements related to the war in Gaza. He added that he will share draft language for a potential statement for the Committee/COH to consider.

b. **Determine Meeting Frequency**

The Committee decided to continue meeting on a monthly-basis and reevaluate their meeting frequency in May. Additionally, the Committee will revert to their original meeting time of 1:00pm-3:00pm

c. **Co-chair Elections**

Co-chair elections were held, and L. Kochems K. Nelson were elected as Committee co-chairs for 2024.

V. DISCUSSION ITEMS

9. 2023-2024 LEGISLATIVE DOCKET – UPDATES

The Committee will begin monitoring the state Assembly and Senate for any bills introduced of interest to the PPC and the Commission. Commission staff will update the legislative docket as needed and update any status changes to bills introduced in 2023. The last day for bills to be introduced is on February 16, 2024. The last day for each house to pass bills introduced in that house is May 24, 2024. Committee members will encourage commissioners, partner organizations, and any other HIV stakeholders to submit any bill recommendations to be included in the docket. The Committee will review the recommendations and hold their deliberations at the March 2024 PPC meeting.

10. 2023-2024 POLICIES PRIORITY

L. Kochems noted that the Committee will revise this item in February 2024. Sandra Cuevas requested that a copy of the current document be sent to Committee members prior to the February meeting.

11. STATE POLICY & BUDGET UPDATE

K. Nelson shared that on January 7, 2024, Congress reached an agreement on $1.6 trillion top-line federal spending level which is aimed at averting a partial government shutdown. The first deadline will be on January 19, 2024. She added that Committee will closely monitor any updates related to the Federal budget as the deadline for the current Continuing Resolution approaches.

12. FEDERAL POLICY UPDATE

L. Kochems noted that budget negotiations will be tough in 2024. The current Continuing Resolution is set to expire on January 17,2024.

13. COUNTY POLICY UPDATE

- **DPH Memo in Response to STD Board of Supervisors (BOS) Motions**
  The Director of the Department of Public Health, Barbara Ferrer, and the Director of the Division on HIV and STD Programs (DHSP), Mario Perez provided a report on Sexually Transmitted Infection Crisis to the Board on December 19, 2023. K. Nelson attended the BOS meeting in-person and provided public comment and shared that she was a bit discouraged by the low turnout of COH stakeholders and the low number of public comments submitted. K. Nelson will work with COH staff to encourage Commissioners to participate in BOS meetings when HIV-related items are on the meeting agenda.
- **2023 Public Comment Schedule for Health Deputies Meetings and BOS Meetings**
  C. Barrit has sent reminders to the PPC members that signed up to provide public comment. In the reminder, she includes the agenda for the BOS and Health Deputies meetings and a confirmation that the meeting is taking place. Alasdair Burton asked if it were possible to invite Health Deputies to attend a PPC or COH meeting and listen to the comments and recommendations from PPC members and COH members. K. Nelson noted that the coordinating efforts for this are not realistic and recommended that PPC and COH members participate in the Health Deputies meetings. COH staff will continue to send reminders.

VI. <u>NEXT STEPS</u>

14. TASK/ASSIGNMENTS RECAP

➲ COH staff will

15. AGENDA DEVELOPMENT FOR THE NEXT MEETING

- Review and update the 2024 workplan
- Review and update the 2023-2024 Legislative Docket

- COH staff will send a copy of the current Policy Priorities document in preparation for a review in February.

VII. ANNOUNCEMENTS

16. OPPORTUNITY FOR MEMBERS OF THE PUBLIC AND THE COMMITTEE TO MAKE ANNOUNCEMENTS

There were no announcements.

VIII. ADJOURNMENT

17. ADJOURNMENT FOR THE MEETING OF JANUARY 8, 2024.

The meeting was adjourned at 2:34pm.

LOS ANGELES COUNTY COMMISSION ON HIV

2024 WORK PLAN – PUBLIC POLICY COMMITTEE—DRAFT

Committee Name: **PUBLIC POLICY COMMITTEE (PPC)**				
Co-Chairs: Katja Nelson, Lee Kochems			Committee Adoption Date: TBD	
Purpose of Work Plan: To focus and prioritize key activities for COH Committees and subgroups for 2024				
#	**TASK/ACTIVITY**	**DESCRIPTION**	**TARGET DATE**	**STATUS/NOTES/OTHER COMMITTEES INVOLVED**
1	Review and refine 2024 workplan	COH staff to review and update 2024 workplan monthly	Ongoing, as needed	Workplan revised/updated on: 12/04/23, 01/04/24, 1/31/24, 2/29/24
2	Develop 2023-2024 Legislative Docket and update as needed.	Review legislation aligned with information gathered from public hearing(s) as well as recommendations from Commission taskforces, caucuses, and workgroups to develop the Commission docket, and discuss legislative position for each bill.	Sep 2024	The COH staff will monitor bill status and update docket as needed.
3	Develop 2023-2024 Policy Priorities document and update as needed.	The Committee will revise the Policy Priorities document to include the alignment of priorities from Commission stakeholder groups	Feb 2024	The Committee will review and update their policy priorities document as needed.
4	Continue to advocate for an effective County-wide response to the STI crisis in Los Angeles County.	The Committee will review government actions that impact funding and implementation of sexual health and HIV services. Assess and monitor federal, state, and local government policies and budgets that impact HIV, STIs, Viral Hepatitis and other sexual health issues.	Ongoing	Track and monitor BOS correspondence website and BOS agenda items related to the County-wide response to the STI crisis in Los Angeles County. Commissioners are encouraged to provide public comments at BOS meetings.
5	Continue to advocate for an effective County-wide response to the Act Now Against Meth (ANAM) platform.	The Committee will review government actions that impact funding and implementation of sexual health and HIV services. Assess and monitor federal, state, and local government policies and budgets that impact activities under the ANAM platform.	Ongoing	Track and monitor BOS correspondence website and BOS agenda items related to the County-wide response to the ANAM platform. Commissioners are encouraged to provide public comments at BOS meetings.
6	Monitor and support Harm Reduction efforts in LA County and LA City		Ongoing	
7	Efforts to Modernize the Ryan White Care Act (RWCA)	The Committee developed a policy brief outline. The policy brief will summarize key issues to address and include in a modernized RWCA legislation.	Postponed to 2025	Committee co-chairs met with COH staff and determined to postpone the development of a white paper on RWCA modernization to 2025.

Last updated: 02/29/2024

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DRAFT PUBLIC POLICY COMMITTEE 2024 MEETING CALENDAR

DATE	KEY AGENDA ITEMS/TOPICS (subject to change; for planning purposes)
Jan. 8, 2024 1:30pm to 3:30pm Vermont Corridor TK05	Elect Co-Chairs for 2024 Review 2024 workplan, meeting calendar, and determine meeting frequency *01/03/24—CA Legislature Reconvenes* *01/31/24—Last day for each house to pass bills introduced in that house in the odd-numbered year (2023).*
Feb. 5, 2024 1pm to 3pm Vermont Corridor TK05	Meeting Cancelled due to unsafe weather conditions. *02/16/24—Last day for bills to be introduced.*
Mar. 4, 2024 1pm to 3pm Vermont Corridor TK05	Review and revised Policy Priorities document as needed. Monitor bill status and update docket as needed.
Apr. 1, 2024 1pm to 3pm Vermont Corridor TK05	Review and deliberate on bill recommendations for docket.
May 6, 2024 1pm to 3pm Vermont Corridor TK08	*05/24/24—Last day for each house to pass bills introduced in that house.*
Jun. 3, 2024 1pm to 3pm Vermont Corridor TBD	*06/15/24—Budget bill must be passed by midnight.*
Jul. 1, 2024 1pm to 3pm Vermont Corridor TBD	*08/31/24—Last day for each house to pass bills.*
Aug. 5 2024 1pm to 3pm Vermont Corridor TBD	
September 2 1pm to 3pm Vermont Corridor TBD	*09/30/24—Last day for Governor to sign or veto bills passed by the Legislature before Sep. 1 and in the Governor's possession on or after Sep. 1.*
October 7 1pm to 3pm Vermont Corridor TBD	
November 4 1pm to 3pm Vermont Corridor TBD	*11/05/24—General Election.*
December 2 1pm to 3pm Vermont Corridor TBD	

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February 27, 2024

Honorable Holly J. Mitchell, Supervisor
Honorable Hilda L. Solis, Supervisor
Honorable Lindsey P. Horvath, Chair
Honorable Janice Hahn, Supervisor
Honorable Kathryn Barger, Supervisor
Los Angeles County Board of Supervisors
500 West Temple Street
Los Angeles, CA 90012

Dear Chair Horvath and Supervisors Solis, Mitchell, Hahn, and Barger,

While the latest continuing resolution keeps the government going until March 1 for some agencies and March 8 for others, the persistent threats to funding for HIV, Sexually Transmitted Infections (STIs), housing, substance use, and mental health continue to put in peril our collective efforts to end HIV and achieve health equity for all. With these important intersecting and syndemic health conditions, we cannot achieve health equity and justice for people living with HIV (PLWH) and communities that shoulder the burden of HIV and STIs without sustained and significant federal and state investments to support a vigorous community-wide response in Los Angeles County.

House Republicans are seeking $767 million in cuts to HIV care and prevention funding, - a direct attack on life saving care for millions of people PLWH and communities that bear the disproportionate burden of HIV. The House bill also proposes to drastically cut funding for the Minority HIV/AIDS Initiative, which seeks to eliminate racial and ethnic health disparities in HIV. The bill would completely eliminate funding for Minority AIDS Initiative Funding within the Substance Abuse and Mental Health Administration and cuts the Minority HIV/AIDS Fund by 53%. These funding cuts would eliminate all activities of the Ending the HIV Epidemic (EHE), reverse recent progress in bringing down new HIV cases, and leave state and local health departments and community-based organizations without needed funding to provide services to their community. With 70% of the 1.2 million Americans living with HIV projected to be 50 and older by 2030, the impact on the aging HIV community would be particularly severe. In contrast, the Senate bipartisan spending bill proposes to maintain HIV funding for FY24 and

includes a proposed increase of $3 million dollars to continue the fight to end the epidemic and begin work toward a National PrEP Program. *We urge you send a five-signature letter to Congress urging them to protect funding for STIs, HIV, housing, mental health, and substance use programs. In addition, we urge you to include our community appeals in your Sacramento and Washington DC advocacy efforts.*

The most recently released 2022 STD Surveillance Report from the Centers for Disease Control and Prevention (CDC) shows that syphilis and chlamydia numbers have climbed to record highs and that the nation continues to struggle to gain control of the epidemics of STIs. The data show an 80% increase in syphilis over five years, as well as an alarming 3,755 congenital syphilis cases. The reported STI numbers are from 2022 and do not reflect the impact of the shortage of congenital syphilis treatment drug Bicillin L-A, which started last spring, or last summer's STI workforce cuts in the debt ceiling deal.

Affordable and safe housing remains the greatest unmet need for PLWH and communities most at risk for HIV/STI exposure and acquisition. As one of the strongest predictors of health outcomes, housing stability plays an important role in both HIV prevention and care. According to National Alliance of State & Territorial AIDS Directors (NASTAD), among individuals who are homeless or marginally housed, the rates of HIV infection are up to 16 times higher than those stably housed. Additionally, the homeless men who have sex with men (MSM) population is 15 times more likely to delay HIV testing than stably housed MSM. At any time, three to ten percent of all homeless persons are living with HIV. Across the U.S, upwards of 70% of all PLWH report experiencing homelessness or housing instability. This impacts entrance into care, as homelessness can delay this crucial step for an average of six months.

The national political landscape continues to be hostile towards the HIV movement, people of color, LGBTQ+ communities, and women, as evidenced by the continuous onslaught of funding cut threats and legislative bills at all levels of government attacking access to healthcare, reproductive rights, access to HIV PrEP/PEP and other lifesaving medications, to name a few. We appreciate and recognize your leadership in tackling the STI epidemic in the County and supporting local and national efforts to end HIV, homelessness, and improve mental health and substance use services. We remain committed to ending HIV for all and stand ready to partner with you in preventing needless and drastic cuts that threatened our collective progress to end HIV.

In partnership and solidarity,
Los Angeles County Commission on HIV Executive Committee

Danielle Campbell, PhDc, MPH, Co-Chair

Joseph Green, Co-Chair

Miguel Alvarez, Executive-At-Large

Erika Davies, Standards and Best Practices Committee Co-Chair

Kevin Donnelly, Planning, Priorities, and Allocations Committee Co-Chair

Felipe Gonzalez, Planning, Priorities, and Allocations Committee Co-Chair

Lee Kochems, Public Policy Co-Chair

Jose Magaña, Operations Co-Chair

Katja Nelson, Public Policy Co-Chair

Kevin Stalter, Standards and Best Practices Committee Co-Chair

Justin Valero, Operations Co-Chair

cc: Barbara Ferrer, PhD, MPH, MEd
Mario J. Peréz, MPH
Jeff Levinson

2024 TRAINING SCHEDULE

SUBJECT TO CHANGE

- "*" Asterisk denotes mandatory training for all commissioners.
- All trainings are open to the public.
- Click on the training topic to register.
- Certifications of Completion will be provided.
- All trainings are virtual.

Training	Date/Time
Co-Chair Roles and Responsibilities	February 13, 2024 4:00-5:00PM
General Orientation and Commission on HIV Overview *	March 26, 2024 3:00-4:30PM
Priority Setting and Resource Allocation Process & Service Standards Development *	April 23, 2024 3:00-4:30PM
Ryan White Care Act Legislative Overview Membership Structure and Responsibilities *	July 17, 2024 3:00-4:30PM
Policy Priorities and Legislative Docket Development Process	October 2, 2024 3:00-4:30PM

LOS ANGELES COUNTY COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 9003.0 • TEL (213) 738-2816 • FAX (213) 637-4748

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DUTY STATEMENT, COMMISSIONER (subject to change)

POLICY:

1) Candidates for membership on the Commission on HIV must complete a membership application and are evaluated/scored by the Commission's Operations Committee, consistent with Policy/ Procedure #09.4205 *(Commission Membership Evaluation and Nomination Process).* The Operations Committee recommends candidates for membership to the Commission, which, in turn nominates them to the Board of Supervisors by a majority vote. The Board of Supervisors is responsible for appointing members to the Commission.

DUTIES AND RESPONSIBILITIES: In order to be an effective, active member of the Commission on HIV, an individual must meet the following demands of Commission membership:

1. Representation/Accountability:

- Possess a thorough knowledge of HIV/AIDS/STI issues and affected communities, and the organization or constituency the member represents;
- Continually and consistently convey two-way information and communication between the organization/constituency the member represents and the Commission;
- Provide the perspective of the organization/constituency the member represents and the Commission to other, relevant organizations regardless of the member's personal viewpoint;
- Participate and cast votes in a manner that is best for the entire County, regardless of the personal opinions of the member personal or the interests/opinions of the organization/constituency the member represents.

2. **Commitment/Participation:**

a) Commitment to fill a full two-year Commission term.

b) A pledge to:

- respect the views of other members and stakeholders, regardless of race, ethnicity, sexual orientation, HIV status or other factors;
- comply with "Robert's Rules of Order, Newly Revised", the Ralph M. Brown Act, the Commission's Code of Conduct and applicable HIPAA rules and requirements;
- consider the views of others with an open mind;
- actively and regularly participate in the ongoing decision-making processes; and
- support and promote decisions resolved and made by the Commission when representing the Commission.

c) A commitment to devote a minimum of ten hours per month to Commission/committee attendance, preparation and other work as required by your Commission membership.

d) Each year of the two-year term, the Commissioner is expected to attend* and participate in, at a minimum, these activities:

- Two all-day Commission orientation meetings *(firstyear only)* and assorted orientations and trainings of shorter length throughout the year;
- One to two half-day County commission orientations *(alternate years);*
- One half- to full-day Commission meeting monthly;
- One two- to three-hour committee meeting once a month;
- All relevant priority- and allocation-setting meetings;
- One all-day Commission Annual Meeting in the Fall;
- Assorted voluntary workgroups, task forces and special meetings as required due to committee assignment and for other Commission business.

***Stipulation:** Failure to attend the required meetings may result in a Commissioner's removal from the body.*

3. **Knowledge/Skills:**

a) A commitment to constantly develop, build, enhance and expand knowledge about the following topics:

- general information about HIV/STIs and its impact on the local community;
- a comprehensive HIV/STI continuum of care/prevention services, low-income support services, and health and humanservice delivery;
- the Commission's annual HIV service priorities, allocations and plans;
- the Ryan White Program, County health service and Medicaid information and other information related to funding and service support.

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PUBLIC POLICY COMMITTEE (PPC)[1]
2023-2024 POLICY PRIORITIES

HIV has been raging in communities across the world for almost 40 years and with advancements in biomedical interventions, research and vaccines, the time for the HIV cure is now. With a renewed sense of optimism and urgency, the PPC remains steadfast in its commitment to universal health care, eradication of racism in all forms, and unfettered access to trauma informed care and supportive services, including comprehensive harm reduction services, to ensure that all people living with HIV and communities most impacted by HIV and STDs, live full, productive lives.

The COVID-19 global pandemic has demonstrated that with political will, funding, and most important of all, urgency, rapid and safe vaccine development is possible. Nevertheless, like the HIV epidemic, (globally, nationally, and locally), it is our most marginalized communities, including youth, who are disproportionately impacted with higher rates of disease and death. In addition, the COVID-19 global pandemic is severely impacting the delivery of HIV prevention and care services. The PPC is compelled to encourage and support innovative efforts to reduce bureaucracy, increase funding, enhance HIV prevention, and care service. This effort is to address the negative impacts of COVID-19 and restore pre-COVID service levels, preferably exceeding the quantity and quality of HIV and prevention services.

The PPC recommends the Commission on HIV endorse the prioritization of the following issues. PPC will identify support legislation, local policies, procedures, and regulations that address Commission priorities in calendar years 2022 and 2023. (Issues are in no order.)

Systemic and Structural Racism

a. Establish health equity through the elimination of barriers and addressing of social determinants of health such as: implicit bias; access to care; education; social stigma, (i.e., homophobia, transphobia, and misogyny); housing; mental health; substance abuse; income/wealth gaps; as well as criminalization.
b. Reduce and eliminate the disproportionate impact of HIV/AIDS and STIs in the Black/African American community. To include the identification of and rooting out of systemic and systematic racism as it affects Black/African American communities.

Racist Criminalization and Mass Incarceration[2]

[1] The Public Policy Committee acts in accordance with the role of the Commission on HIV, as dictated by Los Angeles County Code 3.29.090. Consistent with Commission Bylaws Article VI, Section 2, no Ryan White resources are used to support Public Policy Committee activities.
[2] Black/African Americans, while making up only 8% of the LA County population, represent over 30% of the jail population. In the Los Angeles County Alternatives to Incarceration Report, "Los Angeles County operates the largest jail system in the United States, which imprisons more people than any other nation on Earth." As documented in the Los Angeles County HIV/AIDS Strategy for 2020 and Beyond; "Incarceration destabilizes communities, disrupts family relationships, and magnifies the accumulation of health and social disadvantage for

a. Eliminate discrimination against or the criminalization of people living with or at risk of HIV/AIDS including those who exchange sex for money (e.g., Commercial Sex Work).
b. Support the efforts of Measure J, the Alternatives to Incarceration and closure of Men's Central Jail and seek increased funding for services and programming through Measure J as well as through redistribution of funding for policing and incarceration. [3]

Housing[4]

a. Focus b, c, and d below especially in service to LGBTQIA+ populations
b. Improve systems, strategies and proposals that expand affordable housing, as well as prioritize housing opportunities for people living with, affected by, or at risk of transmission of HIV/AIDS
c. Improve systems, strategies, and proposals that prevent homelessness for people living with, affected by, or at risk of contracting HIV/AIDS.
d. Promote Family housing and emergency financial assistance as a strategy to maintain housing.

Mental Health

a. Expand and enhance mental health services for people living with, affected by, or at risk of contracting HIV/AIDS.
b. By increasing services for those with underlying mental health issues, there will be less reliance on incarceration. Los Angeles County Jail has also become the largest mental health institution in the country.
c. Support the building of community-based mental health services.
d. Support the placement in mental health facilities of the estimated 4,000+ individuals currently incarcerated and in need of mental health services and support closing of Men's Central Jail. (See footnote 3)

Sexual Health

a. Increase access to prevention, care and treatment and bio-medical intervention (such as PrEP and PEP) services. Promote the distribution of services to people at risk for acquiring HIV and people living with HIV/AIDS.
b. Increase comprehensive HIV/STD counseling, testing, education, outreach, research, harm reduction services including syringe exchange, and social marketing programs.

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already marginalized populations. Incarceration is associated with harmful effects on viral suppression, lower CD4/T-cell counts, and accelerated disease progression."

[3] Developing a plan for closing men's central jail as Los Angeles county reduces its reliance on incarceration (item #3 July 7, 2020, board meeting)

[4] Homelessness is a risk factor for HIV transmission and acquisition. LGBTQIA+ experience a number of factors which increased the risk of being unhoused, from family discrimination at home to discrimination in employment. Such discrimination contributes to higher rates of poverty; undermines their ability to thrive; and increases the risk of arrest and incarceration.

c. Maximize HIV prevention to reduce and eliminate syphilis and gonorrhea cases; especially among young MSM (YMSM), African American MSM, Latino MSM, transgender persons and women of color.
d. Advance and enhance routine HIV testing and expanded linkage to care.
e. Maintain and expand funding for access and availability of HIV, STD, and viral hepatitis services.
f. Promote women centered prevention services including domestic violence and family planning services for women living with and at high-risk of acquiring HIV/AIDS.
g. Preserve full funding and accessibility to Pre-Exposure Prophylaxis Assistance Program (PrEP-AP).

Substance Abuse

a. Advocate for substance abuse services to PLWHA.
b. Advocate for services and programs associated with methamphetamine use and HIV transmission.
c. Expand alternatives to incarceration/diversion programs to provide a "care first" strategy and move those who need services away from incarceration to substance abuse programs.
d. Expand harm reduction services (including and not limited to syringe exchange, safe administration sites, over-dose prevention strategies) across all of Los Angeles County (LAC).
e. Support trauma informed services for substance users.

Consumers

a. Advocate and encourage the empowerment and engagement of People Living with HIV/AIDS (PLWH/A) and those at risk of acquiring HIV. Focusing on young MSM (YMSM), African American MSM, Latino MSM, transgender persons (especially of color), women of color, and the aging.

Aging

a. Create and expand medical and supportive services for PLWHA ages fifty 50 and over.

Women

a. Create and expand medical and supportive services for women living with HIV/AIDS. This includes services such as family housing, transportation, mental health, childcare, and substance abuse.
b. Advocate for women's bodily autonomy in all areas of health care services including and not limited to full access to abortions, contraception, fertility/infertility services and family planning.

Transgender

a. Create and expand medical and supportive services for transgender PLWHA.
b. Promote and maintain funding for the Transgender Wellness Fund created by the passage of AB2218.

General Health Care

a. Provide access to and continuity of care for PLWHA focusing on communities at highest risk for the acquisition and transmission of HIV disease.
b. Fund and expand eligibility for Medicaid, Medicare, and HIV/AIDS programs and health insurance coverage for individuals with pre-existing conditions.
c. Increase and enhance compatibility and effectiveness between RWP, Medicaid, Medicare, and other health systems. This includes restructuring funding criteria to **not** disincentives contractors from referring clients to other contractors.
d. Expand access to and reduction of barriers (including costs) for HIV/AIDS, STD, and viral hepatitis prevention and treatment medications.
e. Preserve full funding and accessibility to the AIDS Drug Assistance Program (ADAP), Office of AIDS Health Insurance Premium Payment (OA-HIPP) Assistance, Employer Based Health Insurance Premium Payment (EB-HIPP), and Medigap.
f. Provide trauma informed care and harm reduction strategies in all HIV Disease health care settings

Service Delivery

a. Enhance the accountability of healthcare service deliverables. This would include a coordinated effort between federal, state, and local governments.
b. Incorporate COVID strategies to reduce administrative barriers, increase access to health services and encourage the development of an HIV vaccine mirroring the COVID 19 vaccine process.

Data

a. Use data, without risking personal privacy and health, with the intention of improving health outcomes and eliminating health disparities among PLWHA.
b. Promote distribution of resources in accordance with the HIV burden within Los Angeles County.

2023-2024 Legislative Docket | Approval Date: Last approved by COH on 6/8/23. Updated 02/29/24.

POSITIONS: SUPPORT | OPPOSE | SUPPORT w/AMENDMENTS | OPPOSE unless AMENDED | WATCH

BILL	TITLE	DESCRIPTION / COMMENTS	Recommended Position	STATUS
ACA 5 (Low)	Marriage Equality	ACA= Assembly Constitutional Amendment This measure would express the intent of the Legislature to amend the Constitution of the State relating to marriage equality. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240ACA5	Support	20-JUL-23 Chaptered by Secretary of State.
ACA 8 (Wilson)	Slavery	Removes language in the state Constitution that allows involuntary servitude as punishment to a crime. Major Provisions 1. Amends the California Constitution by prohibiting the use of involuntary servitude as punishment for a crime. 2. States that slavery includes forced labor compelled by the use of threat of physical or legal coercion. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240ACA8 **Follow-up questions regarding the phrasing of the ACA:** The ACA removed “Involuntary servitude is prohibited except to punish a crime” from phrasing and added “Slavery in any form.”	Support with follow-up questions	13-SEP-23 In Senate. Read first time. To Committee on Rules for assignment.
AB 4 (Arambula)	Covered California: Expansion	Requires Covered California to develop options for expanding access to affordable health care coverage to Californians regardless of immigration status and report these options to the Governor and Legislature. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB4 **Follow-up questions regarding the phrasing of the AB:** Starting Jan. 2024, undocumented Californians 26-49 years of age will be eligible for full scope Medi-Cal coverage; however, undocumented Californians who earn too much money to qualify for Medi-Cal are excluded from being able to purchase coverage through Covered California since the federal Affordable Care Act (ACA) did not extend eligibility to undocumented individuals. The Centers for Medicare and Medicaid Services (CMS) would need to approve a 1332 waiver which would allow Covered California to offer coverage to undocumented immigrants.	Support with follow-up questions	13-JUL-23 In Senate. Read second time and amended. Re-referred to Com. on APPR.

BILL	TITLE	DESCRIPTION / COMMENTS	Recommended Position	STATUS
AB 5 (Zbur)	The Safe and Supportive Schools Program	Requires the California Department of Education (CDE) to complete the development of an online training curriculum and online delivery platform by July 1, 2025, and requires local educational agencies (LEAs) to provide and require at least one hour of training annually to all certificated staff, beginning with the 1025-26 school year through the 2029-30 school year, on cultural competency in supporting lesbian, gay, bisexual, transgender, queer, and questioning students. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB5&search_keywords=transgender	Support	23-SEP-23 Approved by Governor.
AB 223 (Ward)	Change of gender and sex identifier	This bill enhances protections for minors seeking changes of name or gender by making the proceedings presumptively confidential. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB223&search_keywords=transgender	Support	23-SEP-23 Approved by Governor.
AB 254 (Bauer-Kahan)	Confidentiality of Medical Information Act: reproductive or sexual health application information	This bill would revise the Confidentiality of Medical Information (CMIA) to include reproductive or sexual health application information into the definition of medical information. Defines reproductive or sexual health application information to mean information about a consumer's reproductive health, menstrual cycle, fertility, pregnancy, miscarriage, pregnancy termination, plans to conceive, or type of sexual activity collected by a reproductive or sexual health digital services, including, but not limited to, information from which one can infer someone's pregnancy status, menstrual cycle, fertility, hormone levels, birth control use, sexual activity, or gender identify. Defines reproductive or sexual health digital health application information from a consumer, markets itself as facilitating reproductive or sexual health services to a consumer, and uses the information to facilitate reproductive or sexual health services to a consumers. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB254&search_keywords=sexual+health	Support	27-SEP-23 Approved by Governor.

BILL	TITLE	DESCRIPTION / COMMENTS	Recommended Position	STATUS
AB 352 (Bauer-Kahan)	Health Information	This bill limits the sharing of information related to sensitive services in electronic health records without specific authorization from the patient. This bill also requires a specified stakeholder advisory group to include providers of sensitive services and to identify policies and procedures to prevent electronic health information related to sensitive services form automatically being shared with individuals and entities in another state. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB352&search_keywords=sexual+health **Follow-up questions regarding phrasing of AB:** "Sensitive services" means all health care services related to mental or behavioral health, sexual and reproductive health, substance use disorder, gender affirming care, and intimate partner violence.	Support with follow-up questions	27-SEP-23 Approved by Governor.
AB 367 (Maienschein)	Controlled Substances: Enhancements	This bill, until January 1, 2029, applies the "great bodily injury" enhancement to any person who sells, furnishes, administers, or gives away fentanyl or an analog of fentanyl when the person to whom the fentanyl was sold, furnished, administered, or given suffers a significant or substantial physical injury from using the substance. https://leginfo.legislature.ca.gov/faces/billHistoryClient.xhtml?bill_id=202320240AB367 **"Watch" position selected due to follow-up questions regarding the AB:** The bill applies a 3-year sentence enhancement. Provides that the enhancement does not apply to juvenile offenders.	Watch	*01-FEB-24* *Filed with the Chief Clerk pursuant to Joint Rule 56.*
AB 470 (Valencia)	Continuing medical education: physicians and surgeons	This bill updates continuing medical education (CME) standards to further promote cultural and linguistic competency and enhance the quality of physician-patient communication. Requires the updated standards for cultural and linguistic competency priorities languages in proportion to primary languages spoken by at least 10% of the state population, meet the needs of California's changing demographics, and address language disparities as they emerge. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB470	Support	07-OCT-23 Approved by Governor.

BILL	TITLE	DESCRIPTION / COMMENTS	Recommended Position	STATUS
AB 598 (Wicks)	Sexual health education and human immunodeficiency virus (HIV) prevention education: school climate and safety: California Health Kids Survey	This bill would revise the information included in this instruction related to local resources and abortion, as specified, and would require that pupils received a physical or digital resource detailing local resources upon completion of the applicable instruction. This bill would require the State Department of Education to ensure the California Health Kids Survey includes questions about sexual and reproductive care as a core survey module for pupils in grades 7,9 and 11. The bill would require each school district serving pupils in any grades 5,7,9 or 11 to administer the California Health Kids Survey to pupils in the applicable grades, as provided. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB598&search_keywords=HIV	Support	05-JUL-23 In Senate. Referred to Com. on ED. Hearing canceled at the request of author.
AB 719 (Boerner Horvath)	Medi-Cal benefits	Requires Medi-Cal managed care plans to contract with and reimburse public paratransit service operators for nonemergency medical transportation and nonmedical transportation services. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB719&search_keywords=HIV **Governor's Veto Message:** This bill would require Medi-Cal managed care plans that provide nonemergency or nonmedical transportation to contract with public paratransit service operators for the purpose of establishing reimbursement rates if federal approvals are obtained. I support efforts to encourage more public paratransit service operators to enroll as nonmedical transportation providers in Medi-Cal, which is permitted under existing law. It would be beneficial to have more options for nonmedical transportation in the Medi-Cal system. This bill takes a different approach, however, requiring the Department of Health Care Services (DHCS) to pursue a series of federal approvals that are not currently allowable under federal guidance. It would not be prudent to use state resources for this purpose. For these reasons, I cannot sign this bill.	Support	07-OCT-23 Vetoed by Governor.

BILL	TITLE	DESCRIPTION / COMMENTS	Recommended Position	STATUS
AB 760 (Wilson)	California State University and University of California: records: affirmed name and gender identification	This bill would require California State University (CSU) and requests the Regents of the University of California (UC), to implement a process by which students, staff, and faculty can declare an affirmed name, gender, or both name and gender identification to be used in records where legal names are not required by law. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB760&search_keywords=gender **Support w/Amendments: Require the bill to apply to the UC system too.** Because of the constitutional autonomy of the UC system, the Donahue Higher Education Act, which governs postsecondary education in the State of California, does not apply to the UC system. As a result, a bill must request the UC Regents to make education code provisions applicable to the UC system.	Support with Amendments	23-SEP-23 Approved by Governor.
AB 793 (Bonta)	Privacy: reverse demands	The bill bans reverse-location searches, which allow law enforcement agencies to obtain cell phone data about unspecified individuals near a certain location, and reverse-keyword searches, which allow law enforcement agencies to obtain data about unspecified individuals who used certain search terms on an internet website. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB793	Support with Amendments	30-JUN-23 In Senate. In Com. on JUD. Hearing canceled at the request of author.

BILL	TITLE	DESCRIPTION / COMMENTS	Recommended Position	STATUS
AB 957 (Wilson)	Family law: gender identity	This bill would require the court to strongly consider that affirming the minor's identity is in the best interest of the child if a nonconsenting parent objects to a name change to conform to the minor's gender identity. This bill would require a court, when determining the best interests of a child, to also consider a parent's affirmation of the childe's gender identity. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB957 **Governor's Veto Message:** This legislation would require a court, when determining the best interests of a child in a child custody or visitation proceeding, to consider, among other comprehensive factors, a parent's affirmation of the child's gender identity or gender expression. I appreciate the passion and values that led the author to introduce this bill. I share a deep commitment to advancing the rights of transgender Californians, an effort that has guided my decisions through many decades in public office. That said, I urge caution when the Executive and Legislative branches of state government attempt to dictate - in prescriptive terms that single out one characteristic - legal standards for the Judicial branch to apply. Other-minded elected officials, in California and other states, could very well use this strategy to diminish the civil rights of vulnerable communities. Moreover, a court, under existing law, is required to consider a child's health, safety, and welfare when determining the best interests of a child in these proceedings, including the parent's affirmation of the child's gender identity.	Support	22-SEP-23 Vetoed by Governor.
AB 1022 (Mathis)	Medi-Cal: Program of All-Inclusive Care for the Elderly	This bill, among other things relating to the Program of All-Inclusive Care for the Elderly (PACE) would require those capitation rates to also reflect the frailty level and risk associated with those populations. The bill would also expand an approved PACE organization's authority to use video telehealth to conduct all assessments, as specified. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1022&search_keywords=HIV	Support	*01-FEB-24* *Filed with the Chief Clerk pursuant to Joint Rule 56.*

BILL	TITLE	DESCRIPTION / COMMENTS	Recommended Position	STATUS
AB 1060 (Ortega)	Health care coverage: naloxone hydrochloride (NH)	Requires coverage of prescription or nonprescription NH and all other drugs or products under a health plan contract, health insurance policy, and the Medi-Cal program, if that medication is approved, for prescription or nonprescription use, respectively, by the U.S. Food and Drug Administration (FDA) for the complete or partial reversal of an opioid overdose. Prohibits a health plan contract or health insurance policy from imposing any cost-sharing requirements exceeding $10 per package of naloxone hydrochloride or another drug approved by the FDA for the complete or partial reversal of an opioid overdose. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB1060 **<u>Governor's Veto Message:</u>** This bill would require health plans to cover prescription and over the counter naloxone and all other U.S. FDA approved drugs for opioid overdose reversal, with a maximum of $10 cost sharing. Combating the opioid crisis is one of my top priorities. I appreciate the author's shared commitment to this critical public health and public safety imperative. Together with the Legislature, we have invested more than $1 billion to combat overdoses, support those with opioid use disorder, raise awareness, and crack down on trafficking. Further, the 2023 Budget Act included $30 million for the CalRx Naloxone Access Initiative, to support partners in developing, manufacturing, procuring, and distributing a low-cost naloxone nasal product. While I support providing access to opioid antagonists to individuals with opioid use disorder or other risk factors, this bill would exceed the state's set of essential health benefits, which are established by the state's benchmark plan under the provisions of the federal Affordable Care Act (ACA). As such, this bill's mandate would require the state to defray the costs of coverage in Covered California. This would not only increase ongoing state General Fund costs, but it would set a new precedent by adding requirements that exceed the benchmark plan. A pattern of new coverage mandate bills like this could open the state to millions to billions of dollars in new costs to cover services relating to other health conditions. This creates uncertainty for our healthcare system's affordability. For these reasons, I cannot sign this bill.	Support	10-OCT-23 Vetoed by Governor.

BILL	TITLE	DESCRIPTION / COMMENTS	Recommended Position	STATUS
AB 1078 (Jackson)	Instructional materials: removing instructional materials and curriculum: diversity	Makes various changes to the adoption of instructional materials for use in schools, including a provision that would prohibit a governing board form disallowing the use of an existing textbook, other instructional material, or curriculum that contains inclusive and diverse perspectives, as specified. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1078&search_keywords=transgender	Support	25-SEP-23 Approved by Governor.
AB 1163 (Luz Rivas)	Lesbian, Gay, Bisexual, and Transgender Disparities Reduction Act	This bill expands the data collection requirements in the Lesbian, Gay, Bisexual, and Transgender (LGBT) Disparities Reduction Act, to additionally apply to the State Department of State Hospitals (DSH), the Department of Rehabilitation (DOR), the State Department of Developmental Services (DDS), and the Department of Community Services and Development (CSD). https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1163&search_keywords=transgender	Support	13-OCT-23 Approved by Governor.
AB 1314 (Essayli and Gallagher)	Gender identity: parental notification	This bill would, notwithstanding the consent provisions described above, provide that a parent or guardian has the right to be notified in writing within 3 days from the date any teacher, counselor, or employee of the school becomes aware that a pupil is identifying at school as a gender that does not align with the child's sex on their birth certificate, other official records, or sex assigned at birth, using sex-segregated school programs and activities, including athletic teams and competitions, or using facilities that do not align with the child's sex on their birth certificate, other official records, or sex assigned at birth. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB1314	Oppose	*01-FEB-24* *Filed with the Chief Clerk pursuant to Joint Rule 56*.
AB 1431 (Zbur)	Housing: the California Housing Security Act	This bill would establish the California Housing Security Program to provide a housing subsidy to eligible persons to reduce housing insecurity and help Californians meet their basic housing needs. To create the program, the bill would require the Department of Housing and Community Development to establish a 2-year pilot program in up to 4 counties, as specified. The bill would require the department to issue guidelines to establish the program that include, among other things, the amount of the subsidy that shall be the amount necessary to cover the portion of a person's rent to prevent homelessness but shall not exceed $2,000 per month. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1431&search_keywords=HIV	Support	*01-FEB-24* *Filed with the Chief Clerk pursuant to Joint Rule 56.*

BILL	TITLE	DESCRIPTION / COMMENTS	Recommended Position	STATUS
AB 1432 (Carrillo)	Health insurance: policy	This bill subjects an out-of-state policy, or certificate of group health insurance that is marketed, issued, or delivered to a Californian resident to specified provisions of the Insurance Core requiring coverage of abortion, abortion-related services, and gender-affirming care, regardless of the origin of the contract, subscriber, or master group policyholder. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1432 **Governor's Veto Message:** This bill would require any out-of-state health insurance plan regulated by the California Department of Insurance (CDI) that is marketed, issued, or delivered to a California resident to provide coverage for abortion, abortion-related services, and gender-affirming care. I commend the author for working to provide additional assurances that California residents can access abortion services and gender affirming care. It is a priority of my Administration to ensure that abortion and gender-affirming care are safe, legal, and accessible. However, it is not evident that out-of-state health insurance plans serving Californians do not already cover this care. Further, though well intentioned, this bill could invite litigation where an adverse ruling would outweigh a potential benefit. For these reasons, I cannot sign this bill.	Support	07-OCT-23 Vetoed by Governor.
AB 1487 (Santiago)	Public health: Transgender, Gender Variant, and Intersex Wellness Reentry Fund	Establishes the Transgender, Gender Variant, and Intersex (TGI) Wellness Reentry Fund in the State Treasury to fund grant programs focused on reentry programs to support TGI people who have experiences carceral systems. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB1487		13-OCT-23 Approved by Governor.
AB 1549 (Carrillo)	Medi-Cal: federally qualified health centers and rural health clinics	This bill revises the prospective payment system (PPS) per-visit rate calculation to account for staffing and care delivery models for Medi-Cal services provided by Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) (collectively, health centers). https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1549&search_keywords=HIV	Support	*01-FEB-24* *Filed with the Chief Clerk pursuant to Joint Rule 56.*

BILL	TITLE	DESCRIPTION / COMMENTS	Recommended Position	STATUS
AB 1645 (Zbur)	Health care coverage: cost sharing	Prohibits a large group health plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2024, or an individual or small group contract or policy issued, amended, or renewed on or after January 1, 2025, from imposing a cost-sharing requirement for office visits of specified preventive care services and screenings and for items or services that are integral to their provision. Prohibits health plan contracts and insurance policies from imposing a cost-sharing requirement, utilization review, or other specified limits on a recommended sexually transmitted infections (STI) screening, and from imposing a cost-sharing requirement for any items and services integral to a STI screening, as specified. Requires a health plan or insurer to directly reimburse specified nonparticipating providers or facilities of STI screening, specified rates (unless otherwise agreed to by a nonparticipating essential community provider (ECP) and the health plan or insurer, the greater of its average contracted rate or 125% of the amount Medicare reimburses on a fee-for-service basis for the same or similar items or services in the general geographic region in which the items or services were rendered) for screening tests and integral items and services rendered, and prohibits the nonparticipating provider from billing or collecting a cost-sharing amount for a STI screening from an enrollee or insured. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1645&search_keywords=sexual+health **Governor's Veto Message:** This bill would prohibit health plans from imposing cost sharing for specified preventive or screening services and associated office visits and would require plans to directly reimburse nonparticipating essential community providers for STI screenings and services. I appreciate the author's efforts to increase access to preventive health care, including HIV and STI testing, colorectal screening, and other services. However, components of this proposal depart from structures in federal and state law, such as the existing policies for reimbursement to non-contracted providers. Further, because this bill exceeds the cost-sharing provisions under the Affordable Care Act, it would result in increased costs to health plans passed on to consumers through premiums. The State must weigh the potential benefits of all new mandates with the comprehensive costs to the entire delivery system. For these reasons, I cannot sign this bill.	Support	07-OCT-23 Vetoed by Governor.

BILL	TITLE	DESCRIPTION / COMMENTS	Recommended Position	STATUS
AB 2007 (Boerner)	*Establish Unicorn Homes Pilot Program*	*Establishes a 3-year pilot program—the Unicorn Homes Transitional Housing for Homeless LGBTQ+ Youth Program—to place unhoused LGBTQ+ youth with affirming volunteer host families and provide trauma-informed crisis intervention care, with the ultimate goal of reunification with the youth's family when possible.* *https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB2007*		*12-FEB-24* *Referred to Coms. On H. & C.D. and HUM. S.*
AB 2034 (Rodriguez)	*Crimes: loitering for the purpose of engaging in a prostitution offense*	*This bill would make it a misdemeanor to loiter in a public place with the intent to commit prostitution, as defined, and make other conforming changes. By creating a new crime, this bill would impose a state-mandated local program.* *https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB2034*		*12-FEB-24* *Referred to committee on public services.*
AB 2523 (Patterson)	*Needle and syringe exchange services*	*Existing law authorizes the State Department of Public Health to authorize certain entities to apply to the department to provide hypodermic needle and syringe exchange din any location where the department determines that the conditions exist for the rapid spread of HIV, viral hepatitis, or any other potentially deadly or disabling infections that are spread through the sharing of used hypodermic needles and syringes.* *This bill would make a technical, non-substantive change to this provision.* *https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB2523&search_keywords=HIV*		*14-FEB-24* *From printer. May be heard in committee March 15.*

BILL	TITLE	DESCRIPTION / COMMENTS	Recommended Position	STATUS
AB 2229 (Wilson)	*California Healthy Youth Act: menstrual health education*	*This bill would additionally include in that definition of "comprehensive sexual health education" the topic of menstrual health, defined for these purposes to mean a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in relation to the menstrual cycle. The bill would add to the above-described criteria that instruction and materials also teach pupils about the menstrual cycle, premenstrual syndrome and pain management, menstrual hygiene, menstrual disorders, menstrual irregularities, menopause, menstrual stigma, and any other relevant topics related to the menstrual cycle. By imposing additional duties on local educational agencies, the bill would impose a state-mandated local program. This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.* *https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB2229&search_keywords=HIV*		*08-FEB-24* *From printer. May be heard in committee March 9.*
AB 2258 (Zbur)	*Health care coverage: cost sharing*	*This bill would prohibit a group or individual non-grandfathered health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, from imposing a cost-sharing requirement for items or services that are integral to the provision on the above-described preventive care services and screenings. The bill would require those contracts and policies to cover items and services for those preventive care services and screenings, including home test kits for sexually transmitted disease and specified cancer screenings. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program.* *https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB2258*		*09-FEB-24* *From printer. May be heard in committee March 10.*
AB 2442 (Zbur)	*Expedite Licensure for Gender-Affirming Care Providers*	*Expands the network of gender-affirming care providers in the state to improve accessibility of care by expediting licensure applications for health care providers who intend to provide gender-affirming health care or gender-affirming mental health care in California.* *https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB2442*		*14-FEB-24* *From printer. May be heard in committee March 15.*

BILL	TITLE	DESCRIPTION / COMMENTS	Recommended Position	STATUS
AB 2498 (Zbur and Quirk-Silva)	*Housing: the California Housing Security Act*	*This bill would, upon appropriation of the Legislature, establish the California Housing Security Program to provide a housing subsidy to eligible persons, as specified, to reduce housing insecurity and help Californians meet their basic housing needs. To create the program, the bill would require the Department of Housing and Community Development to establish a 2-year pilot program in up to 4 counties, as specified. The bill would require the department to issue guidelines to establish the program that include, among other things, the amount of the subsidy that shall be the amount necessary to cover the portion of a person's rent to prevent homelessness but shall not exceed $2,000 per month. Under the bill, the subsidy would not be considered income for purposes of determining eligibility or benefits for any other public assistance program, nor would participation in other benefits exclude a person from eligibility for the subsidy. Under the bill, an undocumented person, as specified, who otherwise qualifies for the subsidy would be eligible for the subsidy. The bill would require the department to submit a report on the program to the Legislature, as described.* https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB2498		*14-FEB-24* *From printer. May be heard in committee March 15.*
AB 3031 (Lee and Low)	*LGBTQ+ Commission*	*Establishes a statewide LGBTQ+ Commission representing California's diverse LGBTQ+ community to shine a light on the unique challenges LGBTQ+ people face, assess and monitor programs and legislation to address systemic barriers, and make recommendations to improve the health, safety, and well-being of LGBTQ+ Californians.* https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB3031		*17-FEB-24* *From printer. May be heard in committee March 18.*
SB 36 (Skinner)	Out-of-state criminal charges: prosecution related to abortion, contraception, reproductive care, and gender-affirming care	This bill would prohibit the issuance of warrants for persons who have violated the laws of another state relating to abortion, contraception, reproductive care, and gender-affirming care, that are legally protected in California. The bill would also prohibit apprehending, detaining, or arresting a bail fugitive based on such offenses, and impose criminal and civil liability for doing so. In addition, the bill would restrict the sharing of information by law enforcement related to such protected activity and provide that convictions in other states would not result in ineligibility for state benefits. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB36&search_keywords=gender	Support	*01-FEB-24* *Returned to Secretary of Senate pursuant to Joint Rule 56.*

BILL	TITLE	DESCRIPTION / COMMENTS	Recommended Position	STATUS
SB 37 (Caballero)	Older Adults and Adults with Disabilities Housing Stability Act	This bill establishes the Older Adults and Adults with Disabilities Housing Stability Pilot Program (Program), administered by the Department of Housing and Community Development (HCD), to provide housing subsidies to older adults and adults with disabilities who either are experiencing or at risk of experiencing homelessness, in up to five geographic regions or counties. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB37&search_keywords=HIV	Support	*29-JAN-24* *In Assembly. Read first time. Held at Desk.*
SB 339 (Wiener)	HIV preexposure prophylaxis and postexposure prophylaxis	This bill authorizes a pharmacists to furnish up to a 90-day course of preexposure prophylaxis (PrEP), or beyond 90-days if specified conditions are met and requires the Board of Pharmacy (Board) to adopt emergency regulations to implement these provisions by July 1, 2024. This bill requires a health care service plan and health insurer to cover PrEP and postexposure prophylaxis (PEP) furnished by a pharmacists, including costs for the pharmacist's services and related ordered by the pharmacists. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB339&search_keywords=HIV ***Assembly Amendments:*** 1. *Add coauthors and an urgency clause* 2. *Clarify that the authority for pharmacists related to PrEP and PEP does not expand the scope of practice of a pharmacist beyond that authorized under current law* 3. *Exclude Medi-Cal managed care plans contracting with the Department of Health Care Services (DHCS) from the coverage provisions of the measure* 4. *Strike the requirement for the rate of reimbursement for PEP and PEP pharmacists services to be at 100% of the fee schedule for physician services to instead require a health care service plan to pay or reimburse the cost of pharmacist services at an in-network pharmacy or pharmacist services at an out-of-network pharmacy if the health care service plan has an out-of-network pharmacy benefit.*	Support	*06-FEB-24* *Approved by Governor.*

BILL	TITLE	DESCRIPTION / COMMENTS	Recommended Position	STATUS
SB 372 (Menjivar)	Department of Consumer Affairs: licensee and registrant records: name and gender changes	This bill requires a board within the Department of Consumer Affairs (DCA) to update licensee or registrant records with that individual's updated legal name or gender upon receiving government-issued documentation, as specified. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB372&search_keywords=gender	Support	23-SEP-23 Approved by Governor.
SB 427 (Portantino)	Health care coverage: antiretroviral drugs, devices, and products	Prohibits a non-grandfathered or grandfathered health plan contract or health insurance policy from imposing any cost-sharing or utilization review requirements for antiretroviral drugs, drug devices, or drug products (ARVs) that are either approved by the United States Food and Drug Administration (FDA) or recommended by the federal Centers for Disease Control and Prevention (CDC) for the prevention of human immunodeficiency virus (HIV)/ acquired immunodeficiency syndrome (AIDS). Prohibits a health plan or health insurer from subjecting ARVs that are either approved by the FDA or recommended by the CDC for the prevention HIV/AIDS, to prior authorization or step therapy, but authorizes prior authorization or step therapy if at least one therapeutically equivalent version is covered without prior authorization or step therapy and the insurer provides coverage for a noncovered therapeutic equivalent antiretroviral drug, device, or product without cost sharing pursuant to an exception request. Does not require coverage by an out-of-network pharmacy, unless in the case of an emergency or if there is an out-of-network benefit. Delays implementation of this bill for an individual and small group health plan contract or insurance policy until January 1, 2025 https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB427&search_keywords=HIV	Watch	14-SEP-23 Ordered to inactive file on request of Assembly Member Zbur.
SB 524 (Caballero)	Pharmacists: furnishing prescription medications	This bill authorizes a pharmacist to furnish medications to treat various diseases and conditions based on the results of a federal Food and Drug Administration (FDA) test the pharmacist ordered, performed, or reported and adds these additional pharmacy services to the Medi-Cal schedule of benefits. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB524&search_keywords=HIV	Support	*01-FEB-24* *Returned to Secretary of Senate pursuant to Joint Rule 56.*

BILL	TITLE	DESCRIPTION / COMMENTS	Recommended Position	STATUS
SB 525 (Durazo)	Minimum wages: health care workers	This bill (1) enacts a phased in multi-tiered statewide minimum wage schedule for health care workers employed by covered healthcare facilities, as defined; (2) requires, following the phased-in wage increases, the minimum wage for health care workers employed by covered healthcare facilities to be adjusted, as SB 525; (3) provides a temporary waiver of wage increases under specified circumstances; (4) and establishes a 10-year moratorium on wage ordinances, regulations, or administrative actions for covered health care facility employees, as specified. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB525&search_keywords=%22health+care%22	Support with Amendments	13-OCT-23 Approved by Governor.

BILL	TITLE	DESCRIPTION / COMMENTS	Recommended Position	STATUS
SB 541 (Menjivar)	Sexual Health: contraceptives: Immunization	This bill requires all public high schools to make condoms available to students by the start of the 2024-25 school year and requires schools to provide information to students on the availability of condoms, as well as other sexual health information. Prohibits public schools from preventing distribution of condoms or preventing a school-based health center from making condoms available and easily accessible to students at the school-based health center site. Prohibits retailers from restricting sales of nonprescription contraception on the basis of age. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB541&search_keywords=HIV **Governor's Veto Message:** This bill requires all public high schools to make free condoms available to students and would prohibit retailers from refusing to sell condoms to youth. While evidence-based strategies, like increasing access to condoms, are important to supporting improved adolescent sexual health, this bill would create an unfunded mandate to public schools that should be considered in the annual budget process. In partnership with the Legislature, we enacted a budget that closed a shortfall of more than $30 billion through balanced solutions that avoided deep program cuts and protected education, health care, climate, public safety, and social service programs that are relied on by millions of Californians. This year, however, the Legislature sent me bills outside of this budget process that, if all enacted, would add nearly $19 billion of unaccounted costs in the budget, of which $11 billion would be ongoing. With our state facing continuing economic risk and revenue uncertainty, it is important to remain disciplined when considering bills with significant fiscal implications, such as this measure. For this reason, I cannot sign this bill.	Support	08-OCT-23 Vetoed by Governor.

BILL	TITLE	DESCRIPTION / COMMENTS	Recommended Position	STATUS
SB 953 (Menjivar)	*Medi-Cal: Menstrual products*	*This bill would add menstrual products, as defined, to that schedule of covered benefits. The bill would require the department to seek any necessary federal approvals to implement this coverage. The bill would require the department to seek, and would authorize the department to use, any and all available federal funding, as specified, to implement this coverage.* https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB953&search_keywords=HIV		*14-FEB-24* *Referred to Committee on Health.*

SB 954 (Menjivar)	*Sexual health: contraceptives*	*This bill would, in order to prevent and reduce unintended pregnancies and sexually transmitted infections, on or before the start of the 2025–26 school year, require each public school, including schools operated by a school district or county office of education, charter schools, and state special schools, to make internal and external condoms available to all pupils in grades 9 to 12, inclusive, free of charge, as provided. The bill would require these public schools to, at the beginning of each school year, inform pupils through existing school communication channels that free condoms are available and where the condoms can be obtained on school grounds. The bill would require a public school to post at least one notice regarding these requirements, as specified. The bill would require this notice to include certain information, including, among other information, information about how to use condoms properly. The bill would require each public school serving any of grades 7 to 12, inclusive, to allow condoms to be made available during the course of, or in connection with, educational or public health programs and initiatives, as provided. The bill would authorize a state agency, the State Department of Education, or a public school to accept gifts, grants, and donations from any source for the support of a public school carrying out these provisions, including, but not limited to, the acceptance of condoms from a manufacturer or wholesaler. The bill would, in order to comply with these provisions, encourage public schools to explore partnerships, including, but not limited to, partnerships with local health jurisdictions, as defined, community health centers, nonprofit organizations, and the State Department of Public Health. By imposing additional duties on public schools, the bill would impose a state-mandated local program.* *The bill would additionally prohibit a public school, as defined, maintaining any combination of classrooms from grades 7 to 12, inclusive, a school district, the State Department of Education, or a county office of education from prohibiting certain school-based health centers, as defined, from making internal and external condoms available and easily accessible to pupils at the school-based health center site. This bill would, with certain exceptions, prohibit a retail establishment, as defined, from refusing to furnish nonprescription contraception to a person solely on the basis of age by means of any conduct, including, but not limited to, requiring the customer to present identification for purposes of demonstrating their age.* *https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB954*		*14-FEB-24* *Referred to Committees on Education and Health.*

BILL	TITLE	DESCRIPTION / COMMENTS	Recommended Position	STATUS
SB 957 (Wiener)	*Data collection: sexual orientation and gender identity*	*This bill would require the State Department of Public Health, for purposes of the data collected by the department on sexual orientation, gender identity, and intersexuality, to comply with the above-described requirements by July 1, 2026. This bill would add the patient's or client's sexual orientation and gender identity to the list of information subject to disclosure. The bill would make conforming changes to the above-described provisions on data sharing.* *The bill would require the State Department of Public Health to prepare an annual report concerning sexual orientation and gender identity (SOGI) data collected by the department. The bill would require the department to annually post and make available the report on the department's internet website, and to annually submit the report to the Legislature, excluding any personally identifiable information.* *The bill would require the annual report to include, among other certain information, the department's efforts to collect, analyze, and report SOGI data, and, until fully implemented, the progress that the department has made in implementing recommendations set forth in a related 2023 report by the California State Auditor's Office.* *https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB957*		*14-FEB-24* *Referred to Committees on Health and Judiciary.*
SB 959 (Menjivar)	*Ensure Comprehensive Access to Information*	*Creates an online resources for transgender, gender non-conforming, and intersex (TGI) Californians and their families to combat misinformation and provide accurate information about access to trans-inclusive health care, existing legal protections for patients and providers, and other available support services.* *https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB959*		*28-FEB-24* *From committee with author's amendments. Re-referred to Com. on RLS.*
SB 990 (Padilla)	*LGBTQ+ Disaster Preparedness*	*Requires California to update the State Emergency Plan to include LGBTQ+ inclusive policies and best practices to ensure that LGBTQ+ people can access affirming services and resources before, during, and after an emergency or natural disaster.* *https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB990*		*14-FEB-24* *Referred to Com. on RLS.*

BILL	TITLE	DESCRIPTION / COMMENTS	Recommended Position	STATUS
SB 996 (Wilk)	*Comprehensive Sexual health Education and Human Immunodeficiency Virus (HIV) Prevention Education*	*This bill would require the governing board of a school district to adopt a policy at a publicly noticed meeting specifying how parents and guardians of pupils may inspect the written and audiovisual educational materials used in comprehensive sexual health education and HIV prevention education, including that the materials, including updates or changes to the materials, are made available, within prescribed timeframes, at each school site and, except as provided, publicly posted on the school district's internet website or, if applicable, on a school district's parent or guardian portal, as specified.* https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB996		*14-FEB-24* *Referred to committee on Education.*
SB 1022 (Skinner)	*Strengthen Enforcement of Civil Rights*	*Enables the Civil Rights Department to more effectively investigate and prosecute long-running civil rights violations affecting groups or classes of people by making technical changes to the Fair Employment and Housing Act.* https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB1022		*14-FEB-24* *Referred to Com. on JUD.*
SB 1278 (Laird)	*LGBTQ seniors: health care services*	*This bill would state the intent of the Legislature to enact legislation that would enhance health care services for LGBTQ seniors in the state.* https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB1278		*16-FEB-24* *May be acted upon on or after March 17.*
SB 1290 (Roth)	*Health care coverage: essential health benefits*	*This bill would express the intent of the Legislature to review California's essential health benefits benchmark plan and establish a new benchmark plan for the 2027 plan year. The bill would limit the applicability of the current benchmark plan benefits to plan years on or before the 2027 plan year.* https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB1290		*16-FEB-24* *May be acted upon on or after March 17.*

BILL	TITLE	DESCRIPTION / COMMENTS	Recommended Position	STATUS
SB 1333 (Eggman and Roth)	*Communicable diseases: HIV reporting*	*This bill would require employees and contractors to annually sign the agreement and would repeal the annual review of the agreements. By increasing obligations on local health departments to annually obtain signed agreements, this bill would impose a state-mandated local program.* *This bill would additionally authorize disclosure when the confidential information is necessary for the coordination of, linkage to, or reengagement in care for the person.* *Existing law authorizes local public health agency staff to disclose information to state and federal public health agency staff for purposes of enhancing the completeness of reporting to the federal CDC of persons coinfected with HIV and specified transmittable diseases.* *This bill would repeal that authority.* *https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB1333*		*20-FEB-24* *From printer. May be acted upon on or after March 18.*
SB 1346 (Durazo)	*Worker's compensation: aggregate disability payments*	*This bill would authorize, on or after January 1, 2025, the Worker's Compensation Appeals Board to award temporary disability benefits, as specified, if a denial of treatment requested by a treating physician is subsequently overturned by independent medical review. The bill would prohibit the temporary disability awarded by the Worker's Compensation Appeals Board from exceeding the time from the date of the treatment denial through the date of the independent medical review determination overturning the treatment denial.* *https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB1346*		*20-FEB-24* *From printer. May be acted upon on or after March 18.*

BILL	TITLE	DESCRIPTION / COMMENTS	Recommended Position	STATUS
SB 1368 (Bogh)	*School curriculum: sexual health education and human immunodeficiency virus (HIV) prevention education: health framework: pregnancy centers*	*This bill would require the Instructional Quality Commission, when the Health Framework for California Public Schools is next revised after January 1, 2025, to include information on pregnancy centers as a resources in that health framework. This bill would require the department to make information about pregnancy centers available on its internet website and would require pregnancy centers to be includes by school districts in the above-described information about local resources. By imposing additional duties on school districts, the bill would impose a state-mandated program. This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the State, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.* https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB1368		*20-FEB-24* *From printer. May be acted upon on or after March 18.*

FEDERAL BILLS				
Bill	Title	Description / comments	Recommended position	Status
H.R. 62 (Jackson Lee)	SHIELD Act	SHIELD = Safeguarding Healthcare Industry Employees from Litigation and Distress This bill established a framework to limit interference with persons seeking to provide or access reproductive health services at the state level. The bill reduces the allocation of funds under certain law enforcement grant programs for a state that has in effect a law authorizing state or local officers or employees to interfere with persons seeking to provide or access reproductive health services. The bill authorizes civil remedies for a violation, including damages and injunctive relief. Additionally, it authorizes criminal penalties for a violation involving the use of deadly or dangerous weapon or the infliction of bodily injury. https://www.congress.gov/bill/118th-congress/house-bill/62/actions?s=8&r=5&q=%7B%22search%22%3A%5B%22%5C%22reproductive+health%5C%22%22%5D%7D	SUPPORT	09-Jan-23 Introduced in House. Referred to the Committee on Energy Commerce, and in addition to the Committee on the Judiciary.
H.R. 73 (Biggs)	No Pro-Abortion Task Force Act	This bill prohibits federal funding of the Reproductive Healthcare Access Task Force. The Department of Health and Human Services launched the task force on January 21, 2022, to identify and coordinate departmental activities related to accessing sexual and reproductive health care. https://www.congress.gov/bill/118th-congress/house-bill/73?q=%7B%22search%22%3A%5B%22%5C%22reproductive+health%5C%22%22%5D%7D&s=8&r=7	OPPOSE	09-JAN-23 Introduced in House. Referred to Committee on Energy and Commerce.
H. Res. 185 (Hayes)	Declaring racism a public health crisis	Resolved, That the House of Representatives— (1) supports the resolutions drafted, introduced, and adopted by cities and localities across the Nation declaring racism a public health crisis; (2) declares racism a public health crisis in the United States; (3) commits to— (A) establishing a nationwide strategy to address health disparities and inequity across all sectors in the United States; (B) dismantling systemic practices and policies that perpetuate racism in the United States; (C) advancing reforms to address years of neglectful and apathetic policies that have led to poor health outcomes for communities of color in the United States; and	SUPPORT	28-FEB-23 Introduced in House. Referred to the Committee on Energy and Commerce, and in addition to the Committee on the Judiciary.

		(D) promoting efforts to address the social determinants of health—especially for Black, Latino, and Native-American people, and other people of color in the United States; and (4) charges the Nation with moving forward with urgency to ensure that the United States stands firmly in honoring its moral purpose of advancing the self-evident truths that all people are created equal, that they are endowed with certain unalienable rights, and that among these are life, liberty, and the pursuit of happiness. https://www.congress.gov/bill/118th-congress/house-resolution/185/text?s=1&r=15&q=%7B%22search%22%3A%5B%22%5C%22HIV%5C%22%22%5D%7D		
H.R. 407 (Clyde)	Protect the UNBORN Act	UNOBORN: Undo the Negligent Biden Orders Right Now This bill prohibits federal implementation of and funding for specified executive orders that address access to reproductive care services, including services related to pregnancy or the termination of a pregnancy. https://www.congress.gov/bill/118th-congress/house-bill/407?q=%7B%22search%22%3A%5B%22%5C%22reproductive+health%5C%22%22%5D%7D&s=8&r=6	OPPOSE	27-JAN-23 Introduced in House. Referred to the Subcommittee on Health.
H.R. 445 (Williams)	HHS Reproductive and Sexual health Ombuds Act of 2023	This bill creates a position within the Department of Health and Human Services to support access to reproductive and sexual health services (including services relating to pregnancy and the termination of a pregnancy) that are evidence-based and medically accurate. Functions of the position include (1) educating the public about medication abortions and other sexual and reproductive health services, (2) collecting and analyzing data about consumer access to and health insurance coverage for those services, and (3) coordinating with the Federal Trade Commission on issues related to consumer protection and data privacy for those services. https://www.congress.gov/bill/118th-congress/house-bill/445?q=%7B%22search%22%3A%22%5C%22sexual+health%5C%22%22%7D	SUPPORT	27-JAN-23 Introduced in House. Referred to the Subcommittee on Health.
H.R. 459 (Eshoo)/ S. 323 (Hirono)	SAFER health Act of 2023	SAFER: Secure Access For Essential Reproductive Health This bill would ensure the privacy of pregnancy termination or loss under the HIPAA privacy regulations and the HITECH Act. https://www.congress.gov/bill/118th-congress/house-bill/459/text?s=8&r=8&q=%7B%22search%22%3A%5B%22%5C%22reproductive+health%5C%22%22%5D%7D	SUPPORT	09-FEB-23 Introduced in Senate. Read twice and referred to the Committee on Health,

		https://www.congress.gov/bill/118th-congress/senate-bill/323/text?s=8&r=9&q=%7B%22search%22%3A%5B%22%5C%22reproductive+health%5C%22%22%5D%7D		Education, Labor, and Pensions.
H.R. 517 (Mace)	Standing with Moms Act	This bill requires the Department of Health and Human Services (HHS) to disseminate information about pregnancy-related resources. Specifically, HHS must maintain a public website (life.gov) that lists such resources that are available through federal, state, and local governments and private entities. The bill excludes form life.gov, the portal and the hotline resources provided by entities (1) perform, induce, refer for, or counsel in favor of abortions; or (2) financially support such entities. The bill also requires HHS to report on traffic to life.gov and the portal, gaps in services available to pregnant and postpartum individuals, and related matters. https://www.congress.gov/bill/118th-congress/house-bill/517?q=%7B%22search%22%3A%5B%22%5C%22reproductive+health%5C%22%22%5D%7D&s=8&r=19	OPPOSE	25-JAN-23 Introduced in House. Referred to the House Committee on Energy and Commerce.
H.R. 561 (Lee)	EACH Act of 2023	This bill requires federal health care programs to provide coverage for abortion services and requires federal facilities to provide access to those services. The bill also permits qualified health plans to use funds attributable to premium tax credits and reduced cost sharing assistance to pay for abortion services. https://www.congress.gov/bill/118th-congress/house-bill/561?q=%7B%22search%22%3A%5B%22%5C%22transgender%5C%22%22%5D%7D&s=8&r=8	SUPPORT	21-FEB-23 Introduced in House. Referred to the Subcommittee on Indian and Insular Affairs
H.R. 1224 (Trahan)	INFO for Reproductive Care ACT OF 2023	INFO= Informing New Factors and Options This bill requires the Department of Health and Human Services to carry out a campaign to educate health care professionals (and health care professions students) about assisting patients to navigate legal issues related to abortions and other reproductive health care services. https://www.congress.gov/bill/118th-congress/house-bill/1224?q=%7B%22search%22%3A%5B%22%5C%22reproductive+health%5C%22%22%5D%7D&s=8&r=4	SUPPORT	27-FEB-23 Introduced in House. Referred to the House Committee on Energy and Commerce.
S. 644 (Markey)	*Modernizing Opioid Treatment Access Act*	*This bill expands access to methadone for an individual's unsupervised use to treat opioid use disorder (OUD). Typically, methadone must be dispensed to individuals in person through opioid treatment programs. The bill (1) waives provisions of the Controlled Substances Act that require qualified practitioners to obtain a separate registration from the Drug Enforcement Administration (DEA) to prescribe and dispense methadone to treat OUD,*		

BILL	TITLE	DESCRIPTION / COMMENTS	Recommended Position	STATUS
		and (2) requires the Substance Abuse and Mental Health Services Administration and the DEA to jointly report on the waiver. Additionally, the bill directs the DEA to register certain practitioners to prescribe methadone that is dispensed through a pharmacy for an individual's unsupervised use. Qualified practitioners must be licensed or authorized to prescribe controlled substances, and they must either work for an opioid treatment program or be a physician or psychiatrist with a specialty certification in addiction medicine. A state may request that the DEA stop registering such practitioners in its jurisdiction. Individuals who receive methadone for unsupervised use must continue to have access to other care through an opioid treatment program. For purposes of the waiver, the bill also requires the exclusive use of electronic prescribing, establishes prescription limits, and sets out requirements for informed consent. Further, the bill permits the use of telehealth to provide methadone treatment and related services if the state and the Department of Health and Human Services jointly determine the use is feasible and appropriate. *https://www.congress.gov/bill/118th-congress/senate-bill/644*		
S. 701 (Baldwin)	Women's Health Protection Act of 2023	To protect a person's ability to determine whether to continue or end a pregnancy, and to protect a health care provider's ability to provide abortion services. https://www.congress.gov/bill/118th-congress/senate-bill/701/text?s=8&r=14&q=%7B%22search%22%3A%5B%22%5C%22reproductive+health%5C%22%22%5D%7D	SUPPORT	08-MAR-23 Introduced in Senate. Placed on Senate Legislative Calendar under General Orders.

* The bill was not approved by the Commission on HIV

** Commission on HIV recommended bill for the Legislative docket

Footnotes:

(1) Under Joint Rule 56, bills introduced in the first year of the regular session that do not become carry-over bills shall be returned to the Chief Clerk of the Assembly or the Secretary of the Senate.

Notes:

Items italicized in blue indicate a new status or a bill for consideration for inclusion in the docket.

Whereas the *Vision* of the Los Angeles County Commission on HIV is to be

> *A comprehensive, sustainable, accessible system of prevention and care that empowers people at-risk, living with or affected by HIV to make decisions and to maximize their lifespans and quality of life.* *https://hiv.lacounty.gov/*

Whereas the Los Angeles County Commission on HIV has pledged to operationalize the *Anti-Racism, Diversity, and Inclusion Initiative which* states

> *The Commission supports and actively incorporates in its planning, the County's Anti-Racism, Diversity, and Inclusion Initiatives (ARDII); an initiative that articulates an anti-racist agenda that guides, governs, and increases the County's ongoing commitment to fighting racism in all its dimensions, especially racism that systemically and systematically affects Black residents.*
> *The Commission welcomes commissioners, guests, and the public into a space where people of all opinions and backgrounds can 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.*

Whereas the Los Angeles County Comprehensive HIV Plan (2022-2026) acknowledges the impact of structural racism and incarceration

> *Beyond the direct association of incarceration and poor health outcomes among PLWH, we also recognize incarceration as a force in LA and across the country that destabilizes communities, disrupts family relationships, and magnifies the accumulation of health and social disadvantage for already marginalized populations. The LA County Sheriff's Department (LASD) operates the largest municipal jail system in the US, and the US, in turn "imprisons more people than any other nation on Earth... In addition to the sheer volume of people in LA County jails, there are stark racial disparities. Black/African Americans, while making up only 9% of the LA County population, represent over 29% of the jail population.*
> *https://hiv.lacounty.gov/our-work/*

Whereas every general commission meeting is opened with the Los Angeles County *Land Acknowledgement*, which was unanimously voted to adopt by the Board of Supervisors on November 1, 2022 which states,

> *The County of Los Angeles recognizes that we occupy land originally and still inhabited and cared for by the Tongva, Tataviam, Serrano, Kizh, and Chumash Peoples. We honor and pay respect to their elders and descendants — past, present, and emerging — as they continue their stewardship of these lands and*

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waters. We acknowledge that settler colonization resulted in land seizure, disease, subjugation, slavery, relocation, broken promises, genocide, and multigenerational trauma. This acknowledgment demonstrates our responsibility and commitment to truth, healing, and reconciliation and to elevating the stories, culture, and community of the original inhabitants of Los Angeles County. We are grateful to have the opportunity to live and work on these ancestral lands. We are dedicated to growing and sustaining relationships with Native peoples and local tribal governments, including (in no particular order) the

- *Fernandeño Tataviam Band of Mission Indians*
- *Gabrielino Tongva Indians of California Tribal Council*
- *Gabrieleno/Tongva San Gabriel Band of Mission Indians*
- *Gabrieleño Band of Mission Indians – Kizh Nation*
- *San Manuel Band of Mission Indians*
- *San Fernando Band of Mission Indians*

https://lacounty.gov/government/about-la-county/land-acknowledgment/

Whereas on October 17, 2023 the Los Angeles County Board of Supervisors unanimously passed a resolution despite mass opposition.

Whereas, all human life is precious, and the targeting of civilians, no matter their faith or ethnicity, is a violation of international humanitarian law; and
Whereas, hundreds of thousands of lives are at imminent risk if humanitarian aid is not delivered without delay; and
Whereas, Israel has the right to defend itself but must take caution to protect civilian life and move towards de-escalation.
https://p6y530.p3cdn1.secureserver.net/wp-content/uploads/2023/10/Read-In-SD2-Motion-Resolution-Human-Rights-in-Gaza-10.17.23-FINAL.pdf
Why it matters: The motion, introduced by Supervisor Lindsey Horvath with Supervisor Kathryn Barger, states that the county "unequivocally supports the right of the State of Israel to exist as a sovereign and independent nation with full recognition of its borders and territory."
Before the supervisors had a chance to vote, public commentators lined up in person and over the phone to criticize the move. People in the audience then began to shout at the supervisors, saying the resolution was "one-sided" and represented a "blank check" for Israeli violence against Palestinians in Gaza.
https://laist.com/brief/news/politics/la-county-supervisors-vote-to-support-israel-at-tense-meeting

Whereas the Israeli government has imposed an apartheid state through structural racism, occupation and settler-colonialism in Gaza and the West Bank

So is Israel an apartheid state? After more than two years of research and arduous debate on the question, experts at Human Rights Watch released a 200-plus-page

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report with an answer to that question. Citing Israeli officials who stated that they were determined to maintain Jewish Israeli control "over demographics, political power and land," the organization found that "authorities have dispossessed, confined, forcibly separated, and subjugated Palestinians by virtue of their identity to varying degrees of intensity." It concluded that in Gaza and the West Bank — which together are home to 5 million Palestinians — "these deprivations are so severe that they amount to the crimes against humanity of apartheid and persecution." https://www.latimes.com/politics/story/2024-01-09/is-israels-treatment-of-palestinians-a-form-of-apartheid

Structural racism is not separate from imperialism and national projects of settler-colonialism. The harm created by these oppressive forces is driven by white supremacy and unfettered capitalism and creates a reality in which the United States, the Global North, and their allies believe they are entitled to the land, people, and resources all over the world. All three of these systems are inherently connected to each other; they create and sustain racialized hierarchies and produce the inequities antiracism work seeks to eliminate…

Palestinians have been resisting occupation, state- and internationally sanctioned violence, and hyper-surveillance for 75 years since the establishment of Israel and the Nakba in 1948. What is happening now in Gaza is genocide. Like Black, Indigenous, and other racialized communities in the US, Palestinians are suppressed through police violence, mass incarceration, and resource deprivation. Their suppression is legitimized through rhetorical dehumanization (e.g., "children of darkness," "human animals," etc.), a tactic employed across racialized communities throughout US history. https://medium.com/@antiracistsatwork/the-struggle-for-palestinian-liberation-is-antiracism-work-35f195531d6d

Whereas the Los Angeles law enforcement agencies have adopted policing and surveillance technologies from Israeli Defense Forces and have also participated with hundreds of law enforcement agencies around the US in joint police-military trainings with Israel's police-state apparatus

LAPD has bolstered its online surveillance operations by adding another piece of technology to its roster. LAPD's newest surveillance partner, Cobwebs Technologies, gathers data from your phone and social media activity and turns it into intelligence. The Israeli company's surveillance software, which outsources much of their surveillance work to AI and machine learning, gives police warrantless access to your personal information.

Cobwebs Technologies was founded in 2015 by former IDF special operatives Omri Timianker, Shay Attias, and former Mossad official Udi Levy. The company is part of the controversial billion-dollar surveillance industry in Israel, where the technology is often tested on Palestinians before being implemented elsewhere in the world.

During a 2014 trip to Israel, LAPD's top brass saw firsthand how Israel used drones,

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social media surveillance software, and automatic license plate readers.
https://knock-la.com/lapd-is-using-israeli-surveillance-software-that-can-track-your-phone-and-social-media/
According to the organization Jewish Voice for Peace (JVP) and Researching the American-Israeli Alliance (RAIA), one common theme shared between United States and Israel is the exchange of tactics and expertise in state violence, which has been ongoing for 18 years. https://www.aljazeera.com/news/2020/6/12/how-the-us-and-israel-exchange-tactics-in-violence-and-control
In 2018, police in Long Beach, California applied for a Homeland Security grant to send three officers to an ADL seminar in Israel. "I'm told out of state training is highly scrutinized, but this was approved immediately, which I believe lends credibility to the program's value," Long Beach Police Commander Randy Allen wrote in a memo later released to MuckRock, an online public records platform.
https://reason.com/2022/06/20/do-small-town-cops-need-training-in-israeli-counterterror-techniques/
Whether it is in Ferguson or L.A., we see a similar response all the time in the form of a disproportionate number of combat-ready police with military gear who are ready to use tear gas at short notice," Syed said. "Whenever you find 50 people at a demonstration, there is always a SWAT team in sight or right around the corner."
The law enforcement seminars in some ways resemble other privately funded trips to Israel, such as the birthright trips for Jewish young adults and programs for politicians, educators and other professionals. Stops on the law enforcement tours include not just the Western Wall, but also West Bank border checkpoints, military facilities and surveillance installations... Participants represented the New York and Los Angeles police departments, the Major County Sheriffs' Association, the New York and New Jersey Port Authority police and the New York Metropolitan Transportation Authority police. https://revealnews.org/article-legacy/us-police-get-antiterror-training-in-israel-on-privately-funded-trips/
Internationally, the United States military is engaged in Black and Brown countries as convenient battlefields. Domestically, the militarization of police departments is linked to the expansion of surveillance, harassment and Black and Brown extrajudicial deaths.
Since the "war on terror" began in 2001, militarization of American policing has been amplified by training in Israel. Hundreds of law enforcement officials and government agents from across our country have been sent to Israel to meet with military and police forces, and thousands more have participated in conferences, trainings and workshops with Israeli officials in the United States.
https://www.sandiegouniontribune.com/opinion/commentary/story/2020-07-17/commentary-time-to-end-police-training-in-israel

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Whereas at least 22,835 Palestinians had been killed (as of January 7, 2024) with an estimated 70% are women and children and estimated 1.9 million people that have been internally displaced – nearly 85% of the population.

> *The 22,835 dead represent about one in a hundred of Gaza's total population. They have been killed at a rate of just under 250 a day (an average that has come down a bit in the last few weeks). It is not known exactly how many of those killed were combatants, but Israel's own ratio would suggest that on average, more than 160 civilians have died each day. That is a much faster rate than in other broadly comparable recent conflicts...*
> Figures from the government media office in Gaza cited by the UN Office for the Coordination of Humanitarian Affairs (OCHA) estimate that about 65,000 residential units have been destroyed or rendered uninhabitable. Another 290,000 have been damaged. That means that about half a million people have no home to return to...
> *While 500,000 people have no home to return to, many more will remain displaced because of the scale of the devastation of Gaza's crucial public facilities. The World Health Organization (WHO) says that 23 of 36 hospitals had been rendered completely inoperable by 3 January, with a previous count of 3,500 beds down to 1,400 by 10 December amid vastly increased need.*
> *https://www.theguardian.com/world/2024/jan/08/the-numbers-that-reveal-the-extent-of-the-destruction-in-gaza*

Whereas the *World Health Organization* and the UN has called the offensive on Gaza a "public health disaster" and warns that infectious diseases may ultimately kill more people than Israel's offensive.

> *In Gaza, the World Health Organization warns that illness may ultimately kill more people than Israel's offensive. Infectious diseases are "soaring," says the WHO. Over 100,000 cases of diarrhea have been reported, with rates among children 25 times higher than before the war... "It's a cauldron of possibility of infectious disease," says Amber Alayyan, deputy program manager for Doctors Without Borders in the Palestinian territories. "If you have no access to antibiotics because you can't get to the doctor," she says, "then something that's so simple to treat can turn into something quite deadly. This really just is an infectious disaster in waiting.*
> *https://www.npr.org/sections/goatsandsoda/2023/12/26/1221414237/gaza-infectious-disease-outbreak-public-health-israel-palestine#:~:text=In%20Gaza%2C%20the%20World%20Health,higher%20than%20before%20the%20war.*
> *The U.N. humanitarian office said on Wednesday that Gaza faced a public health disaster due to the collapse of its health system and the spread of disease amid an offensive by Israel that has hit hospitals and displaced hundreds of thousands of people. "We all know that the health care system is or has collapsed," said Lynn*

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Hastings, the U.N. Humanitarian Coordinator for the Occupied Palestinian Territory. https://www.reuters.com/world/middle-east/gaza-faces-public-health-disaster-un-humanitarian-office-says-2023-12-13/

Whereas the fight against HIV is a global fight that which has shaped other global fights against pandemics and

Many of the same inequalities that drive HIV, Covid-19, and MPox, would drive future outbreaks. Lessons learnt from inequality-busting approaches demonstrated in the AIDS pandemic can guide how we can beat all pandemics, and new inequality-focused responses to AIDS will make the world more prepared. To help the people who are marginalized in responses... we must understand why they are marginalized. The answeres are found by looking at the relationship between those who have control of power an dhtose who do not: at the way services are structured, at laws, policies and social norms which empower some and disempower others. These inequalityes perpetuate pandemics. https://www.inequalitycouncil.org/inequalities/

Whereas the HIV/AIDS epidemic in the Middle East and North Africa, and in particular Palestine, was considered of growing concern prior to the conflict

In 2018, the United Nations AIDS Program (UNAIDS) reported about 220,000 people infected with HIV and living with AIDS in the Middle East and North Africa (MENA), 35% of them are children and about 18,000 are new HIV infections. Despite the low prevalence of HIV/AIDS in the MENA region, it is considered an area of increasing concern for HIV infection; 9,800 people (4.5%) died of AIDS-related illness in 2018, and there is limited knowledge about the epidemic of HIV in MENA countries (Hemelaar et al., 2019, UNAIDS, 2019). The prevalence and incidence of HIV are expected to be very low in some MENA countries, and it is believed to be underestimated due to high social stigma. It was reported that HIV risk groups are often subject to homophobia, harassment, discrimination and criminalization (Chemaitelly et al., 2019; Gökengin et al., 2016; Mumtaz et al., 2018). Religious faiths in MENA countries (Islam, Christianity and Judaism) do not support non-marital sexual behaviors, which is the main risk factor associated with HIV infection. Palestine (the West Bank and Gaza Strip) is part of this concern; HIV incidence and AIDS-related mortality are slowly rising year after year. Between 1988 and 2017, there have been 98 cases (Figure 1); 79 AIDS and 19 HIV positive cases reported by the Palestinian Ministry of Health (PMOH, 2017). These numbers do not reflect the actual status of HIV/AIDS, and there is a shortage of information about the actual numbers in Palestine, probably due to insufficient investment in surveillance and collection and analysis of data. However, the available information has been never analyzed or synthesized at the country or regional level due to religious and cultural stigma. https://www.sciencedirect.com/science/article/pii/S1201971219304126

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Whereas armed conflict and displacement has already proven to be a driver of the HIV epidemic globally which hurts our global EHE efforts particularly, UNAIDS Goal 3: Ensure Healthy Lives

> *The patterns of HIV spread within the Libyan regions were traced, and the risk factors were determined during the conflict period. A total of 4,539 patients with HIV/AIDS were studied from the four regions during the Libyan conflict. Our data analysis indicated that Benghazi, the biggest city in the Eastern region, was the significant exporter of the virus to the rest of the country. The viral dissemination changes were observed within the country, particularly after 2015. A major virus flows from the Eastern region during the armed conflict associated with internally displaced people. This resulted in the dissemination of new HIV strains and accumulations of HIV cases in western and middle regions.*
> https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9009867/
> *A core principle of the 17 Sustainable Development Goals (SDGs), and of the AIDS response, is that no one should be left behind. The AIDS epidemic cannot be ended without the needs of people living with and affected by HIV, and the determinants of health and vulnerability, being addressed. People living with HIV often live in fragile communities and are frequently discriminated against, marginalized and affected by inequality and instability—their concerns therefore must be at the forefront of sustainable development efforts.* *https://www.unaids.org/en/AIDS_SDGs*

Whereas ensuring an uninterrupted supply of treatment to warzones such as in Ukraine has shown to help stave off the impact of war

> *The war has caused significant migration – more than 7.9 million Ukrainians have fled to other countries and another 6.5 million remain internally displaced within the country. More than 30 medical institutions providing HIV services stopped their operations, because of destruction or occupation. Logistic chains also were broken. However, Ukraine has demonstrated unique resilience in its HIV response. Today, thanks to partners like the Global Fund and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), Ukraine has received enough ARV medicines to ensure uninterrupted treatment for everyone, leaving no one with HIV/AIDS behind. Civil society, which always was the heart and engine of the national response to the epidemic, did the nearly impossible, delivering services, medicines, and humanitarian aid even where the fighting was taking place.*
> https://www.undp.org/ukraine/news/aids-and-war-how-ukraine-combatting-hiv/aids-2022

Whereas international health organizations such as the UN, Doctors Without Borders, The World Health Organization, the International Committee of the Red Cross and national health and labor organizations such as the American Public Health Association, the United

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Auto Workers Union, SEIU has called for an immediate ceasefire and restoration of water, fuel, electricity and safe passage humanitarian aid

The United Nations on Tuesday demanded an immediate humanitarian ceasefire in the Gaza Strip as U.S. President Joe Biden warned Israel it was losing international support because of its "indiscriminate" bombing of civilians in its war against Hamas militants. After dire warnings by U.N. officials about a deepening humanitarian crisis in Gaza, the 193-member U.N. General Assembly passed a resolution calling for a ceasefire with 153 countries voting in favor and 23 abstaining. The U.S. and Israel, which argue a ceasefire only benefits Hamas, voted against the measure along with eight other countries. *https://www.reuters.com/world/middle-east/hunger-rises-gaza-un-prepares-vote-ceasefire-resolution-2023-12-12/*

I am writing to you on behalf of Doctors Without Borders/Médecins Sans Frontières (MSF), our staff, and our patients to urgently request that the United States call for an immediate and sustained ceasefire in Gaza. MSF has delivered medical aid in many high-intensity conflicts over more than 50 years, yet rarely have we encountered such a catastrophic combination of escalating humanitarian and medical needs, ravaged infrastructure, and intentionally limited humanitarian access. We urge you to use your influence to secure an end to the widespread and indiscriminate attacks against civilians, forced displacement, and siege of Gaza. Vital humanitarian aid must be allowed to enter the Gaza Strip at scale. *https://www.doctorswithoutborders.org/latest/us-must-call-immediate-ceasefire-gaza*

"There Simply Is No Safe Place in Gaza": Aid Groups Demand Ceasefire as Israel Intensifies Its War
https://www.democracynow.org/2023/12/5/no_safe_zones_in_gaza

In light of the continuing escalating of civilian casualties in Gaza and Israel and the collapse of the healthcare infrastructure in Gaza, APHA calls upon President Biden and Congress to urgently demand an immediate ceasefire and to call for de-escalation of the current conflict by securing the immediate release of hostages and those detained; the restoration of water, fuel, electricity and other basic services; and the passage of adequate humanitarian aid to the Gaza Strip. (American Public Health Association Policy Statement) APHA Urges Biden to Call for Immediate Ceasefire in Israel-Hamas Conflict | MedPage Today

"From opposing fascism in WWII to mobilizing against apartheid South Africa and the CONTRA war, the UAW has consistently stood for justice across the globe," Region 9A Director Brandon Mancilla said. "That is why I am proud that the UAW International is today officially calling for a ceasefire in Israel and Palestine." *https://uaw.org/uaw-statement-israel-palestine/*, *https://www.seiu-uhw.org/stories/seiu-uhw-executive-board-resolution-on-the-conflict-in-gaza-and-israel/*

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NOW, THEREFORE BE IT RESOLVED that the Los Angeles County Commission on HIV joins with health advocacy and labor organizations around the world and demand:

1. Demand immediate permanent and unconditional ceasefire to allow the provision of an immediate unlimited humanitarian aid to the besieged, displaced, and injured population of Gaza.

2. Immediately halt all financial support and funding to the Israeli government that directly or indirectly contributes to the ongoing genocide in Gaza. In addition, incorporate Boycott, Divestment and Sanctions (BDS) of industries and entities that support and/or fund the Israeli military including ending use of surveillance technologies and halting the exchanges in training of local law enforcement by Israeli police and military forces.

3. Incorporate BDS to institutions of structural racism such as the Los Angeles County Sherrif's Department and Jail system and LAPD and other systems of punishment that are exacerbating the HIV epidemics locally and globally.

4. Cease the provision of weapons to Israel immediately, as continued arms sales only serve to perpetuate and escalate the genocide against innocent civilians. The United States must not be complicit in the loss of more lives and the destruction of communities.

5. Withdraw all political support and cover for the Israeli government's actions and support the international call to end the war and genocide now.

6. The Los Angeles County Board of Supervisors retract or amend their previously resolution based on over 100 days of warfare that has led to the enormous loss of life, particularly innocent civilians, mainly women and children.

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Other links and resources below

- https://drive.google.com/file/d/1VBYYocdPwUF8ogC9uuQ71WhjEKaDmuWz/view
- https://www.change.org/p/the-souls-of-12-000-murdered-children-and-the-icj-are-coming-your-way

Actions/plans, upcoming Jan 26th National Day of Action:
https://docs.google.com/document/d/1hpHkM9KlH5Yn3xq7nk9xfPtlkWZDblWnCKD8xt5DBx0/edit

UNICEF – New York Times Op-ed The Public Health Crisis in Gaza That Could Devastate a Generation
https://www.nytimes.com/2023/11/22/opinion/gaza-children-food-malnutrition.html

Human Rights Watch
https://www.hrw.org/news/2023/12/18/israel-starvation-used-weapon-war-gaza
https://www.hrw.org/news/2023/11/01/gaza-israeli-attacks-blockade-devastating-people-disabilities

WHO (updates listed)
https://www.emro.who.int/opt/priority-areas/occupied-palestinian-territory-health-crisis-2023.html

John's Hopkins - The Humanitarian Health Effects of the Israel-Hamas War Among Civilians in Gaza
https://publichealth.jhu.edu/2023/the-humanitarian-health-effects-of-the-israel-hamas-war-among-civilians-in-gaza
"Absolutely Unimaginable": Children in Gaza Face Amputations Without Anesthesia, Death & Disease
https://www.democracynow.org/2023/12/28/palestinian_children_gaza
"Please Stop This War Against Us": Gaza Doctor Begs for World's Help as Hunger & Disease Spread
https://www.democracynow.org/2023/12/11/gaza_hospitals

https://www.democracynow.org/2023/11/30/gaza_truce_doctors_without_borders

Reuters - Gaza faces public health disaster, UN humanitarian office says
https://www.reuters.com/world/middle-east/gaza-faces-public-health-disaster-un-humanitarian-office-says-2023-12-13/

https://www.inequalitycouncil.org/inequalities/
Amnesty International "With Whom are Many U.S. Police Departments Training? With a Chronic Human Rights Violator – Israel"

https://www.amnestyusa.org/updates/with-whom-are-many-u-s-police-departments-training-with-a-chronic-human-rights-violator-israel/

The Intercept - MEMPHIS POLICE CHIEF TRAINED WITH ISRAEL SECURITY FORCES

https://theintercept.com/2023/02/02/memphis-police-israel/

The Intercept - ISRAEL SECURITY FORCES ARE TRAINING AMERICAN COPS DESPITE HISTORY OF RIGHTS ABUSES

https://theintercept.com/2017/09/15/police-israel-cops-training-adl-human-rights-abuses-dc-washington/

The Guardian - ADL leaders debated ending police delegations to Israel, memo reveals
ADL leaders debated ending police delegations to Israel, memo reveals
https://www.theguardian.com/us-news/2022/mar/17/adl-police-delegations-israel

DRAFT

Substance Abuse and Mental Health Services Administration

5600 Fishers Lane • Rockville, MD 20857
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

January 30, 2024

Dear Colleague:

On behalf of the Substance Abuse and Mental Health Services Administration (SAMHSA), I want to alert you to increased rates of syphilis and other sexually transmitted infections (STIs) and provide guidance on the use of grant funds and SAMHSA's programmatic work to address this public health concern.

Syphilis and congenital syphilis along with substance use disorder, mental illness, and other STIs such as HIV, gonorrhea, and chlamydia represents a syndemic. Syndemics happen when two or more health conditions cluster and interact within a population because of social and structural factors and inequities, leading to an excess burden of disease and continuing health disparities. Addressing the syphilis syndemic requires collaboration between substance use preventionists, substance use disorder treatment providers, sexual health service providers, and supportive services providers (e.g., housing).

Screening, testing, and treating for STIs is part of SAMHSA's whole person approach to behavioral health treatment and substance use prevention. The U.S. Preventive Services Task Force recommends providers screen early for syphilis in all pregnant women as well as screen asymptomatic, nonpregnant adolescents and adults who are at increased risk for syphilis infection. Data from the Centers for Disease Control and Prevention (CDC) show a 74% increase in syphilis diagnoses from 2017-2021, including 2,800 congenital, or mother-to-child, syphilis cases in 2021 leading to 220 infant deaths. STIs overall have increased by 7% from 2020, with more than 2.5 million cases reported in the United States during 2021. Substance use, particularly methamphetamine use, appears to be highly correlated with rising rates of syphilis and other STIs. Among pregnant women with syphilis, substance use is nearly twice as high among those with a congenital syphilis outcome than those without transmission. Disparities also exist in syphilis rates across racial and ethnic groups. For example, among American Indian and Alaska Native (AI/AN) persons, the rate of new syphilis cases of nearly four times the rate of white persons in 2020. Syphilis is also increasing among gay, bisexual, and other men who have sex with men. However, we know that actions can be taken to reverse these trends and prevent transmission of syphilis and other STIs in these and other populations.

Unless expressly stated in the Notice of Funding Opportunity (NOFO) through which a grant is funded, SAMHSA grant recipients are not permitted to directly use SAMHSA funds for syphilis treatment. However, SAMHSA grant recipients may use their grant funds to address the syphilis syndemic by providing syphilis and other STI screening, testing, and referral to treatment in conjunction with SAMHSA supported work. Additional allowable activities include, but are not limited to, training for staff, case management for people who test positive for STIs, service navigation for people served by SAMHSA funds to syphilis or other STI prevention resources

and mental health support, and the development of memoranda of understanding (MOUs) or other agreements with STI treatment providers.

Additionally, some current SAMHSA grant programs include required or allowable activities that address the syphilis syndemic. Those grant programs are listed below, with additional information provided in Appendix 1.

1. The SAMHSA Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG).
2. Minority AIDS Initiative: Substance Use Disorder Treatment for Racial/Ethnic Minority Populations at High Risk for HIV/AIDS (Short title: MAI – High Risk Populations: fiscal year (FY) 2023 grant cohort only, TI-23-008.
3. Minority HIV/AIDS Fund (MHAF): Minority HIV/AIDS Fund: Integrated Behavioral Health and HIV Care for Unsheltered Populations Pilot Project (Short Title: Portable Clinical Care Pilot Project)**:** TI-23-024.
4. Minority AIDS Initiative: The Substance Use and Human Immunodeficiency Virus Prevention Navigator Program for Racial/Ethnic Minorities (Short Title: Prevention Navigator): FY 2023 grant cohort only, SP-23-005.
5. Services Program for Residential Treatment for Pregnant and Postpartum Women (Short Title: PPW): FY 2023 grant cohort only, TI-23-002.
6. Building Communities of Recovery (Short Title: BCOR): FY 2022 and FY 2023 grant cohorts only, TI-22-014.
7. Recovery Community Services Program (Short Title: RCSP): FY 2023 cohort only, TI-23-018.
8. Medication-Assisted Treatment-Prescription Drug and Opioid Addiction (Short Title: MAT-PDOA): FY 2021 (TI-21-006), FY 2022 (TI-22-013), and FY 2023 (TI-23-001) grant cohorts.
9. Grants for the Benefit of Homeless Individuals (Short Title: GBHI): FY 2023 grant cohort only, TI-23-005.
10. Targeted Capacity Expansion: Special Projects (Short Title: TCE – Special Projects): FY 2022 and FY 2023 grant cohorts, TI-22-002.

Note that this list does not include any future grant programs; for grant programs FY 2024 and later, please refer to the grant NOFO and/or contact your Government Project Officer if you have additional questions about how SAMHSA-supported programs can help to address the syphilis syndemic.

SAMHSA also oversees Opioid Treatment Programs (OTPs), which play an important role in addressing the syphilis syndemic. In addition to providing medications for opioid use disorder and other treatment and support services to address substance use and substance use disorders, OTPs are required by 42 Code of Federal Regulations (CFR) Part 8 Rules to "establish the risk of undiagnosed conditions such as Hepatitis C, the human immunodeficiency virus (HIV), sexually transmitted infections (STIs)." These requirements are important for assessing and providing whole-person care.

The rising rates of syphilis and other STIs in the United States, particularly among people who use substances, necessitate action across the healthcare field. For a list of resources to assist

clinicians in addressing the syphilis syndemic, see this link. By assessing the whole person needs of individuals with behavioral health conditions, we can make progress together. Thank you for your partnership in this effort. Please contact your Government Project Officer if you have any questions about your award or need additional information about STI prevention and substance use and how SAMHSA funding can be used to address the syphilis syndemic.

Sincerely,

/Miriam E. Delphin-Rittmon/

Miriam E. Delphin-Rittmon, Ph.D.
Assistant Secretary for Mental Health and Substance Use

Appendix 1: SAMHSA grant programs that include required or allowable activities that address the syphilis syndemic are listed below.

1. The SAMHSA Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) Provides funding as a "payment of last resort" in very limited circumstances for syphilis screening, testing, prevention education, and medical treatment. Those three limited circumstances are:
   I. For **pregnant people in SUBG-funded SUD treatment programs** and for people in SUD treatment with dependent children. Allowable services include providing an array of primary medical care for women and primary pediatric care for their children, including syphilis screening, testing, prevention education, and medical treatment for syphilis and congenital syphilis.
   II. For **persons with HIV in SUBG-funded SUD treatment programs** in CDC designated states. The SUBG requires the delivery of a defined array of HIV Early Intervention Services (EIS) in states with a prevalence of 10 or more cases of AIDS per 100,000 persons. The provision of EIS and post-test counseling includes screening and testing individuals with HIV and are engaged in SUD treatment for syphilis and referral to treatment.
   III. SUBG funds may also be used to address syphilis if a SUBG grant recipient has been **approved by their assigned Center for Substance Abuse Treatment (CSAT) State Project Officer (SPO) to use grant funds for approved elements of a Syringe Service Program (SSP)**, with the important exception that SUBG grant funds may not be used for distribution of needles or syringes for purposes of injection drug use of illegal substances. In the circumstances in which SUBG funds have been approved by the CSAT SPO to fund approved elements of a Syringe Services Program, these approved elements may include screening and testing for HIV, HCV, TB, and STIs, including syphilis.

      Note: Aside from these three limited circumstances, the SUBG does not allow the use of general block grant funds for routine testing for infectious diseases for individuals who are engaged in SUD treatment. If you are a SUBG grant recipient and have additional questions, please reach out to your CSAT SPO directly.

2. Minority AIDS Initiative: Substance Use Disorder Treatment for Racial/Ethnic Minority Populations at High Risk for HIV/AIDS (Short title: MAI – High Risk Populations:), TI-23-008: Recipients awarded from this NOFO in FY 2023 may use no more than 5 percent of the total award for staff training and screening and testing participants for HIV and other STIs, including test kits and required supplies, and referral to treatment services as appropriate.

3. Minority HIV/AIDS Fund (MHAF): Minority HIV/AIDS Fund: Integrated Behavioral Health and HIV Care for Unsheltered Populations Pilot Project (Short Title: Portable Clinical Care Pilot Project)**:** TI-23-024.
   I. Recipients awarded from this NOFO are required to provide the following activities:
      i. Screen clients and their drug-using and/or sexual partners on-site for HIV, viral hepatitis, STIs, mpox, and tuberculosis.
      ii. Provide case management and referral/linkage to treatment as necessary based on the client's individual needs. Case management includes a comprehensive assessment of the client's needs and the development of an individualized

service plan, including infectious disease prevention and/or treatment services, as well as helping clients with funding for treatment, including HCV treatment, as necessary.

iii. Test participants for STIs (gonorrhea, chlamydia, and syphilis) and provide treatment on-site as needed.

II. As stated in the NOFO, no more than 15 percent of the total grant award may be used for the purchase of, among other expenses, STI screening, testing, and treatment medications (chlamydia, gonorrhea, and syphilis).

4. Minority AIDS Initiative: The Substance Use and Human Immunodeficiency Virus Prevention Navigator Program for Racial/Ethnic Minorities (Short Title: Prevention Navigator): SP-23-005: Recipients awarded from this NOFO in FY 2023 may provide and/or refer individuals to supportive services that address social determinants of health and childhood adverse experiences to prevent the onset of mental health (MH)/SUD and reduce risk for HIV/viral hepatitis and STIs, including syphilis.

5. Services Program for Residential Treatment for Pregnant and Postpartum Women (Short Title: PPW): TI-23-002**:** Recipients awarded from this NOFO in FY 2023 are required to provide required supplemental services for women, including counseling on risk and testing for HIV, Hepatitis C, and other communicable diseases, including syphilis.

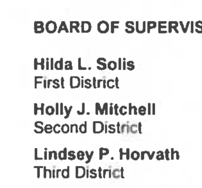
6. Building Communities of Recovery (Short Title: BCOR). TI-22-014: Recipients awarded from this NOFO in FY 2022 and FY 2023 are allowed to provide education, screening, care coordination, risk reduction interventions, testing, and counseling for HIV/AIDS, hepatitis, and other infectious diseases, including syphilis, for individuals with SUD.

7. Recovery Community Services Program (Short Title: RCSP): TI-23-018: Recipients awarded from this NOFO in FY 2023 are allowed to provide HIV/AIDS, viral hepatitis, and other infectious diseases education, including syphilis, screening, case management, and/or risk reduction interventions for individuals with Substance Use Disorder (SUD) or co-occurring substance use and mental disorders (COD), including those in recovery.

8. Medication-Assisted Treatment-Prescription Drug and Opioid Addiction (Short Title: MAT-PDOA): FY21 (TI-21-006), FY22 (TI-22-013), and FY23 (TI-23-001) grant cohorts: Recipients awarded from the NOFOs in FY 2021, FY 2022, and FY 2023 are allowed to provide education, screening, including screening and confirmatory laboratory testing, care coordination, risk reduction interventions, and counseling for HIV, hepatitis C, and other infectious diseases for people with Opioid Use Disorder (OUD) who are receiving Medication for Opioid Use Disorder (MOUD), including syphilis.

9. Grants for the Benefit of Homeless Individuals (Short Title: GBHI), TI-23-005: Recipients awarded in FY 2023 are allowed to provide training, screening, including laboratory screening and confirmatory testing, counseling, and treatment linkage as appropriate for Hepatitis C and other sexually transmitted infections, including syphilis.

10. Targeted Capacity Expansion: Special Projects (Short Title: TCE – Special Projects): FY22 and FY23 grant cohorts only, TI-22-002: Recipients awarded from the NOFO in FY 2022 and FY 2023 are allowed to provide education, screening, care coordination, risk reduction interventions, testing, and counseling for HIV/AIDS, hepatitis, and other infectious diseases, such as syphilis, for people with SUD who are receiving MOUD.



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December 21, 2023

TO: Each Supervisor

FROM: Barbara Ferrer, Ph.D., M.P.H., M.Ed.
Director

SUBJECT: **CONFRONTING THE DRUG OVERDOSE EPIDEMIC (BOARD AGENDA OF JULY 26, 2022, ITEM 11)**

This report is in response to the July 26, 2022 Board motion instructing the Director of Public Health (DPH), in partnership with the Department of Health Services (DHS), Department of Mental Health (DMH), Department of Children and Family Services (DCFS), Medical Examiner, Probation Department, Los Angeles County Homeless Services Authority (LAHSA), Los Angeles County Office of Education, Chief Executive Office inclusive of the Alternatives to Incarceration and Anti-Racism, Diversity and Inclusion initiatives, Long Beach Department of Health and Human Services, Pasadena Department of Public Health, other applicable entities and community stakeholders such as Federally Qualified Health Centers, managed care plans, hospitals, community-based organizations (CBO), and faith-based organizations, to develop and regularly update a plan of action to address the growing crisis of overdose deaths related to methamphetamine, fentanyl, opioids and other substances.

The following is the third report back on the following Board directed projects and reflects updates since the report back on September 21, 2023.

<u>Project #1</u>: Build on current planning processes and strategies to support shared goals around reducing the risk of drug overdoses.

DPH's Bureau of Substance Abuse Prevention and Control (SAPC) leads, coordinates, and participates in a spectrum of ongoing overdose prevention and response initiatives which involve the entities identified in the motion. DPH invited leadership from these

agencies and priority groups to participate in a third convening on November 6, 2023, to discuss how to continue to advance the overdose-related projects outlined below and to promote the elevation and coordination of these prevention and response strategies within this multi-sector coalition.

The Harm Reduction Steering Committee (HRSC), jointly operated by DPH-SAPC and DHS' Harm Reduction Division (HRD), convened meetings on September 27, 2023, October 25, 2023, and November 29, 2023; and four Listening Sessions with Los Angeles City community members in July that brought together people who use drugs (PWUD), engage in sex work (PESW), have justice system involvement and are experiencing homelessness (PEH) to inform future programming.

DPH-SAPC and DHS-HRD hosted a joint Opioid Settlement Funding Listening Session on October 17, 2023. It was well attended with participants actively discussing what types of strategies and programming should be funded with the settlement dollars and responded to a supplemental survey open through November 15, 2023. Major themes were abstracted to inform how DPH-SAPC and DHS-HRD apply the opioid settlement funding to community-based harm reduction programming.

<u>Project #2</u>: Ensure strategies to address the drug overdose epidemic among populations disproportionately impacted by overdoses, including persons of color, individuals who are justice-involved, people experiencing homelessness, and LGBTQ+ residents.

Since the update on September 21, 2023, DPH, DHS and DMH, continue to implement harm reduction programs and services, directly or in partnership with subcontracted providers. Key data highlights and new developments are as follows:

- DPH-SAPC's seven (7) contracted Engagement and Overdose Prevention (EOP) Hubs, described within the previous report back, conducted 11,944 service encounters, distributed 22,427 units of naloxone, 15,525 fentanyl test strips, 688,803 sterile syringes, and 6,299 wound care kits between September 1 and December 31, 2023. EOP Hubs reported 1,328 overdose reversals and 525 referrals to substance use treatment. Eighty-three percent of encounters were with PEH and the majority identified as Black or Latinx. More than 30 new outreach sites were also added.

- DHS-HRD and its contracted programs conducted 22,848 service encounters, distributed 58,982 units of naloxone to PWUD, PEH, PESW, and people recently released from incarceration; and reported approximately 3,200 overdose reversals and distributed approximately $1,330,664 worth of harm reduction supplies between July 1, 2023, and November 30, 2023.

- DHS-HRD Overdose Response Team operating in the Skid Row area, and as further described within the previous report back, distributed over 10,000 units/20,000 doses of naloxone, reversed over 30 overdoses with an additional 120

reported reversals from community members and distributed over $705,000 in harm reduction supplies since the previous report back to PWUD, PEH, and PESW.

- DHS-HRD's countywide Overdose Education and Naloxone Distribution (OEND) program, run in partnership with Community Health Project Los Angeles (CHPLA), continues to provide overdose education and naloxone through direct distribution to designated community sites, DHS programs and facilities, and community contractors, as described within the previous board report. The Clearinghouse has been supporting DHS hospitals and clinics to support implementation of naloxone and other harm reduction supply distribution. OEND is expected to distribute 20,976 units of naloxone and receive reports of 1,478 overdose reversals from September 21, 2023, throughout this reporting period.

- DHS Housing for Health (HFH) Street-Based Engagement (MDT) programs, described in the previous report back, distributed 6,000 units of naloxone and distributed over $100,000 in harm reduction supplies between July 1, 2023, and November 30, 2023.

- DHS-HFH Mobile Clinic, described within the previous board report, provided nearly 2,000 individuals with direct care and vital linkage to resources and recently began distributing xylazine test trips to document if community xylazine is present to intervene with information and education.

- DHS-HFH is establishing a Harm Reduction Health Hub in Skid Row (likely at a location at 5th and Crocker Street) which will offer case management, respite beds, behavioral health services, light touch health care interventions, a drop in space and set-aside space for an Overdose Prevention Program if County approved.
  - DPH-SAPC and DHS are collaborating to ensure that the Harm Reduction Health Hub will also offer medications for opioid use disorder (OUD) onsite.

- DHS continues its transition of the 30-bed David L. Murphy Sobering Center, described in the previous report back, which may include case management, a drop-in space, and a dedicated space for an Overdose Prevention Program if County approved. The project was awarded $2.7 million from AB109 in the Supplemental Budget Process, and $5.0 million from AB109 in a previous funding cycle to make physical changes to the Sobering Center footprint and accommodate new services. The project is tentatively slated to begin operations in early 2024.
  - DPH-SAPC is collaborating with DHS-HRD to establish an on-site opioid treatment program (OTP) which offers people with OUD methadone, buprenorphine, and naltrexone.

- DHS' grant-funded LA County MAT (Medications for Addiction Treatment) Consultation Line, as described in the previous report back, was a finalist for the 2023 DHS IDEA Award. DHS and DPH continue to collaborate to expand the reach

of the LA County MAT Consultation Line to LA County residents using investments from Measure H, opioid settlement, and CDC funding.

- DMH placed naloxone overdose stations in all 16 directly operated clinics and trained staff on the use of fentanyl test strips and appropriate supplies, made available naloxone kits for clinic clients, equipped field-based providers with naloxone kits and fentanyl test strips, and offered training to prevent and respond to overdoses.

- DMH Homeless Outreach and Engagement (HOME) Team, the Men's Community Reentry Program (MCRP), and Full-Service Partnership (FSP) staff responded to a number of overdoses in the field among PEH clients; and non-DMH clients can receive naloxone and fentanyl test strips at the newly created drop-in center, headed by the Skid Row Concierge Outreach Team which provides overdose prevention education and supplies, housing navigation, and mental health services.

Additionally, Departments continued to implement and develop the following programs and efforts as outlined in previous reports, and ensure continued operation and growth:

- DPH and DHS are operationalizing the Centers for Disease Control and Prevention (CDC) $3.2 million per year for five (5) years (Fiscal Year [FY] 23-24 through FY 27-28) award for overdose prevention and response activities.

- DPH is expanding access to SUD services for youth residing in Short Term Residential Therapeutic Programs (STRTPs); and collaborating with DPH, Probation, DMH, DCFS, and Office of Child Protection to provide recommendations and promote access to SUD services for youth with complex needs.

- DHS is creating access to low barrier MAT, harm reduction services like teaching and providing naloxone before discharge, education and safer consumption supplies like fentanyl test strips and syringes via mobile street teams and through partnership with emergency departments, hospital, clinics, and Community Health Services (CHS).

- DPH, DHS and DMH continued their collaboration on task forces to: 1) streamline navigation to MAT for those being discharged from jail; 2) coordinate overdose prevention in Skid Row; 3) address and coordinate methamphetamine prevention and treatment approaches; and 5) determine if xylazine is present in the drug supply (currently seen in about 4% of samples tested) and discuss use of xylazine test strips and educate patients and staff.

<u>Project #3</u>: Work with the housing system to expand the housing continuum and availability of recovery-oriented permanent, interim, and emergency housing options throughout the County, in addition to currently available Housing First models, with particular focus on unhoused individuals with justice involvement who use drugs.

Since the update on September 21, 2023, DPH, DHS and DMH continued to expand recovery-oriented housing options for PEH as follows:

- DPH conducted two separate surveys to identify agencies who can quickly expand access to add 550 Recovery Bridge Housing (RBH) under the State's Behavioral Health Bridge Housing (BHBH) program and local Opioid Settlement funding, as described within the previous report back. A total of 545 potential RBH beds were offered by contracted agencies, and as of October 30, 2023, DPH met with 16 agencies and confirmed 208 beds are available for immediate occupancy and is currently in the contracting process. DPH will have approximately 1,650 RBH beds countywide after this expansion and has continued to meet with local and State leadership to emphasize the importance of ensuring a housing continuum inclusive of recovery-oriented options.

- DHS provided housing resources at all ambulatory, emergency, and inpatient service levels, and HFH teams work diligently to provide immediate housing referrals and resources, including Intensive Case Management Services (ICMS) that assist patients with complex care needs that require intensive medical, mental health and/or social service needs.

- DMH, in collaboration with UCLA and Eisenhower Medical Center, added SUD treatment as a service option for programs housing justice-involved youth.

Additionally, Departments continued to implement and develop the following programs and efforts as outlined in previous reports, and ensure continued operation and growth:

- DHS field services for the People Assisting the Homeless (PATH) program that provides vital linkage for unhoused patients that would not otherwise seek care.

- DHS HFH work on the Skid Row Action Plan and developing a second Safe Landing program in Skid Row.

- DMH offers housing services as a key component of justice-involved care at the Men's and Women's Re-Entry Programs (MCRP, WCRP); assists PWUD enter housing, which is a key activity of their efforts, including: the HOME Team, FSP, the Veteran Peer Access Network (VPAN), Enhanced Emergency Shelters for Transitional Age Youth (TAY, EESP), Interim Housing, Assisted Outpatient Treatment (AOT), and Prevent Homelessness Promote Health $(PH)^2$ programs. The

Skid Row Concierge Team also helps residents of Skid Row navigate current housing system labyrinth.

- DMH provides specialty mental health services in permanent supportive housing (PSH) through its Housing Supportive Services Program (HSSP), in collaboration with DHS' ICMS teams and DPH's Client Engagement and Navigation System (CENS) teams with the common goal of providing supports to help residents maintain and retain their housing.

***Project #4*: Provide recommendations to expand and promote access to navigation services for people with SUDs, including the unhoused and justice-involved, to access services, including permanent supportive housing.**

Since the update on September 21, 2023, DPH, DHS and DMH continue to expand access to navigation services for people with SUD and co-occurring mental health and/or physical health service needs as follows:

- DPH is currently working on a new contract solicitation for release in early 2024 to operationalize new State BHBH funding for the provision of Housing Navigation services for all residents in RBH or Recovery Housing (RH), as outlined in previous report backs. Housing Navigation teams will work with clients while they are enrolled in RBH or RH to ensure they have a safe and stable housing plan ready for when they are discharged from these programs.

- DPH is working with CENS providers to expand use of Drug Medi-Cal (DMC) for select services (e.g., screening, referral, outreach) to better leverage available funding options and expand access to navigation services at critical locations and for high-priority populations. Two CENS providers have successfully piloted this process and DPH is working with all CENS providers to implement DMC billing/reimbursement by January 2024. Leveraging DMC will result in the ability to reinvest non-DMC funding in expanding other services for justice-involved, PEH, and other hard to engage populations.

- DHS, DMH and DPH are collaborating on the Interim Housing Outreach Program (IHOP) that will serve all eight SPAs and provide onsite services to individuals with physical and behavioral health needs including SUD linkage, support interim housing stability, facilitate transitions to permanent housing, and onsite harm reduction interventions (e.g., distribution of naloxone and fentanyl test strips) and SUD informational/educational sessions (individuals and group). Full implementation of the IHOP multi-disciplinary team (MDT) is projected for the third quarter of FY 23-24.

- DHS began piloting services in SPA 4 in mid-November 2023. The SPA 4 DPH provider has agreed to support the IHOP pilot project, part-time, with existing CENS staff.

- DPH received Mental Health Services Act (MHSA), Innovations Grant funding to further expand access to SUD treatment for unhoused individuals in interim housing sites.

- DMH received funding through the new BHBH program and will use the funding to enhance its current non-congregate interim housing and expand to new sites across the County for PEH with serious mental illness, many of whom have co-occurring SUDs.

- DPH added seven new PSH co-locations and one Mainstream Services Integration (MSI) site for a total of 181 PSH and 65 MSI sites where CENS providers deliver SUD services. DPH continues to collaborate with DHS-Correctional Health Services and DMH partners to leverage opportunities through CalAIM to promote behavioral health warm hand-offs through navigation services for justice-involved individuals with SUDs.

- DMH Men's Community Reentry should be expanded and decentralized throughout each SPA to promote reintegration, and provide supportive services such as employment, education, and housing for justice-involved populations. Dual DMH specialty mental health and Department of Health Care Services substance use treatment certification of these services would advance this goal.

Additionally, Departments continued to implement and develop the following programs and efforts as outlined in previous reports, and ensure continued operation and growth:

- DHS continues to collaborate with DPH and DMH with in-kind and grant funding to sustain and expand services that are vital in obtaining services for post-justice involved patients that are at a much higher risk of overdose death. DHS has one post-justice involved clinic at Harbor UCLA Department of Family Medicine called REACH that has served as a model for other clinics on how to provide expedited medical, social services, mental health services after incarceration. With CalAIM funding, DHS has a Community Health Worker (CHW) with lived experience who effectively helps post justice involved patients establish medical, mental health and psychosocial care.

- The DMH programs MCRP and WCRP have been involved in the planning and implementation of the CalAIM Justice-Involved Initiative for LA County. Together with DPH and DHS-Correctional Health Services, these DMH programs have developed workgroups to operationalize the initial screening, create the 90 days prior-to-release assessments, and establish the Adult Behavioral Health Warm Hand-Off and Youth Behavioral Health Warm Hand-Off protocol.

***Project #5**: Provide recommendations to expand harm reduction efforts including, but not limited to, developing a plan to establish safer consumption sites in the County, expanded distribution of fentanyl strips, naloxone, drug checking and low-threshold Medications for Addiction Treatment (MAT), including in carceral facilities for adults and youth, and exploring the feasibility of funding for prevention case management.*

Since the update on September 21, 2023 DPH, DHS and DMH continue to expand harm reduction as follows:

- DPH is expanding its network of EOP Hubs to advance these services. DPH supports DHS' Youth Opioid Response program to increase staff capacity in the DHS hospital system to provide MAT to youth with complex needs. DPH has partnered with DHS to create and delivered MAT trainings for all the providers at the VIP (Violence Intervention Program) clinics (Pediatricians and SW) at DHS sites that see mostly DCFS youth with complex needs and DHS and DPH are conducting ongoing trainings and planning meetings.

- DPH is convening regular Community Meetings on Harm Reduction with the public, local government, and health officials, as well as law enforcement to provide a forum to address questions, concerns, and to hear about the positive impacts of harm reduction in order to inform its expansion of its EOP Hub network.

- DPH, DHS and a CBO (SSG/HOPICS), as described in the previous report back, visited safer consumption sites in Copenhagen, Denmark; Barcelona, Spain; and Lisbon, Portugal. The major findings of this visit included an understanding that safer consumption spaces (SCS) should be seen as part of the continuum of substance use services offered to LA county residents in addition to low-threshold harm reduction and treatment services. Presentations summarizing the learnings from these visits were delivered in July and October 2023.

- DHS-HRD's OEND program continues to work with DHS and DHS partners, including LAHSA, DPH, and DMH, to provide overdose prevention and response training and expand naloxone and fentanyl test strip distribution. OEND has provided increased technical assistance to housing sites countywide to reduce overdose deaths.

- LAHSA interim housing sites are participating in training, increasing naloxone distribution and started installing wall boxes with naloxone in common areas to ensure 24-hour access for housing participants.

- DHS HFH and Office of Diversion and Reentry (ODR) interim and permanent housing sites are installing wall boxes with naloxone offering 24-hour access, with an initial focus on Skid Row. To date, over 170 wall boxes have been installed at over 25 housing sites.

- DMH is offering trainings to its Interim Housing and Enriched Residential Care licensed residential care facilities on preventing overdoses through the use of naloxone. DMH uses Housing First and Harm Reduction models in its PSH and offers training on these models to DMH case managers.

- DHS-HRD is developing a series of spaces designed to be able to offer safer consumption spaces including Drop-In Centers and Harm Reduction Health Hubs as described above. DHS-HRD has selected 3 community contractors to establish harm reduction drop-in centers, and the contracts are expected to be executed by the end of December.

Additionally, Departments continued to implement and develop the following programs and efforts as outlined in previous reports, and ensure continued operation and growth:

- DPH and DHS remain engaged with a coalition of stakeholders to determine what legal pathways exist for establishing a safer consumption site pilot in Los Angeles County, including the Los Angeles County Harm Reduction Steering Committee, academic partners, law enforcement, and prosecutors. If a safer consumption site pilot is established, it will require allocation of flexible local funding as well as support from County leadership across health, judicial, law enforcement, and other sectors in order to remain viable.

- DHS remains committed to sustaining and expanding harm reduction and low threshold MAT at all DHS operated facilities and DHS has ambulatory MAT clinics at most of its locations with MAT visits embedded in primary care in these settings. Four DHS clinics (High Desert Regional Health Centers, Edward R. Roybal Comprehensive Health Center, Hubert H Humphrey Comprehensive Health Center, and the DHS Mobile Clinic Program) are recipients of the Centers for Care Innovation Addiction Treatment Starts Here capacity building grant award to increase capacity of treating SUD in primary care settings with MAT, integrated behavioral health services, and collaborations with community-based providers. As described in the previous report back, DHS-HRD continues to collaborate with DHS hospitals and the Ambulatory Care Network (ACN) to expand and coordinate safer use supplies distribution across their facilities.

- DHS' emergency departments, inpatient settings, and ambulatory settings currently provide SUD/MAT care via in-kind and/or grant supported programs. Sustaining and/or expanding services will require secure funding. The Board of Supervisors can further support the efforts of DHS hospitals and clinics by allocating flexible funds for the purchase of harm reduction supplies and directing medical providers throughout the system to be trained on harm reduction and safer use strategies.

- DHS' Integrated Correctional Health Services – Addiction Medicine Services (ICHS-AMS) provides a wide range of in-custody SUD treatment services for all adult patients who are housed in the Los Angeles County Sheriff Department's (LASD) jail system. As of October 2023, 5,804 individuals received sublingual buprenorphine and 2,886 received injectable buprenorphine. The waitlist has decreased and it is expected that all patients will receive treatment in a timely manner when entering the jail or expressing need.

- DMH provided training to psychiatrists, psychiatric nurse practitioners, and clinical pharmacists on the use of low-threshold MAT within its treatment services. DMH Clinics established co-occurring disorder treatment groups that do not require that clients have their SUD already in remission as a condition of participation. In this way, the harm of using substances is reduced as clients move at their own pace toward recovery. This program, Integr8Recovery, uses cognitive behavioral therapy (CBT) and contingency management (CM). Providing naloxone and fentanyl test strips is now a regular routine at DMH Clinics. Expansion of these services should include test strip for xylazine as well. Case management that addresses overdose prevention is currently in place, although ongoing training is needed.

***Project #6*: Expand bidirectional screening and referral processes across systems caring for persons with shared risk factors for SUD, HIV, sexually transmitted infections (STI) and viral hepatitis, such that individuals who are receiving any of these services are screened and referred for other service needs associated with risk factors, including the need for HIV Pre-Exposure Prophylaxis/Post-Exposure I.**

Since the update on September 21, 2023 DPH, DHS and DMH continue to expand bidirectional referrals for clients with SUD who are at-risk of or diagnosed with STIs:

- Five additional syringe services programs across the County have had staff participate in HIV pre-and post-test counseling trainings and are currently in the process of obtaining Clinical Laboratory Improvement Amendment (CLIA) waivers to support HIV testing of participants during harm reduction outreach.

- DHS clinics, emergency departments and hospitalizations offer directional screening, treatment and referral as needed supported by expected Practices emphasize the importance of screening priority patients, as described in the previous report back. DHS Mobile Services are now providing expansion of these vital services.

- DMH has updated its HIV testing policies to use an “opt-out” rather than “opt-in” approach, to assure broad testing among its clients.

<u>Project #7</u>: Implement evidence-based, age-appropriate substance use curricula for students K-12 and for those in Probation camps and halls and their parents/guardians.

DPH, DHS and DMH implemented a variety of prevention, early intervention, and treatment services for young people directly and in collaboration with contracted CBOs as follows:

- DPH conducted over 450 fentanyl related outreach events and delivered 178 educational presentations to 9,231 parents, students, and school faculty since 2022.

- In partnership with LACOE, DPH has reached out to all secondary schools across the County to explore the expansion of substance use education across their respective curricula and also to support training of their Health Educators to support elevated recognition of substance use considerations in the school setting.

- 39 of the total 50 DPH Student Wellbeing Centers will be staffed by Winter 2024. Highlights during the period include:
  - Sixty-four classroom education sessions are scheduled for over 1900 students on substance use and overdose prevention.
  - All SWBCs in the Los Angeles Unified School District (LAUSD) have naloxone kits for distribution and training for students who request them. 35 naloxone kits were distributed between July and October 2023. Fentanyl test strips have been available beginning in November.
  - The Peer Health Advocate Program of the SWBCs will present training of all peer leaders (394 students) by EndOverdose in November.
  - The SWBC Program Manager is participating in the LAUSD Opioid Task Force, a collaboration of school and community partners identifying additional strategies for prevention of overdose among students.

- DPH collaborated with Probation to launch substance use services at juvenile halls:
  - DPH CENS receive referrals for youth with an identified substance use concern as of September 2023, and provide additional SUD screening and coordinates referrals to community SUD treatment providers. CENS staff are trained for and deliver early intervention curriculum to youth housed within the juvenile hall as of November 2023. The screening process will be enhanced by the adoption of improved tools.
  - DMH psychiatrists closely follow youth taking medications for SUD as well as other mental health disorders for ongoing counseling, evaluation, and treatment planning.

- DPH collaborated with Probation to launch SUD treatment services for the Secure Youth Treatment Facilities (SYTF) youth and young adults diverted from the California Department of Corrections and Rehabilitation, Division of Juvenile Justice:
  - At Barry J. Nidorf, onboard staff to serve male youth in the SUD Unit, that launched on December 8, 2023, and which fosters a therapeutic environment for those in recovery. Future efforts will include (1) improving mental health staff knowledge and skills to better incorporate goals of substance abuse treatment into treatment planning, (2) prioritizing and titrating services for those youth known to be at the highest risk, and (3) improving care coordination between partner agencies to enhance client engagement. DPH also incorporated early intervention groups for all SYTF youth to increase access to on-site SUD services.
  - At Campus Kilpatrick, implementation continues as outlined in the previous report back.

- DHS collaborates with multiple agencies including DPH and DMH on the California Youth Opioid Response 3 "Quick Start for Youth" (YOR) assisting LA General and DHS addiction physicians to enhance access to services, incorporate the youth voice into work, and institutionalize interagency linkage and service to addiction care that includes MAT services. DHS physicians and SUD counselors work in partnership with DCFS, DMH, and DPH to provide a culturally, developmentally appropriate, trauma-informed medical model for treating youth with SUD; and links high risk priority youth to DHS addiction specialists. Priority population include youth engaged in DCFS, in out-of-home care, in public clinics, hospitals and emergency departments, or released from law enforcement. YOR aims to rapidly start treatment while bridging identified youth to longitudinal addiction care in medical homes.

<u>Project #8</u>: Expand the accessibility of contingency management interventions including consideration of prescription digital therapeutics for addiction treatment.

Since the update on September 21, 2023 DPH, DHS and DMH continue to implement contingency management strategies as follows:

- DPH is expanding the network of treatment providers who offer Contingency Management (CM) through the Medi-Cal benefit under the DMC program, which began on May 4, 2023. This program uses a digital delivery platform for the recovery incentive. The State has currently authorized CM services to be delivered at 37 sites, operated by 15 provider agencies. Another 30 provider sites are in the process of completing training and lab registration. DHCS approvals will be completed on a rolling basis. DPH has considered prescription digital therapeutics for addiction treatment but is not pursuing implementation at this time.

- DHS Mobile Services will be collaborating with the PEH Mortality Workgroup to launch a grant funded CM program in November 2023. DHS has already piloted CM at ambulatory and emergency department-based programs with grant funding. The goal remains to find secure funding and models for larger CM programs across DHS.

- DHS-HRD launched the Hilton Foundation-funded Housing Retention CM pilot in August of 2023, with eight enrollees in the first month at one Permanent Supportive Housing site on Skid Row and expanded to another site in Lancaster in late October with a total of 14 participants to date. Participants are already achieving their personally identified goals designed to help stabilize their housing. Additionally, leadership at housing sites has reported an overall reduction in problematic behavior that had previously impacted staff’s ability to engage clients.

- DMH uses CM as a tool in its Integr8Recovery Co-occurring Disorder Treatment Programs, and in the Skid Row Concierge services. DMH plans to expand CM further in its clinics and programs.

<u>Project #9</u>: Expand efforts to explore and offer MAT options for methamphetamine and other SUDs.

Since the update on September 21, 2023 DPH, DHS and DMH continue to implement MAT options for methamphetamine and other SUDs as follows:

- DPH continues to prioritize the launch of CM as an evidenced-based strategy for those with stimulant use disorder (StUD) as outlined under Project 8.

- DHS continues to provide culturally, developmentally appropriate, trauma-informed medical care for treating SUDs and since the last report back there

has been an increase in the number of patients with alcohol (AUD), stimulant, and/or opioid use disorders (OUD). To help meet the treatment needs, the SUD Working Group is actively seeking in-kind, grant and DHS funding.

- DHS HFH Mobile Clinics continue to provide MAT in the field (e.g., encampment, RV interim housing) and explore how to best educate the homeless outreach community at large on MAT availability.

***Project #10*: Work with County Departments who serve people who use drugs to expand trauma-informed and culturally responsive trainings around harm reduction, overdose prevention and other related topics.**

Since the update on September 21, 2023 DPH, DHS and DMH continue to expand trauma-informed and culturally responsive harm reduction and overdose prevention trainings as follows:

- DPH continues to host Cultural Competency Trainings and its network of prevention providers regularly conduct trainings to county staff and the community that describe the substance use resources, as outlined in the previous report.

- DPH and DMH continue to offer Seeking Safety trainings to both the SUD and mental health treatment network.

- DHS-HRD continues to expand trauma-informed and culturally responsive trainings for street-based homeless outreach teams and other community providers, housing site staff and participants, and DHS Hospitals and Clinics.

- DHS-HRD's Harm Reduction Workforce Development program, contracted with the Worker Education and Resource Center (WERC), commenced in-depth cohort-based learning for supervisors and direct service staff currently providing harm reduction services. Trainings include ‘Trauma-Informed Care, Vicarious Trauma, and Boundaries’ and ‘Modeling Trauma-Informed Sensitivity and Recovery-Oriented Supervision.

- DPH-SAPC's Harm Reduction Leadership Program for harm reduction executives is a partner in this initiative.

- DHS-OEND is providing training on best practices for engaging PWUD using a trauma-informed lens and in August and began training DHS Hospital and Clinic staff. Further, DHS and OEND teams have trained the Social Workers, Community Health Workers, SUD Counselors, and Medical Case Workers working in the DHS Hospital and Clinic system of care in August 2023.

- DHS-OEND began providing training and technical assistance to housing sites that recently experienced overdose deaths, including trauma- and grief-sensitive overdose response trainings with both housing staff and participants and technical assistance on harm reduction interventions that can prevent overdoses including installation of wall boxes described above. Since the last report back, OEND contractor Community Health Project Los Angeles will have trained approximately 1,100 individuals on overdose prevention and response and trauma-informed engagement with PWUD.

- DMH continues to provide training on overdose prevention to all of its field-based teams and has equipped them with Naloxone. Ongoing trainings are planned to educate staff at various levels about harm reduction. The MCRP uses a culturally sensitive and population specific model when working with individuals with an incarceration history, and advocates for clients who experience discrimination from treatment programs or housing facilities. DMH MCRP works collaboratively DPH-contracted residential substance use programs to serve these populations.

***Project #11*: Develop a framework and timeline, including key metrics and milestone goals, to define success related to addressing the overdose epidemic in the County.**

Building upon the work outlined in this Board Motion and subsequent responses, DPH developed the following framework to define success in addressing the overdose epidemic in the County and determining progress towards those goals. This involves:

- New reports and data dashboards updated since September 21, 2023 include updated 2022 overdose numbers for DPH-SAPC's Fentanyl Data Report and updated Methamphetamine Dashboard: Tracking Patterns in Methamphetamine Use and Opioid Dashboard: Tracking Patterns in Opioid Use as part of DPH's Alcohol and Other Drug Surveillance Dashboard. Documents are available here: http://publichealth.lacounty.gov/sapc/providers/data-reports-and-briefs.htm

- Increased distribution of naloxone and other harm reduction supplies proportionally to the public health burden of overdose. As discussed in Project #2 above, DPH, DHS, and DMH distributed over 43,403 units of naloxone in LA County, including 20,976 units to people leaving LA County jails of which 85% were distributed directly to PEH, PWUD and PESW, and increased the distribution of over 20,000 units of harm reduction supplies to PWUD biannually, representing an increase from baseline that exceeds the increase in overdose prevalence from 2021-2022.

- Increase in the count of overdoses reversed with naloxone as reported by CBOs and first responders that exceeds the increase in overdose prevalence each year in LA County from the prior FY. Since September 21, 2023, CBOs and first responders reported over 2,802 community overdose reversals and 505 first responder reversals,

both of which are undercounted from the actual count of reversals because not every community member and first responder who reverses an overdose reports it via established reporting mechanisms.

- Increased provision of MAT and other SUD services to PWUD in LA County, demonstrating an increase in MAT and SUD service delivery from the prior FY via a service delivery data dashboard. Within residential levels of care, as one example, the provision of MAT services to patients with AUD/OUD increased five-fold between FY 2021-2022 and FY 2022-2023.

- Collaboration with probation where when naloxone is administered within Los Padrinos Juvenile Hall, an automatic notification to CENS is generated to ensure that screening and referral to SUD services are made available.

***Project #12*: Assess the funding in each Department's budget that is used to serve people who use drugs to determine how best to leverage funding to maximize the County's resources for this population, including the allocation of opioid settlement dollars, and identify funding gaps and work with the Chief Executive Officer on strategies to address those gaps.**

Since the last update provided, the Board approved an Opioid Settlement Spending Plan (Plan) for the Distributors and Janssen national opioid settlements. The Opioid Settlement Spending Plan authorized allocation of $15.6 million to four departments, including the DPH, DHS-ODR, the County Fire Department, and the County Medical Examiner's Office. Funding was allocated as part of the FY 2023-24 Supplemental Budget and funding is anticipated to be allocated to these departments for Board-approved uses for at least the next three years. Departments received funding for programming previously identified as areas of need related to overdose prevention, harm reduction, naloxone distribution, MAT, positive youth development, as well as various other opioid mitigation efforts.

The Chief Executive Office (CEO) is also tracking the potential for receipt of funds resulting from future opioid settlements and will develop proposed spending plans for Board approval, when appropriate, ensuring the continued collaboration between CEO and impacted departments, to address the County's most pressing needs related to the opioid crisis.

***Project #13*: Direct the Chief Executive Officer, through the Legislative Affairs and Intergovernmental Relations Branch (CEO-LAIR), and the Los Angeles County Advocates in Sacramento and Washington D.C., to coordinate with the Directors of Public Health and Health Services, and the Acting Director of Mental Health, to advocate with Governor Gavin Newsom, the State Legislature, the California Department of Public Health, and the California Department of Health and Human Services, and Congress, for additional Federal and State resources to combat substance use and the overdose epidemic, this includes increasing Federal- and State-level recruitment, retention, training and educational resources and requirements for SUD counselors, the primary workforce delivering specialty SUD prevention, harm reduction and treatment services across the County.**

In June 2023, CEO-LAIR's Sacramento Advocates collaborated with DPH to successfully advocate for revisions to the draft Substance Use Disorder Licensing and Certification trailer bill which would have undermined the advances made by last year's County-sponsored AB 2473 (Nazarian) by completely repealing the Health and Safety Code 11833. As enacted, AB 2473 requires the California DHCS to implement changes by December 31, 2025, to the qualifications and registration or certification of personnel working within alcoholism or drug abuse recovery and treatment programs licensed, certified, or funded under state law. CEO-LAIR's Sacramento Advocates worked through the Assembly Budget Health & Human Services Subcommittee and the Administration to reinstate the language in the final Health Trailer Bill (AB 118, Chapter 42, Statutes of 2023) that repeals the voluntary certification procedure for alcohol and other drug treatment recovery services, and instead requires those programs to be certified. The bill also prohibits a program from offering alcohol and other drug treatment recovery services without certification and establishes procedures for certification, inspections of certified programs, and for revocation of certification from noncompliant programs.

In July 2023, the U.S. House of Representatives Committee on Energy and Commerce marked up and reported out H.R. 4531, the Support for Patients and Communities Act, which would reauthorize the SUPPORT Act, the bipartisan opioid package enacted in 2018. Some of the key provisions under consideration which would increase federal resources for the County's SUD prevention and treatment efforts include: a permanent reauthorization of the Medicaid state plan option to lift the Institutions for Mental Disease (IMD) for SUD treatment that would allow states with Medicaid 1115 waivers for SUD treatment in IMDs, such as the DMC-ODS waiver, to transition to a permanent state plan option; prohibiting states from terminating Medicaid enrollment due to incarceration in order to simplify the reactivation of benefits upon reentry, and lifting the Medicaid inmate exclusion for pregnant women in pretrial custody; and, reauthorization of other public health programs focused on prevention, treatment, and recovery for patients with substance use disorder, and a permanent extension of Medicaid's required coverage of medication-assisted treatments. CEO-LAIR is collaborating with DPH to support the inclusion of these provisions into H.R. 4531.

In July 2023, the State Legislature and Governor Gavin Newsom finalized the State Budget Act of 2023 (State Budget) that included funding for several County-supported activities related to substance use and overdose prevention. Specifically, the State Budget includes $14 million one-time Opioid Settlements Fund (OSF) over four years for fentanyl program grants to increase local efforts in education, testing, recovery, and support services to implement the State's fentanyl overdose reduction grant program (AB 2365, Chapter 783, Statutes of 2022), and to support innovative approaches to make fentanyl test strips and naloxone more widely available. Moreover, the State Budget provides $74.8 million in Fiscal Year (FY) 2023-24, $35.8 million in FY 2024-25, $24.8 million in FY 2025-26, and $24.1 million in FY 2026-27 from the OSF to expand the Naloxone Distribution Project, to increase distribution to first responders, law enforcement, community-based organizations, and county agencies. For the Overdose Prevention and Harm Reduction Initiative, the State Budget includes $61 million one-time OSF over four years to provide grants to local health jurisdictions and community-based organizations to support syringe exchange and disposal program activities, including treatment navigators. Finally, the State Budget provides $3.5 million ongoing Proposition 98 General Fund for Reversing Opioid Overdoses, for all middle schools, high schools, and adult school sites to maintain at least two doses of naloxone hydrochloride or another medication to reverse an opioid overdose on campus for emergency aid.

On October 10, 2023, Governor Newsom signed into law SB 43 (Eggman, Chapter 637, Statutes of 2023), which expands the definition of "gravely disabled," for purposes of involuntarily detaining an individual with a severe SUD, or a co-occurring mental health disorder and a severe SUD, or chronic alcoholism that is unable to additionally provide for personal safety or necessary medical care. CEO-LAIR worked with the impacted County departments during the State legislative session to assess the bill language and share County's concerns with Senator Eggman's office.

CEO-LAIR continues to work with the impacted County departments to advocate for federal and State level funding and legislation to combat substance use and the overdose epidemic, including but not limited to additional resources for behavioral health workforce development, harm reduction and treatment services across the County.

NEXT STEPS

The County Departments and partner agencies will continue to collaborate on implementation of the projects described herein and report back to the Board of Supervisors biannually with the next report back in July 2024.

BF:gt

c: Chief Executive Officer
County Counsel
Executive Officer, Board of Supervisors
Health Services
Mental Health
Children and Family Services
Chief Medical Examiner
Probation

Congress of the United States
Washington, DC 20510

February 23, 2024

The Honorable Kay Granger
Chairwoman
Appropriations Committee
Washington, DC 20515

The Honorable Rosa DeLauro
Ranking Member
Appropriations Committee
Washington, DC 20515

Dear Chairwoman Granger and Ranking Member DeLauro:

We appreciate your commitment to addressing the HIV/AIDS epidemic in the United States, and we urge you to provide robust funding for domestic HIV/AIDS programs as you continue to negotiate legislation to fund the Federal government in Fiscal Year 2024.

Robust funding in these programs is urgently needed in order to achieve the goals of the Ending the HIV Epidemic Initiative, an initiative that has enjoyed bipartisan support since its inception in 2019. Enhanced investment in HIV/AIDS prevention, screening, and treatment is essential to reduce the rate of new HIV infections, improve treatment outcomes, reduce hospital and emergency room costs, eliminate disparities, and make progress towards the eradication of HIV.

We are deeply concerned about the proposed $767 million in cuts to domestic HIV/AIDS programs that were included in the Labor, Health and Human Services, Education, and Related Agencies (LHHS) Appropriations bill for FY 2024. Specifically, this bill severely cuts or eliminates the following programs:

- **Eliminates** funding for the Ending the HIV Epidemic Initiative within the Centers for Disease Control and Prevention (CDC) (-$220 million), the Ryan White HIV/AIDS Program (-$165 million), and the Community Health Centers Program (-$157 million).

- **Eliminates** funding for Part F of the Ryan White HIV/AIDS Program, which includes:
    - Dental Programs (-$13.6 million),
    - AIDS Education and Training Centers (-$34.9 million), and
    - Special Projects of National Significance (-$25 million).

- **Eliminates** funding for the Minority AIDS Initiative activities within the Substance Abuse and Mental Health Services Administration (-$119.3 million).

- **Cuts** funding for the Minority HIV/AIDS Fund by 53% (-$32 million).

These drastic cuts will needlessly endanger our nation's progress towards the eradication of HIV. Slashing funds for the Minority AIDS Initiative will exacerbate racial disparities, and the elimination of the Ending the HIV Epidemic Initiative could leave thousands of people without comprehensive care for HIV and tens of thousands of people without access to pre-exposure prophylaxis (PrEP), which is critical to prevent new infections.

Indeed, funding for each of these critical programs should be increased significantly in order to effectively end the impact of HIV in communities throughout the United States. According to the CDC, more than 36,000 people were newly diagnosed with HIV, and there were more than 19,600 deaths among people with HIV in 2021, the most recent year for which data is available. Furthermore, there are an estimated 1.2 million Americans living with HIV. Meanwhile, HIV disparities are persistent, and the impacts upon African Americans are especially severe. Black Americans now account for 40% of new HIV diagnoses, and Latinos account for 25%. Asian Americans, Native Americans, and persons of multiple races account for an additional 6%. Minorities now represent the majority of new HIV diagnoses, people living with HIV/AIDS, and deaths among people with HIV/AIDS.

Regardless of the statistics, every person living with HIV needs to be screened, retained in medical care, and virally suppressed. Moreover, because effective HIV treatment prevents HIV transmission, comprehensive care for people living with HIV is vital to our nation's public health and has the potential to dramatically decrease new HIV infections.

Increasing our nation's investment in domestic HIV/AIDS programs will ensure that we can make progress towards eliminating new infections while providing life-prolonging care and treatment to people living with HIV/AIDS.

We cannot afford to retreat in our battle against HIV and AIDS. Again, we thank you for your continued leadership and support for these critical HIV/AIDS programs, and we look forward to working with you to ensure that they continue to receive robust funding in FY 2024 and beyond.

Sincerely,

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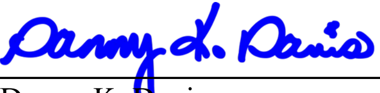

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February 21, 2024

Pending Medicare National Coverage Determination (NCD) for HIV PrEP: What It Could Mean for PrEP Access

Under federal law, the Centers for Medicare and Medicaid Services (CMS), the agency that oversees the Medicare program, can ensure coverage of preventive services under Medicare Part A and Part B through a process called a National Coverage Determination (NCD). CMS has started this process for HIV Pre-Exposure Prophylaxis (PrEP), with a few unexpected twists and turns along the way. Read on to learn more about what NCD is, what an NCD would mean for PrEP availability in Medicare, why the NCD process for PrEP has been particularly complex, and what to expect going forward.

What's a Medicare NCD and How Does It Work?

Medicare covers services and items that are "reasonable and necessary" for care. For services covered by Medicare Part A (which covers hospital and inpatient services) and Part B (which covers outpatient services and provider-administered drugs), CMS uses the NCD process to determine which services are reasonable and necessary and must be covered by Medicare nationwide. This process includes an extensive review of evidence and multiple public comment periods.

For Medicare coverage of preventive services, there is another twist. CMS may use the NCD process to decide to cover a preventive service in Medicare Part A or Part B, but if the service has a grade A or B from the U.S. Preventive Services Task Force, CMS may use the NCD to require coverage of the preventive service under Medicare Part B without cost sharing. To make this determination, CMS must determine that the service is "reasonable and necessary for the prevention or early detection of an illness or disability" and appropriate for the population that Medicare serves.

The graphic below shows the process that CMS follows in undertaking an NCD.

Medicare National Coverage Determination Process

Formal request for NCD	CMS decides whether to initiate national coverage analysis	Proposed decision memo	Final NCD decision memo
A Medicare beneficiary or an interested party (e.g., manufacturers or providers) may request that CMS issue an NCD. (CMS may also initiate the NCD process itself).	Once CMS initiates the process, there is a 30-day public comment period followed by an extensive review of evidence. CMS may solicit independent expert advice.	CMS releases a proposed decision memo with a summary of research and evidence. The decision memo is subject to another 30-day comment period.	Following review of public comments, CMS releases final NCD decision.

Services may be covered by Medicare even without an NCD at the discretion of local entities charged with making regional decisions about Medicare Part A and B coverage, but the NCD is necessary to create a federal mandate for coverage for every Medicare enrollee. The NCD process is only for Medicare Part A and Part B services and is not used to develop coverage requirements for prescription drugs covered under Medicare Part D. NCDs apply to Medicare Part A and B services that are available through traditional Medicare or through Medicare Advantage plans.

The PrEP NDC Process and Proposed Decision Memo

PrEP, a highly effective method of preventing HIV transmission through medications and services for uninfected individuals, has a grade A from the USPSTF. PrEP medications can be in the form of a daily oral pill or a long-acting injection. In February 2022, ViiV Healthcare, the drug manufacturer that makes the only long-acting injectable PrEP product currently available, submitted a formal NCD request to CMS. ViiV asked the agency to develop an NCD for long-acting injectable PrEP administered by a provider. ViiV sought a decision requiring Medicare Part B to cover

How Does Medicare Currently Cover Oral and Injectable Forms of PrEP?

- Oral medications are typically covered under the Medicare Part D benefit, which is provided through private plans in which Medicare beneficiaries can enroll.
- For most drugs, Part D plans determine which ones to cover on their formularies. However, HIV antiretroviral medications (whether used for prevention or treatment) are a "protected class," meaning that all Part D plans must cover these drugs and cannot use prior authorization or step therapy. Part D plans can (and do) use high cost sharing for oral HIV medications.
- Provider-administered drugs, including long-acting injectable medications to prevent HIV, are typically covered under the Medicare Part B benefit. Part B covered drugs ordinarily come with a 20% coinsurance.
- Although CMS can issue an NCD to cover PrEP in Medicare Part B, there is no mechanism for CMS to require Part D plans to cover PrEP without cost sharing.

long-acting injectable PrEP, and the ancillary services that go with the medication, without cost sharing. CMS formally accepted ViiV's NCD request in January 2023 and initiated its evidence review process.

In July 2023, CMS issued a proposed coverage decision memo. In the memo, CMS proposed to do the following—which included a few surprises:

- Long-acting injectable medications for PrEP would be covered without cost sharing.
- Coverage of oral medications for PrEP, which are currently covered under the Medicare Part D benefit, would be moved to Medicare Part B. This means that oral PrEP medications would also be covered without cost sharing. Oral medications used for HIV treatment would not be affected and would continue to be covered under Medicare Part D. (While unusual, coverage of oral medications in Medicare Part B is not unprecedented.)

CHLPI, along with 31 other members of the HIV Health Care Access Working Group, the HIV Prevention Action Coalition, and the Federal AIDS Policy Partnership, submitted comments in response to the proposed decision memo. The comments applauded the move to make PrEP more affordable for Medicare members but highlighted concerns, particularly around coverage of ancillary services.

- Medicare Part B would cover seven individual counseling visits every 12 months without cost sharing. Services would include HIV risk assessment, HIV risk reduction and medication adherence services.
- Medicare Part B would cover HIV screening for those initiating and taking PrEP antiretroviral medications up to seven times annually and a single screening for hepatitis B virus (HBV) without cost sharing.
- CMS did not include all services recommended to be provided in coordination with PrEP medications, as described in CDC guidelines and in guidance issued by the Departments of Health and Human Services, Treasury, and Labor that govern private insurance coverage of PrEP. These include tests for other sexually transmitted infections (STIs) that are recommended as part of the PrEP intervention.

How Did PrEP Advocates, Providers, and Industry Representatives Respond to the Proposed Decision Memo?

The response to the decision was somewhat mixed. While commenters expressed support for any administrative change that would make PrEP more accessible and affordable, they noted other concerns with the way CMS is proposing to implement these protections.

First, commenters noted that moving oral PrEP medications from the Medicare Part D benefit to Medicare Part B may cause administrative challenges for pharmacies and clinics and, by extension, access concerns for Medicare enrollees. They pointed out that not every pharmacy that currently provides PrEP is certified to bill Medicare Part B. This may be particularly true of community clinics with in-house pharmacies or smaller independent pharmacies. The process for becoming a Medicare Part B pharmacy is arduous and may not be worthwhile for pharmacies with a relatively low volume of Medicare beneficiaries on PrEP.

This challenge may not be insurmountable, but commenters implored CMS to develop a more specific implementation plan, which should include technical assistance for pharmacies and solutions to overcome the administrative barriers to becoming eligible to bill Part B. Adding to the billing complexity is the fact that under

Part B, there is sometimes a lag between when a pharmacy dispenses a drug and when it gets reimbursed from Medicare, an issue that may present financial and administrative challenges for some pharmacies.

Second, commenters were concerned that moving oral medications used for PrEP from Part D to Part B would mean these drugs would no longer be protected by provisions that prohibit Medicare Part D plans from subjecting HIV drugs to prior authorization or step therapy. Inappropriate prior authorization requirements – such as requiring providers to go through a burdensome prior authorization process to verify that a plan member is at high risk for HIV and eligible for PrEP – remains a barrier to even generic PrEP. This issue would be important primarily for enrollees in Medicare Advantage plans, as standard Medicare Part B doesn't require prior authorization for most items and services.

And third, commenters raised concerns that the ancillary services that must be covered in addition to PrEP medications under the proposed decision were inadequate and not aligned with CDC guidelines for PrEP. The failure to include STI services – a mainstay of PrEP clinical care – was noted as a particularly egregious omission. This issue was raised by almost all of the comments submitted.

What's Next?

CMS had indicated that the final coverage determination was imminent last fall, but the final NCD has yet to materialize. It is possible that CMS did not anticipate the concerns raised in public comments around moving oral HIV medications from the Medicare Part D benefit to the Part B benefit and is taking more time to consider the best way forward. Many NCDs are issued with an immediate effective date, but with something so complex as the pharmacy changes proposed, there may be lead time needed for a PrEP NCD. In the meantime, long-acting injectable coverage is not guaranteed for Medicare enrollees, and enrollees continue to incur cost sharing for all forms of PrEP.

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Health Care in Motion is written by Carmel Shachar, Health Law and Policy Clinic Faculty Director; Kevin Costello, Litigation Director; Elizabeth Kaplan, Director of Health Care Access; Maryanne Tomazic, Clinical Instructor; Rachel Landauer, Clinical Instructor; Johnathon Card, Staff Attorney; and Suzanne Davies, Clinical Fellow. This issue was written with the assistance of Amy Killelea of Killelea Consulting.

*For further questions or inquiries please contact us at **chlpi@law.harvard.edu**.*

Screening Guidelines for Sexually Transmitted Infections (STIs), Viral Hepatitis, and Tuberculosis (TB) in California Correctional/Detention Facilities

These guidelines summarize U.S. Centers for Disease Control and Prevention (CDC) recommended routine/opt-out screenings and actions for chlamydia, gonorrhea, human immunodeficiency virus (HIV), hepatitis C virus (HCV), hepatitis B virus (HBV), syphilis, trichomonas, and tuberculosis (TB) in correctional/detention facilities. Supplemental recommendations from the California Department of Public Health (CDPH) and American College of Obstetricians and Gynecologists (ACOG) are provided, when applicable.

Recommended screening at intake, during incarceration, and additional testing for pregnant persons[1]

Disease/ Condition	Recommended Routine/Opt-Out Screening at Intake*	Additional Screening During Incarceration/Detention	Additional Testing for Pregnant Persons
Chlamydia/ Gonorrhea	All females[2] ≤35 years of age and all males <30 years of age	▪ At least every 3 months for individuals on PrEP[3] ▪ Persons reporting/presenting with genitourinary, oropharyngeal, anorectal symptoms or rash ▪ Persons potentially exposed to an STI or HIV[4]	All pregnant persons <24 years of age; pregnant persons ≥25 years of age at increased risk[5] **CDPH[6]/ACOG[7]:** all pregnant persons regardless of age
HCV	All persons. Test for HCV antibody (anti-HCV) followed by HCV RNA if positive **CDPH:** Order anti-HCV with an automatic reflex to HCV RNA to ensure timely diagnostic testing	▪ Periodic screening for persons reporting ongoing risk factors (e.g., people who inject drugs [PWID], hemodialysis patients) including those with new diagnosis of an STI or HIV[8] ▪ Annual screening for men who have sex with men [MSM], transgender women and PWID on HIV pre-exposure prophylaxis (PrEP)[3] ▪ Persons with signs/symptoms or laboratory findings consistent with hepatitis ▪ Persons potentially exposed to HCV ▪ **CDPH:** Persons with new, non-sterile tattoos received during detention/incarceration	During each pregnancy
HBV	All persons. Test for hepatitis B surface antigen (HBsAg), total hepatitis B surface antibody (anti-HBs), and total hepatitis B core antibody (anti-HBc)	▪ Periodic screening for persons reporting ongoing risk factors (e.g., PWID, MSM) including those with new diagnosis of an STI, HIV, HCV[9] ▪ Periodic routine testing for persons serving long-term sentences ▪ Persons with signs/symptoms or laboratory findings consistent with hepatitis ▪ Persons potentially exposed to HBV	During each pregnancy[10]
HIV	All persons unless prevalence of undiagnosed HIV infection in the facility population has been documented to be <0.1%, or <1 in 1,000 persons screened	▪ Periodic screening for persons reporting ongoing risk factors (e.g., PWID, MSM) including those with new diagnosis of an STI, HCV, HBV or TB ▪ At least every 3 months for individuals on oral PrEP, or every 2 months on injectable PrEP[3] ▪ Persons with signs/symptoms of STIs, hepatitis, TB, or other HIV co-morbid or co-transmitted infections ▪ Persons potentially exposed to HIV[4]	During each pregnancy; repeat testing during third trimester and delivery for those at increased risk[11]
Syphilis	All persons based on local area and institutional prevalence of early (primary, secondary, and early latent) infectious syphilis **CDPH[12]:** All people who are or could become pregnant entering an adult correctional facility located in a local health jurisdiction (LHJ) with high congenital syphilis morbidity	▪ Periodic screening for those with new diagnosis of another STI, HIV, or HCV ▪ At least every 3 months for individuals on PrEP[3] ▪ Persons reporting/presenting with signs/symptoms of syphilis[13] or other STIs ▪ Persons potentially exposed to an STI or HIV[4]	During each pregnancy ▪ at intake (treat as first prenatal visit) ▪ at 28 weeks ▪ at delivery
TB	All persons should be screened for symptoms of pulmonary TB[14] Persons with new risk factors for TB infection or risk for progression to TB disease since last TB test[15] should be further screened with an Interferon-Gamma Release Assay (IGRA)^, a tuberculin skin test (TST), or chest radiograph	▪ Persons serving long-term sentences who have history of positive TB test result should be screened annually for TB symptoms ▪ Anyone with an exposure to infectious TB should receive a TB test if the exposed person has no history of a positive TB test; exposed persons with a history of a positive TB test should be screened for symptoms of TB	None
Trichomonas	All females[2] ≤35 years of age	▪ Persons reporting/presenting with vaginal discharge	None

* California Penal Code 4023.8(a) requires that a person incarcerated in a county jail who is identified as possibly pregnant or capable of becoming pregnant during an intake health examination or at any time during incarceration shall be offered a pregnancy test upon intake or by request, within 72 hours of arrival at the jail. Pregnancy tests shall be voluntary and not mandatory, and may only be administered by medical or nursing personnel.

^ Interferon-Gamma Release Assay (IGRA) is preferred over tuberculin skin test (TST), especially among individuals born outside of the United States.

Additional Recommended Actions During Period of Incarceration/Detention[1]

- Offer vaccination for hepatitis A (HAV), HBV, and human papillomavirus (HPV) if clinically appropriate.

CDC-Recommended Actions for Release Planning and Linkage to Care[1]

All	▪ Treat persons with diagnosed infections in accordance with established clinical guidance (*see table below*).[16] ▪ Provide all persons or their identified health care provider with an individual health record (including information on immunizations, medications, and follow up care and treatment needed) upon release.
HIV	▪ Provide persons with HIV with an adequate supply of antiretroviral medication upon release to bridge the gap until the patient can receive care from a community-based HIV provider. ▪ Provide information on pre-exposure prophylaxis (PrEP) to all persons who are known to be at risk of HIV infection in their community.
HIV and viral hepatitis	▪ Refer persons with HBV infection, HCV infection, or HIV to community-based medical and social services as needed to support continued medical care, risk-reduction, and, where needed, treatment for substance use disorder.
HIV, viral hepatitis, and STIs	▪ Provide persons with HIV, viral hepatitis, or any STI with counseling on how to prevent transmission to household, sexual, and drug-use contacts as applicable (including risk reduction and condom use).
TB & latent TB infection (LTBI)	▪ Communicate with local/state public health and community healthcare providers to facilitate treatment completion after release for persons on treatment for TB disease or LTBI. ▪ Provide persons being treated for TB or LTBI counseling on the importance of completing a full course of treatment.

Clinical Treatment Guidance[1]

Disease/Condition	Clinical Treatment Guidance: General	Clinical Treatment Guidance: For Pregnant Persons
STIs	CDC 2021 STI Treatment Guidelines	CDC Sexually Transmitted Infections Treatment Guidelines: Pregnant Women
HIV	▪ Health & Human Services (HHS) Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV ▪ CDC US Public Health Service: Preexposure prophylaxis for the prevention of HIV infection in the United States—2021 Update: a clinical practice guideline	HHS Recommendations for the Use of Antiretroviral Drugs During Pregnancy
HBV	Update on prevention, diagnosis, and treatment of chronic hepatitis B: American Association for the Study of Liver Diseases (AASLD) 2018 hepatitis B guidance	CDC Screening and Referral Algorithm for HBV Infection Among Pregnant People
HCV	Recommendations for Testing, Managing, and Treating Hepatitis C	AASLD/Infectious Disease Society of America (IDSA) HCV Guidance: HCV in Pregnancy
TB	Treatment for TB Disease	CDC Treatment for TB Disease & Pregnancy
LTBI	Guidelines for the Treatment of Latent Tuberculosis Infection: Recommendations from National TB Controllers Association (NTCA) and CDC, 2020 (short-course, rifamycin-based regimens are preferred)	CDC Treatment for TB Disease & Pregnancy

Technical Assistance and Available Support

CDPH offers consultation and training on best practices for the implementation and evaluation of STI screening and testing within adult jails and juvenile facilities. For more information, please contact the STD Control Branch at stdcb@cdph.ca.gov.

For technical assistance related to TB testing and treatment, contact your local health department TB program. A directory can be found on the CA Tuberculosis Controllers Association website.

Notes and Sources

[1] Unless otherwise noted, source is CDC, At-A-Glance: CDC Recommendations for Correctional and Detention Settings, reviewed 4/24/2023.

[2] The experience and needs of transgender and gender diverse persons is not well reflected in gender-based screening recommendations. CDC recommends that gender-based STI screening recommendations be adapted on the basis of anatomy. For example, recommendations to screen females ≤35 years of age for chlamydia/gonorrhea should be extended to transgender men and nonbinary persons with a cervix in the age group. See: CDC, STI Treatment Guidelines, 2021: Transgender and Gender Diverse Persons, reviewed 7/22/2021.

[3] CDC, US Public Health Service: Preexposure prophylaxis for the prevention of HIV infection in the United States—2021 Update: a clinical practice guideline, published 2021.

[4] CDC recommends routine (e.g., annual) STI/HIV risk assessments. Although risk behaviors including drug use and sexual activity are prohibited in correctional and detention environments, they may still occur. Clinicians should note that individuals may be hesitant to report these behaviors due to fear of reprisal.

[5] "Increased risk" means new or multiple sex partners, sex partner with concurrent partners, or a sex partner who had an STI. (CDC, Recommended Clinician Timeline for Screening for Syphilis, HIV, HBV, HCV, Chlamydia, and Gonorrhea, reviewed 8/11/2022.)

[6] CDPH, California STI/HIV Screening Recommendations in Pregnancy, updated 11/17/23.

[7] Kilpatrick SJ, Papile LA, et al., editors. Guidelines for Perinatal Care. 8th ed. American Academy of Pediatrics (AAP) & American College of Obstetricians & Gynecologists (ACOG), September 2017.

[8] See also: U.S. Preventive Services Task Force (USPSTF), Hepatitis C Virus Infection in Adolescents and Adults: Screening, published 3/2/2020.

[9] See also: USPSTF, Hepatitis B Virus Infection in Adolescents and Adults: Screening, published 12/15/2020.

[10] See also: USPSTF, Hepatitis B Virus Infection in Pregnant Women: Screening, published 7/23/2019.

[11] HIV.gov, Recommendations for the Use of Antiretroviral Drugs During Pregnancy and Interventions to Reduce Perinatal HIV Transmission in the United States: Maternal HIV Testing and Identification of Perinatal HIV Exposure, updated 1/31/2023.

[12] CDPH, Expanded Syphilis Screening Recommendations for the Prevention of Congenital Syphilis: Guidelines of California Medical Providers, 2020.

[13] See: Workowski KA, Bachmann LH, Chan PA, et al. STI Treatment Guidelines, 2021. MMWR Recomm Rep. 2021;70(4):1-187. Published 7/23/2021.

[14] Symptoms of pulmonary TB include prolonged cough (>3 weeks), hemoptysis (bloody sputum), or chest pain.

[15] New risk factors since the last TB test was performed should include: a) Birth, travel, or residence in a country with an elevated TB rate; b) Immunosuppression, current or planned; c) Close contact to someone with infectious TB during lifetime (CDPH, TB Risk Assessment, updated 6/15/2020).

[16] Some medications (e.g., for HCV and for syphilis) may be cost prohibitive for county jails without access to discounted medications (e.g., via the 340B program). However, screening and diagnosis supports patient awareness and linkages to care. Resources from the Department of Health Care Services (DHCS) Cal-AIM Justice Involved Initiative may be available for pre-release planning, treatment during incarceration, and/or post-release linkages to medical care and social supports for eligible adults (e.g. with mental health/substance use disorder diagnosis or suspected diagnosis, chronic condition, pregnant/postpartum) and all youth.

HHS Intends to Propose Rulemaking on HIV-positive Organ Transplantation

Content From: B. Kaye Hayes, MPA, Deputy Assistant Secretary for Infectious Disease, Director, Office of Infectious Disease and HIV/AIDS Policy (OIDP), Executive Director, Presidential Advisory Council on HIV/AIDS (PACHA), and James Berger, Senior Advisor for Blood and Tissue Policy, Office of HIV/AIDS and Infectious Disease Policy, U.S. Department of Health and Human Services

Published: February 15, 2024

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Years of HOPE Act Research Informs Potential Organ Transplant Policy Change for People with HIV

As people with HIV live longer, end-stage diseases of the kidney, liver, heart and lung continue to rise. As a result, the need for organs available for transplantation has increased. However, donor organs are in chronic short supply nationwide for people with and without HIV. While people with HIV can and do continue to receive organs from HIV-negative donors, transplants from donors with HIV may reduce time on the transplant waiting list and associated costs for these recipients. Nearly a decade of research into organs transplanted from donors with HIV to recipients with HIV will inform an intended proposed rule from the U.S. Department of Health and Human Services (HHS) that, if finalized, would remove some of the current restrictions that authorize such transplants only under research protocols, potentially making them more widely available. As more people with HIV become organ donors, the overall pool of available organs is anticipated to increase, benefiting all people on transplant waiting lists since every successful transplant shortens the waitlist for all patients.

The Department's action will be informed by recommendations from the Advisory Committee on Blood and Tissue Safety and Availability and the Blood, Organ, and Tissue Senior Executive Council, which considered evidence accumulated from years of research authorized by the HIV Organ Policy Equity Act (HOPE Act). Enacted in 2013 and implemented beginning in 2015, the HOPE Act made possible previously prohibited research related to the transplantation of organs in which both the donor and recipient have HIV. Since its implementation, more than 440 organs have been transplanted from donors with HIV to recipients with HIV. Nearly all of those transplants were kidney and liver transplants, and advisory committees have found that the accumulated evidence shows that these transplants are safe for both living donors and recipients. The research was conducted as part of two large-scale clinical trials supported by NIH's National Institute of Allergy and Infectious Diseases, the HOPE in Action Multicenter Kidney Study and the HOPE in Action Multicenter Liver Study.

HHS intends to move forward with an NPRM, and once public comments are received and considered, HHS will decide whether to modify or implement the proposed policy change.

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You may be eligible for both Medicare and Medicaid.

Medicare and **Medicaid** are both government-funded health coverage programs that help people pay for their health care costs. **Medicare** is the federal program for people who are 65 and older, people under 65 with a qualifying disability, or people of any age who have end-stage renal disease (ESRD) or amyotrophic lateral sclerosis (ALS). **Medicaid** is a state-run program for people who have limited income who may also belong to a specific population group, such as pregnant people, individuals with disabilities, and the elderly. Some people are **dually eligible**, which means they qualify for both programs at the same time. The term dual eligibility means the same thing as "dually eligible."

Medicaid: Did You Know?

Medicaid may have a different name depending on where you live. For example, **Medicaid** is referred to as "MassHealth" in Massachusetts, "Medi-Cal" in California, and "KanCare" in Kansas.

Medicaid looks different depending on where you live. Not only does **Medicaid** eligibility vary from state to state, but your state **Medicaid** program may offer multiple plan options, each with a different set of eligibility criteria and benefits, and often with another name.

People who are **dually eligible** for both **Medicare** and **Medicaid** can receive different levels of **Medicaid** benefits.

- **Full dual eligibility:** You qualify for full state **Medicaid** benefits as well as full **Medicare** benefits, and your state **Medicaid** program provides financial help to cover your **Medicare** costs.
- **Partial dual eligibility:** You qualify for full **Medicare** benefits, and your state **Medicaid** program provides financial help to cover some of your **Medicare** costs.

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Jan 24, 2024

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Methamphetamine Use and Public Perceptions in Los Angeles

METHAMPHETAMINE

Findings from the 2022 Community Needs Assessment

Health Outcomes and Data Analytics Division
Substance Abuse Prevention and Control Bureau
Los Angeles County Department of Public Health

February 2024

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Cambodian Association of America
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Child and Family Center
Children's Hospital Los Angeles
Community Coalition for Substance Abuse Prevention & Treatment
Day One
Helpline Youth Counseling, Inc.
Institute for Public Strategies
Korean American Family Services
Koreatown Youth & Community Center
Los Angeles County Office of Education Friday Night Live
National Council on Alcoholism and Drug Dependence of East San Gabriel and Pomona Valleys
National Council on Alcoholism and Drug Dependence of the San Fernando Valley
Pacific Clinics
Parents Anonymous
People Coordinated Services of Southern California
Phoenix House of Los Angeles
Prototypes
Pueblo Y Salud
San Fernando Valley Partnership, Inc.
Social Model Recovery Systems, Inc.
South Central Prevention Coalition
Tarzana Treatment Centers
The Wall Las Memorias Project
Watts Healthcare Foundation, Inc.

Prevalence and Use Behaviors

- 8.0% of LAC residents aged 12 or older used methamphetamine at least once in their lifetime, and 1.6% used methamphetamine in the past 30 days.
- Among those who currently use methamphetamine, the average number of days used in the last month was 13 days.
- LAC residents were, on average, 20 years old when they first used methamphetamine, with 47.8% of people who use methamphetamine (PWUM) first using before age 18.
- The most common reasons cited for using methamphetamine were for fun (47.5%), enhanced mood/euphoria (44.2%), increased energy (41.6%), and getting more done (34.5%).
- Most LAC residents who used methamphetamine typically used with friends (48.6%) or alone (40.7%).
- The most popular method for using methamphetamine was smoking (74.8%) followed by snorting (65.4%), taking it orally (by pill, 20.5%), and injecting (20.2%).
- PWUM were more likely than people who do not use methamphetamine (non-PWUM) to have close friends (33.5% vs. 3.8%) or family members who use methamphetamine (25.9% vs. 3.6%).
- The most common locations of last methamphetamine use included home (34.0%), a friend's home (23.8%), or a public place (19.6%).
- The most common locations of first methamphetamine use included a friend's home (30.4%) their own home (19.9%), followed by a public place (15.6%) or work/school (12.2%).
- Of all PWUM, 65.4% reported binging methamphetamine. Of those who reported binging, 16.2% did so within the last 30 days.

Accessibility/Availability

- 41.1% of LAC residents aged 12 or older perceived easy methamphetamine access around their neighborhood.
- Among PWUM, 77.0% reported that methamphetamine was easy for them to obtain.
- PWUM most commonly obtained their methamphetamine supply from a friend (46.7%) or through a dealer (31.9%).

Harms and Risks of Use

- Over half of PWUM (55.7%) reported driving under the influence of methamphetamine (DUI); however, when asked about the ways their methamphetamine use caused harm, only 22.2% reported DUI as a harm.
- About one-quarter (26.1%) of those who reported driving under the influence of methamphetamine reported that there were consequences to the DUI (e.g., accident, citation).
- The most common harms reported among PWUM were addiction/dependence (61.9%), causing mental health distress (51.4%), causing problems with friends/family (46.8%), and aggressive/violent behavior (42.6%). Only 6.3% indicated no harms associated with their use.
- 8.2% of LAC residents had been a passenger in a car when the driver was driving under the influence of methamphetamine. For those who had indicated ever using methamphetamine, the percentage increased to 60.3% who indicated being a passenger when a driver was under the influence (vs. 3.5% of those who had never used).
- 74.8% of LAC residents aged 12 or older perceived that it is a great risk for youth to use methamphetamine 1-2 times per week (i.e., regular use).
- 77.3% of LAC adult residents (aged 18+) perceived that it is a great risk for adults to use methamphetamine 1-2 times per week (i.e., regular use).

Purpose
The Community Needs Assessment (CNA) was a community-wide effort to address the current data gap for smaller regions, specific topics, and underrepresented demographic groups related to methamphetamine use and associated problems and perceptions, and to identify disparities and potential risk or protective factors to target communities in Los Angeles County (LAC). The CNA provides a comprehensive profile of methamphetamine use problems that will facilitate community prevention service providers, other stakeholders, and policymakers in making informed decisions about prioritizing problems, strategic planning, and resource allocation for implementing solutions to address the needs of the target communities.

CNA Workgroup
The CNA Workgroup was established to oversee and conduct the CNA, to ensure geographic and sociodemographic coverage, and to conduct the CNA in a culturally competent way throughout the process. The CNA Workgroup was comprised of representatives from the Health Outcomes and Data Analytics (HODA) Division and Prevention Services Division at the LAC Department of Public Health (DPH), Substance Abuse Prevention and Control (SAPC) Bureau, and SAPC-contracted community prevention service providers. The CNA Workgroup was led by HODA Division and worked closely together in the project conception, planning, survey design and development, pilot testing, community outreach, participant recruitment, and data collection.

Research Ethics
The CNA project was approved by the LAC DPH Institutional Review Board.

Adaptation of 2017 CNA
This survey tool was adapted from the first round of the CNA (2017) which included questions about marijuana use and prescription medication misuse. The current CNA tool preserved the wording of previous items as much as possible, while also revising and extending some items (e.g., attitudes about sharing prescription medications) and expanding the scope of the survey to also include questions about methamphetamine, alcohol, and heroin.

Survey Tool
The survey was a comprehensive 72-item questionnaire that included questions about a variety of substances including: methamphetamine, alcohol, heroin, marijuana, and prescription medications. Along with asking about usage behaviors, perceived accessibility and risk, the survey also included sociodemographic and geographic questions. Paper (about 20-30 minutes) and online Qualtrics (about 10-15 minutes) versions of the CNA were available in English, Spanish, Chinese, Korean, Armenian, and Khmer. Several questions on the youth survey (aged 12-17) were worded differently from the adult survey (aged 18+).

Participant Recruitment
The prevention providers promoted the CNA efforts by mailing SAPC support letters to school administrators and community and business leaders, and by distributing flyers and delivering presentations to prevention agencies, community centers, public events, and other public places (e.g., libraries). In exchange for taking the survey, all participants were offered a $20 gift card to Amazon, Starbucks, Subway, or Target.

Data Collection
From August 2022 to February 2023, SAPC-contracted prevention service providers administered the survey to a diverse sample of youth and adult participants across LAC from a wide array of community settings, including schools, after-school programs, college campuses, shopping plazas, grocery stores, strip malls, coffee shops, parks, libraries, neighborhood council meetings, public and senior housing developments, churches, farmer's markets, health/resource fairs, health and social services waiting rooms, veteran/low-income housing, community events, government buildings, and YMCAs. Note that much of the youth data was collected outside of the school setting.

Population Weights
Sampling weights accounting for differences in the age, sex, race/ethnicity, and geographic distribution between the sample and population were calculated based on the LAC Internal Services Department's Population Estimates for LAC Tract-City and Countywide Statistical Area Splits (2022). These sampling weights were applied to the sample data to reduce sampling error and to produce estimates representative of the population. Sampling weights could not be calculated for demographic groups not available in the population data. Therefore, population estimates for some demographic groups, such as the transgender group, were not provided in this report. For SPA and SD population estimates, we allocated sample zip code data to respective SPA and SD based on the proportion of census block population distribution and subsequently calculated sampling weights.

Analytic Sample
After applying the exclusion criteria of individuals <12 years of age and individuals indicating a residency outside of Los Angeles County, we compiled our final sample of 9,221 surveys that were collected by SAPC-contracted prevention providers. Of those 9,221 surveys, records with missing values on any of the population weighting variables (i.e., age, sex, race/ethnicity, zip code) were excluded (N=1,098) from further analysis due to ineligibility for population weighting. The final analysis sample consisted of 8,123 surveys. All missing and unknown response values were excluded from individual calculations where applicable. Estimates with a large proportion of missing values for some categories (e.g., sexual orientation) should be interpreted with caution.

Statistical Methods
Estimates and their variances were calculated using statistical procedures PROC SURVEYFREQ and PROC SURVEYMEANS. Criteria for determining that the estimate is statistically stable included a relative standard error (RSE) less than 30% and a sample size for subgroup analyses ≥ 30.

Given that methamphetamine use is a major contributor to the drug overdose crisis in LAC and the lack of available data, estimates that do not meet these statistical criteria may still be appropriate for planning or policy purposes. Thus the minimum criteria for RSE were applied and estimates with RSE between 30%-50% were reported with an asterisk and note[1].The estimates with RSE greater than 50% and/or sample size < 30 were also not

[1] Utah Department of Health. (2005). *Report of Guidelines for Data Result Suppression.* https://ibis.health.utah.gov/ibisph-view/pdf/resource/DataSuppression.pdf

suppressed so that underrepresented populations could be visible in our data. Please interpret with caution. All RSEs were based on non-missing values.

Report Organization
This report provides an overview of the findings of the countywide CNA, including prevalence of use; use behaviors; perceived risk, accessibility, and availability; and consequences of use within LAC communities. Results are presented for LAC overall, geographic region (SPA and SD) and by demographics. Key findings are presented in the *Executive Summary* section, and a detailed summary of the findings are presented at the end of the report. Detailed result tables with confidence intervals for all items in the main report are presented in *Appendices A-V*.

Data for Native Hawaiian and other Pacific Islanders (N = 46) and American Indian/Alaskan Natives (N = 39), and those indicating “Other” as their racial identity (N = 46) were presented only for prevalence indicators and suppressed in all other instances due to the small numbers of respondents indicating that they had ever used methamphetamine (N < 15), which was required for most downstream questions. This cutoff was determined via a data-driven approach.

Limitations of CNA
The convenience sampling method may not result in a representative sample of the general LAC population. Non-response bias may be present. All data collected were self-reported, which may not accurately reflect actual use, related behaviors, or perceptions. Thus, the results should be interpreted with caution.

Prevalence of Methamphetamine Use

- Among LAC residents aged 12 and older, 8.0% reported ever using methamphetamine at least once in their lifetime (lifetime methamphetamine use). This rate was higher than that reported in the 2021 National Survey on Drug Use and Health (NSDUH), in which 6.0% of the US population 12 and older had ever used methamphetamine.
- The rate of current methamphetamine use (at least once in the past 30 days) among LAC residents aged 12 and older was 1.6%. This was higher than that reported in the 2021 National Survey on Drug Use and Health (NSDUH), in which 0.6% of the US population 12 and older reported using methamphetamine at least once in the past month.
- Lifetime methamphetamine use was highest among males (11.6%), those aged 35-44 (11.3%), and American Indians/ Alaska Natives (40.3%), US born (9.8%), and LGBQ individuals (10.9%).
- Current methamphetamine use was highest among males (2.5%), those aged 18-25 and 35-44 (both 1.9%), American Indians/ Alaska Natives (14.8%)*, US born (1.8%) and LGBQ individuals (3.1%).
- The rate of lifetime methamphetamine use among youth aged 12-17 was 2.0%, which matches the prevalence reported in the 2021 Youth Risk Behavior Survey (YRBS), in which 2.0% of high school students in the Los Angeles Unified School District reported lifetime use of methamphetamine.
- Service Planning Area (SPA) 4 reported the highest rate of current use of methamphetamine (3.5%), followed by SPA 6 (2.4%), SPA 1 (2.0%)*, SPA 8 (1.9%)*, SPA 3 (1.2%), SPA 2 (0.9%)*, SPA 5 (0.7%)*, and SPA 7 (0.4%)*.
- Supervisorial District (SD) 2 reported the highest rate of current methamphetamine use (2.9%), followed by SD 1 (1.7%), SD 5 (1.5%)*, SD 3 (0.8%)*, and SD 4 (0.7%)*.
- Current PWUM[1] (people who use methamphetamine) used methamphetamine an average of 13 days in the past 30 days.

Age of Initiation

- The average age of first use of methamphetamine among LAC residents aged 12 and older was 20 years; 47.8% of PWUM first used methamphetamine before age 18.
- SPA 4 reported the oldest age of initiation (25 years of age), followed by SPA 3 (22 years), SPAs 2 and 7 (21 years), SPAs 6 and 8 (18 years), and SPAs 1 and 5ǂ (16 years).
- SD 4 indicated the highest percentage of those initiating methamphetamine use under the age of 18 (51.7%), followed by SD 2 (50.0%), SD 5 (47.9%), SD 3 (44.6%), and SD 1 (43.4%).

Accessibility

- Of those who used methamphetamine at least once in their lifetime, more than three-quarters (77.0%) reported it was easy or very easy for them to obtain.
- Among youth aged 12-17 who used methamphetamine at least once, 72.4% indicated it was easy/very easy to obtain.

1) "PWUM" indicates people who have ever used methamphetamine.
* The estimate is for planning or policy purposes (RSE is between 30% and 50%);
ǂ The estimate is statistically unstable (sample size < 30); Interpret with caution.

- SPA 1 (83.2%) indicated the highest prevalence of PWUM who reported it was easy to obtain methamphetamine, followed by SPA 6 (82.6%), SPA 7 (82.3%), SPA 8 (80.6%), SPA 4 (77.9%), SPA 3 (76.8%), SPA 2 (65.4%), and SPA 5 (34.2%)ǂ**.
- SD 2 (85.1%) reported the highest prevalence of PWUM who reported it was easy/very easy for them to obtain methamphetamine, followed by SD 1 (81.6%), SD 4 (74.2%), SD 5 (73.6%), and SD 3 (61.3%).

Reasons for Use

- The most common reasons for using methamphetamine were for fun (47.5%), enhanced mood/euphoria (44.2%), increased energy (41.6%), and to get more done (34.5%).
- Females were more likely than males to indicate "dealing with difficult emotions" (38.0% vs. 25.1.%) and weight loss (32.9% vs. 19.1%) as reasons to use. Males were more likely than females to indicate enhanced sexual experience as a reason to use methamphetamine (35.7% vs. 20.0%).
- "To get more done" was more often cited as a reason for use in the following groups: females (37.6%), those aged 35-44 (44.0%), Whites (47.1%), and US born (37.5%).

Setting of Use

- Overall, LAC PWUM typically used methamphetamine with friends (48.6%) or alone (40.7%).
- Typically using with friends was more commonly selected for females (53.2%), youth (66.1%), Multiracial individuals (92.0%)ǂ , US born (51.7%), and heterosexual individuals (50.7%).

Route of Administration

- Nearly three-quarters PWUM (74.8%) had used methamphetamine by smoking it. Over half had snorted (65.4%) methamphetamine, while 20.5% used orally, 20.2% injected, and 4.9% indicated "Other" (e.g., "on skin").
- Smoking methamphetamine was the most common in Latino PWUM (78.2%). Snorting methamphetamine was more common in White (74.9%) and Multiracial (79.8%)ǂ respondents, as compared to other racial groups.
- Smoking was a more popular method among males than females (77.0% vs 70.5%), as was injecting (22.7% vs. 15.2%). Snorting was more popular among females than males (71.0% vs. 62.5%).
- Smoking methamphetamine was a more popular method among heterosexual PWUM (76.7%) as compared to LGBQ individuals (68.8%) or "Other" (46.7%)ǂ respondents.

Source of Methamphetamine

- PWUM most commonly obtained methamphetamine from a friend (46.7%), followed by a dealer (31.9%), "other" (5.1%), family/relative (4.8%), or made by the person who used (4.3%)*. Coworkers/schoolmates (2.5%)*, stealing from family/friends (2.4%)*, internet (1.4%)*, and social media (0.8%)** accounted for the smallest portion among all sources.
- Friends were the most common source of obtaining methamphetamine for all demographic groups except youth (12-17) who indicated stealing from friends and family as the most common source (32.1%)*, along with those aged 18-25, Blacks/African Americans and Asians who indicated a dealer as their most common source (32.1%, 34.4%, and 44.5%, respectively).

* The estimate is for planning or policy purposes (RSE is between 30% and 50%);
** The estimate is statistically unstable (RSE >50%); Interpret with caution.
ǂ The estimate is statistically unstable (sample size < 30); Interpret with caution.

- Females were more likely than males to indicate friends as their source (50.1% vs. 45.0%), while males were more likely than females to indicate dealers as their source (34.4% vs. 27.3%).

Place of Last Use

- Home (34.0%) was the most common place of last methamphetamine use, followed by a friend's home (23.8%), public place (19.6%), party/kick-back (7.2%), "other" (6.8%), work/school (3.7%)*, relative's home (2.7%)*, and a rave (2.1%)*.
- Females (36.3%), those aged 55-64 (48.9%), Whites (45.1%), US born (36.9%) and LGBQ (37.3%) were more likely than other groups to indicate home as the last place of use
- A friend's home was more likely to be reported as the place of last methamphetamine use among adults aged 26-34 (29.3%), Latinos (29.3%), and LGBQ individuals (26.7%).
- A public place was more commonly indicated as the last place of use for males than females (23.6% vs. 12.2%).
- Respondents aged 26-34 were the most likely to indicate a party/kick-back as the last place of use (12.9%)*, at nearly double the rate of respondents overall (7.2%).

Place of First Use

- A friend's home (30.4%) was the most common place of first methamphetamine use, followed by home (19.9%), public place (15.6%), and work/school (12.2%), party/kick-back (8.7%), other (5.1%), relative's home (4.6%)* and a rave (3.5%)*.
- A friend's home was more likely to be the place of first methamphetamine use among males (31.8%) and adults aged 35-44 (38.5%), and "Other" sexual orientation (37.9%)*.
- Whites (31.2%), respondents aged 55-64 (31.4%)*, and those born in the US (21.0%) were more likely than other groups to indicate home as first place of methamphetamine use.

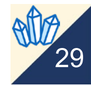
Harms of Use

- Only 6.3% of PWUM reported no harms had resulted from their personal use of methamphetamine.
- PWUM cited the following as the most common harms from their methamphetamine use: addiction (61.9%), mental health problems (51.4%), problems with friends/family (46.8%), aggression (42.6%), and physical health problems (38.8%).
- Latinos (65.1%), those aged 45-54 (73.8%), those born in the US (64.7%), and heterosexual individuals (63.7%) were more likely than other groups to indicate addiction as a resulting harm.
- Males were more likely than females to indicate that aggression/violent behavior had resulted from their methamphetamine use (46.8% vs. 34.7%).

Driving Under the Influence

- Overall, 55.7% of PWUM had driven a car while under the influence of methamphetamine, while only 22.2% had indicated it as a harm.
- The groups most likely to indicate driving a car while under the influence of methamphetamine were males (60.0%), adults aged 35-44 (60.8%), Whites (69.2%), US born (57.3%), and heterosexual individuals (59.0%).

* The estimate is for planning or policy purposes (RSE is between 30% and 50%);
** The estimate is statistically unstable (RSE >50%); Interpret with caution.
ɫ The estimate is statistically unstable (sample size < 30); Interpret with caution.



- SPA 7 reported the highest prevalence (67.0%) of PWUM who had driven a car while under the influence of methamphetamine, followed by SPA 1 (61.5%), SPA 8 (60.8%), SPA 5 (59.0%)ƚ*, SPA 2 (58.1%), SPA 4 (50.6%), SPA 6 (46.9%), and SPA 3 (46.3%).
- SD 5 reported the highest prevalence (65.6%) of PWUM who had driven a car while under the influence of methamphetamine, followed by SD 4 (59.8%), SD 3 (58.0%), SD 2 (52.8%), and SD 1 (47.9%).
- 26.1% of those who had driven under the influence of methamphetamine also indicated that there were consequences (e.g., arrest, accident, etc.).

Methamphetamine Use Among Close Friends

- 6.1% of LAC residents aged 12 and older had close friends who use methamphetamine. PWUM were more likely than non-PWUM[1] to have close friends who use methamphetamine (33.5% vs. 3.8%).
- Reports of having close friends who use methamphetamine were highest among males (9.0%), adults aged 26-34 (8.4%), Blacks/African Americans (9.5%), those born in the US (7.2%), and LGBQ (7.8%).
- Those in SPA 4 (8.7%) were most likely to indicate that they had a close friend who used methamphetamine, followed by SPA 1 (6.9%), SPA 3 (6.7%), SPA 6 (6.4%), SPA 5 (6.1%)*, SPA 7 (5.8%), SPA 2 (4.8%), and SPA 8 (4.6%).
- Reports of having close friends who use methamphetamine were highest in SD 1 (7.2%), followed by SD 5 (7.0%), SD 2 (6.5%), SD 3 (5.3%), and SD 4 (4.8%).

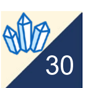
Methamphetamine Use Among Family Members

- 5.3% of LAC residents aged 12 and older had family members who use methamphetamine. Those who have used methamphetamine were more likely than non-PWUM to have family members who use methamphetamine (25.9% vs. 3.6%).
- The groups who were most likely to indicate that family members use methamphetamine were male (6.3%), those aged 26-34 (7.0%), Blacks/African Americans (9.2%), US born (6.3%), and LGBQ individuals (6.8%).
- SPA 5 (7.6%)* reported the highest prevalence of having family members who use methamphetamine, followed by SPA 3 (7.2%), SPA 1 (6.8%), SPA 8 (6.2%), SPAs 4 and 6 (5.5%), SPA 7 (4.8%), and SPA 2 (2.6%).
- SD 1 (6.8%) had the highest prevalence of having family members who use methamphetamine, followed by SD 2 (6.0%), SD 5 (5.3%), SD 4 (4.6%), and SD 3 (3.3%).

Prevalence of Binging Methamphetamine

- Among LAC residents aged 12 and older who have ever used methamphetamine, 65.4% have binged[2] methamphetamine at least once in their lifetime. Of those who ever binged, 16.2% did so within the past 30 days.
- Of those who have ever used methamphetamine, males (70.6%), Latinos (71.4%), those aged 45-54 (75.3%), US born (67.3%), and heterosexual individuals (66.9%) had the highest prevalence of lifetime binging.

1) "Non-PWUM" indicates people who have never used methamphetamine.
2) A "binge" was defined as "going without food and sleep while continuing to take methamphetamine for 48 hours or more".
* The estimate is for planning or policy purposes (RSE is between 30% and 50%);
ƚ The estimate is statistically unstable (sample size < 30); Interpret with caution.



- Among PWUM, SPA 7 indicated the highest prevalence of lifetime binging (75.3%) followed by SPA 8 (72.1%), SPA 6 (65.2%), SPA 3 (63.4%), SPA 2 (61.6%), SPA 4 (60.6%), SPA 1 (53.3%), and SPA 5 (38.4)[ǂ**].
- Among PWUM, SD 4 indicated the highest prevalence of lifetime binging of methamphetamine (69.8%), followed by SD 1 (69.3%), SD 2 (65.0%), SD 3 (60.1%), and SD 5 (58.7%).

Perceived Accessibility

- 41.1% of LAC residents aged 12 and older perceived that it would be easy or very easy for someone to obtain methamphetamine around their neighborhood.
- Those who have used methamphetamine were more likely to perceive easy access to methamphetamine around their neighborhood than those who have not used methamphetamine (69.3% vs. 38.6%).
- Overall, females (43.5%), those aged 45-54 (50.5%), Blacks/African Americans (50.3%), Foreign Born (44.9%), and “Other” sexual orientation (42.0%), were more likely to perceive easy access to methamphetamine around their neighborhood than other groups.
- SPA 4 (49.2%) had the most reports of perceived easy access to methamphetamine around their neighborhood, followed by SPA 6 (47.1%), SPA 3 (41.6%), SPA 7 (40.8%), SPA 1 (39.0%), SPA 2 (37.5%), SPA 8 (34.9%), and SPA 5 (24.8%).
- SD 2 (45.3%) had the most reports of perceived easy access to methamphetamine around their neighborhood, followed by SD 1 (45.2%), SD 4 (38.8%), SD 3 (38.2%), and SD 5 (33.5%).

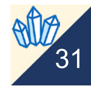
Perceived Risk of Youth Regular Use

- Three-quarters (74.8%) LAC residents aged 12 and older perceived regular methamphetamine use (1-2 times per week) to be a great risk for youth.
- Overall, males (73.4%), young adults aged 12-17 (61.6%), Multiracial individuals (69.4%), US born (71.4%), and LGBQ individuals (67.4%) were least likely to perceive regular methamphetamine use to be a great risk for youth.
- SPA 3 (78.6%) had the highest percentage of those perceiving regular methamphetamine use to be a great risk for youth, followed by SPA 8 (77.8%), SPA 6 (75.4%), SPA 2 (75.3%), SPAs 1 and 7 (both 72.5%), SPA 5 (71.6%), and SPA 4 (70.2%).
- SD 5 (76.1%) had the highest percentage of those perceiving regular methamphetamine use to be a great risk for youth, followed by SD 4 (75.2%), SD 2 (74.8%), SD 3 (74.4%), and SD 1 (74.0%).

Perceived Risk of Adult Regular Use

- More than three-quarters (77.3%) of LAC residents aged 18 and older perceived regular use of methamphetamine to be a great risk for adults.
- Males (76.6%), adults aged 18-25 (70.9%), Multiracial individuals (68.8%), US born (74.9%), and LGBQ individuals (74.5%) were least likely to perceive regular use of methamphetamine to be a great risk for adults.

* The estimate is for planning or policy purposes (RSE is between 30% and 50%);
ǂ The estimate is statistically unstable (sample size < 30); Interpret with caution.



- SPA 3 (80.7%) was the mostly likely to perceive regular use of methamphetamine to be a great risk for adults, followed by SPA 5 (80.3%), SPA 6 (77.8%), SPA 8 (77.5%), SPA 2 (77.1%), SPA 7 (76.1%), SPA 1 (75.7%), and SPA 4 (73.8%).
- SD 5 (79.2%) was the most likely to perceive regular methamphetamine use to be a great risk for adults, followed by SD 1 (78.8%), SD 4 (77.2%), SD 3 (76.3%), and SD 2 (76.0%).

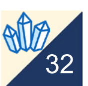
Perceived Harms

- Overall, addiction/dependence was the most commonly perceived harm (67.0%), followed by aggression/violent behavior (57.2%), mental health problems (53.7%), physical health problems (50.8%), brain damage (40.8%), and relationship problems (40.2%).
- PWUM were more likely than non-PWUM to think that methamphetamine use could cause harm for nearly all the provided options, with the widest discrepancies for the following: risky decision making (27.6% vs. 11.9%), causing problems at work/school (27.5% vs. 16.9%), engaging in illegal activities (28.4% vs. 17.9%), causing financial problems (24.6% vs. 14.6%), causing problems with friends/family (48.8% vs. 39.3%), addiction (73.9% vs. 66.5%), and causing mental health problems (59.3% vs. 53.2%).
- Non-PWUM were more likely than PWUM to select “overdose” as a perceived harm (29.7% vs. 23.9%), along with “Don’t Know” (18.7% vs. 9.2%). Non-PWUM were also slightly more likely than PWUM to indicate aggression as a common harm (57.2% vs. 56.8%).

Passengers of Drivers Under the Influence

- 8.2% of LAC residents have been a passenger in a car when the driver was driving under the influence of methamphetamine, with PWUM more likely to report the experience than non-PWUM (60.3% vs. 3.5%).
- 12.7% of those who indicated that they had been a passenger when the driver was under the influence of methamphetamine indicated that there had been consequences of the DUI (e.g., accident, crash, arrest).
- The following demographic groups were most likely to report being a passenger when the driver was under the influence of methamphetamine: males (12.1%), those aged 35-44 (12.4%), Whites (14.2%), US born (10.1%), and LGBQ individuals (11.1%).
- SPA 7 (11.3%) had the highest prevalence of residents who had been a passenger in a car when the driver was driving under the influence of methamphetamine, followed by SPA 5 (9.3%)*, SPA 2 (8.5%), SPA 4 (7.8%), SPA 8 (7.6%), SPA 6 (7.0%), SPA 1 (6.7%), and SPA 3 (6.6%).
- SDs 4 and 5 (8.7%) had the highest prevalence of residents who had been a passenger in a car when the driver was driving under the influence of methamphetamine, followed by SD 3 (8.1%), SD 1 (7.9%), and SD 2 (7.8%).

* The estimate is for planning or policy purposes (RSE is between 30% and 50%); Interpret with caution.



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FEBRUARY 2024

QUICK TAKE

MEDICAID ACCESS TO LONGER-ACTING (LA) PRODUCTS FOR HIV TREATMENT AND PREVENTION

HIV TREATMENT AND PREVENTION HAVE COME A LONG WAY. While there is a broad array of highly effective and well-tolerated antiretroviral (ART) regimens for both HIV treatment and prevention, new formulations and modalities are being developed to give users more options than daily pill taking that may remove some barriers to adherence. Medicaid is the largest source of insurance coverage for people with HIV and a major source of coverage for PrEP. As we seek to expand access to longer-acting (LA) products, it is important to be aware of the tools used by Medicaid programs to manage prescription drug benefits.

Federal-state partnership: Medicaid is a voluntary federal program that all states choose to participate in. States are guaranteed open-ended matching financing, but they must follow federal rules. Some states go far beyond minimum federal requirements and others do not. Therefore, there is a lot of variation in Medicaid from state to state. Traditional Medicaid includes low-income children, parents, seniors, and people with disabilities, a category that includes many people with an AIDS diagnosis. The Affordable Care Act (ACA) permitted states to expand Medicaid to most adults up to 138% of the poverty level while previously access had been limited for nondisabled adults. Forty states plus the District of Columbia have expanded their Medicaid programs which greatly expanded access for people with HIV. The ten states that have not yet expanded Medicaid, however, tend to be heavily impacted by HIV in the southern U.S.

Key protections in Federal law, but states design their prescription drug programs: State programs are not required to offer prescription drugs, but all do so. Medicaid law requires that all groups have comparable access to prescription drugs. And, drug coverage must be adequate to achieve its purpose, meaning that they cannot limit the amount of drugs a person can receive to reasonably treat an individual's medical condition, but some limits on prescription drugs are permitted. In order to have their drugs covered by Medicaid, pharmaceutical manufacturers must pay rebates to the program and in exchange, Medicaid programs cover virtually all FDA-approved drugs.

States use many tools to manage access to prescription drugs: States are required to operate drug utilization review (DUR) programs to prevent clinical abuse and misuse of prescription drugs. They also use these programs to ensure that dispensed drugs meet state criteria for coverage and to control costs. While too complex to fully describe here, tools used by states include contracting with third-parties (such as managed care organizations, MCOs, or pharmacy benefit managers, PBMs) to administer the prescription drug benefit. They can also use prior authorization for some drugs to ensure that specific clinical criteria are met before they will pay for a medication. They can have policies to require step therapy, meaning that a beneficiary can only access a specific medication (often a higher cost one) if they tried and failed on a preferred medication. States can give preferred access to certain drugs in a class. This may involve setting a maximum price for a drug in a class and states will provide easier access to drugs below the maximum or they could negotiate a supplemental rebate with the manufacturer and give easier access to a single product within a class. **Nonetheless, utilization management cannot unreasonably restrict access to needed outpatient prescription drugs**.

MEDICAID IS THE LARGEST SOURCE OF HEALTH COVERAGE FOR PEOPLE WITH HIV

MEDICAID IS:

- The **largest source of insurance coverage** for people with HIV in the U.S., covering 40% of people with HIV compared to 15% of the general population.
- The **largest source of federal spending** on HIV care. In FY 2022, 45% of federal spending on HIV was for Medicaid. In FY 2022, federal Medicaid spending for HIV care was $13 billion and state spending was $5.4 billion.

Sources: KFF. Medicaid and People with HIV, March 2023, available at https://www.kff.org/hivaids/issue-brief/medicaid-and-people-with-hiv/.

POLICY CONSIDERATIONS

HIV providers and stakeholders must work with Medicaid programs to:

Ensure adequate payment: New and innovative products are often priced higher than existing therapies. When they offer benefits through improved adherence and outcomes, they can remain a good investment for Medicaid programs. It will be important for states to understand the value proposition of newer products and include the delivery and monitoring of injectables or other modalities in building their rates.

Build the systems to deliver LA products: LA products alter how HIV treatment and prevention is delivered and

A NEW YORK STATE MEDICAID PLAN'S EXPERIENCE WITH CURATIVE HCV TREATMENT

Direct-acting agents (DAAs) that provide curative treatment for Hepatitis C (HCV) have been available for about a decade. While transformative in offering a cure, access was initially slow, in part, due to widespread resistance from payors, including Medicaid programs in covering these products. The early experience with HCV treatment access may offer insights for extending access to innovative HIV products.

Untreated, HCV can lead to severe liver damage and death. Indeed, it is a leading cause of death for people living with HIV. Amida Care, the largest Medicaid managed care Special Needs Health Plan in New York (currently with 9,500 members) was one of first plans in New York to offer ready access to DAAs for persons co-infected with HIV. Amida Care found that:

Reimbursement rates were inadequate: The state allocated $50 million to cover HCV treatment costs statewide, when the plans estimated the need was greater than $200 million. Amida Care alone anticipated treating its clients would cost more than $10 million.

Health Plans (i.e., MCOs) Limited Access: Due to the early high cost of these medications, access was limited by prior authorization requirements, limited formularies where the preferred DAA medications were not on MCO formularies, or they required step therapy, often requiring failure on less effective medications with very significant side-effects.

Amida Care took a financial risk to serve its members: They advocated for New York Medicaid to cover DAAs without the restriction of waiting for end stage liver disease. They were able to achieve positive health outcomes and long-term cost savings. They could document that the high initial costs of treatment are less than the impacts of end-stage liver disease of HCV. Ultimately 1,500 of their members were cured. Over time, HCV costs have come down significantly and New York Medicaid removed prior authorization requirements. Progress, however, has been incremental—just 34% of people with HCV on Medicaid being cured nationally, indicating that drug coverage is not the only barrier to access.

administered (such as in clinics in place of pharmacies). Medicaid programs must understand the complexities of delivery system transformation necessary to support the staffing and support services needed for these products.

Ensure the policy incentives can lead to good access: States can deliver care through fee-for-service or managed care delivery systems. While MCOs typically receive a single capitated payment for each enrollee to cover all of their care, this may create undue pressure on MCOs to deny coverage of LA products. In FY 2022, 6 states (CA, ND, MO, WI, TN, WV) of the 41 states that deliver some care through MCOs carved out pharmacy benefits, meaning they exclude drugs from capitation and pay on a fee-for-service basis. Michigan and the District of Columbia specifically carve-out ARTs used to treat HIV. Carve-outs are just one tool for protecting drug access. Others include risk-sharing arrangements between states and MCOs, as well as supplemental payments to MCOs to account for the high-cost of certain medications.

Invest to achieve sustained improved outcomes: As Amida Care has shown with HCV treatment, long-term cost savings can be achieved. But, this requires a vision of improving patient outcomes as well as monitoring costs and service needs in a way that permits documentation of such savings.

TO LEARN MORE

For additional background information, see:

KFF. *Medicaid and People with HIV*, March 2023, available at https://www.kff.org/hivaids/issue-brief/medicaid-and-people-with-hiv/#.

KFF and Health Management Associates. *How State Medicaid Programs are Managing Prescription Drug Costs: Results from a State Medicaid Pharmacy Survey for State Fiscal Years 2019 and 2020*, April 2020, available at https://www.kff.org/medicaid/report/how-state-medicaid-programs-are-managing-prescription-drug-costs-results-from-a-state-medicaid-pharmacy-survey-for-state-fiscal-years-2019-and-2020/.

O'NEILL INSTITUTE FOR NATIONAL & GLOBAL HEALTH LAW
GEORGETOWN LAW

FEBRUARY 2024

Ending The HIV Epidemic

This Quick Take is a product of the Infectious Diseases Initiative of the **O'Neill Institute for National and Global Health Law** and was developed with grant support from ***Gilead Sciences, Merck, and ViiV Healthcare***. They had no input into the development of this document. It was developed in partnership with **Amida Care** and **CAI**.

It was authored by **Lyndel Urbano** and **Shakira Croce** (Amida Care) and **Jeffrey S. Crowley** and **Kirk Grisham** (O'Neill Institute). The views expressed are solely those of the authors.

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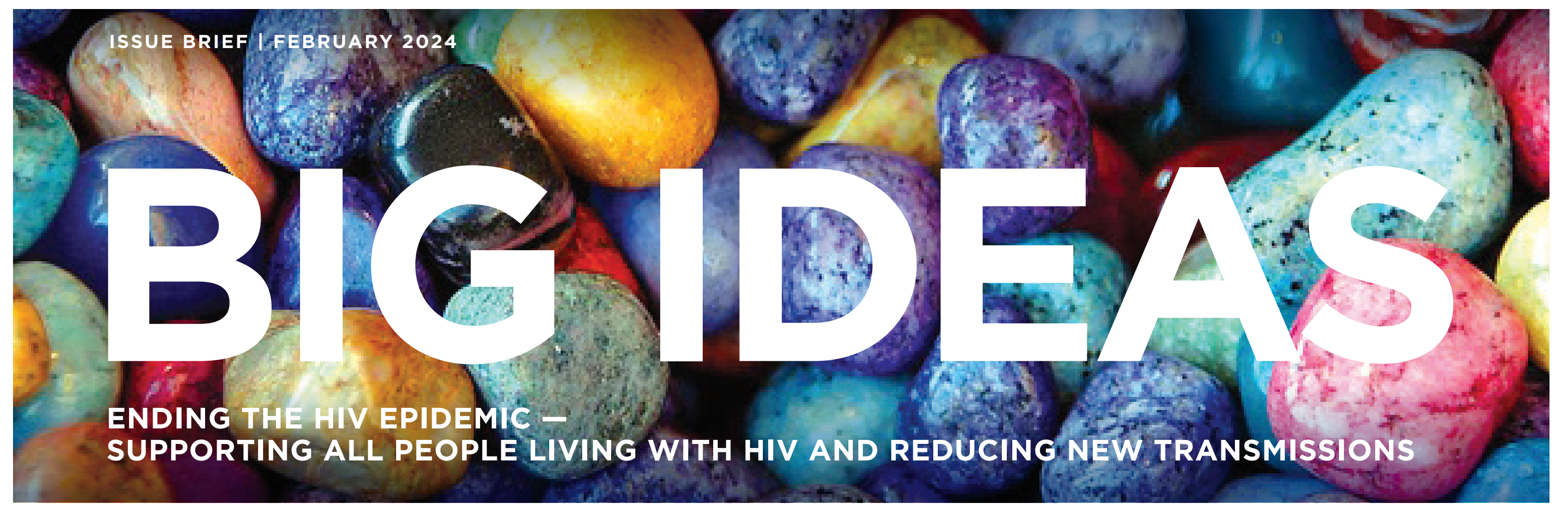


PROMOTING EQUITY IS ESSENTIAL TO EFFECTIVELY IMPLEMENT DOXYCYCLINE AS STI PEP

DOXYCYCLINE, A COMMONLY PRESCRIBED ANTIBIOTIC that has been in use for more than fifty years, recently has been shown to be useful in preventing the bacterial sexually transmitted infections (STIs) chlamydia, gonorrhea, and syphilis.[1] This offers a new tool for preventing STIs when administered as post-exposure prophylaxis (PEP); that is, after sex, as part of a comprehensive sexual health intervention that also includes risk reduction counseling, STI screening and treatment, recommended vaccinations, and linkage to HIV pre-exposure prophylaxis (PrEP) and HIV PEP, HIV care, or other services. The Centers for Disease Control and Prevention (CDC) is considering public comments on draft guidelines for the use of doxycycline as STI PEP (hereafter doxy PEP) to guide prescribers,[2] but additional policies and actions are needed. The CDC draft guidelines recommend doxy PEP only for populations at elevated risk for these STIs, specifically gay, bisexual and other men who have sex with men (MSM) and transgender women with at least one bacterial STI in the last 12 months. These STIs are often asymptomatic and undetected in these populations, however, suggesting that a broader range of MSM and transgender women (and possibly other populations) could benefit from doxy PEP based on individual sexual behaviors. Because this is a new intervention that is connected to sex and focused on often stigmatized and marginalized populations, adopting strategies to counter negative public attitudes and

REDUCING STIs AMONG MSM AND TRANSGENDER WOMEN

Policy action is needed to:

EMBRACE A SEXUAL HEALTH PARADIGM

- Center MSM and transgender women as the front-line educators, ambassadors, and implementers of doxy PEP
- Develop pro-active messaging for the general public to counter anti-LGBTQ+ messages and sexual shaming
- Standardize sexual health training during medical education and conduct detailing with clinical providers and clinics

FOCUS ON EQUITY

- CDC and other federal health agencies should fund and encourage their grantees to support and deliver doxy PEP implementation activities that focus on Black and Latinx MSM and transgender women
- HRSA should develop a strategy for implementing doxy PEP that leverages the Health Centers Program and Ryan White HIV/AIDS Program.
- Non-governmental entities, including pharmaceutical manufacturers, foundations, and corporations should fund community efforts to implement doxy PEP

BRIDGE KNOWLEDGE GAPS

- CDC and NIH should convene a cross-agency working group to fund priority studies to maximize the benefits of doxy PEP

ensure that the populations that can benefit the most are aware of, have access to, and are encouraged to use doxy PEP will determine its impact.

While condoms and barrier methods of prevention are considered highly effective at preventing STI acquisition, condom use has never been universal and has been declining among MSM.[3] Doxy PEP offers a new tool for preventing STIs that is more consistent with supporting many users' own sexual health goals and priorities. How this new intervention is integrated into practice is critically important and calls for new approaches to prevention. Acknowledging three concepts can offer a framework for effective implementation:

1. EMBRACE A SEXUAL HEALTH PARADIGM

The benefit of doxy PEP as an intervention is not only that it is a safe, widely available, and relatively inexpensive medication that is easy to use and distribute, but it is the first biomedical STI prevention tool that also is a necessary element of a comprehensive sexual health approach that has the potential to reduce the stigma and shame about sex that complicates STI prevention efforts.

In 2021, the National Academies of Sciences, Engineering and Medicine (NASEM) published a consensus study report funded by CDC to review the current state of STIs in the United States, *Sexually Transmitted Infections: Adopting a Sexual Health Paradigm*.[4] The report is organized around four key areas of action: 1) adopt a holistic sexual health paradigm, 2) broaden ownership and accountability for responding to STIs, 3) bolster existing systems and programs for responding to STIs, and 4) embrace innovation and policy change to improve sexual health. These recommendations may sound intuitive, but they actually represent a sea change in how the nation has sought to prevent and treat STIs. For more than a hundred years, society and public health have focused on individual risk behaviors and behavior change as the primary strategies for countering STIs. We have moralized against sex outside of monogamous heterosexual marriage. This has largely failed for many reasons, but for MSM and transgender people, it offered no path for sexual enjoyment and pleasure. Adopting a sexual health approach is an opportunity to move away from failed strategies by integrating sex, pleasure, and STI prevention and treatment in a broader conception of what it means to be healthy.

POLICY ACTION: Center MSM and transgender women as the front-line educators, ambassadors, and implementers of doxy PEP

MSM and transgender women must be allowed to define for themselves what it means to be sexually healthy, and this may be very different than how cisgender heterosexuals define sexual health for themselves. While MSM and transgender communities overlap, they also have distinct identities and needs. Programs to implement doxy PEP should be established to reinforce community values and norms and should be developed to allow community members to educate and deliver services in ways that are accessible and acceptable to these communities.

- **CDC** should enhance funding for LGBTQ+ organizations through its STD prevention and HIV programs and other parts of the National Centers for HIV, Viral Hepatitis, STD and TB Prevention (NCHHSTP), to articulate and promote a vision for sexual health that proactively promotes the benefits of doxy PEP and provides resources for individuals to access it.

THE U.S. HAS AN STI CRISIS

The United States is facing a serious crisis of STIs.

1 in 5 adults: The CDC estimates that at any given time, one in five U.S. adults has an STI.(1)

Rapidly rising rates: Since 2000, the number of syphilis cases has increased more than five-and-a-half times (up 555%), chlamydia cases have nearly doubled (up 197%) and gonorrhea cases increased by half (up 51%).(2)

MSM and transgender people heavily impacted: STI cases are not evenly spread across the population with gay, bisexual, and other men who have sex with men (MSM) and transgender people being disproportionately impacted. For example, MSM make up 2-3% of the U.S. population yet accounted for 34% of primary and secondary syphilis cases in 2022.(3) Indeed, MSM make up more than two-thirds of new HIV cases, and 10.2% of HIV cases among MSM are attributed to co-infection with chlamydia and/or gonorrhea.(4)

Significant Economic Impact: CDC estimates that STIs cost more than $16 billion per year in direct medical costs.(5)

Sources: (1) Sexually Transmitted Infections Prevalence, Incidence, and Cost Estimates in the United States, Ctrs. For Disease Control & Prevention, https://www.cdc.gov/std/statistics/prevalence-2020-at-a-glance.htm, (last visited Jan. 25, 2024), (2) *CDC's 2022 STI Surveillance Report underscores that STIs must be a public health priority*, Ctrs. For Disease Control & Prevention, https://www.cdc.gov/std/statistics/2022/default.htm (last visited Feb. 15, 2024), (3) Id. 4) Jones J, et al. *Proportion of Incident Human Immunodeficiency Virus Cases Among Men Who Have Sex With Men Attributable to Gonorrhea and Chlamydia: A Modeling Analysis*. 46 Sex Transm. Dis 357,363 (2019), (5) *Reversing the Rise of STI's: Integrating services to address the syndemic of STIs, HIV, substance use, and viral hepatitis*, Ctrs. For Disease Control & Prevention, https://stacks.cdc.gov/view/cdc/128691 (last visited Jan. 25, 2024).

- The **Health Resources and Services Administration (HRSA)** through its Health Centers and the Ryan White HIV/AIDS Programs, along with the **Substance Abuse and Mental Health Services Administration (SAMHSA)** and the **Indian Health Service**, should enhance their efforts not only to educate patients and providers about doxy PEP, but should ensure access to this low-cost intervention for their clients.
- **State and local health departments** should not only hire members of these communities as staff, but also should fund individuals and organizations with the deepest roots into communities that are often overlooked to conduct doxy PEP education and linkage to clinical care.

POLICY ACTION: Develop pro-active messaging for the general public to counter anti-LGBTQ+ messages and sexual shaming

While there is much greater acceptance of LGBTQ+ people in this country compared to a decade ago, we are still living through a period of prejudice and backlash where LGBTQ+ people are facing stigma, discrimination, and the threat of violence. In addition, debates about bodily autonomy have been renewed in the last few years because of controversial decisions regarding gender affirming care and sexual and reproductive health. We must anticipate that opponents of LGBTQ equality will seek to use doxy PEP as a new tool to shame and stigmatize LGBTQ+ people.

- **CDC and state and local health departments** should develop messaging and public communications that introduces doxy PEP to broader audiences within a sexual health framework. Messaging should convey that we all want to live healthy lives, and that STI rates are rising, imposing significant financial burdens on individuals and health care programs, with devastating impacts on neonates and reduced future fertility of sexually active adults. Doxy PEP is a new evidence-based intervention that is currently recommended only for MSM and transgender women, but which could reduce the burden of STIs for other populations and provide evidence that STI PEP offers a pathway for population-level reductions in STIs.
- **HIV and LGBTQ+ organizations** should apply lessons related to the introduction and rollout of HIV PrEP in communities. Regrettably, there was significant sex shaming from both providers and community members tied to HIV PrEP along with unaddressed access issues, and messages of caution that inaccurately suggested that PrEP was only for some people. In implementing doxy PEP, we need educational campaigns, community forums, and other activities that are less judgmental, and more affirmatively positive in promoting sexual health and pleasure and that introduce doxy PEP as an important tool to reduce the risk of acquiring bacterial STIs.
- **Philanthropic organizations and social marketing agencies** should develop messaging, visuals, and social media resources to create acceptance of and excitement for doxy PEP as a way to prevent STIs. CDC has experience with its prior Business and Labor Respond to AIDS initiative, KFF operates its Greater Than HIV social marketing campaigns, and the Ad Council promotes socially conscious public service announcements. These and other agencies have resources that may be able to create knowledge and acceptance of doxy PEP as a critical public health intervention.

1 IN 10 HIV DIAGNOSES IN MSM ARE ATTRIBUTED TO CO-INFECTION WITH CHLAMYDIA AND/OR GONORRHEA

POLICY ACTION: Standardize sexual health training during medical education and conduct detailing with clinical providers and clinics

Primary care and specialist physicians, physician assistants (PAs), Advanced Practice Registered Nurses (APRNs) and other providers receive non-standardized and often inadequate sexual health education during their medical education and many were trained with the same societal beliefs that valued shaming as a tool to curb sexual activity. We currently have a clinical workforce with inadequate capacity to deliver quality sexual health services, especially to sexual and gender minorities whose share of the population is growing with successive generations.[5] Further, a study of STI- and non-STI provider attitudes about doxycycline for STI prevention found the majority of providers in both groups are concerned about resistance, which may limit its use in practice.[6]

- **CDC** should review and implement the Sexually Transmitted Infections: Adopting a *Sexual Health Paradigm*, recommendation 11-1 that provides comprehensive policy actions to improve sexual health education and training. This could include working with accreditation bodies such as the **American Council for Graduate Medical Education** and the **National League for Nursing** to train a new generation of clinical providers in the core precepts of sexual health so they can have the skills to provide the affirming and non-stigmatizing health care (inclusive of sexual health) that gender and sexual minorities need and deserve.
- **Health Departments**, **the National Network of STD Clinical Prevention Training Centers (NNPTC)**, **Title X Family Planning Programs**, **AIDS Education and**

IS DOXYCYCLINE SAFE AND EFFECTIVE?

In developing its draft guidelines, CDC examined several important questions that are raised by the use of doxycycline as PEP(1). These include:

Is it safe? Doxycycline first received FDA approval in 1967. It is used for a range of conditions including as prophylaxis or treatment for malaria and Lyme disease, as well as to treat acne and rosacea. It is well-absorbed and tolerated with a half-life of roughly twelve hours. Adverse events associated with doxycycline are typically not severe and include photosensitivity and gastrointestinal symptoms that went away when it was discontinued.(2) Further studies are needed to assess the safety of doxycycline for long-term use at the dosages in the current doxy PEP regimen.

Is it effective for MSM and transgender women (TGW)? A 2015 study of MSM with HIV showed promise of doxycycline as STI PrEP,(3) but additional follow-up studies have not been conducted to support recommending it as PrEP at this time. CDC reviewed three recent studies, however, of doxycycline as PEP for MSM and TGW:

IPERGAY (OPEN-LABEL EXTENSION)(4)

Population	Intervention	Results
Randomized MSM/TGW HIV PrEP users (TDF/FTC)	200mg doxycycline 24-72 hours after condomless anal or oral sex up to 3x per week vs. no medication	• Chlamydia: HR: 0.30 (CI: 0.13-0.70) • Syphilis: HR: 0.27 (CI: 0.07-0.98) • Gonorrhea: HR: 0.83 (CI: 0.47-1.47) **Results show a 70% reduction in chlamydia and syphilis and a non-statistically significant reduction in gonorrhea cases**

SAN FRANCISCO/SEATTLE DOXYPEP(5)

Population	Intervention	Results
Randomized MSM/TGW HIV PrEP users + People with HIV with history of condomless sex and STI in past 12 months	200mg doxycycline 24-72 hours after sex up to once every 24 hours vs. no medication	• Chlamydia: PrEP RR: 0.12 (CI: 0.05-0.25) — HIV RR: 0.26 (CI: 0.12-0.57) • EARLY Syphilis: PrEP RR: 0.13 (CI: 0.03-0.59) — HIV RR: 0.23 (CI: 0.04-1.29) • Gonorrhea: PrEP RR: 0.45 (CI: 0.34-0.65) — HIV RR: 0.43 (CI: 0.26-0.71) **Results show more than a 70% reduction in chlamydia, more than a 75% reduction in early syphilis, and more than a 55% reduction in gonorrhea. Study stopped early due to effectiveness**

FRENCH ANRS DOXYVAC(6)

Population	Intervention	Results
Randomized MSM HIV PrEP users with at least one STI in past 12 months	200mg doxycycline 24-72 hours after sex vs. no medication and then randomized to receiving or not 4CMenB vaccine approved for individuals 10-25 for *Neisseria meningitdis* serogroup B with potential effectiveness against gonorrhea	• Chlamydia: aHR: 0.11 (CI: 0.04-0.30) • Syphilis: aHR: 0.21 (CI: 0.09-0.47) •Gonorrhea: aHR: 0.49 (CI: 0.32-0.76) **Results showed nearly a 90% reduction in chlamydia, nearly an 80% reduction in syphilis, and a 50% reduction in gonorrhea. Study stopped early due to effectiveness**

Sources: (1) *Guidelines for the use of doxycycline post-exposure prophylaxis for bacterial sexually transmitted infection prevention*, Ctrs. For Disease Control, https://www.cdc.gov/std/treatment/guidelines-for-doxycycline.htm, (last visited Feb. 1, 2024), (2) Doxycycline use and adverse events, Ctrs. For Disease Control, https://www.cdc.gov/std/treatment/doxy-adverse-events-toe.htm, (last visited Feb. 1, 2024), (3) Bolan RK et al. *Doxycycline prophylaxis to reduce incident syphilis among HIV-infected men who have sex with men who continue to engage in high-risk sex: a randomized, controlled pilot study. 42* Sex Transm Dis. 98,103 (2015) (4) Molina JM et al. *Post-exposure prophylaxis with doxycycline to prevent sexually transmitted infections in men who have sex with men: an open-label randomised substudy of the ANRS IPERGAY trial. 18* Lancet Infect Dis. 308,317 (2018), (5) Luetkemeyer AF et al. *Postexposure Doxycycline to Prevent Bacterial Sexually Transmitted Infections. 388* N Engl. J. Med. *1296,1306 (2023)*, and, (6) *Molina JM et al. ANRS 174 DOXYVAC: An Open-Label Randomized Trial to Prevent STIs in MSM on PrEP. CROI [Internet]. 2023 Feb 19;Seattle, Washington.*

WHAT HAS BEEN OBSERVED REGARDING DOXY PEP AND DRUG RESISTANCE?

Antimicrobial resistance is a serious issue that threatens the safety and effectiveness of a broad range of antibiotics and other therapeutics. Arising naturally, but spurred on by over-use in agriculture and medicine, concern over resistance is leading to greater efforts to provide proper stewardship of effective therapeutics. This causes legitimate questions to be raised over whether the benefits of use of doxycycline outweigh the potential risks of resistance.

CDC's draft guidance provides the available evidence related to resistance from the three previously cited studies of doxy PEP in MSM and transgender women. These data, however, do not provide a context for understanding this information. An article describing the San Francisco/Seattle DoxyPEP study, however, provides a useful way to interpret these initial observations on resistance. Annie Leutkemeyer, MD a co-principal investigator of the study stated that, "this isn't a choice between antibiotics and no antibiotics in men and transgender women with a history of recurrent STIs. The alternative here for many is repeated STIs that lead to recurrent antibiotics. Doxy PEP may mitigate the amount of antibiotics used, including broader spectrum antibiotics like ceftriaxone, the use of which was reduced by 50% by those taking doxy PEP." The study examined resistance in 1) gonorrhea, 2) *Staphylococcus aureus* that lives on the skin and, 3) non-disease-causing *Neisseria* species that live in the throat. Researchers found:

- More tetracycline resistant gonorrhea (30% vs 11%) in those taking doxy PEP than those not taking it, which suggests that doxy PEP may be less protective against strains of gonorrhea that already have tetracycline resistance. More studies are needed to determine if doxy PEP use increases tetracycline resistance in gonorrhea.
- Doxy PEP reduced colonization by *Staphylococcus aureus* from 44% to 31%, but the cultures resistant to doxycycline went up from 5% to 13%, a small but statistically significant increase. There was no increase in methicillin-resistant *Staphylococcus aureus* (MRSA) overall or with doxycycline-resistant MRSA.
- *Neisseria* species live in the throat without causing disease and can be a reservoir for resistance genes. Neisseria species did not appear to be affected by doxy PEP use.

Limiting antimicrobial exposure is an important objective to prevent antibiotic resistance and must be carefully balanced with the potential benefits of doxy PEP. The high prevalence of STIs among MSM and transgender women influences the calculation of net benefit for these populations. The balance may be different for other populations with lower STI prevalence.

Sources: "Doxycycline for STI Prevention: Highly Effective, Minimal Drug Resistance," Laura Kurtzman, University of California San Francisco, February 22, 2023, available at https://www.ucsf.edu/news/2023/02/424861/doxycycline-sti-prevention-highly-effective-minimal-drug-resistance.

Training Centers (AETCs), and the **Heath Centers Program** should fund detailing efforts (face-to-face education of providers about a product or intervention to support its use in clinical practice). This should include education in the concepts of sexual health, and a forthright discussion of antimicrobial stewardship that gives current evidence in support of the use of doxy PEP for MSM and transgender women.

2. FOCUS ON EQUITY

If the goal of an intervention is to produce the largest possible public health benefit, then it is imperative that implementation efforts are focused on equity. Time and again, when we have implemented interventions and assumed that all people could benefit, racial and ethnic minorities, lower-income people, and sexual and gender minorities have been left behind. When COVID-19 testing was first rolled out, in place after place, testing sites were either located in more affluent and largely white communities, or when they were located in lower-income communities, they were still inaccessible, such as by setting up drive-through testing sites accessible only to people with cars.[7] The states with the highest rates of STIs are often those with the greatest access barriers and where a far larger share of the population are people of color than the nation as a whole.[8]

Implementation of HIV PrEP offers perhaps the most salient example of what happens when equity is not a central implementation focus from the outset. HIV PrEP was approved by the Food and Drug Administration (FDA) in 2012. CDC recently published estimates of PrEP use in 2022 that show that while 94% of white people with an indication for PrEP were using it, only 24% of Latinx and 13% of Black people with an indication for PrEP were using it.[9] AIDSVu analyzed these data and found that as PrEP use has increased, equity has decreased. Regionally, Black people made up 52% of new HIV diagnoses in the

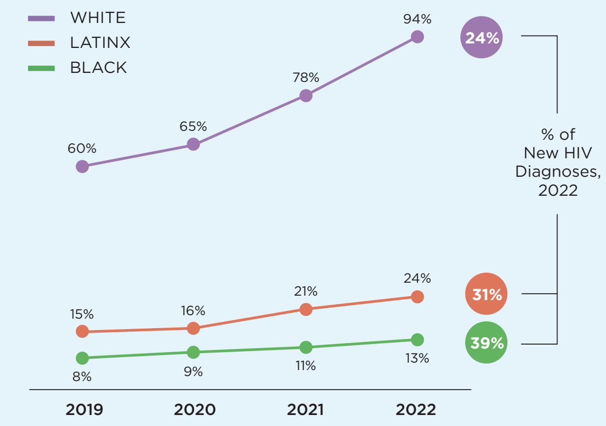
South, but only 21% of PrEP users; in the Midwest, Black people made up 48% of new HIV diagnoses, but only 12% of PrEP users. Additionally, they found that in 2022, there were only 5 Black PrEP users for every Black HIV diagnosis and only 9 Latinx PrEP users for every Latinx HIV diagnosis, compared to 36 white PrEP users for every white HIV diagnosis.[10] The success of doxy PEP may hinge on pro-actively countering these inequities from the beginning. To monitor doxy PEP coverage (i.e., the proportion of the population using the intervention), emerging disparities, and population-level impact, CDC and their health department partners will need estimates of the population that can benefit from the intervention by race/ethnicity, and other relevant demographic information, applying lessons from HIV PrEP monitoring activities.

POLICY ACTION: CDC and other federal health agencies should fund and encourage their grantees to support and deliver doxy PEP implementation activities that focus on Black and Latinx MSM and transgender women.

CDC and other federal agencies and their health department partners have a critical role in creating the infrastructure to educate about doxy PEP, provide guidance to integrate doxy PEP services with HIV and STI screening and treatment, and support a network of publicly funded clinics. Eighty percent of STIs are reported, however, from non-STD clinics.[11] While support for safety net clinics remains critical, the most effective outreach and messaging likely will come from non-governmental partners. Therefore, CDC and state and local health departments need to prioritize funding for community-based organizations led and trusted by Black and Latinx MSM and transgender people. Additionally, public health has long recognized the value of community leaders in engaging diverse communities, whether it is through barbershops, faith institutions, or social clubs.[12] For MSM and transgender communities, key partners may include event promoters, social media influencers, bartenders, and others. To support such individuals to promote sexual health and the use of doxy PEP, new avenues for training and engagement are needed. This may include funding educational retreats, offering webinars and trainings, creating new LGBTQ Lay Health Educator certifications, or other means of creating a community of sexual health ambassadors and connecting them to researchers and clinical providers so that their work is based on the latest clinical information.

U.S. PREP USE, BY RACE AND ETHNICITY

PERCENTAGE OF POPULATION WITH AN INDICATION FOR PREP USING IT AND SHARE OF NEW HIV DIAGNOSES



SOURCE: Sources: Centers for Disease Control, *Overall Trends in PrEP Prescriptions Among People Who Could Benefit, 2019-2022*, CDC Division of HIV Prevention: Dear Colleagues (October 17, 2023), https://www.cdc.gov/hiv/policies/dear-colleague/dcl/20231017.html. and *NCHHSTP AtlasPlus*, Ctrs. For Disease Control & Prevention, https://www.cdc.gov/nchhstp/atlas/index.htm (last visited Feb. 1, 2024).

POLICY ACTION: HRSA should develop a strategy for implementing doxy PEP that leverages the Health Centers Program and Ryan White HIV/AIDS Program.

HRSA is the prime federal agency to provide leadership in extending doxy PEP access both through its Health Center Program and the Ryan White HIV/AIDS Program. They also have experience working with the Centers for Medicare and Medicaid Services (CMS) to provide leadership and technical assistance to Medicaid and Medicare programs. Indeed, the Ryan White HIV/AIDS Program has a proven track record at improving equity in HIV outcomes that should be applied to doxy PEP implementation. CDC reports that in 2021, only 66% of all people with HIV were virally suppressed.[13] Within the Ryan White HIV/AIDS Program, however, in 2022, 89.6% of all clients were virally suppressed, including 87.1% of Black clients and 91.3% of Latinx clients.[14]

POLICY ACTION: Non-governmental entities, including pharmaceutical manufacturers, foundations, and corporations should fund community efforts to implement doxy PEP.

Doxycycline is a generic medication and there are no company-sponsored access programs. Non-governmental resources are needed to: 1) support sexual health messaging and communications by MSM and transgender communities that are not constrained by governmental clearance processes, 2) purchase medication and pay for related services for the uninsured, in limited circumstances; and, 3) integrate doxy PEP messaging as part of a sexual

CRITICAL QUESTIONS REQUIRE A COMPREHENSIVE RESEARCH AGENDA

As doxy PEP is a new intervention that offers great promise, it will be important to develop a prioritized research agenda that tackles critical questions, including:

1. **IS DOXYCYCLINE VIABLE AS STI PrEP?**

   Doxycycline has been shown to be effective as PEP, but questions about its effectiveness suggest that the timing of dosing is important. This further raises questions as to whether it is best delivered as PrEP or PEP. As stated previously, a 2015 study found that doxycycline was effective as PrEP among MSM with HIV. Further studies must be conducted to evaluate this for different populations, and to compare the relative effectiveness of daily doxy PrEP, event-driven doxy PrEP, and doxy PEP.

2. **WHAT ARE KEY ELEMENTS OF A DOXYCYCLINE RESISTANCE MONITORING PLAN?**

   In recommending doxy PEP, CDC is indicating that their judgment is that the limited resistance observed is outweighed by the clinical benefits for MSM and transgender women. It will be essential, however, to create a monitoring plan, consider new resistance reporting requirements, and educate providers, doxy PEP users and potential users, and policymakers about how to understand and interpret available data on resistance.

3. **IS LONG-TERM USE OF DOXYCYCLINE SAFE AND WHAT IS THE IMPACT ON THE MICROBIOME?**

   To date, doxy PEP studies have evaluated safety for only up to 12 months. Longer-term studies for other uses of doxycycline have looked at lower doses. Further, there are no data on the intermittent use of doxycycline. Additional safety assessments are needed as this new use of doxycycline is put into practice. A related issue is the impact of doxycycline on the microbiome. The use of antibiotics has been described as akin to clear-cutting a forest wherein they indiscriminately wipeout the flora of the gut microbiome, which is believed to be essential for maintaining health. Studies are needed to assess the impact of extended use of doxycycline on the microbiome, and how this affects overall health. Further, research must elucidate proactive steps that can be taken to protect or reconstitute the microbiome during or after using doxycycline.

4. **WHAT ARE OPTIMAL WAYS TO USE DOXYCYCLINE TO BOTH ACHIEVE PUBLIC HEALTH IMPACT AND REDUCE THE RISK OF RESISTANCE?**

   CDC's draft guidance is based on available evidence yet is limited by gaps in knowledge. The guidance states that it is safe to take 200mg of doxycycline daily and it should be taken within 72 hours of a sexual encounter. Given concerns over the microbiome and side-effects from long term use, many users will make decisions about how to use doxycycline in the absence of additional data. Some MSM and transgender women may be more sexually active than others. Even if it is safe, should they take doxycycline daily, day after day? Are there alternative dosing strategies that may reduce exposure to doxycycline without impacting its effectiveness? It will be important for NIH, CDC and health departments to conduct consultations with community members to inform a research agenda and also to create avenues for doxy PEP educators and ambassadors to answer questions in an evidence-informed way even when evidence-based answers for user questions may not be available.

5. **IS DOXY PEP APPROPRIATE FOR OTHER POPULATIONS?**

   CDC draft guidance says that no recommendation is given for cisgender women, cisgender heterosexual men, transgender men, and other queer and nonbinary individuals because of insufficient evidence to assess the balance of benefits and harms of doxy PEP in these populations. Notably, it does not say that doxy PEP should not be offered to these other populations. A randomized trial from 2020 to 2022 of cisgender women in Kenya found no reduction in bacterial STIs, but analysis of hair samples detected doxycycline in only 44% of participants suggesting that lack of use of this intervention may have led to this result (Stewart J et al. Doxycycline Prophylaxis to Prevent Sexually Transmitted Infections in Women. New England Journal of Medicine. 2023). Additional studies among these populations are needed and consideration must be given to how to use population prevalence of STIs and the number needed to treat to guide recommendations for use of doxy PEP for other populations.

health package of actions when pharmaceutical manufacturers are promoting their products.

3. BRIDGE KNOWLEDGE GAPS

Available evidence suggests that doxy PEP is safe and effective, yet we have much to learn about how to maximize its public health impact. Various parts of HHS can contribute to understanding how to best use doxy PEP and they must come together and delineate responsibilities for working collaboratively.

POLICY ACTION: CDC and NIH should convene a cross-agency working group to fund priority studies to maximize the benefits of doxy PEP.

To ensure that doxy PEP is implemented in ways that prioritize the populations of MSM and transgender women with the greatest needs, there is a need for a cross-agency research strategy that sets clear priorities and delineates lead agency responsibilities. CDC's Division of STD Prevention (DSTDP) and the National Institutes of Health (NIH) National Institute of Allergy and Infectious Diseases (NIAID) both have critical expertise and lead responsibility for answering many of these research questions. Either these agencies working together, or some other component of the Department of Health and Human Services (HHS), should establish a broadly-represented cross-agency working group to establish a doxy PEP research plan. This working group should consult broadly with various stakeholders including clinicians, researchers public health professionals, and community-based services providers with a special emphasis on engaging affected communities in meaningful ways.

THE TIME IS NOW

MSM and transgender women in the U.S. face high and often rising rates of chlamydia, gonorrhea, and syphilis. Doxycycline as PEP offers an important new tool to prevent these infections. Policymakers must prioritize the Black and Latinx communities that rarely receive sufficient culturally and linguistically congruent health services by partnering with individuals and organizations to deliver affirming messaging and sexual health services. While acknowledging uncertainty and carefully monitoring for the emergence of drug resistance, policymakers and health care providers must not allow unsubstantiated fears to negate the potential benefits of doxy PEP for MSM and transgender women.

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FEBRUARY 2024

Prepared by **Jeffrey S. Crowley**. Critical input was provided by **Leandro Mena, MD** (former Director, CDC Division of STD Prevention) and **Greg Millett**, amfAR.

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PROMOTING EQUITY IS ESSENTIAL TO EFFECTIVELY IMPLEMENT DOXYCYCLINE AS STI PEP

DOXYCYCLINE, A COMMONLY PRESCRIBED ANTIBIOTIC that has been in use for more than fifty years, recently has been shown to be useful in preventing the bacterial sexually transmitted infections (STIs) chlamydia, gonorrhea, and syphilis. This offers a new tool for preventing STIs when administered as post-exposure prophylaxis (PEP); that is, after sex, as part of a comprehensive sexual health intervention that also includes risk reduction counseling, STI screening and treatment, recommended vaccinations, and linkage to HIV pre-exposure prophylaxis (PrEP) and HIV PEP, HIV care, or other services. The Centers for Disease Control and Prevention (CDC) is considering public comments on draft guidelines for the use of doxycycline as STI PEP (hereafter doxy PEP) to guide prescribers, but additional policies and actions are needed for this intervention to be successfully implemented. The CDC draft guidelines recommend doxy PEP only for populations at elevated risk for these STIs, specifically gay, bisexual and other men who have sex with men (MSM) and transgender women with at least one bacterial STI in the last 12 months. These STIs are often asymptomatic and undetected in these populations, however, suggesting that a broader range of MSM and transgender women (and possibly other populations) could benefit from doxy PEP based on individual sexual behaviors.

THE U.S. HAS AN STI CRISIS

1 in 5 adults: The CDC estimates that at any given time, one in five U.S. adults has an STI.

Rapidly rising rates: Since 2000, the number of syphilis cases has increased more than five-and-a-half times (up 555%), chlamydia cases have nearly doubled (up 197%) and gonorrhea cases increased by half (up 51%).

MSM and transgender people heavily impacted: MSM make up 2-3% of the U.S. population yet accounted for 34% of primary and secondary syphilis cases in 2022 and roughly two-thirds of new HIV cases.

Significant Economic Impact: CDC estimates that STIs cost more than $16 billion per year in direct medical costs.

REDUCING STIs AMONG MSM AND TRANSGENDER WOMEN

How this new intervention is integrated into practice is critically important and calls for new approaches to prevention:

1. EMBRACE A SEXUAL HEALTH PARADIGM

The benefit of doxy PEP as an intervention to prevent STIs among MSM and transgender women is not only that is it a safe, widely available, and relatively inexpensive medication that is easy to use and distribute, but it is the first biomedical STI prevention tool that also is a necessary element of a comprehensive sexual health approach that has the potential to reduce the stigma and shame about sex that complicates STI prevention efforts.

POLICY ACTION: Center MSM and transgender women as the front-line educators, ambassadors, and implementers of doxy PEP

POLICY ACTION: Develop pro-active messaging for the general public to counter anti-LGBTQ+ messages and sexual shaming

POLICY ACTION: Standardize sexual health training during medical education and conduct detailing with clinical providers and clinics

2. FOCUS ON EQUITY

Time and again, when we have implemented interventions and assumed that all people could benefit, racial and ethnic minorities, lower-income people, and sexual and gender minorities have been left behind. CDC recently published estimates of HIV PrEP use in 2022 that show that while 94% of white people with an indication for PrEP were using it, only 24% of Latinx and 13% of Black people with an indication for PrEP were using it. AIDSVu analyzed these data and found that there were only 5 Black PrEP users for every Black HIV diagnosis and only 9 Latinx PrEP users for every Latinx HIV diagnosis, compared to 36 white PrEP users for every white HIV diagnosis. The success of doxy PEP may hinge on pro-actively countering these inequities from the beginning.

POLICY ACTION: CDC and other federal health agencies should fund and encourage their grantees to support and deliver doxy PEP implementation activities that focus on Black and Latinx MSM and transgender women

POLICY ACTION: HRSA should develop a strategy for implementing doxy PEP that leverages the resources of the Health Centers Program and Ryan White HIV/AIDS Program

POLICY ACTION: Non-governmental entities, including pharmaceutical manufacturers, foundations, and corporations should fund community efforts to educate and implement doxy PEP

IS DOXYCYCLINE SAFE AND EFFECTIVE?

CDC REVIEWED THREE RECENT STUDIES OF DOXYCYCLINE AS PEP FOR MSM AND TRANSGENDER WOMEN.

IPERGAY (open-label extension)

Results show a 70% reduction in chlamydia and syphilis and a non-statistically significant reduction in gonorrhea cases.

San Francisco/Seattle DoxyPEP

Results show more than a 70% reduction in chlamydia, more than a 75% reduction in early syphilis, and more than a 55% reduction in gonorrhea. Study stopped early due to effectiveness.

French ANRS DOXYVAC

Results showed nearly a 90% reduction in chlamydia, nearly an 80% reduction in syphilis, and a 50% reduction in gonorrhea. Study stopped early due to effectiveness.

WHAT HAS BEEN OBSERVED REGARDING DOXY PEP AND DRUG RESISTANCE?

Antimicrobial resistance is a serious issue that threatens the safety and effectiveness of a broad range of antibiotics and other therapeutics. This causes legitimate questions to be raised over whether the benefits of use of doxycycline outweigh the potential risks of resistance.

Annie Leutkemeyer, MD a co-principal investigator of the San Francisco/Seattle DoxyPEP study stated that, “this isn’t a choice between antibiotics and no antibiotics in men and transgender women with a history of recurrent STIs. The alternative here for many is repeated STIs that lead to recurrent antibiotics. Doxy PEP may mitigate the amount of antibiotics used, including broader spectrum antibiotics like ceftriaxone, the use of which was reduced by 50% by those taking doxy PEP.”

San Francisco/Seattle researchers found:

- More tetracycline resistant gonorrhea (30% vs 11%) in those taking doxy PEP than those not taking it, which suggests that doxy PEP may be less protective against strains of gonorrhea that already have tetracycline resistance.
- Doxy PEP reduced colonization by *Staphylococcus aureus* from 44% to 31%, but the cultures resistant to doxycycline went up from 5% to 13%, a small but statistically significant increase. There was no increase in methicillin-resistant *Staphylococcus aureus* (MRSA) overall or with doxycycline-resistant MRSA.
- *Neisseria* species found in the throat did not appear to be affected by doxy PEP use.

Limiting antimicrobial exposure is an important objective to prevent antibiotic resistance and must be carefully balanced with the potential benefits of doxy PEP. The high prevalence of STIs among MSM and transgender women influences the calculation of net benefit for these populations. The balance may be different for other populations with lower STI prevalence.

3. BRIDGE KNOWLEDGE GAPS

Available evidence suggests that doxy PEP is safe and effective at preventing STIs in MSM and transgender women when administered after sex, yet we have much to learn about how to maximize its public health impact.

POLICY ACTION: CDC and NIH should convene a cross-agency working group to fund priority studies to maximize the benefits of doxy PEP

DOXYCYCLINE AS PEP offers an important new tool to prevent STIs. Policymakers must prioritize the Black and Latinx communities that rarely receive sufficient culturally and linguistically congruent health services by partnering with individuals and organizations to deliver affirming messaging and sexual health services. While acknowledging uncertainty and carefully monitoring for the emergence of drug resistance, policymakers and health care providers must not allow unsubstantiated fears to negate the potential benefits of doxy PEP for MSM and transgender women.

CRITICAL QUESTIONS REQUIRE A COMPREHENSIVE RESEARCH AGENDA

It will be important to develop a prioritized research agenda that tackles critical questions, including:

1. **Is doxycycline viable as STI PrEP?**
2. **What are key elements of a doxycycline resistance monitoring plan?**
3. **Is long-term use of doxycycline safe and what is the impact on the microbiome?**
4. **What are optimal ways to use doxycycline to BOTH achieve public health impact and reduce the risk of resistance?**
5. **Is doxy PEP appropriate for other populations?**

FEBRUARY 2024

This summarizes a Big Ideas issue brief that is available at the link below. It is a product of the HIV Policy Project of the **O’Neill Institute for National and Global Health Law** and is supported by a grant from ***Gilead Sciences, Inc.*** Gilead Sciences, Inc. has had no input into the development or content of this brief.

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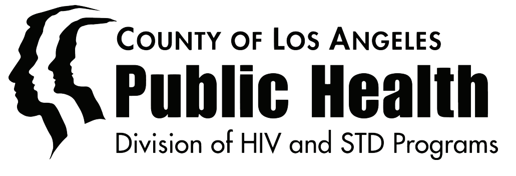

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