LOS ANGELES COUNTY
COMMISSION ON HIV

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PUBLIC POLICY COMMITTEE

Virtual Meeting

Monday, October 3, 2022

1:00PM-3:00PM (PST)

***Meeting Agenda + Packet will be available on our website at: http://hiv.lacounty.gov/Public-Policy-Committee**

REGISTER VIA WEBEX ON YOUR COMPUTER OR SMART PHONE:

https://tinyurl.com/49ym734e

**Link is for non-Committee members only*

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PUBLIC COMMENTS

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 via https://www.surveymonkey.com/r/PUBLIC_COMMENTS .

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

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LOS ANGELES COUNTY
COMMISSION ON HIV

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

PUBLIC POLICY COMMITTEE

MONDAY, October 3, 2022 | 1:00 PM – 3:00 PM

To Join by Computer:

https://tinyurl.com/49ym734e

Link is for non-committee members only

To Join by Phone: 1-415-655-0001
Access code: 2599 526 8017

Public Policy Committee Members:			
Katja Nelson, MPP Co-Chair	Lee Kochems, MA Co-Chair	Alasdair Burton, (Alternate)	Felipe Findley
Jerry D. Gates, PhD	Eduardo Martinez (Alternate)	Ricky Rosales	Martin Sattah, MD
Courtney Armstrong			
QUORUM: 5			

AGENDA POSTED September 28, 2022

VIRTUAL MEETINGS: Assembly Bill (AB) 361 amends California's Ralph M. Brown Act Section 54953 to allow virtual board meetings during a state of emergency. Until further notice, all Commission meetings will continue to be held virtually via WebEx. For a schedule of Commission meetings, please click here.

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 via https://www.surveymonkey.com/r/PUBLIC_COMMENTS. 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.

SUPPORTING DOCUMENTATION can be obtained at the Commission on HIV Website at: http://hiv.lacounty.gov. The Commission Offices are located at 510 S. Vermont Ave. 14th Floor, one building North of Wilshire on the eastside of Vermont just past 6th Street. Validated parking is available.

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

If a stakeholder is interested in joining the meeting to keep abreast of or participate in consideration of a specific agenda item, the Commission suggests that the stakeholder plan on attending the full meeting in case the agenda order is modified or timing of the items is altered. All Commission committees make every effort to place items that they are aware involve external stakeholders at the top of the agenda in order to address and resolve those issues more quickly and release visiting participants from the obligation of staying for the full meeting.

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

Call to Order, Introductions and Check-in, Conflict of Interest Statements 1:00 PM – 1:05 PM

I. ADMINISTRATIVE MATTERS 1:05 PM – 1:08 PM

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

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

II. PUBLIC COMMENT 1:08 PM – 1:10 PM

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

III. COMMITTEE NEW BUSINESS ITEMS 1:10 PM – 1:15 PM

4. 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.

IV. REPORTS

5. Executive Director/Staff Report 1:15 PM – 1:20 PM
   a. Operational and Staffing Updates

6. Co-Chair Report 1:20 PM – 1:45 PM
   a. Act Now Against Meth (ANAM) Update
   b. Workplan updates

V. DISCUSSION ITEMS

7. Legislative Docket 1:45 PM – 1:50 PM

8. Policies Priority – Action Plan 1:50 PM – 2:10PM

9. State Policy & Budget Update 2:10 PM – 2:20 PM

10. Federal Policy Update 2:20 PM – 2:30 PM

11. County Policy Update 2:30 PM – 2:50 PM
   a. COH Response to the STD Crisis

VI. NEXT STEPS 2:50 PM – 2:55 PM

12. Task/Assignments Recap

13. Agenda development for the next meeting

VII. ANNOUNCEMENTS 2:55 PM – 3:00 PM

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

VIII. ADJOURNMENT 3:00 PM

15. Adjournment for the meeting of October 3, 2022

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

LOS ANGELES COUNTY COMMISSION ON HIV

510 S. Vermont Ave., 14th Floor• Los Angeles, CA 90020 • TEL (213) 738-2816 •
FAX (213) 637-4748HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov ORG •
VIRTUAL WEBEX MEETING

Presence at virtual 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.

Draft

PUBLIC POLICY COMMITTEE MEETING MINUTES

September 12, 2022

COMMITTEE MEMBERS P = Present | A = Absent |EA = Excused Absence			
Katja Nelson, MPP, Co-Chair	P	Eduardo Martinez (Alternate)	A
Lee Kochems, MA, Co-Chair	P	Ricky Rosales	P
Alasdair Burton (Alternate)	P	Martin Sattah, MD	P
Felipe Findley	P	Courtney Armstrong	P
Jerry Gates, PhD	P		
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Catherine Lapointe, Jose Rangel-Garibay			

*Some participants may not have been captured electronically. 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 agenda and materials can be found on the Commission's website at https://assets-us-01.kc-usercontent.com/0234f496-d2b7-00b6-17a4-b43e949b70a2/95eb2848-b50f-4996-8396-5d8e023f7171/Pkt-PPC-091222-Revised.pdf

CALL TO ORDER-INTRODUCTIONS-CONFLICTS OF INTEREST

Katja Nelson, Co-Chair, called the meeting to order at 1:05 PM, welcomed attendees, and led introductions.

I. ADMINISTRATIVE MATTERS

1. APPROVAL OF AGENDA

MOTION #1: Approval of the Agenda Order as presented or revised (✓Passed by Consensus)

2. APPROVAL OF MEETING MINUTES

MOTION #2: Approve the August 2, 2022 Public Policy Committee meeting minutes as presented or revised (✓Passed by Consensus)

II. PUBLIC COMMENT

3. OPPORTUNITY FOR MEMBERS OF THE PUBLIC TO ADDRESS THE COMMISSION ON ITEMS OF INTEREST THAT ARE WITHIN THE JURISDICTION OF THE COMMISSION. *There were no public comments.*

III. COMMITTEE NEW BUSINESS ITEMS

4. 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

5. EXECUTIVE DIRECTOR/STAFF REPORT

a. Operational Updates

- Cheryl Barrit reported that AJ King, Comprehensive HIV Plan (CHP) Consultant, will present the first draft of the CHP to the Planning, Priorities and Allocations (PP&A) Committee and the Division of HIV and STD Programs (DHSP) for feedback. C. Barrit reminded the Public Policy Committee (PPC) that PP&A will be meeting on September 27th instead of their regularly scheduled September 20th meeting to allow commissioners to attend the Presidential Advisory Council on HIV/AIDS (PACHA) Conference on September 19th and 20th. K. Nelson asked how many commissioners are planning to attend PACHA in-person. C. Barrit noted that she is not yet certain how many commissioners will be in attendance.
- C. Barrit reported that in June 2022, the Board of Supervisors (BOS) had issued a press release stating that in-person meetings would resume when COVID-19 transmission levels were categorized as "low" for seven consecutive days. On Friday, September 9th, the BOS announced that the BOS will resume in-person meetings on September 27th. Commission on HIV (COH) staff will be working with the Executive Office and the County Counsel to receive guidance on how the COH will vote to either continue meeting virtually or resume in-person meetings.
- The PPC held a robust discussion on how in-person meetings would reconvene. Lee Kochems asked if the COH votes would apply to all committees. C. Barrit responded that the vote would apply to the full-body COH meetings and the five committee meetings. Task Forces, Workgroups, and Caucuses would be able to continue meeting virtually. Dr. Martin Sattah asked if in-person meetings would only be for commissioners and not members of the public. C. Barrit responded at AB 361 allows for remote participation for commissioners. K. Nelson asked if commissioners need to be physically present for the full-body COH meetings and their respective Committee meetings. C. Barrit responded that commissioners can still attend

meetings remotely under AB 361. Alasdair Burton inquired if there will be a visual component for hybrid meetings. C. Barrit responded that the COH will continue to use Webex for hybrid meetings. L. Kochems inquired if commissioners will still be able receive stipends if they cannot attend in-person meetings. C. Barrit assured that virtual participation still counts for attendance and commissioners will still receive stipends.

6. CO-CHAIR REPORT

a. Act Now Against Meth (ANAM) Update
The Wall Las Memorias

- Jose Magana, Community Organizer, The Wall Las Memorias, provided an update on the Act Now Against Meth (ANAM) Coalition. On July 26th, the BOS passed a motion requesting various county departments to report back within 120 on an updated plan of action on addressing the drug crisis in LA County. ANAM will review the feedback in December.
- K. Nelson asked J. Magana how members of the public can join ANAM meetings. He directed the group to Guilmar Perdomo who can be reached at (323) 257-1056 ext. 30.

b. Workplan Updates

- K. Nelson provided an overview of the PPC 2022 workplan. See meeting packet for details. The PPC will discuss Task/Activity #7: Develop a white paper about the need to reauthorize the Ryan White CARE Act at the 2022 COH Annual Meeting.

V. DISCUSSION ITEMS

7. LEGISLATIVE DOCKET

- The Governor has until the end of the month to sign bills into law, not sign bills into law, or veto any bills.
- SB 57 (Wiener): Controlled substances: overdose prevention program was vetoed. The veto message can be found in the meeting packet.
- SB 1338 (Umberg): Community Assistance, Recovery, and Empowerment (CARE) Court Program was signed into law.

8. POLICIES PRIORITY – PRIORITIES

MOTION #3: Approve the 2022-2023 Policy Priorities document, as presented or revised, and move to the Executive Committee for approval. ✓Passed by Unanimous Roll Call Vote (M. Sattah, R. Rosales, J. Gates, F. Findley, A. Burton, L. Kochems, and K. Nelson)

- L. Kochems and K. Nelson provided an overview of the PPC 2022-2023 Policy Priorities document, which serves to guide the BOS on legislative topics pertinent to the COH.
- L. Kochems suggested adding defending and protecting gay marriage and LGBTQ

alternative families to the document.

9. STATE POLICY & BUDGET UPDATE

- K. Nelson provided an overview of a letter to the State requesting additional funding for the monkeypox outbreak response. The letter can be found in the meeting packet.
- C. Barrit and Kevin Donnelly reported that the PP&A Committee will discuss changes with CalAIM and how this will affect people living with HIV at their next meeting.

10. FEDERAL POLICY UPDATE

- K. Nelson reported that the White House Office of Science and Technology Policy is seeking input from the public to help inform the development of the federal evidence agenda on LGBTQ equity. More information can be found in the meeting packet.
- K. Nelson informed the PPC that the federal government has released their National HIV/AIDS Strategy, which can be found in the meeting packet.
- K. Nelson directed the PPC to a document with more information on The REPEAL HIV Discrimination Act (H.R. 6111), which can be found in the meeting packet.

11. COUNTY POLICY UPDATE

a. COH Response to the STD Crisis
Thank you letter to BOS

- The Thank You letter from the COH to the BOS for addressing the STD Crisis in LA County can be found in the meeting packet.
- K. Nelson announced that the homeless count was released on September 16th.

VI. NEXT STEPS

12. TASK/ASSIGNMENTS RECAP

- PPC co-chairs will forward their action plan to the PPC for feedback.
- K. Nelson will follow up with Mario Perez on CalAIM at the September Executive Committee meeting.
- PPC will forward the policy priorities document to the Executive Committee for approval.
- The PPC will work with COH staff to agendize the Ryan White Program reauthorization for the COH Annual Meeting.

13. AGENDA DEVELOPMENT FOR THE NEXT MEETING

- The PPC will discuss their action plan, legislative docket, and STD motions at their next meeting.

VII. ANNOUNCEMENTS

14. OPPORTUNITY FOR MEMBERS OF THE PUBLIC AND THE COMMITTEE TO MAKE

ANNOUNCEMENTS *There were no announcements.*

VIII. ADJOURNMENT

15. ADJOURNMENT FOR THE MEETING OF SEPTEMBER 12, 2022

The meeting was adjourned by K. Nelson at 3:01 PM.

LOS ANGELES COUNTY COMMISSION ON HIV

2022 WORK PLAN – PUBLIC POLICY

Committee Name: **PUBLIC POLICY COMMITTEE (PPC)**	Co-Chairs: Katja Nelson, Lee Kochems
Committee Adoption Date: January 3, 2022	Revision Dates: 8/9/22, 8/22/22, 9/27/22
Purpose of Work Plan: To focus and prioritize key activities for COH Committees and subgroups for 2022	

#	TASK/ACTIVITY	DESCRIPTION	TARGET COMPLETION DATE	STATUS/NOTES/OTHER COMMITTEES INVOLVED
1	Develop the Comprehensive HIV Plan 2022-26	The Committee will gather, discuss and provide policy issues for inclusion in the plan.	10/2022	The Committee will agendize the CHP and information will flow to the consultant on an ongoing basis.
2	Address Areas of Improvement from the HealthHIV Planning Council Effectiveness Assessment	The Committee will hold public hearing(s) to encourage community engagement and representation in Commission legislative policy making. Public Policy priorities will be streamlined and barriers for community participation reduced.	06/2022	The Committee is scheduled to hold a public hearing in February or March of 2022.
3	Continue to advocate for an effective County-wide response to the STD epidemic. Assess and monitor federal, state, and local government policies and budgets that impact HIV, STD, STIs, Hep C and other sexual health issues. Follow up with BOS motions that include recommendations from the ANAM platform and track reporting.	The Committee will better inform the development of legislative and policy priorities with public hearings. The Committee will review government actions that impact funding and implementation of sexual health and HIV services.	Ongoing	The Committee has included "COH Response to STD crisis" as a standing item on the meeting agenda to track BOS motions related to the BOS STD response and the ANAM platform.
4	Prepare Policy Priorities for 2022 to include the alignment of priorities with the Black/African American Community (BAAC) Task Force, Women Caucus, Aging Task Force, Consumer Caucus, Prevention Workgroup and Trans-gender Caucus recommendations.	The Committee will discuss and craft policy priorities for 2022, ensuring policy efforts prioritize recommendations.	~~04/2022~~ 12/2022	Once established policy recommendations are submitted to the Commission for approval The Committee approved the Policy Priorities 2022-2023 document on 9/12/22 and will move to the Executive Committee for approval.

LOS ANGELES COUNTY COMMISSION ON HIV

2022 WORK PLAN – PUBLIC POLICY—APPROVED 7/14/22

#	TASK/ACTIVITY	DESCRIPTION	TARGET COMPLETION DATE	STATUS/NOTES/OTHER COMMITTEES INVOLVED
5	Develop an Action Plan to align with the Policy Priorities document	The Committee will craft a document to describe and track the goals and action steps related to the recommendations outlined in the Policy Priorities document.	12/2022	Commission staff developed a template to populate with action steps.
6	Develop 2022 Legislative Docket	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.	~~5/2022~~ 07/2022	The Committee will begin legislative bill review in 2/2022. Once the docket is established it will be submitted to the Commission for approval. The legislative docket was approved by the Commission on 7/14/22. The document was edited on 9/27/22 to reflect the Governor's decisions on listed Bills.
7	Monitor and support the City of Los Angeles safe consumption site project.	Coordinate with the City of LA AIDS Coordinator's Office	03/2022 - Ongoing	The Committee is scheduling a presentation with the City of Los Angeles Safe Consumption site providers.
8	Efforts to Modernize the Ryan White Care Act	The Committee will facilitate a discussion for the interest in modernizing the Ryan White Care Act at the Commission's Annual meeting.	2023-Ongoing	The Committee Co-chairs will be listed as topic sponsors on the annual meeting agenda.

LOS ANGELES COUNTY
COMMISSION ON HIV

2022-2023 Legislative Docket
Approval Date: COH 7-14-22

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

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
AB 4 (Arambula)	Medi-Cal: eligibility	The bill would extend eligibility for full scope Medi-Cal benefits to anyone regardless of age, and who is otherwise eligible for those benefits but for their immigration status. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB4	Support	*11-AUG-22 In Committee: Held Under Submission.*
AB 15 (Chiu)	COVID-19 relief: tenancy: Tenant Stabilization Act of 2021	This bill would extend the definition of "COVID-19 rental debt" as unpaid rent or any other unpaid financial obligation of a tenant that came due between March 1, 2020, and December 31, 2021. The bill would also extend the repeal date of the act to January 1, 2026. The bill would make other conforming changes to align with these extended dates. By extending the repeal date of the act, the bill would expand the crime of perjury and create a state-mandated local program. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB15 Per Assembly Chiu Office the Assembly person will hold the bill until the next legislative cycle. Due to the passing of AB 3088, SB 91 and AB 832 which prevent eviction due to non-payment of rent for those whose income was negatively impacted by the pandemic.	Support with questions	01-FEB-22 From committee: Filed with the Chief Clerk pursuant to Joint Rule 56(1)

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
AB 16 (Chiu)	Tenancies: COVID-19 Tenant, Small Landlord, and Affordable Housing Provider Stabilization Act of 2021	This bill would establish the Tenant, Small Landlord, and Affordable Housing Provider Stabilization Program. https://leginfo.legislature.ca.gov/faces/billStatusClient.xhtml?bill_id=202120220AB16 Per Assembly Chiu Office the Assembly person will hold the bill until the next legislative cycle. Due to the passing of AB 3088, SB 91 and AB 832 which prevent eviction due to non-payment of rent for those whose income was negatively impacted by the pandemic.	Watch	01-FEB-22 From committee: Filed with the Chief Clerk pursuant to Joint Rule 56(1)
AB 65 (Low)	California Universal Basic Income Program: Personal Income Tax	This bill would declare the intent of the Legislature to enact legislation to create a California Universal Basic Income Program, with the intention of ensuring economic security for all Californians. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB65	Watch	01-FEB-22 From committee: Filed with the Chief Clerk pursuant to Joint Rule 56(1)
AB 77 (Petrie-Norris)	Substance use disorder treatment services	This bill would declare the intent of the Legislature to enact Jarrod's Law, a licensure program for inpatient and outpatient programs providing substance use disorder treatment services, under the administration of the State Department of Health Care Services. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB77	Support	01-FEB-22 From committee: Filed with the Chief Clerk pursuant to Joint Rule 56(1)
AB 240 (Rodriguez)	Local health department workforce assessment	This bill would require the department to contract with an appropriate and qualified entity to conduct an evaluation of the adequacy of the local health department infrastructure and to make recommendations for future staffing, workforce needs, and resources, in order to accurately and adequately fund local public health. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB240	Support with Questions	*31-AUG-22 Enrolled and presented to the Governor at 4 p.m.*

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
AB 328 (Chiu)	Reentry Housing and Workforce Development Program	This bill would establish the Reentry Housing Program. The bill would require the Department of Housing and Community Development to, on or before July 1, 2022, take specified actions to, upon appropriation by the Legislature, provide grants to counties and continuums of care, as defined, for evidence-based housing and housing-based services interventions to allow people with recent histories of incarceration to exit homelessness and remain stably housed. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB328	Support	01-FEB-22 Filed with the Chief Clerk pursuant to Joint Rule 56. (1)
AB 835 (Nazarian)	Hospital emergency departments: HIV testing	This bill would require every patient who has blood drawn at a hospital emergency department to be offered an HIV test, as specified. The bill would specify the manner in which the results of that test are provided. The bill would state that a hospital emergency department is not required to offer an HIV test to a patient if the department determines that the patient is being treated for a life-threatening emergency or if they determine the person lacks the capacity to consent to an HIV test. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB835	Support	26-AUG-21 In Committee: Held Under Submission
AB 1038 (Gipson)	California Health Equity Program	This bill would establish the California Health Equity Program, a competitive grant program administered by the Office of Health Equity to community-based nonprofit organizations, community clinics, local health departments, and tribal organizations to take actions related to health equity. The bill would establish the California Health Equity Fund. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB1038	Support	26-AUG-21 In Committee: Held Under Submission

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
AB 1400 (Kalra)	Guaranteed Health Care for All	This bill, the California Guaranteed Health Care for All Act, would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB1400	Support	01-FEB-22 Died on third reading file.
AB 1542 (McCarty)	County of Yolo: Secured Residential Treatment Program.	This bill would, until January 1, 2025, authorize the County of Yolo to offer a pilot program, known as the Secured Residential Treatment Program, for individuals suffering from substance use disorders (SUDs) who have been convicted of qualifying drug-motivated felony crimes, as specified. The bill would require the program to meet certain conditions relating to, among other things, a risk, needs, and psychological assessment, a comprehensive curriculum, a determination by a judge of the length of treatment, data collection, licensing and monitoring of the facility by the State Department of Health Care Services, and reporting to the department and the Legislature. Bill Text - AB-1542 County of Yolo: Secured Residential Treatment Program. (ca.gov)	Watch	3-FEB-22 VETOED BY THE GOVERNOR
AB 1928 (McCarty)	Hope California: Secured Residential Treatment Pilot Program	Existing law authorizes a court to grant pretrial diversion to a defendant in specified cases, including when the defendant is suffering from a mental disorder, specified controlled substances crimes, and when the defendant was, or currently is, a member of the United States military. This bill would, until January 1, 2026, the Counties of San Joaquin, Santa Clara, and Yolo to develop, manage, staff, and offer a secured residential treatment pilot program, known as Hope California, for individuals suffering from substance use disorders (SUDs) who have been convicted of qualifying drug-motivated felony crimes, as specified. The bill would require the program to meet certain conditions relating to, among other things, a risk, needs, and psychological assessment, a comprehensive curriculum, a determination by a judge of the length of treatment, data collection, licensing and monitoring of the facility by the State Department of Health Care Services, and reporting to the department and the Legislature. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB1928	Watch	19-MAY-22 In committee: Held under submission.

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
AB 2194 (Ward and Lee)	Pharmacists and pharmacy technicians: continuing education: cultural competency	Requires pharmacists and pharmacy technicians to complete at least one hour of continuing education through a cultural competency course focused on lesbian, gay, bisexual, transgender and queer or questioning (LGBTQ+) patients. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB2194	Support	*31-AUG-22 Enrolled and presented to the Governor at 4 p.m.*
AB 2223 (Wicks)	Reproductive Health	Existing law requires a county coroner to hold inquests to inquire into and determine the circumstances, manner, and cause of violent, sudden, or unusual deaths, including deaths related to or following known or suspected self-induced or criminal abortion. Existing law requires a coroner to register a fetal death after 20 weeks of gestation, unless it is the result of a legal abortion. If a physician was not in attendance at the delivery of the fetus, existing law requires the fetal death to be handled as a death without medical attendance. Existing law requires the coroner to state on the certificate of fetal death the time of fetal death, the direct causes of the fetal death, and the conditions, if any, that gave rise to these causes. This bill would delete the requirement that a coroner hold inquests for deaths related to or following known or suspected self-induced or criminal abortion, and would delete the requirement that an unattended fetal death be handled as a death without medical attendance. The bill would prohibit using the coroner's statements on the certificate of fetal death to establish, bring, or support a criminal prosecution or civil cause of damages against any person. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB2223	Support	*09-SEP-22 Enrolled and presented to the Governor at 4 p.m.*

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
AB 2312 (Lee)	Nonprescription contraception: access	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 or any of the above-listed characteristics by means of any conduct, including, but not limited to, requiring the customer to present identification for purposes of demonstrating their age or other characteristic. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB2312	Watch	6-APR-22 In committee: Set, first hearing. Hearing canceled at the request of author.
AB 2521 (Santiago)	Transgender, Gender Nonconforming, or Intersex Fund	This bill would rename the fund as the Transgender, Gender Nonconforming, or Intersex Fund. The bill would require the office to establish a community advisory committee for the purpose of providing recommendations to the office on which organizations and entities to select for funding and recommendations on the amount of funding for each organization or entity. The bill would require the community advisory committee to be composed of multiple marginalized members of the TGI community for whom the services provided by the funds are intended. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB2521 Sponsored by TransLatin@ Coalition	Support	*06-SEP-22 Enrolled and presented to the Governor at 4 p.m.*
SB 17 (Pan)	Office of Racial Equity	This bill would state the intent of the Legislature to enact legislation to require the department to address racism as a public health crisis. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB17	Support	*31-AUG-22 Ordered to inactive file on request of Assembly Member Reyes*
SB 56 (Durazo)	Medi-Cal: eligibility	This bill would, subject to an appropriation by the Legislature, and effective July 1, 2022, extend eligibility for full-scope Medi-Cal benefits to individuals who are 65 years of age or older, and who are otherwise eligible for those benefits but for their immigration status. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB56	Support	23-JUNE-21 From Committee: Do Pass and Re-refer to Committee on Appropriation

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
SB 57 (Wiener)	Controlled Substances: Overdose Prevention Program	This bill would, until January 1, 2027, authorize the City and County of San Francisco, the County of Los Angeles, and the City of Oakland to approve entities to operate overdose prevention programs for persons that satisfy specified requirements, including, among other things, providing a hygienic space supervised by trained staff where people who use drugs can consume preobtained drugs, providing sterile consumption supplies, and providing access or referrals to substance use disorder treatment. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB57 The City of Los Angeles approved a pilot site for this program and requested a bill amendment to include the City of Los Angeles. The sponsor held the bill for this legislative session and will continue the legislative process in January 2022 (Legislative Session 2022-23).	Support	*22-AUG-22 Vetoed by the Governor. In Senate. Consideration of Governor's item veto pending.*
SB 217 (Dahle)	Comprehensive sexual health education and human immuno-deficiency 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. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB217	Opposed Unless Amended	01-FEB-22 Returned to Secretary of Senate pursuant to Joint Rule 56(1)
SB 225 (Wiener)	Medical procedures: individuals born with variations in their physical sex characteristics	This bill would prohibit a physician and surgeon from performing certain sex organ modification procedures on an individual born with variations in their physical sex characteristics who is under 12 years of age unless the procedure is a surgery required to address an immediate risk of physical harm, as specified. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB225	Support	*09-SEP-22 Enrolled and presented to the Governor at 3:30 p.m.*

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
SB 316 (Eggman)	Medi-Cal: federally qualified health centers and rural health clinics	This bill would authorize reimbursement for a maximum of 2 visits taking place on the same day at a single location if after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment, or if the patient has a medical visit and a mental health visit or a dental visit, as defined. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB316	Support	09-SEP-21 Ordered to inactive file on request of Assembly Member Reyes.
SB 357 (Wiener)	Crimes: loitering for the purpose of engaging in a prostitution offense	Existing law prohibits soliciting or engaging in an act of prostitution. This bill would repeal those provisions related to loitering with the intent to commit prostitution and would make other conforming changes. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220SB357	Support	01-JULY-22 Approved by the Governor
SB 464 (Hurtado)	California Food Assistance Program: eligibility and benefits	This bill, commencing January 1, 2023, would instead make a noncitizen applicant eligible for the California Food Assistance Program if the noncitizen satisfies all eligibility criteria for participation in the CalFresh program except any requirements related to immigration status. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB464	Support	01-JULY-21 From Committee: Do Pass and Re-refer to Committee on Approp-riation. Re-referred to Committee Appropriation
SB 523 (Leyva)	Health care coverage: contra-ceptives	This bill would make various changes to expand coverage of contraceptives by a health care service plan contract or health insurance policy issues, amended, renewed, or delivered on and after January 1, 2022. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220SB523	Support	*09-SEP-22 Enrolled and presented to the Governor at 3 p.m.*

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
SB 923 (Wiener)	Gender-affirming care	This bill requires health plans and insurers to require all of its support staff who are in direct contact with enrollees or insureds to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as transgender, gender nonconforming, or intersex. This bill adds processes to continuing medical education requirements related to cultural and linguistic competency for physician and surgeons specific to gender-affirming care services, as specified. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220SB923	Support	*06-SEP-22 Enrolled and presented to the Governor at 3:30 p.m.*
SB 939 (Pan)	Prescription drug pricing	This bill prohibits payers and drug manufacturers from imposing requirements, conditions, or exclusions that discriminate against certain health care entities participating in a federal drug discount program, including contracted pharmacies of the health care entities. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB939	Support	28-JUNE-22 June 28 set for first hearing canceled at the request of author.
SB 1033 (Pan)	Healthcare Coverage	This bill would require the Department of Managed Health Care (DMHC) and the Insurance Commissioner, no later than July 1, 2023, to revise specified regulations that would require health plans, specialized health plans, or insurance policies, excluding Medi-Cal beneficiaries, for cultural and health-related social needs in order to improve health disparities, health care quality and outcomes, and addressing population health. This bill is referred by the community as the health equity and data bill. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB1033	Support	*11-AUG-22 Joint Rule 62(a) suspended. August 11 hearing: Held in committee and under submission.*

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
SB 1234 (Pan)	Family Planning, Access, Care, and Treatment Program	The bill would require reimbursement, subject to an appropriation by the Legislature and any potential draw down of federal matching funds, for services related to the prevention and treatment of sexually transmitted diseases (STDs), including counseling, screening, testing, follow-up care, prevention and treatment management, and drugs and devices outlined as reimbursable in the Family PACT Policies, Procedures and Billing Instructions manual, to uninsured, income-eligible patients or patients with health care coverage who are income-eligible and have confidentiality concerns, including, but not limited to, lesbian, gay, bisexual, transgender (LGBTQ+) patients, and other individuals who are not at risk for experiencing or causing an unintended pregnancy, and who are not in need of contraceptive services. In addition, the bill would require any office visits, including in-person and visits through telehealth modalities, to be reimbursed at the same rate as office visit. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB1234	Support	*25-SEP-22 Vetoed by the Governor. In Senate. Consideration of Governor's veto pending.*
SB 1338 (Umberg)	Community Assistance, Recovery, and Empowerment (CARE) Program	Senate Bill 1338 would establish the Community Assistance, Recovery, and Empowerment (CARE) Court Program, which would authorize specified persons to petition a civil court to create a CARE plan and implement services for individuals suffering from specified mental health disorders. If the court determines the individual is eligible for the CARE Court Program, the court would order the implementation of a CARE plan, as devised by the relevant county behavioral services agency, and would oversee the individual's participation in the plan. https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=202120220SB1338 Supported by the Los Angeles County Board of Supervisors	Watch with reservations	*14-SEP-22 Approved by the Governor. Chaptered by Secretary of State. Chapter 319, Statues of 2022.*

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
FEDERAL BILLS				
BILL	**TITLE**	**DESCRIPTION / COMMENTS**	**RECOMMENDED POSITION**	**STATUS**
H.R.5 (Cicilline)	Equality Act	This bill prohibits discrimination based on sex, sexual orientation, and gender identity in areas including public accommodations and facilities, education, federal funding, employment, housing, credit, and the jury system. https://www.congress.gov/bill/117th-congress/house-bill/5	Support	17-March-2021 Senate Committee on the Judiciary Hearings Held
H.R. 1201 (Lowenthal-Markey)	International Human 5 Rights Defense Act of 2021	The bill is to establish in the Bureau of Democracy, Human Rights, and Labor of the Department of State a Special Envoy for the Human Rights of LGBTQI Peoples. The Special Envoy shall serve as the principal advisor to the Secretary of State regarding human rights for LGBTQI people internationally. https://www.congress.gov/bill/117th-congress/house-bill/1201/text	Support	02-APRIL-21 Referred to the Subcommittee on Africa, Global Health and Global Human Rights
H.R. 1280 (Bass)	George Floyd Justice and Policing Act of 2021	This bill addresses a wide range of policies and issues regarding policing practices and law enforcement accountability. It increases accountability for law enforcement misconduct, restricts the use of certain policing practices, enhances transparency and data collection, and establishes best practices and training requirements. The Commission on HIV refer this bill back to the Committee because funding for the police is included in the bill. This is at odds with the movement for Black Lives which opposes the bill. https://www.congress.gov/bill/117th-congress/house-bill/1280?q=%7B%22search%22%3A%5B%22George+Floyd+Justice+and+Policing+Act+of+2021%22%5D%7D&s=2&r=1	Watch with reservations	09-March-21 Received in the Senate Referred Back to Committee in Discussion

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
Federal Bill Proposal (Sponsored Movement for Black Lives)	The BREATHE Act	Divesting Federal Resources from Policing and Incarceration & Ending Federal Criminal-Legal System Harms Investing in New Approaches to Community Safety Utilizing Funding Incentives Allocating New Money to Build Healthy, Sustainable & Equitable Communities for All People Holding Officials Accountable & Enhancing Self-Determination of Black Communities	Watch with discussion	Referred Back to Committee in Discussion
HR 5611 (Blunt Rochester)/ S. 1902 (Cortez Masto)	Behavioral Health Crisis Services Expansion Act	This bill establishes requirements, expands health insurance coverage, and directs other activities to support the provision of behavioral health crisis services along a continuum of care. https://www.congress.gov/bill/117th-congress/house-bill/5611?q=%7B%22search%22%3A%5B%22hr5611%22%2C%22hr5611%22%5D%7D&s=1&r=1 https://www.congress.gov/bill/117th-congress/senate-bill/1902?q=%7B%22search%22%3A%5B%22S1902%22%2C%22S1902%22%5D%7D&s=2&r=1	Support	**HR 5611** 02-NOV-21 House Referred to the Subcommittee on Health **S. 1902** 27-MAY-21 Read Senate twice and referred to the Committee on Health, Education, Labor, and Pensions

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
S.1 (Merkley)	For the People Act	This bill addresses voter access, election integrity and security, campaign finance, and ethics for the three branches of government. https://www.congress.gov/bill/117th-congress/senate-bill/1?q=%7B%22search%22%3A%5B%22S+1%22%5D%7D&s=1&r=1	Support	11-AUG-21 Placed on Senate Legislative Calendar Under General Orders. Calendar No. 123
S. 854 (Feinstein)	Methampheta-mine Response Act of 2021	This bill designates methamphetamine as an emerging drug threat (a new and growing trend in the use of an illicit drug or class of drug). It directs the Office of National Drug Control Policy to implement a methamphetamine response plan. https://www.congress.gov/bill/117th-congress/senate-bill/854	Support	14-MARCH-22 Became Public Law/Signed by the President
S.4263/ H.R.4 (Leahy)	John Lewis Voting Rights Advancement Act 2021	To amend the Voting Rights Act of 1965 to revise the criteria for determining which States and political subdivisions are subject to section 4 of the Act, and for other purposes. https://www.congress.gov/bill/117th-congress/house-bill/4?q=%7B%22search%22%3A%5B%22H.4%22%2C%22H.4%22%5D%7D&r=1&s=4	Support	14-SEP-20 Received in the Senate.

OFFICE OF THE GOVERNOR

SEP 25 2022

To the Members of the California State Senate:

I am returning Senate Bill 1234 without my signature.

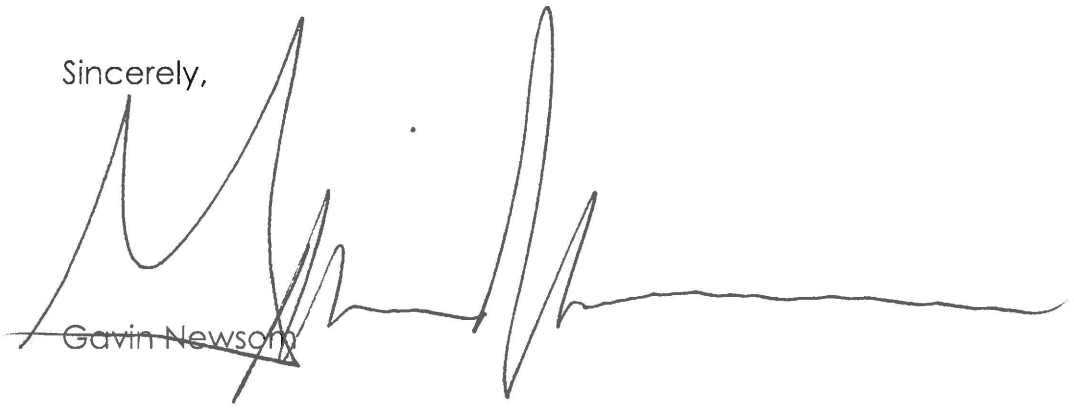
SB 1234 would, subject to an appropriation by the Legislature and any potential draw down of federal matching funds, expand eligibility for the Family Planning, Access, Care and Treatment (Family PACT) program's sexually transmitted disease (STD)-related services to individuals who are not at risk for pregnancy, and those who are not in need of contraceptive services. The bill would require the Department of Health Care Services to report on utilization, costs and other information to the Legislature on or before January 1, 2026. Lastly, the bill would remove the requirement that a STD home test kit be sent by the enrolled Medi-Cal or Family PACT provider to a Medi-Cal-enrolled laboratory.

While I support the author's efforts to reduce STDs and reinfections in California, SB 1234 would expand Family PACT services beyond the federal definition of family planning thereby creating a state-only program that creates significant ongoing General Fund cost pressure not accounted for in the budget.

With our state facing lower-than-expected revenues over the first few months of this fiscal year, it is important to remain disciplined when it comes to spending, particularly spending that is ongoing. We must prioritize existing obligations and priorities, including education, health care, public safety and safety-net programs.

The Legislature sent measures with potential costs of well over $20 billion in one-time spending commitments and more than $10 billion in ongoing commitments not accounted for in the state budget. Bills with significant fiscal impact, such as this measure, should be considered and accounted for as part of the annual budget process. For these reasons, I cannot sign this bill.

Sincerely,



Gavin Newsom

LOS ANGELES COUNTY
COMMISSION ON HIV

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PUBLIC POLICY COMMITTEE (PPC)[1]
2022-2023 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.

[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.

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]

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.

[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 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. Homelessness is a risk factor for HIV transmission and acquisition.

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.
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 to include 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.
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.

LOS ANGELES COUNTY COMMISSION ON HIV

2022 POLICY PRIORITIES – ACTION PLAN

Committee Name: **PUBLIC POLICY COMMITTEE (PPC)**	Co-Chairs: Katja Nelson, Lee Kochems
Committee Adoption Date:	Revision Dates:

Purpose of Action Plan: To outline key action steps for the PPC policy priorities for 2022. Each year there will be a detailed action plan for 1-2 items for the PPC to focus on.

#	ISSUE	DESCRIPTION	ACTION STEPS	TIMELINE
Ex.	*In this section, name the issue.*	*In this section, **describe** the issue, **provide** context, and **explain** the reasoning for selecting the issue as a priority for the year.*	*In this section, **outline** the steps the PPC will take to act on the issue described. The goal is to **develop detailed** and **concrete** the action steps.*	*In this section, **set** a timeframe for completing the action steps.*
1	Effective countywide response to the Sexually Transmitted Disease (STD) epidemic	In October 2021, the PPC submitted a letter to the Board of Supervisors (BOS) outlining the wants of the PPC and requesting the BOS to consider prioritizing the response to the rising STD epidemic in Los Angeles County. In November 2021, the BOS instructed the Department of Public Health (DPH) to provide a description of the current strategies, funding sources, and data developments regarding the county-wide STD response. In April 2022, the DPH provided the BOS a detailed description of current services, data projects and needs, and funding sources. Given the recent momentum with the BOS considering improvements to the countywide STD response, the PPC will consider drafting a letter to respond to the DPH letter to the BOS.	The PPC will draft a letter based on the DPH report to the BOS in which the PPC will outline priorities/recommendations to improve the countywide STD response. The PPC will request a formal letter of support from the BOS to support the Ending the Epidemics budget request to the State of California.	

LOS ANGELES COUNTY COMMISSION ON HIV

2022 WORK PLAN – PUBLIC POLICY--Draft

2	Effective Countywide response around Harm Reduction Services and Syringe Exchange			
3	Aging			
4	Housing			
5	Mental Health			
6	Street Medicine			

‘It is sinking us even further’: STI clinics, already stretched thin, strain under weight of monkeypox response

- 

By Andrew Joseph Sept. 27, 2022

Susan Eng-Na prepares a dose of monkeypox vaccine at the OASIS Wellness Center in New York. *Mary Altaffer/AP*

At the Los Angeles LGBT Center's sexual health clinic, patients are normally seen within 24 hours. Recently, amid the monkeypox outbreak, it's been a five-day wait.

At Open Door Health, an LGBTQ+ community clinic in Providence, R.I., a standard test for a sexually transmitted infection might take 15 minutes. Testing for monkeypox — between authorizing the test and donning and doffing PPE — has dragged up to an hour. Insurance reimbursement doesn't cover all that added time.

At the Detroit Public Health STD Clinic, staff are so tied up responding to the outbreak that they enlisted local medical students to schedule vaccine appointments.

The recent surge of monkeypox cases has largely been concentrated among men who have sex with men, with the virus spreading through sexual contact. In some cases, symptoms have included lesions on the penis or anus. Many people with monkeypox also have HIV or another recent STI.

That means a large brunt of the response has fallen to clinics and organizations that specialize in STI and HIV/AIDS care, a network that for years has complained about a lack of resources even as they faced spiking STI rates. Clinics have rallied for their patients, overcoming red tape and fanning out to bars, clubs, and Pride events to expand access to testing, treatment, and vaccines. But even as monkeypox has been declared a public health emergency both domestically and globally, they haven't been allocated additional funding. Providers and administrators warn they're being stretched thin, running at a pace they won't be able to keep up.

“When you’re working on the ground and you’re seeing how this is actually affecting people’s lives, there is a big urgency,” said Shira Heisler, the clinical lead at the Detroit STD clinic, describing how people scream in pain when their anal lesions get swabbed or how the lesions can scar people’s faces. “Everyone’s doing overtime without getting paid for it, because no one else can do it.”

The limitations on resources have consequences. At times, it’s taken extra days to diagnose monkeypox, which means it’s taking longer to connect patients with treatment. It also means that normal care dedicated to STDs and HIV is being shoved aside to handle the emergency. Advocates say they see what’s happening as another manifestation of the country’s underinvestment in public health infrastructure, coming on top of the hit the field took during the Covid-19 pandemic.

“We ended up using the same staff that we use to provide primary care services for people living with HIV and AIDS,” said Tracy Jones, the executive director of the AIDS Taskforce of Greater Cleveland. “Quite frankly, we were prioritizing monkeypox because people were just showing up.”

In some ways, trends with the monkeypox outbreak are looking up. Transmission has slowed, with average daily cases falling from more than 400 throughout much of August to about 200 now. The thicket providers had to push through to get patients tested or on the antiviral being used to treat the infection has cleared somewhat. But the danger has not passed. It’s not known if monkeypox can be contained in this country. Even if it can, with the virus spreading in so many more countries, providers will have to continue to be on the lookout for reintroductions.

And in other ways, the campaign has grown more difficult. Those who were eager to get vaccinated have done so. Now, clinics have to do the

harder job of reaching additional people to vaccinate, a particularly crucial endeavor to help correct the disparities that have emerged, with infections among Black and Hispanic men outpacing those among white men while vaccine coverage is higher among white people.

“It is critical that education, vaccinations, testing, and treatment are equally accessible to all populations, but especially those most affected by this outbreak,” Rochelle Walensky, the director of the Centers for Disease Control and Prevention, said at a briefing this month. She highlighted a program aimed at improving vaccine equity, with campaigns at events like Southern Decadence in New Orleans and Pride events in Oakland and Atlanta.

While the Biden administration has requested about $4 billion from Congress for the monkeypox response, as part of a broader budget request that also included a $22 billion ask for Covid resources, lawmakers haven’t moved to authorize the money.

Earlier this month, the CDC told groups that had received grants for STD and HIV/AIDS care that they could tap those resources for monkeypox responses.

“Our local jurisdictions have received no resources specific for monkeypox,” Walensky said. “So not only have we had to move some of those resources around, but they’ve been stretched pretty thin with regard to the resources that have been available to them to address this outbreak.”

STI and HIV clinics rely on a hodgepodge of funding sources for their budgets. Some are federally qualified health centers, some depend on grants, and some get money through federal programs like Ryan White. Billing insurers accounts for just a portion of their funding, providers said.

Clinics have been scraping together their response, but should the outbreak drag on, they will need additional resources, providers said — whether from Congress or state governments, or higher payouts from insurers. California authorized $41 million to combat monkeypox, with nearly $16 million going to local public health departments and community groups, but that appears to be an exception.

“We can’t do it forever,” Phil Chan, the chief medical officer at Open Door Health, said about their monkeypox efforts. “We’re going to have to figure out some funding source eventually.”

Chan and other providers said that the amount they’re being reimbursed for organizing and running monkeypox vaccine clinics is also not covering the associated costs. Kaiyti Duffy, the chief medical officer at the Los Angeles LGBT Center, said the clinic received higher reimbursement rates for Covid-19 vaccinations.

“We’re going to do that because who else will, but it is sinking us even further,” Duffy said about the vaccine clinics, which the center has been devoting nursing staff to twice a week. “We’re showing up in a way that we’re proud of but we know is unsustainable.”

Accounting for inflation, CDC funding for STD prevention fell 40% from 2003 to 2019, according to the National Coalition of STD Directors, even as reported STI cases reached all-time highs in 2019 for the sixth year in a row. Federal money during the pandemic helped bolster local public health efforts, but at the same time, agencies’ work on STIs was in many cases paused as staff were diverted to Covid. All the while, cases of chlamydia, gonorrhea, syphilis, and congenital syphilis have continued to climb.

The NCSD has called for Congress to allot STI clinics $500 million.

“The STI field has been tapped specifically for community education, outbreak investigation, contact tracing, vaccine distribution, and clinical care” during the monkeypox outbreak, David Harvey, NCSD’s executive director, said at a briefing this month. “Yet, for the past three months, we have been on the frontlines pleading with officials for the support that our networks and systems need desperately.”

Since the start of the monkeypox outbreak, these organizations have been hubs of information and clinical care. They’ve handled a deluge of phone calls from worried patients. They’ve set up vaccine clinics, and demanded the shots be distributed more equitably. And they’ve encountered bureaucratic barriers as they tried to help their patients.

Early in the outbreak, clinics had to get approval from a public health laboratory before they could test patients, creating both a headache and disincentive. The antiviral treatment tecovirimat, or Tpoxx, is being used under a special program that required doctors to first complete a mountain of paperwork. After providers and patient advocates complained, both those processes have been streamlined.

The response has at times required a hands-on approach, and pulling in help wherever it could be found. And it’s not just about getting people testing or writing prescriptions. Duffy noted that Tpoxx has to be taken twice a day with a meal of at least 600 calories and 25 grams of fat. Some of the clinic’s patients don’t have reliable access to food, so providers are having to navigate those extra challenges.

In Detroit, Heisler almost had to go to a neighboring county to pick up a patient’s Tpoxx early in the outbreak because it wasn’t available locally yet and the patient didn’t have transportation. Someone from that county wound up delivering it.

And when the strategy for administering vaccines changed — going from a more standard subcutaneous shot to an intradermal shot — a tuberculosis clinic in the same complex provided the different needles until the STI clinic could buy its own, Heisler said. Delivering intradermal shots also requires special training, so a TB nurse supervised the monkeypox vaccine clinic as administrators adapted to the new method.

Nicole Roebuck, the executive director of AID Atlanta, said that what's occurred with monkeypox echoes how the organizations have been leaned on in the past.

"HIV organizations tend to be very good at doing more with less, very masterful at doing more with less," Roebuck said. "And I honestly sometimes feel that folks rely on that. You know, 'Oh, they're just going to push through, they're just going to do what they need to do.' Because that's why we're here, right? We care about the people on the ground, so we're going to do whatever we need to do — backflips, stay longer, clean bathrooms — those are just the types of people we hire."

Roebuck raised another point as well.

"I feel like sometimes we're used to this, we're used to like being an afterthought," she said. "And I wonder how that makes our members feel, our clients feel, our patients feel."

About the Author

HEALTH CARE

New CDC data: STD rates shot up in 2021

Syphilis rates saw the biggest annual increase in more than 70 years.

The CDC data found total infections in 2021 beat the record number of STIs documented in the U.S. in 2020 — increasing from 2.4 to 2.5 million. | Ron Harris/AP Photo

By **ALICE MIRANDA OLLSTEIN**
09/15/2022 05:00 AM EDT

Syphilis rates jumped 26 percent last year — reaching the highest number of cases since the Truman administration — amid a broader rise in sexually transmitted infections that worsened considerably during the Covid-19 pandemic.

The preliminary data from the Centers for Disease Control and Prevention released this month shows the steep escalation of an alarming national trend, and comes as local health departments are still battling Covid and contending with an unprecedented monkeypox outbreak.

"Monkeypox is inundating these programs and it is interrupting our ability to diagnose and treat other STIs," said David Harvey, the executive director of the National Coalition of STD Directors. "It's shining a bright light on the fact that safety net clinics who provide essential services are in desperate need of federal support."

Public health officials warn their scarce resources could be further strained and outbreaks could proliferate if a Texas lawsuit succeeds in eliminating Obamacare's requirement that insurance cover services like STD tests and HIV prevention drugs.

Leandro Mena, the director of the CDC's Division of STD Prevention, told POLITICO that chronic underfunding of public health programs is largely to

blame.

“Over two decades of level funding, when you account for inflation and population changes, have effectively decreased the buying power of public health dollars and resulted in the reduction of STI services at the local level,” Mena said. “That reduction in screening, treatment and partner services likely contributed to these STI increases.”

Additionally, opioid and methamphetamine use — which increased significantly during the pandemic — is both leading to more HIV and hepatitis infections among people who share needles and to the spread of other STDs as more people trade sex for drugs and engage in unprotected sex.

Also fueling the rising rates, Mena said, are decreases in condom usage, particularly among young people, and taboos around sex that deter people from talking to their primary care doctors about STD prevention and treatment.

The CDC data found total infections in 2021 beat the record number of STIs documented in the U.S. in 2020 — increasing from 2.4 to 2.5 million.

Gonorrhea increased 2.8 percent — reaching almost 700,000 infections in 2021. Chlamydia, which had declined in 2020, increased 3 percent last year.

And rates of congenital syphilis — babies who contract the condition in the womb — climbed 24 percent. More than 2,600 babies were born with syphilis in 2021, up from 529 in 2000 when the country seemed on the verge of eliminating the condition.

Meanwhile, progress on preventing new HIV infections, which are tracked separately, slowed during the pandemic, and some parts of the country including San Francisco are even seeing HIV rates increase for the first time in nearly a decade. Officials warn that without significantly more funding, the U.S. may not reach its goal of ending the spread of the virus by 2030.

The surge in these preventable infections is alarming public health workers who had hoped the Covid-19 pandemic would convince lawmakers to invest more in testing, vaccines, treatments and outreach to at-risk groups in order to protect the broader population.

But that hasn't happened.

Instead, Covid's disruption exacerbated problems brought about by years of budget cuts to STD programs and the pervasive stigmatization of poor people of color and LGBTQ communities where infection rates tend to be higher, according to health experts and government officials.

When Covid hit, many testing clinics closed their doors or cut back hours, and many patients stopped getting regular checkups out of fear of catching the virus. Workers who had been contact-tracing for STDs were reassigned to Covid, meaning fewer people were notified that they had been exposed. For months, basic testing supplies like glass vials and swabs were scarce.

While many services have been restored and medical supply chains have been fixed, federal funding remains stagnant. Earlier this year, Congress approved far less funding than health departments requested for Title X family planning clinics that provide STI testing to uninsured and low-income patients. And Republican lawmakers are voicing opposition to new pleas from the administration for $4.5 billion to combat monkeypox — which Harvey and other health leaders say would alleviate some of the strain on STI clinics that are distributing the vaccine and testing for the virus.

"It isn't a question of money; you have been given astonishing amounts of money," North Carolina Sen. Richard Burr (R-N.C.), the top Republican on the Health, Education, Labor and Pensions Committee told Biden administration public health leaders during a hearing Wednesday.

Sen. Richard Shelby (R-Ala.), the top Republican in charge of appropriations, agreed.

“I don’t know that there’s an epidemic out there and that we’ve just got to have all this money all at once,” he told reporters earlier this week.

More challenges loom. In particular, health workers and government officials fear a lawsuit backed by former Trump administration officials could make the STD crisis worse still.

A federal judge in Texas ruled last week that the government advisers who decide what minimum services insurance has to cover under the Affordable Care Act lack the authority to do so, and that requiring coverage of things like the HIV prevention drug PrEP violates the religious rights of employers.

The judge has not yet indicated if his ruling will apply just to the conservative business owners who brought the lawsuit, to all of Texas, or to the entire country, and has requested additional briefings by Friday. If applied nationally, the ruling has the potential to strip insurance coverage for preventive care services like STD tests from nearly 170 million Americans.

Democratic policymakers and advocates see the case as a potential cataclysm, warning it could drive up health insurance premiums, bring back high out-of-pocket costs that deter people from seeking STD testing and treatment, and unwind progress on treating both chronic and infectious diseases.

“Picking and choosing what type of basic care is included in an employer-sponsored plan both discriminates against individuals who need important health care and is antithetical to the way health care insurance works, where everybody shares all the costs,” Bobby Scott (D-Va.), chair of the Education and Labor Committee that has jurisdiction over health policy, told reporters on a recent call. “What if someone objects to out-of-marriage births for example and asks why they should pay for half of all births as part of the costs they have to share?”

“If you can pick and choose, it’s no longer insurance,” he added.

Krista Mahr contributed to this report.

CORRECTION: A previous version of this article misstated the description of this year's syphilis outbreak. 2021 was the most total cases since the Truman administration.

FILED UNDER: CENTERS FOR DISEASE CONTROL, HIV, DATA,

HEALTH CARE

STDs are surging. The funding to fight them is not.

The latest figures follow Congress' decision last month to provide far less funding to sexual health clinics that provide free and subsidized testing.

Gonorrhea cases increased 10 percent in 2020, and syphilis infections were up 7 percent. Congenital syphilis, which had all but disappeared in the U.S. at the beginning of the century, increased 15 percent in 2020, contributing to at least 149 stillbirths and infant deaths that year.

And while the new report shows that chlamydia cases declined 13 percent in 2020, top health officials believe that reflects a drop in screenings for the frequently asymptomatic disease, not an actual reduction in the number of infections.

CDC officials told reporters on a call Tuesday that their not-yet-released preliminary data from 2021 indicate the situation has worsened, with higher rates of syphilis and congenital syphilis than in 2020.

“STDs had already been increasing for quite some time, but Covid-19 exacerbated the factors that contribute to it in many ways,” Leandro Mena, the CDC’s director of STD Prevention, told POLITICO in a separate phone interview. “We have had more than a decade of decreasing public health funding that’s caused a dropoff in STD screening, prevention, education and other health services. We’ve also been dealing with an increase in substance use that has been linked to less safe sexual practices.”

While most STDs are preventable and curable if patients are diagnosed and given medication in time, people who go untreated could see severe and potentially fatal consequences — a rising risk during the Covid-19 pandemic, when many clinics paused in-person testing and millions lost their health insurance.

Based on the data from 2020, the CDC's report says the agency is currently on the lookout for a spike in "adverse outcomes, such as pelvic inflammatory disease and infertility."

Despite the worsening rates of STDs, several independent sexual health organizations and state health departments that are part of the federal Title X family planning program are getting significantly less funding this year than they did under the Trump administration.

President Joe Biden moved last year to roll back the Trump administration's restrictions on the program, clearing the way for hundreds of Planned Parenthood clinics, several state health departments and groups that had dropped out in protest of the ban on abortion referrals to rejoin. Yet because Congress in its most recent spending bill kept funding for the program flat at about $286 million, HHS says it had to shift resources around to try to address the areas of the country with the most pressing needs, resulting in deep cuts to some providers in states with high STD rates.

"The significant gap between resources available and what communities need has translated directly into challenging decisions with consequences that reverberate across our highly qualified Title X community," Jessica Swafford Marcella, HHS deputy assistant secretary for population affairs, said in a statement.

In California, for example, the group Essential Access Health received $21 million per year in Title X funding for each of the last three years. In late March, it learned funding for the coming year will be $13.2 million — the largest cut the group has experienced since it joined the federal program in the 1970s.

In Wisconsin, the state health department saw its Title X funding cut from $3.8 million a year to just above $3 million. And in Oklahoma, the group Community Health Connection received $300,000 under the Trump administration but was not given funding by the Biden administration.

“We’ve really been kicked while we’re down,” said Laura Bellis, the executive director of Take Control Initiative, which works with Community Health Connection and other Oklahoma groups on sexual health care. “We have epidemic rates of STIs and they’re getting worse. And now there will be lots more people who won’t be able to afford care. There will also be fewer appointments available, especially for youth who can’t come during school hours.”

While Oklahoma’s state health department received a boost in Title X funding to make up for the cut to Community Health Connection, Bellis and other advocates argue that due to the sensitive nature of STD services, it’s better to fund a variety of options for marginalized populations who may not be comfortable going to a state-run provider.

“Where are undocumented people supposed to go?” she asked. “We have a large immigrant population that has lots of lingering fear because of things like the public charge rule — where immigrants were penalized for seeking government medical care. And Tulsa County officials collaborate a lot with [Immigration and Customs Enforcement], so many of those people are distrustful of governmental entities in general.”

Julie Rabinovitz, president and CEO of California’s Title X grantee Essential Access Health, says the funding cut is forcing her to remove 150 of the roughly 400 clinics in their network and slash budgets at the remaining sites. Their STD services are set to take one of the biggest hits.

“We no longer will be able to have any STD-specific staff who have that technical expertise and training,” she said. “We had applied for $22 million because we wanted to be open longer hours, improve our quality of care, offer wrap-around services and provide more types of birth control. So, we were shocked and dismayed that our funding was cut so drastically to $13 million.”

Mena, the Biden administration’s top official focused on STDs, argued that while Title X is important, it’s just one tool in the fight against gonorrhea, syphilis, chlamydia and other infections. He argued that primary health care providers also need to incorporate STD prevention and treatment into their routine care, saying doing so would help reduce stigma and help people see it as a normal part of health, and said governments need to find new ways to reach people who may be uncomfortable with visiting a Title X clinic or public health department. Mena added that addiction treatment facilities should also offer STD services, and that the private sector needs to develop more effective STD tests, treatments and vaccines.

“So prioritizing resources [for Title X] will be critical for addressing the STI epidemic,” Mena told POLITICO. “But there is no silver bullet.”

Title X providers have long argued that their sexual health services help people who fear that getting an STD test at their doctor’s office will show up on their insurance statement — including young people who are still on their parents’ insurance and people in abusive relationships.

The CDC's report also painted a dire picture of sexual health for teens and young adults, finding that 53 percent of all the reported cases of STDs in 2020 were among people between the ages of 15 and 24, up from 46 percent in 2018.

More recent data indicates the rates for teens may be even worse. A study published by the American Academy of Pediatrics on Monday found that 20 percent of sexually active high school students took an STD test over the last year. The rate for boys was 13 percent.

Rabinovitz says the budget cuts in California will disproportionately effect young people who often come to them for confidential and non-judgemental services.

"I'm very concerned about the area north of San Francisco, the Central Valley and the Inland Empire — all of which have some of the highest STD and teen pregnancy rates in the state," she said.

Despite the climbing STD rates, Congress' support for Title X funding has declined by nearly 10 percent since the program's funding peak in 2010 of $317 million.

While Biden recently proposed a significant budget increase for Title X for 2023, boosting it from $286 to $400 million, the budget recommended no increase for the CDC's other programs for combating STDs — a move advocates called "infuriating" and "deeply frustrating."

“The CDC is failing to use their full weight to prioritize the growing epidemic of STDs in the budgeting process when their own data paint a dismal picture,” said David Harvey, executive director of National Coalition of STD Directors. “This budget misses the mark at this particular juncture, when we see our rates exploding and so much of our workforce redeployed to manage Covid-19.”

Amid the funding crunch, providers are scrambling to stretch dollars and get resources to people in areas where clinics might close their doors.

In Oklahoma, for example, Bellis’ group and others have been discussing ways to make emergency contraception pills like Plan B available to patients before they’re pregnant, exploring partnerships with online pharmacies and setting up “wellness vending machines” that carry condoms and STI tests.

Still, they say it’s no replacement for experienced staff providing comprehensive in-person services.

“We never expected to be in a worse spot for preventative care than we were at the start of the pandemic,” she said. “We’ve been dealing with so many state bans on abortion, but what we didn’t expect is the federal government decimating contraception access and STD care basically by negligence.”

ITUP
Insure the Uninsured Project

» Coverage at a Glance

Overview of California

September 2022

CALIFORNIA TOTAL POPULATION: 39.5M[1]

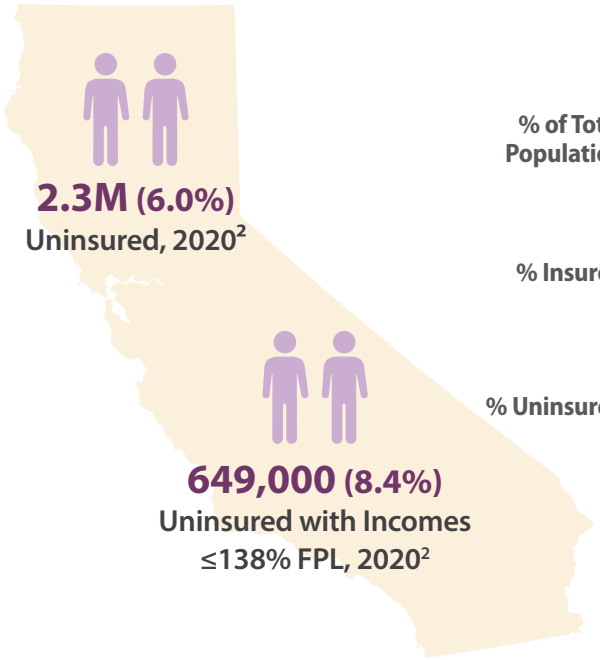


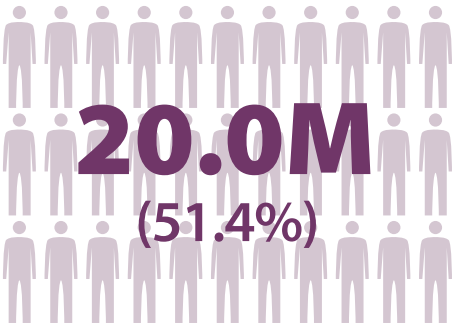
FIGURE 1. Race/Ethnicity and Insurance Status Across California[2]

	Latinx	White	Black	AI/AN	Asian	NH/PI	2+
% of Total Population	39.5%	38.2%	5.5%	0.4%	13.2%	0.4%	2.7%
% Insured	90.3%	97.1%	95.6%	95.7%*	95.4%	91.4%*	95.6%
% Uninsured	9.7%	2.9%	4.4%	4.3%*	4.6%	8.6%*	4.4%

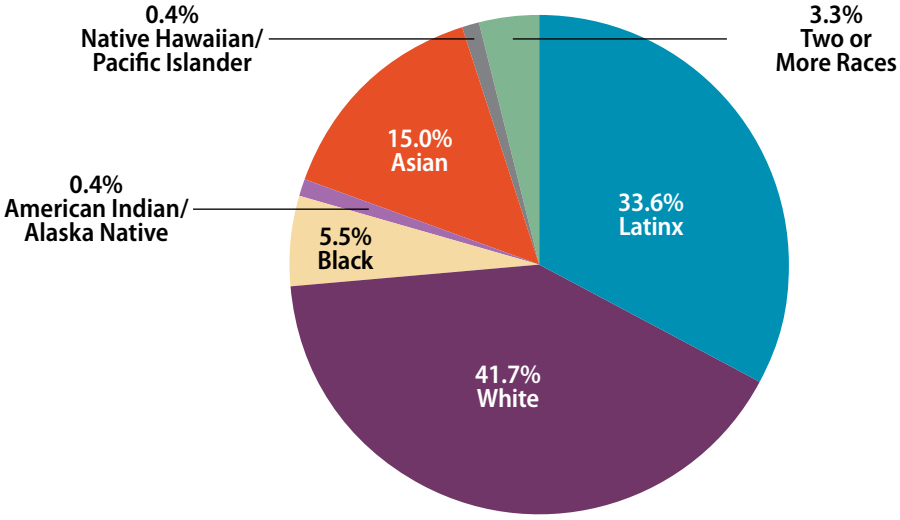
AI/AN=American Indian/Alaska Native | NH/PI = Native Hawaiian/Pacific Islander | 2+ = Two or More Races
* Data for these counties are considered statistically unstable.

FIGURE 2. Employer-Sponsored Coverage, 2020[2]

Total Employment-Sponsored Coverage



Race/Ethnicity Breakdown Among Californians with Employer-Sponsored Coverage



COVERED CALIFORNIA

FIGURE 3. Total Covered California Enrollment by Subsidy Status, December 2021[3]

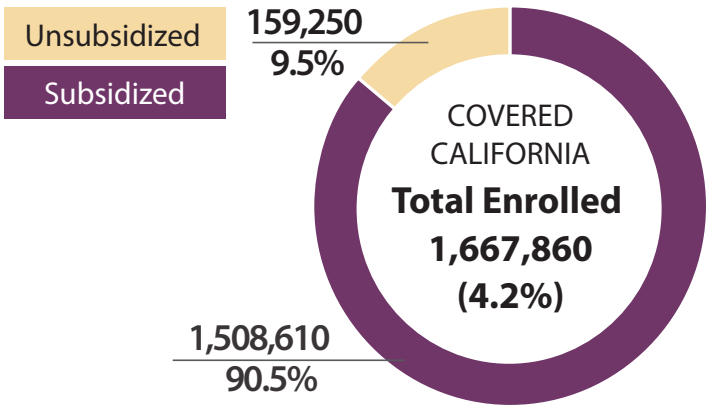
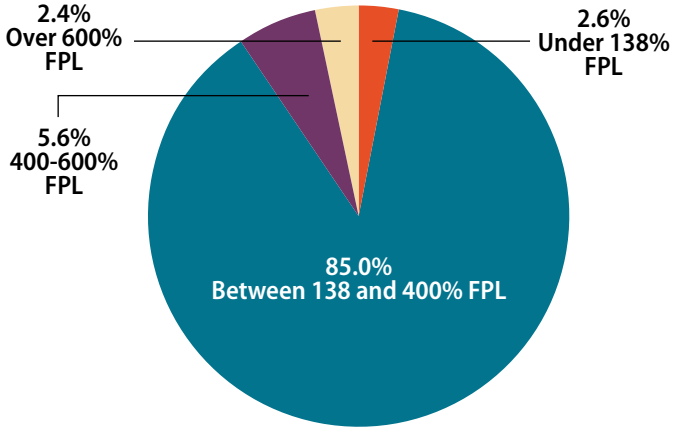


FIGURE 4. Covered California Enrollment by FPL, December 2021[3]



Enrollments where the FPL of the member is not know are not included here.

FIGURE 5. Covered California Enrollment by Race/Ethnicity, December 2021[3]

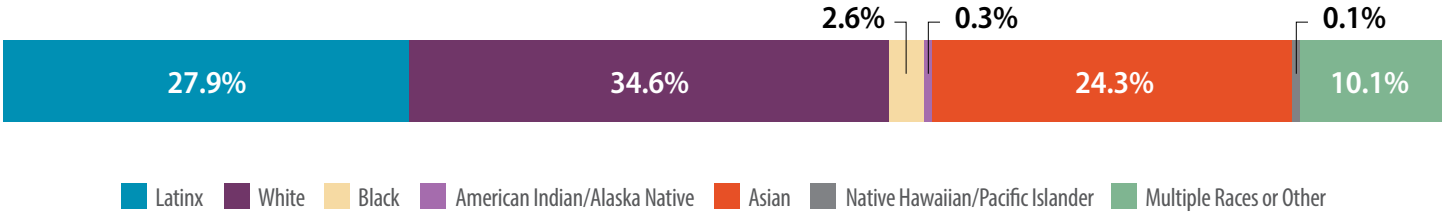
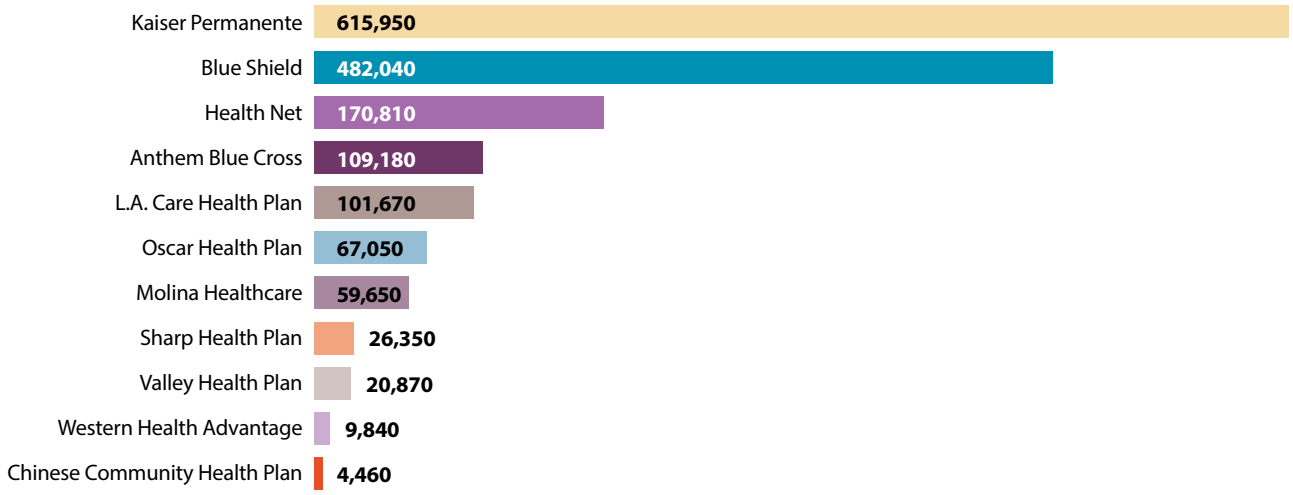


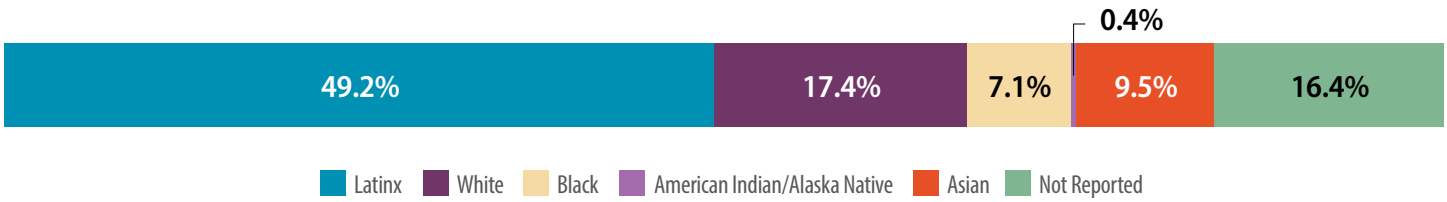
FIGURE 6. Total Covered California Enrollment by Health Plan, December 2021[3]



Covered California's privacy policy rounds all figures to the nearest 10. As a result, grand totals shown may be slightly different from the totals in the individual plan data.

MEDI-CAL

FIGURE 7. Medi-Cal Enrollment by Race/Ethnicity, April 2022[4]



Covered California's privacy policy rounds all figures to the nearest 10. As a result, grand totals shown may be slightly different from the totals in the individual plan data.

FIGURE 8. Total Medi-Cal Enrollment in Managed Care and Fee-For-Service, April 2022[5]

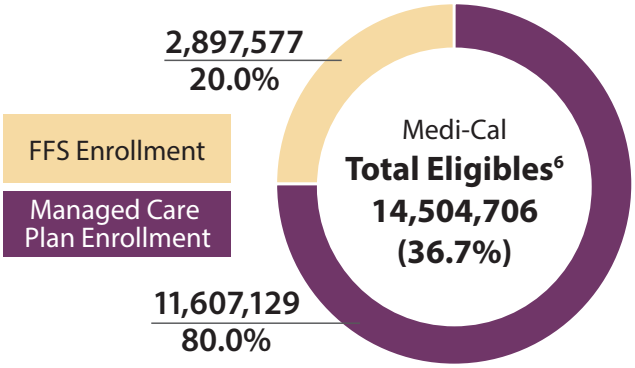


FIGURE 9. Total Undocumented Medi-Cal Enrollees, April 2022[7]

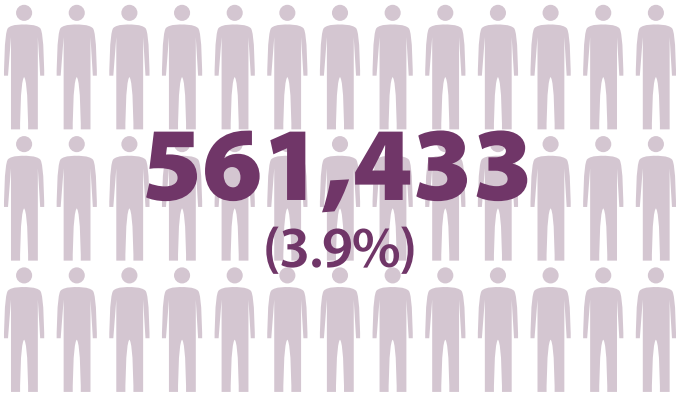


FIGURE 10. Medi-Cal Enrollment by Managed Care Plan Model Type, April 2022[5]

	Total Enrolled	Percent of all Medi-Cal	Percent of Managed Care
Two Plan	8,029,130	55.4%	69.2%
County Organized Health System (COHS)	2,482,460	17.1%	21.4%
Geographic Managed Care	1,393,015	9.6%	12.0%
Regional Model	355,576	2.5%	3.1%
Imperial	87,835	0.6%	0.8%
San Benito	10,516	0.1%	0.1%
Cal MediConnect	112,139	0.8%	1.0%

CALAIM SPOTLIGHT: COMMUNITY SUPPORT SERVICES

Under the CalAIM initiative, Medi-Cal Managed Care Plans (MCPs) are encouraged to offer up to 14 DHCS-approved Community Support (CS) services, which are wraparound benefits that address both health and social needs. These services are currently being phased in through January 2024.

Percentage of Medi-Cal MCPs Across California Offering Each CS Service[8]

CS Service	% of MCPs in 2022	% of MCPs in 2024
Housing Transition/Navigation	95%	98%
Housing Tenancy & Sustaining Services	95%	98%
Medically-Supportive Food/Meals/Medically Tailored Meals	93%	95%
Recuperative Care (Medical Respite)	53%	94%
Housing Deposits	92%	92%
Short-Term Post-Hospitalization Housing	38%	90%
Personal Care and Homemaker Services	40%	86%
Respite Services	38%	86%
Environmental Accessibility Adaptations	62%	75%
Sobering Centers	25%	74%
Community Transition Services/Nursing Facility Transition to a Home	10%	71%
Nursing Facility Transition/Diversion	8%	71%
Day Habilitation Programs	22%	69%

Purple rows indicate CS Services with either high or low availability in both 2022 and 2024.

Most Commonly Available CS Services:
Housing Services & Nutritional Meals

Least Commonly Available CS Services:
Nursing Facility Diversion and Community Transition Services, Day Habilitation Programs & Sobering Centers

MEDICARE

FIGURE 11. Total Medicare Enrollment in Managed Care and Fee-for-Service, 2020[9]

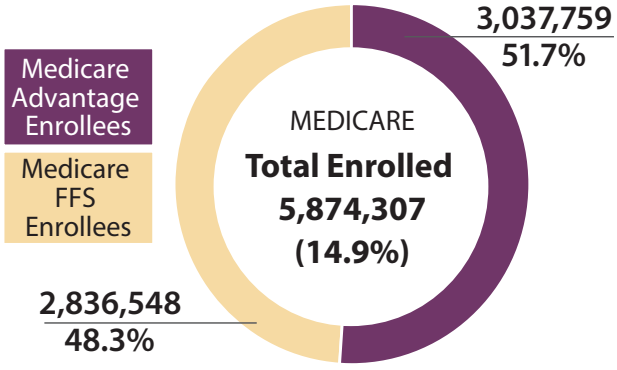


FIGURE 12. Medicare Enrollment by Race/Ethnicity, 2020[9]

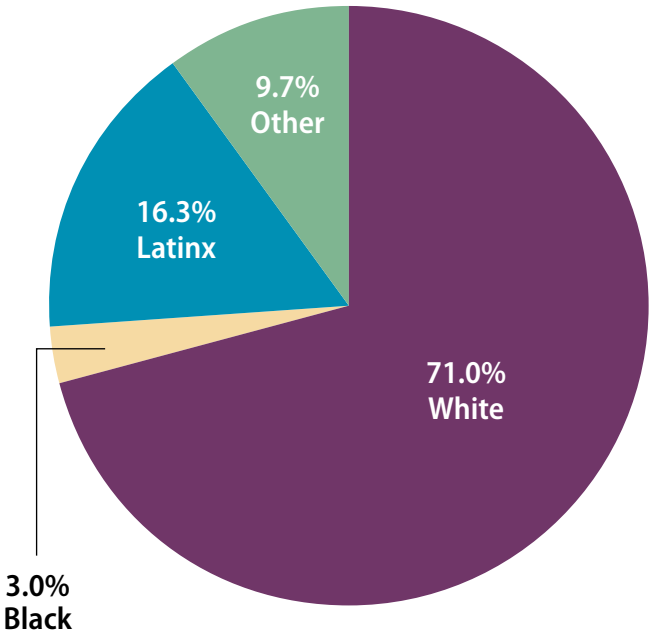
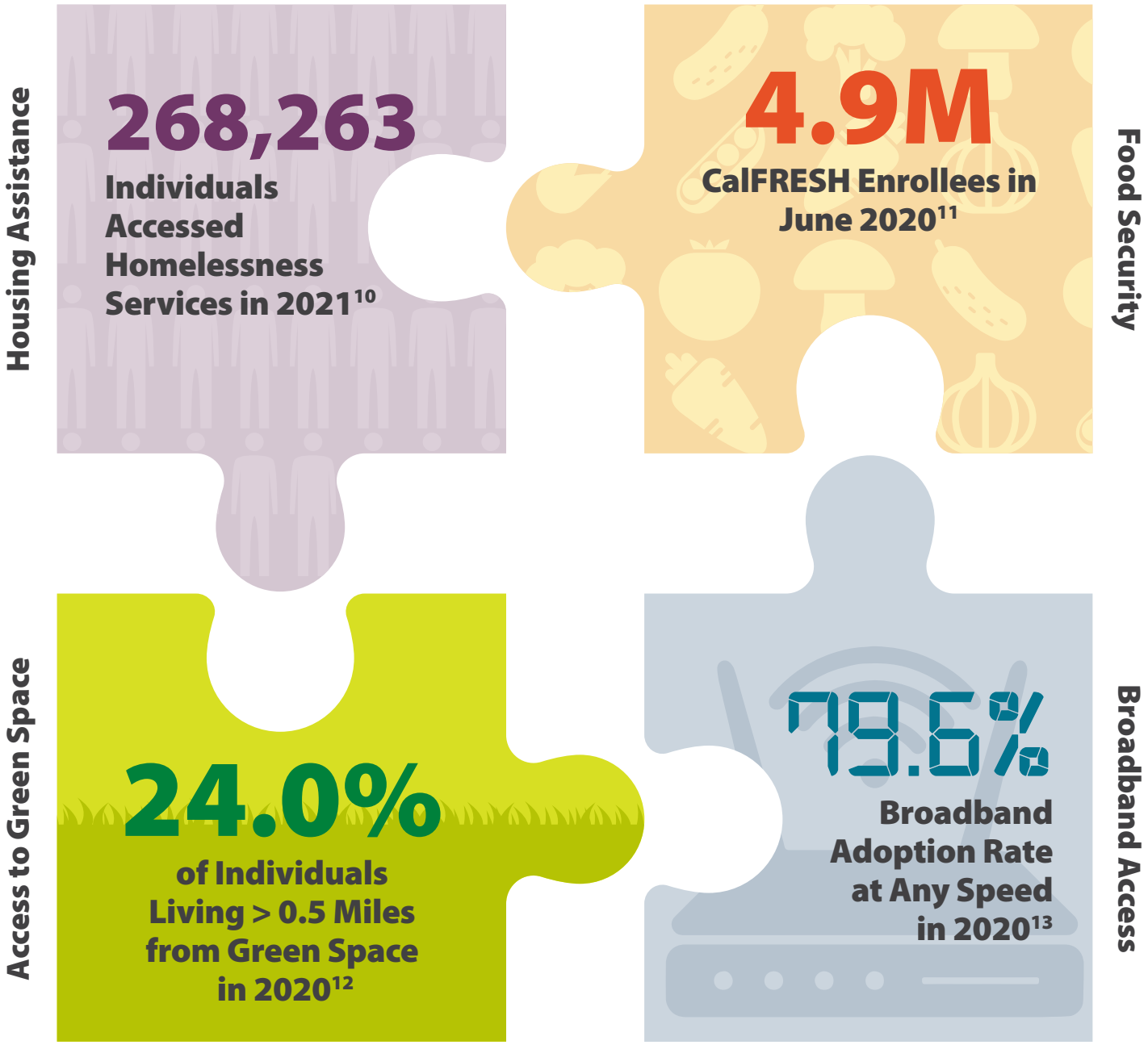


FIGURE 13. Total Dual Eligibles, April 2022[6]

**Dual Eligibles are those eligible for both Medicare and Medi-Cal, also referred to as Medi Medis.

DATA SNAPSHOT: SOCIAL DRIVERS OF HEALTH

Social Drivers of Health (SDoH), also known as Social Determinants of Health, refer to the conditions in environments where people are born, live, learn, work, play, worship, and age that influence their health risks and overall wellbeing. Some of these drivers include access to safe housing, nutritious food, parks and green space, and even broadband and internet connectivity, all of which impact the ability of and opportunity for Californians to live their healthiest lives.



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All decimals rounded to nearest tenth.

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About ITUP

ITUP is an independent, nonprofit, health policy institute that has been a central voice in the California health landscape for more than two decades. ITUP serves as a trusted expert, grounded in statewide and regional connections with a network of policymakers, health care leaders, and stakeholders. The mission of ITUP is to promote innovative and workable policy solutions that expand health care access and improve the health of all Californians.

ITUP is generously supported by the following funders:

- California Community Foundation
- California Health Care Foundation
- The California Endowment
- The California Wellness Foundation


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LOS ANGELES COUNTY COMMISSION ON HIV

POLICY BRIEF NO. 4

POLICY BRIEF

Ryan White Reauthorization* Principles

Recommendations for a comprehensive HIV strategy as we prepare for the next version of Ryan White legislation
RYAN WHITE SUBCOMMITTEE, JOINT PUBLIC POLICY (JPP) COMMITTEE • MARCH 10, 2008

Development of the Commission's Ryan White Reauthorization* Principles.

A subcommittee formed by the Commission's Joint Public Policy (JPP) Committee, along with service consumers and representatives of HIV service providers, met for most of 2007 to agendize Los Angeles County priorities for the next version of Ryan White legislation. In total, there were 11 meetings, representing close to 500 individual stakeholder hours of discussions on these topics. These principles represent the JPP Committee's effort to reflect the care and treatment needs of local consumers, to proactively assert Los Angeles County's interests and priorities, and to help frame the context and discussion for the next incarnation of the legislation. They are intended to present a unified approach and strategy from Los Angeles County, and set the stage for a collaboration with interested stakeholders around the country.

Why the Ryan White Program is Important to Los Angeles County.

As the most populous county in the US, and the 13th largest county geographically, Los Angeles County is a vast and diverse region, with urban, suburban and rural mixes and a complicated political structure (88 separate municipalities plus dozens of other governmental jurisdictions). Los Angeles County is a rich racial, ethnic and cultural tapestry: it incorporates over 100 officially translated languages, is home to the largest number of more than a dozen immigrant populations from around the world, has greater proportions of undocumented and uninsured residents than any other US region, and has the largest majority/minority population in the country.

That same complexity, however, makes responding to the HIV epidemic a unique challenge, as evidenced by alarming HIV infection rates among its transgender, transient youth and other vulnerable populations, along with other indicators of severe and unmet need. Since the days when AIDS was first identified in Los Angeles County, the County has confronted the HIV crisis within this demanding context. In spite of a publicly funded health care system that faces constant budgetary crisis, the lack of a sound transportation system, and cost-of-living and medical/health care costs that outpace most other parts of the country, Los Angeles County has developed a wide range of innovative approaches to HIV care and delivery, and has created new model systems of care management and service quality assessment.

** Although commonly referred to as "reauthorization", the next version of Ryan White will require new legislation since the current Ryan White Treatment and Modernization Act will sunset on September 30, 2009.*

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POLICY BRIEF

Detailing Principles as a Framework for Further Discussion.

The JPP Committee envisioned this work generating "a comprehensive strategy for addressing HIV disease in this country" (Ryan White Subcommittee Vision Statement). The Committee and other participants felt that development of these principles would help "advance federal legislation and other initiatives that provide access to and delivery of equitable, high quality, efficient care and prevention services for people living with or at risk of HIV disease" (Ryan White Subcommittee Mission). These principles serve as the Commission's framework to guide and motivate more specific thought and study throughout 2008 and 2009 of important issues to address in the next iteration of Ryan White legislation.

1. HIV is unique.

In spite of constant claims of "AIDS exceptionalism", HIV remains a unique health condition. It is the only terminal illness that is both communicable and chronic (some might also classify Hepatitis that way as well, which is a primary HIV co-morbidity). However, due to both its terminal and communicable nature and because experts are still learning more about the disease and the efficacy of its treatments every day, HIV cannot be treated like other chronic conditions: it demands more complex care and treatment and population-based public and personal health responses.

Among certain age and ethnic groups, and in certain areas/regions, HIV disease is the number one killer. It is a disease that is directly linked with poverty and low socio-economic status, and is one of the principle co-morbidities of mental illness, substance use and homelessness. It is unique because early, preventive care can delay onset of symptoms and mortality longer than almost all other chronic illnesses. As a communicable disease, prevention initiatives will not only prevent individual infections but also its spread to others and other populations.

Services for HIV are distinctive, and they must remain that way. Otherwise, the assumption is that a pre-determined, conventional response is a sufficient solution. Even if a cure and vaccine were found tomorrow, HIV would still be prevalent due to its communicability, the populations it most impacts, the constant mutation of the underlying virus, and the lack of access to proper medical and pharmaceutical response both domestically and globally. Together, these factors underscore the continuing need for a combined prevention and treatment response and an ongoing federal and local investment and commitment that continues to grow and adapt with the increasing and changing impact of the disease.

2. HIV disease is a continuum.

HIV is a chronic disease that spans a spectrum from healthy status to terminal illness. "AIDS", as the term used to describe the condition, has become less explanatory as the years have passed, and no longer accurately illustrates the continuum of the health condition. Someone diagnosed with AIDS [less than 200 or 14% T-cell count, or identified by an Opportunistic Infection (OI)] at one point in his/her life can be perfectly healthy at a later point, while someone with HIV could be very sick although not diagnosed with AIDS. The term "AIDS" has increasingly become an arbitrary marker that often misrepresents the progression of the disease, and undermines the necessity of an individualistic health care response or a comprehensive strategy for a population significantly impacted by it.

The disease is "HIV". While "HIV/AIDS" describes the full spectrum of its impact, "AIDS" as a marker at one point along that continuum of the disease progression is a less and less reliable indicator. While "HIV disease" would be the most accurate descriptor, a broad cross-section of the public only pays appropriate attention or knows the disease as "AIDS", and that terminology cannot be wholesale discarded until the public is truly and comprehensively educated about the nature of this increasingly chronic condition. The principles call for a change in the language used to depict HIV disease and its impact more accurately, but also for a strong educational campaign that would support such a change.

POLICY BRIEF

There are not only semantic and perceptual distinctions derived from the use of the old terminology, but practical and legal consequences as well. People diagnosed with AIDS are eligible for Medicaid services, for example, while people with HIV (non-AIDS diagnosed) are denied that eligibility—although there may be no detectable difference in their respective health conditions or income status. New legislation and current federal and local programs must veer away from use the old and outdated terminology to drive policy decisions that are arbitrary and/or inaccurate, and must embrace efforts like ETHA (Early Treatment for HIV Act) in the next version of Ryan White to ensure adequacy, fairness and equity of access to and provision of services based on today's realities.

3. New Ryan White legislation must entail a comprehensive HIV strategy.

HIV is foremost a disease. The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act was initially established to address its health care consequences, although, at the time, there were few effective medical responses. With the advent of HIV/AIDS Anti-Retroviral Therapy (HAART) and other medical and pharmaceutical advances, medical treatment can reliably delay the development of the disease or stall its impact. Federal and local Ryan White commitment must continue to focus on the core services that enable medical care and treatment.

However, patients, for example, who do not understand their prescriptions, who cannot get to their appointments, whose medical care is interrupted by mental illness and/or substance addiction, who receive substandard care because their providers are not thoroughly trained in HIV care practice, and/or who cannot access basic necessities such as food and shelter, represent money wasted, lives lost and potential further spread of the disease. HIV continues to disproportionately impact people with multiple conditions, people in poverty who have severe need, and groups that have been traditionally disenfranchised from the health care system. Consequently, a single response for all patients is not effective and a complex matrix of services is necessary to meet the needs of patients with equally complex sets of circumstances. Potentially short-sighted concerns about the cost of expanding coverage (e.g., opposition to ETHA), or limiting certain service responses (e.g., reducing psychosocial support networks) ignores long-term cost savings that result from effective, sustainable care and treatment.

A comprehensive HIV plan will help define and guide how policy and decision-makers address and resolve these complicated equations and integrate the many different response components (e.g., surveillance, prevention, care, housing, research, etc.) seamlessly. It is no longer acceptable for federal stakeholders to trivialize HIV care and treatment by forcing a debate over the definition of health/medical care. That discourse has only served to unnecessarily divide the HIV community and is superfluous when there are numerous federal funding resources inefficiently addressing different aspects of the disease impact.

Consolidating the varied federal responses would engender a better planned and more fully integrated comprehensive system of addressing HIV needs efficiently and effectively. The time has come to merge the various federal agency funds (e.g., HRSA's Ryan White, HUD's HOPWA, SAMHSA's substance abuse services, CDC's prevention and surveillance, etc.) into an omnibus HIV initiative that truly and effectively addresses the multiple layers and myriad ramifications of HIV nationally, spans the spectrum of HIV services from prevention through care and treatment, and combines HIV data, record, surveillance and technology needs into a single, integrated effort.

Consolidating the numerous federal efforts is not, however, an excuse to reduce the overall federal HIV commitment: all existing federal funding directed toward HIV should be preserved and increased. Consolidating the various federal HIV initiatives is, instead, aimed at making the limited federal resources more efficient and less redundant and to improve positive outcomes overall.

POLICY BRIEF

4. Ryan White's "last resort" response is not practical.

The premise of Ryan White-funded services has long been based on using the funds as "last resort"—meaning that Ryan White grantees and recipients must first demonstrate that they have exhausted all other sources of funding before tapping into Ryan White resources. It is a strong, but unrealistic, concept. Non-entitlement resources (or limited funds) cannot be effectively used as "last resort" because there is a finite amount that can be exhausted regardless of need or utilization. In California, the counties are held accountable as health care of the last resort. Los Angeles County has no choice but to expend the funds for health care as long as people need the health care—regardless of budgetary restraints. Further complicating the use of Ryan White funds, federal restrictions do not allow local jurisdictions to combine Ryan White with other federal resources (e.g., Medicaid) for the most efficient response.

Unless the framers intend to advance Ryan White funding as an entitlement resource in the future—as the Institute of Medicine (*Measuring What Matters: Allocation, Planning and Quality Assessment for the Ryan White CARE Act*, November 7, 2003) suggests—then the arcane "last resort" premise should be removed as a condition of its use. Instead, Ryan White should be re-tooled for the role in which it can be most effective: as an essential "wrap-around" or supplement to existing sources of service and funding. There is no debate that HIV disease, due to its chronic nature, costs more than most other health conditions to treat. Conventional Medicaid and other federal reimbursement rates are not adequate for the type of care that practitioners must provide to people with HIV, resulting in vast inefficiencies and administrative circumventions. Re-engineer Ryan White as a critical wrap-around and supplementary component resource intended to enhance and expand other HIV prevention, care and treatment services—or supply those services where there are none—and Ryan White becomes a more cost-efficient and clinically effective program.

This new application of Ryan White funding better prepares it for a more integrated role in the inevitable universal health care access dialogue. Using Ryan White as a wrap-around and cost supplement resource not only comprises an improved application of this source of funding, but unravels the criticism of HIV/AIDS exceptionalism. It is a financing model that can be used for other chronic conditions also exceeding the constraints of current funding limits.

5. "Emergency" and "urgency" are not synonymous.

The Ryan White CARE Act was originally crafted as an "emergency" response to an epidemic that was devastating urban centers, other areas and various populations. It was intended for immediate use for people who, after being diagnosed with the disease, only had a short time left to live. Back then, the "triage" and "quick fix" aspects of an "emergency" response were primary in importance. Now—almost three decades into the epidemic—"urgency" is needed more, indicating a purposeful response, guided by expedited but thorough planning and implementation. Ryan White's continued focus on an "emergency" over "urgency" response leads to an administrative emphasis using the funds more quickly, rather than thoughtfully or deliberately.

Twenty-five years later, the emergency is not the same. The "urgency," however, is even more acute and should compel us to:

- Refocus our efforts to facilitate easy health care access and overwhelming care early on in the disease progresssion to slow its impact on the individual and the spread to others.
- Review program administration for burdensome, outdated procedures that no longer serve their original purpose (e.g., annual applications), and only slow the local response and/or service delivery.
- Devote expenditures to integrated prevention and care, where grantees have been obliged to distinguish between the two in the past.

POLICY BRIEF

- Devote specific funding allocations to address "unmet need," rather than simply planning for it.
- Emphasize the increased prevalence of the disease in emerging communities lacking access, not always assimilated, without adequate resources, and disenfranchised for various reasons and those that continue to be marginalized.
- Invest funding in incorporating HIV expertise into existing systems of care rather than sustaining separate systems.
- Increase investment in HIV care and services because the more we are successful fighting HIV with proper care, the less our population with and impacted by HIV expands.

6. HIV disease is a chronic disease that can be managed, but is not always manageable.

Framing the disease as an emergency often produced quick results, but not always long-term benefits. HIV is now, in part, a chronic condition that must be addressed in both the short- and long-term, and we must enhance and care and treatment service delivery with best practices learned from other chronic conditions. Good care for a chronic condition is untenable in solely a short-term mindset. While HIV is a condition that exceeds the capacity of many components of our health system, how can HIV care be integrated into the larger system so that both HIV medicine and US health care benefit? In the 90s, the emergency had more to do with the community's response; in the first and second decades of the 21st century, the HIV community needs to advance its service, funding and policy response to a level commensurate with strides we have made in health/medical care.

That response entails managing the disease more effectively and comprehensively, toward more positive clinical outcomes, and reducing stigma and protecting affected populations by normalizing health care routines. To the degree the next version of Ryan White requires more systemic, coordinated care management from providers, the more manageable the condition is for people who live with HIV day-to-day. The more manageable it is for them, the more they can contribute to health care improvements and reduced health care costs.

7. A united vision leads to a unified response.

Opponents of HIV care expenditures often cast discussion in light of an increasingly smaller pool of resources. Regions go to battle claiming their special needs demand more attention, their health care systems are in greater decline, and that resources are inadequate. Compatriots in the war against HIV become adversaries. We do not accept the premise that these discussions must ensue in a climate of fewer resources. In the next round of national Ryan White discussions, there must be a more coherent and cohesive strategy for making Ryan White and other HIV services about more than funding and "pieces of the pie."

We strive for more parity of access to services nationally for all people with HIV and believe that it calls for all state and local jurisdictions and federal partners to make strong commitments to HIV services, prevention and responses. Insisting on parity, equity and portability of care cannot be used as an excuse to reduce federal support of those jurisdictions that have made extraordinary commitments of their own resources (such as California, Los Angeles and San Francisco). This is a call, however, for federal, state, local and other resources to advance and accelerate their resource obligations to levels that will effect a unified service, prevention and treatment response. Jurisdictions must play on the same field:

- Receiving resources directly linked to the prevalence of the disease.
- Eliminating arbitrary measures (subjective scoring) of funding.
- Receiving comparable levels of additional funding to address the special needs of their HIV-impacted communities.

POLICY BRIEF

Similarly, unity of vision must engender parity of care, lead to universality of access, and reduce geographic disparities. Movement in the Ryan White 2006 reauthorization toward a more uniform response nationally must be accelerated significantly in the next version of the legislation. Ryan White resources cannot be used to widen the differential gap in care.

- People with HIV in one state should be able to get the same care in another state.
- Waiting lists in one area, where there are none in others, are unacceptable.
- Someone using medications in one region should be able to expect them in another area.
- To the extent this is a national program, care and documentation must be portable.
- ADAP formularies (like the VA or Medicare prescription plans) need to include all HAART and OI medications, not just a partial selection of them.
- ADAP must be consistent and universally applied throughout the country, rebates available in all of the states, and prescription access best practices (such as California and New York) should be the standard, not the ideal.

8. The necessity of a national strategy.

If we ever expect to contain the impact of this disease, Ryan White legislation must represent a national strategy and not a band-aid solution stretched too thin. The strategy must comprise not only prevention, services and care, but a deliberate federal initiative aimed at stopping HIV in its tracks—much as polio and TB were addressed in the 20th century. In the absence of a vaccine or cure, other more radical approaches must be enabled.

- The educational system, where so much of our behavior is learned and practiced, cannot be held immune to federal attention. No child should be left vulnerable and ignorant to the threats of HIV; and comprehensive K-12 HIV education is critical.
- The medical community must embrace the HIV proficiency of its practitioners and mandate the offer of HIV testing and resultant linked referrals to medical providers as the standard of care.
- There should be a national social marketing campaign that local communities can enhance, embellish, and adapt to their own populations, incorporating culturally specific anti-stigma and normalization messages.
- The media and medical communities should contribute to efforts that reduce HIV stigma and barriers by normalizing HIV care in the medical setting and HIV messages in for other purposes.
- While, as the richest country in the world, the US must take the lead on addressing the devastating economic, health and moral consequences of HIV globally, a priority focus on the domestic impact of the disease must be sustained (it is ironic that while the US has defined a global HIV strategy, it has not yet done so domestically).

At this juncture, when the entire federal HIV response is up for review and consideration, it is pivotal that the resulting federal legislation represents a collective spirit to solve the scourge of HIV, not just tolerate it.

9. Financially support quality and efficiency.

While there is more effort invested in quality management and clinical outcomes nationally, there does not seem to be a commensurate quality improvement at the local level, except as a response to federal mandates. Threshold funding must be available and adequate for all of the jurisdictions, but should be used to enhance clinical outcomes and cost-efficiency efforts and to reward improvements in health and clinical status and improved administrative and care efficiencies. For example:

- funding should not be awarded simply because more drugs have been disseminated, but because better and more efficient drug regimens are producing better health outcomes;
- resources should be used to support the standard medical visit, but also to encourage more effective use and efficiencies from resistance testing;
- Electronic Medical Record (EMR) systems are a costly investment, but an investment that will yield financial savings when it leads to more efficient administrative processes; and

POLICY BRIEF

- just the demonstration of unmet does not necessarily merit funding, but proof that the funds have generated increased access and visits from the targeted communities does.

Coordinated care has been modeled across the country and across health conditions to produce better health outcomes, so providers should be financially encouraged to adopt disease management models that rely on high quality care, and that incorporate inter-disciplinary, team-oriented service delivery, medical and primary health care account-ability, and a patient-centered focus. Efficiency of care liberates resources for other purposes, in particular prevention which, in turn, results in lower transmission and infection rates.

In the same vein, Ryan White resources can be used as incentive to improve local commitment.

- Federal funding can encourage regions to address HIV in their respective areas, and the investment must be significant enough that local communities cannot disregard it.
- Rather than solely designating Maintenance of Effort (MOE), it should be combined with matching requirements incentivized with the promise of additional funding when the match increases.
- Local communities should identify factors to measure the effectiveness of financing and administrative processes, and should be awarded additional resources when their indictors show more efficient operations and/or less cumbersome service delivery.

An Opportunity to Improve our HIV/AIDS Response.

The Ryan White CARE Act has served this country well during the first three decades of the HIV epidemic. However, the epidemic, its impact and the way we deal with it have all changed dramatically during that time. Our response must change too. This is the time to do it.

The upcoming sunset of the Ryan White Treatment and Modernization Act in 2009 represents a unique opportunity to re-examine and potentially redefine our federal HIV/AIDS policy. It is an exciting chance to create and implement an improved strategy for addres-sing HIV/AIDS in our country. Los Angeles County looks forward to engaging a construc-tive and collaborative national dialogue to craft legislation outlining the most effective use of resources and delivering the best services to people living with HIV/AIDS.

The Commission on HIV is chartered in Los Angeles County Code 3.29 to "study, advise and recommend to the board of supervisors and the grantee on matters related to HIV/AIDS" (3.29.090 D), and serves as LA County's Ryan White planning council.

LOS ANGELES COUNTY COMMISSION ON HIV

POLICY BRIEF #7
August 24, 2009

POLICY BRIEF

The Urgency of Ryan White Reauthorization

In December 2006, the Ryan White HIV/ AIDS Treatment Modernization Act of 2006 (RWTMA) became law. The Act replaced the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act that had been initially signed into law in 1990, and subsequently "reauthorized" (renewed) in 1996 and 2000.

The RWTMA involved significant changes but, overall, kept the federally funded Ryan White Program intact for another three years (until September 30, 2009). The Ryan White Program is the single largest non-entitlement source of federal funding for HIV/AIDS services throughout the country, and forms the core of the local HIV/AIDS care and treatment response in most local jurisdictions.

September 2009 Sunset

The inclusion of a "sunset" clause entails the end of the legislation in September 2009 was one of the more prominent features of RWTMA. Consequently, HIV/AIDS advocates around the country have urged Congress to extend ("reauthorize") RWTMA for another three years in order to allow changes in RWTMA to have an effect and to give the community an opportunity to more thoughtfully consider additional innovations—especially in light of pending health care reform legislation and a National HIV/AIDS Strategy.

Extending Ryan White Legislation for 3 Years

Given the shortened time span of the RWTMA and the magnitude of changes (such as new core medical service requirements and the enhanced prominence of HIV reporting requirements) that were included in it, local jurisdictions have only begun to implement those changes in the last two years. As a result, most HIV/AIDS consumers, organizations and stakeholders believe that additional innovations from a renewed reauthorization effort at this juncture would be premature and ill-conceived.

As reflected in the attached "HIV/AIDS Community Consensus on the Future of the Ryan White HIV/AIDS Treatment Modernization Act" (hereinafter called the "Community Consensus Document"), signed by 282 organizations as of 8/5/09 (including the Commission and OAPP), there is widespread consensus that a simple three-year extension of the RWTMA is the most effective approach at this point.

Minimal Language Changes

Even when reauthorized legislation is simply extended, though, some minor "tweaks" will be needed to in response to emerging conditions or legislative challenges. As the accompanying document details, these alterations have been kept to a minimum:

① "Restarting the Clock"

All of the dates in the legislation need to be modified to reflect a new three-year extension. That will ensure that unless language has been specifically modified, conditions of RWTMA will remain constant through 2012.

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② Appropriation Language

Currently the RWTMA specifies an annual 3.7% increase, but that annual increase has not kept pace with economic conditions. The Community Consensus Document calls for the 3.7% increase to be changed to "such sums necessary" in order to allow the flexibility for Ryan White appropriations to adapt to a changing economic climate.

③ HIV Reporting Requirements

Several jurisdictions have been modifying their HIV surveillance systems in accordance with Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) standards. Language has been suggested to allow these jurisdictions to continue to fully mature their systems without additional penalties.

④ Transitional Grant Area (TGA) Eligibility

Several of the 34 currently funded TGAs may lose eligibility for Ryan White funding without the proposed language to maintain their eligibility status.

⑤ Hold Harmless Provisions

The Community Consensus Document recommends language extending "hold harmless" provisions in the RWTMA that protect certain areas from devastating reductions.

⑥ Core Medical Service Definitions

Language is proposed to redefine two services as core medical functions: "food and nutrition services" [the provision of food (medical nutrition therapy is already considered a core medical service)] and medical transportation. Redefining them as core medical services allows funding for those services to fall within the 75% core medical service threshold.

Technical Fixes

There are also a small number of "technical fixes" for which language has been suggested to address specific problems resulting from changes in RWTMA:

① AIDS Drug Assistance Program (ADAP) Rebate Dollars:

Proposed changes attempt to clarify conflicting interpretations of the ways in which ADAPs are currently allowed to budget pharmaceutical rebate dollars. The proposal will allow ADAP rebate states, such as California, to maximize funding.

② Unobligated Funds

The 2% threshold before a jurisdiction incurs penalties for funds left over at the end of a program year is too high and unobtainable in many areas for reasons beyond their control. The proposed language lowers the threshold to 5% and suspends the penalties.

③ Part D Expenditures:

Currently, Part D (services for women and children) funds are required to be allocated for medical expenses even when there are other existing resources, contradicting the "last resort" intent of the Ryan White Program. The proposed language removes this requirement.

④ Client-level Data Systems and Severity of Need Indexes (SONIs)

The RWTMA included language that began requiring client-level data systems and SONIs—expensive new mandates for many local jurisdictions. The proposed language requires that funding be allocated for the development of these systems.

Urgent Action Needed

Unlike in former Ryan White reauthorizations, **the inclusion of a sunset clause mandates the termination of the Ryan White Program if new legislation is not implemented before the sunset date (October 1, 2009).** As a result, confirmed recently by HRSA, a "continuing resolution" (how reauthorization of RWTMA was put off from September until December 2006) or appropriations without authorization (how SAMHSA is currently funded) cannot continue the Ryan White Program alone without authorizing legislation.

POLICY BRIEF

If Congress fails to act and reauthorize RWTMA before September 30, 2009, the Ryan White Program will expire. With only five weeks left, legislation to reauthorize the Ryan White Program has yet to be introduced. Although Ryan White reauthorization—as defined in the Community Consensus Document—has support by the Administration and in Congress, health reform efforts have overwhelmed Congressional and Administration attention.

Failure by Congress and the Administration to act on it in a timely manner may leave this important program dismantled. Health reform, in the best of circumstances, will take years to implement and will not eclipse the need for a strong and vibrant Ryan White Program.

What Can You Do?

The need for a continued Ryan White Program is clear. If you are meeting with a Congressional representative or other party who does not understand the program's importance, refer to the attached document from the CAEAR Coalition that effectively establishes the necessity of the Ryan White Program.

Your voice is the most powerful and compelling tool to help raise the visibility of the need for Ryan White reauthorization in the next month. Don't be afraid to use it. Decision-makers in the Administration and Congress need to hear from you. Share your personal experiences and stories, and let your leaders know how their action, or lack thereof, on Ryan White reauthorization will significantly impact your lives. Following are ways that you can help in that effort:

① Call, write and visit your Congressional representatives to urge their action on Ryan White reauthorization—especially,

- in California, your personal Congressional representative; the Speaker of the House, Nancy Pelosi; Senators Boxer and Feinstein; and,
- in any jurisdiction, members of the House's Energy and Commerce Committee and the Senate's Health, Education, Labor and Pensions (HELP) Committee (the two authorizing committees).

You can look up Congressional contact information www.takeaction.lwv.org). In August, most Congressional representatives are in their districts during recess.

② Call, email and write the Administration to encourage their leadership on this issue, and to urge that they make Ryan White reauthorization a priority within the next month. You can contact.

- President Barack Obama and senior administration officials, including Jeff Crowley, Director of the Office of National AIDS Policy (ONAP),

  at 202.456.1111 or
  www.whitehouse.gov/contact;
- Secretary Kathleen Sebelius and senior officials at the Department of Health and Human Services

  at 877.696.6775 or 202.619.0257,
  or www.dhhs.gov
  or by mailing to:
  US Department of Health and Human Services
  200 Independence Avenue, SW
  Washington, DC 20201

*August 5, 2009**

Federal AIDS Policy Partnership
Ryan White Work Group

HIV/AIDS Community Consensus on the Future of the Ryan White HIV/AIDS Treatment Modernization Act

(Public Law 109-415)

The Ryan White Work Group is a coalition of national, local and community-based service providers and HIV/AIDS organizations that represent HIV medical providers, public health, advocates and people living with HIV/AIDS committed to ensuring that the Ryan White Program continues to ensure appropriate primary care and treatment and support services to uninsured and underinsured individuals living with HIV/AIDS.

In December of 2006, the Ryan White Program was reauthorized for a three year period and contained a sunset clause. Without action, the Program will expire on September 30, 2009. The reauthorization included many significant changes including changing the distribution formulas from estimated living AIDS cases to actual living HIV and AIDS cases, a core services requirement, and provisions regarding unobligated funds. The impact of these changes has not yet been fully or sufficiently analyzed as the changes are ongoing and sufficient data are currently unavailable.

The HIV/AIDS community has come together over the past several months to examine the possibilities for the future of the Ryan White Program. During a series of meetings and teleconferences, a broad range of participating organizations considered a number of factors including available data, information on how changes from the last reauthorization have affected services provided to Ryan White clients and the effects of these changes on their lives and health status/access to services. The Ryan White Work Group has carefully considered the time necessary to work through complicated program mechanics in order to make recommendations for change with the time available prior to sunset of the current legislation. After discussion the undersigned HIV/AIDS organizations have agreed to recommend the course of action as described in this *Community Consensus.*

The *Community Consensus* is largely cohesive; however, with such a large number of organizations involved and a large number of issues discussed there is some divergence on a few provisions. Those minority views are noted below. In addition to this *Community Consensus, participating* organizations submitted a document to Congress in the fall of 2008 recommending four technical fixes to the current legislation. These technical fixes are included at the end of the recommendations.

Additionally, the HIV/AIDS community is involved in a variety of additional policy discussions that potentially impact the Ryan White Program such as the development of a National AIDS Strategy, as well as broader health care reform. In order to maintain health stability for persons living with HIV/AIDS, it is necessary to secure an extension of the Ryan White Program while

the larger issues of our nation's health care system and a national strategic plan for HIV prevention, care and treatment are developed, assessed and analyzed.

Recommendations on the Legislative Future of the Ryan White Program

The undersigned organizations unanimously agree that the Ryan White Program must be extended for a period of at least three years. We believe an extension is the most prudent course of action given the many concurrent factors impacting the legislative future of the Program. Additionally, the HIV/AIDS community believes that the Ryan White Program must be reexamined in a comprehensive manner after the implementation of much-anticipated health care reform proposals and/or a national HIV/AIDS strategy. It would be premature to alter the Ryan White Program without waiting for specific proposals and programs.

During an extension process the dates in the legislation must be carefully examined and changed to reflect the new authorization period of FY2010 through FY2012. It is important that the dates be changed consistently and language no longer applicable to the Ryan White legislation be eliminated so as not to cause unintended consequences. This process can be looked at as "restarting the clock" on the current three-year authorization. The remainder of our recommendations honors this "restarting" concept and keeps alterations to the legislation at a minimum.

Authorization Levels

The current legislation includes authorization levels for each of the three fiscal years that are inadequate to address program need. Included in the current legislation is a 3.7 percent increase for the majority of the Parts, an increase which is significantly less than what is seen in other health authorization legislation such as for the Community Health Centers. For this reason, the community asks that for fiscal years 2010, 2011 and 2012 (the years included in a three year extension of the Program) the section of *Authorization of Appropriations* be altered to include language allowing for such sums as necessary.

Proposal: We ask that the extension bill include *Such Sums Necessary* language. This allows appropriators to respond to current economic conditions and provide adequate funding levels. Each Part of the legislation includes a section on *Authorization of Appropriations.* Each section be altered to state: "For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2012.

Continued Protection for States with Maturing HIV Case Data

Currently all states are collecting name-based HIV data. However, some states have only recently made this transition and do not yet have mature named-based HIV surveillance systems. In the last reauthorization, states with maturing systems were allowed to submit their HIV data directly to HRSA and incur a five percent penalty. If at any time during the three-year authorization period, the state's name-based HIV data is certified by the Secretary as accurate and reliable, the state has the ability to have CDC directly report the cases and avoid the five percent penalty. CDC has estimated that the earliest that all states may have mature HIV

systems is in FY2012. As the new authorization period goes on, fewer and fewer states will submit their data directly to HRSA and will use the CDC system.

Proposal: We recommend that states continue to have the option of submitting name-based data to HRSA until their state's name-based reporting system is deemed accurate and reliable by the HHS Secretary. Under this scenario, the five percent penalty would stay the same. In Parts A and B of the legislation, the section on *Requirement of Names-Based Reporting* must be updated for fiscal years 2010 through 2012 so that the provision remains the same.

Extension of TGA Eligibility

The last reauthorization created two separate tiers of Part A jurisdictions – Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs). It also created a prevalence test that had been intended to apply after three years of the bill. HRSA has notified six current TGAs that they are in jeopardy of losing their eligibility in FY2010. The community believes it is premature to discontinue funding to these (and any other jurisdictions) before client level data is fully realized and an analysis can be done of the services provided to individuals. In addition, because HIV data is not currently mature, eligibility is based only on AIDS cases. Once HIV case data becomes available it is assumed that EMA and TGA eligibility will be updated to include HIV and AIDS cases. Continuity of care is vitally important for persons receiving Ryan White-funded services.

Proposal: We recommend that all TGAs retain their status and continue to receive Ryan White funding. *Sec. 2609 (c) Certain Eligiblity Rules* under Title I of the current legislation should be updated to ensure that transitional grant areas retain their status. Language referencing subpart I should specifically be made to refer to transitional grant areas and the years should be updated as follows: References to fiscal year 2006 should be changed to fiscal year 2009 and references to fiscal year 2007 should be changed to fiscal year 2010.

Extension of Hold Harmless Provisions

Over the years, The HIV/AIDS community has wrestled with the issue of "hold harmless" provisions which, as of the last reauthorization, are now applied to the Part A Eligible Metropolitan Area (EMA) to eligible cities and Part B formula grants to states. Many organizations within the community maintain that the formulas should operate without adjustment in an effort to allow funds to follow the epidemic as closely as possible. At the same time, many (often the same) organizations have expressed concern that programs serving Ryan White clients need consistent levels of funding to make investment in infrastructure and build comprehensive programs. Large shifts, particularly drops in funding, can be destabilizing and lead to gaps in the provision of primary care and support services. As the numbers of reported HIV cases have changed relative to other jurisdictions and as the formulas for both Parts A and B have changed over the years to emphasize different factors, Congress has created a hold harmless clause to ensure that jurisdictions do not lose levels of funding that jeopardize the provision of HIV/AIDS services. Thus, "hold harmless" provisions were instituted to attempt to control the rate at which jurisdictions felt the full impact of new formulas. It should be noted that while a jurisdiction's proportion of HIV/AIDS cases relative to other jurisdictions might decrease, the number of persons living with HIV/AIDS in need of Ryan White services continues to increase in every jurisdiction. Many organizations have expressed concern that the discussion over hold

harmless has at times overshadowed the real issue facing all funded jurisdictions which is that current funding levels are inadequate to meet demands in all areas of our country.

The current legislation instituted new "hold harmless" provisions for Part A Eligible Metropolitan Areas (EMAs) and Part B formula awards by authorizing funding for grants in FY 2007 at not less than 95% of funding for FY 2006 and funding in FY 2008 and FY 2009 at not less than 100% of 2007. The formulas for Parts A and B continue to be in a period of adjustment due to several factors including the switch in formulas to living HIV/AIDS cases from estimated living AIDS cases and the fact that some states' new name-based HIV reporting systems have not yet matured. The CDC has estimated that the earliest a nationwide mature HIV system would be available is 2012. Further, the number of living HIV and AIDS cases continue to fluctuate and additional cases from maturing name-based HIV reporting systems will be added to overall case counts. Due to a convergence of all the above factors, eliminating hold harmless provisions in this transitional period would likely result in a loss of funding in some jurisdictions that would lead to destabilized HIV/AIDS care and support services.

Proposal: In keeping with other proposals in this document, the HIV/AIDS community recommends that the hold harmless provisions for Parts A and B should be restarted by simply adjusting the dates on current legislation as follows: formula grants in FY 2010 should be no less than 95% of funding for FY 2009 and funding for FY 2011 and FY 2012 should be no less than 100% of FY 2010.

Minority View: AIDS Alabama, Colorado AIDS Project, Community Access National Network, Connecticut AIDS Resource Coalition, Northern Colorado AIDS Project, the Southern AIDS Coalition, The AIDS Institute and Western Colorado AIDS Project agree with the majority viewpoint that FY 2010 should be set at no less than 95% of funding for FY 2009. For FY 2011 and FY 2012 this group would like to see the formula funding for Parts A and B better match the number of HIV/AIDS cases in each jurisdiction without destabilizing existing systems of care. Additionally, these organizations believe the same hold harmless measures should be adopted for Transitional Grant Areas as for EMAs.

Allow the Provision of Food Pursuant to a Doctor's Prescription as a Core Medical Service

Under the 2006 reauthorization, Medical Nutrition Therapy (MNT) is an allowable core service. MNT involves the assessment of the nutritional status of a person with a condition, illness or injury that puts them at risk, by a registered dietitian. It is a comprehensive examination of each individual that includes the review and analysis of medical and diet history, anthropometric measurements and laboratory values, after which the registered dietitian provides nutritional counseling and education about a specific disease state. In the case of HIV, a therapeutic nutrition plan that is most appropriate to manage or treat HIV/AIDS is chosen.

Access to adequate and appropriate food is fundamental, as it is the foundation of any medical therapy and has numerous benefits. For people living with HIV/AIDS, a well-balanced diet can help strengthen the immune system, prevent infections and reduce hospitalizations. The majority of the HIV/AIDS community supports the inclusion of food and nutrition services provided pursuant to medical nutrition therapy as a core medical service. Such a provision has no impact on any pre-existing definition of medical nutrition therapy and has many positive medical

outcomes: it connects clients with primary care services, increases adherence to drug regimens and requires maintenance in primary care services for Ryan White Program eligible clients. The Association of Nutrition Services Agencies states that based on an estimate of meal provision throughout their membership only about 20% of meals provided through their membership would qualify for eligibility under this standard, assuming a local planning council prioritized the service in a particular EMA or TGA. Most meals provided would not be affected by this proposal and would continue to be regarded as a support service within the current guidelines of the Ryan White Program.

Proposal: Under Parts A and B, core medical services provisions, amend item (H) "Medical nutrition therapy" to state " Medical Nutrition Therapy, and food and nutrition services when provided pursuant to such therapy as advised by a physician" as part of the package of services that can be considered core medical services. Under this proposed approach, the definition of medical nutrition therapy is unaltered, and food and nutrition services not provided pursuant to MNT would continue to be treated as support services.

Minority Viewpoint: The American Academy of HIV Medicine (AAHIVM), the HIV Medicine Association (HIVMA) and the Ryan White Medical Providers Coalition (Coalition) define medical nutrition therapy as nutritional supplements prescribed by a licensed dietitian or medical provider. The Academy, Coalition, and HIVMA support the current HRSA interpretation of "medical nutrition therapy" as it applies to core medical services for Ryan White. These organizations do not support an expansion of the definition of medical therapy to include food or other nutrition services. These groups maintain that such an expansion would be a substantive change and goes beyond the scope of technical fixes that are currently under consideration for an extension of the current Ryan White Program through 2012.

Alter the Definition of Medical Transportation and Allow it as a Core Medical Service

As a result of the most recent reauthorization, "medical transportation" has been classified as a support service. Medical transportation has been narrowly defined to mean transportation solely to and from Ryan White-funded medical-related services. This interpretation of the term medical transportation fails to accommodate areas that do not have strong public transportation infrastructure or that are comprised of large rural areas. For example the narrow modification may disallow rural gas vouchers, affecting the ability of clients to obtain food or other necessities. In areas with public transportation, it may prevent providers from purchasing the least expensive forms of tickets such as monthly vouchers, instead forcing clients to make multiple trips to service providers for individual bus passes or using more expensive forms of transportation such as taxis. Consequently local authorities are precluded from making common sense decisions about providing transportation in the service of treatment and care. For this reason, we recommend that transportation services within support services be broadened by removing the qualifier "medical."

The HIV/AIDS community has long pointed out the need for a constellation of services to ensure that people living with HIV/AIDS receive the best possible care. The inability of a person living with HIV to access needed medical treatment, including physician services, due to a lack of transportation is itself a lack of medical care. For this reason we additionally recommend that "medical transportation" specifically should be included as a core medical service.

Proposal: The HIV/AIDS community recommends removing the qualifier "medical" from transportation in the support services category and including "medical transportation" specifically in the definition of core medical services.

Minority Viewpoint: The American Academy of HIV Medicine, the HIV Medicine Association and the Ryan White Medical Providers Coalition support the current HRSA interpretation of transportation and do not support changes to the definition of transportation or the addition of medical transportation to the core medical service definition. These groups agree that medical transportation is important but many HIV programs are facing serious challenges covering the current list of core medical services, including critical components of the standard for HIV care, such as laboratory monitoring. They also feel that such an expansion would be a substantive change in the opinion of these groups and goes beyond the scope of technical fixes that are currently under consideration for an extension of the current Ryan White Program through 2012.

Technical Fixes

These technical fixes were submitted to Congress in the fall of 2008 and remain a high priority for the HIV/AIDS community.

ADAP Rebate Dollars

Rebate model ADAPs (those that purchase via a pharmacy network and then request rebates from pharmaceutical companies to obtain the 340B program drug prices), which make up over half of the states, have been instructed by HRSA that they must spend rebate dollars first (considered "program income" by HRSA) before using their federal ADAP grant award. With new carryover rules and penalties in the Ryan White HIV/AIDS Treatment Modernization Act, this will lead to some states losing future ADAP funding should they have more than two percent of their federal ADAP grant unobligated. Regardless of how rebate income is classified, the Ryan White Program requires rebates to be put back into the Part B program with preference given to ADAP services. Rebate income should not be considered program income or result in a reduction of expenditures and therefore should be allowed to accrue after a grant year has ended and spent after federal funds are expended.

Proposed Language: "In keeping with Congressional intent and Section 2622 (d) of Public Law 109-415, rebate funds associated with Section 2616 of Public Health Service Act (42 U.S.C. 300ff-26) are exempt from 45CFR92.21. HRSA will consult with state grantees to develop a process that certifies and describes that such funds are in compliance with Section 2616 (g) of Public Law 109-415."

Unobligated Funds

The current legislation contains a provision that penalizes Part A and B grantees if they have more than two percent of their award unobligated at the end of a grant year by making them ineligible for the supplemental components of their awards. This provision presents an undue burden on grantees, who must comply with basic grants management such as working with subgrantees, but also deal with state budget factors such as hiring freezes, spending caps, etc. that make obligating grant dollars down to a very small amount difficult. Due to these uncertain economic times, it is not appropriate to penalize HIV/AIDS programs for circumstances beyond their programmatic control. We support an increase in the penalty threshold from two to five

percent. Additionally, we ask that the penalties for having more than five percent of grants unobligated be suspended, allowing grantees access to subsequent years supplemental funding and eliminating reductions in future grant awards.

Proposed Language: For Parts A and B, strike or suspend "Corresponding Reduction in Future Grant" section under Section 104 and Section. 207 – "Timeframe for Obligation and Expenditure of Grant Funds." Additionally, in all Parts providing a penalty for failure to obligate funds, change the language of the exception to the penalty from 2 percent to 5 percent. For example, for language reading, "except that this clause does not apply to the eligible area if the amount of the unobligated balance was 2 percent or less", strike "2" and replace with "5".

Minority Viewpoint: The AIDS Institute does not support this proposal in total. It supports expanding the amount of unobligated balances allowed to up to 5 percent, and striking one penalty, specifically the one that makes jurisdictions ineligible for future supplemental funding.

Ryan White Part D (Services for Women, Infants, Children, Youth and Families) Medical Expense Reporting Requirements

For FY2007 and FY2008 budgets, Ryan White Part D grantees have been instructed by HRSA to include medical expenses in their program budget. Unlike other parts of the Ryan White Program, Part D is not required to allocate a proportion of funds to medical expenses, as Part D grantees are able to access Medicaid, SCHIP and other public programs to pay for most primary medical care for their clients. In fact, Part D was exempted from the core medical services set aside in the 2006 reauthorization legislation. Part D must, however, provide access to these services either directly or through contract. This has been a requirement of Part D since its inception, and HRSA has historically allowed Part D grantees to enter into memoranda of understanding (MOUs) with medical providers to ensure access to primary care, even when financial reimbursement was not involved. The Ryan White Program is required to be the payer of last resort, and asking Part D dollars to go toward medical expenses that can be paid for through other sources is in direct conflict with this requirement.

Proposed Language: Section 2671 (h) definitions (3) Services add the following "(C) Nothing in this part shall be construed as requiring funds to be used for primary medical care when other payers are available for such care."

Add (4) Contracts.-The term "contracts" includes memoranda of understanding when outpatient or ambulatory care is provided outside of this part.

Severity of Need Index and Client Level Data

The current legislation allows for the development of both Client Level Data (CLD) and a Severity of Need Index (SONI), but intentionally does not include provisions for implementing the CLD or the SONI as components of the funding allocation process. CLD will commence on January 1, 2009 with a portion of grantees and will run parallel with the current HRSA data systems for one to two years. A version of SONI has been developed, but not tested. Since HIV data will not be mature for all states until at least 2012, we believe that Part A and Part B resources should continue to be distributed by existing formula and supplemental mechanisms through 2012. Additionally, HRSA issued a competitive grant notice to Part A and B for funds to assist in the development of their CLD system. The grant announcement was issued so early

in the process that many states and cities did not apply for the funds but are now realizing they need them. SPNS funds should be made available on a continuing basis to cities and states that need them to support activities to develop, maintain, and train on use of a CLD systems.

Proposed Language: "It is the intent of Congress that Part A and Part B resources continue to be distributed by existing formula and supplemental mechanisms." Amend Section 2691 Special Projects of National Significance, Subparagraph (b) by inserting after "The Secretary shall award grants under subsection (a) to entities eligible for funding under parts A, B, C, and D" the following "to support them in implementing the new client level data system and make funds available to each Part in the same percentage as each Part's contribution to the SPNS budget."

Note: This document has been created by the Ryan White Work Group of the Federal AIDS Policy Partnership. For additional information, please contact Co-Chairs Ann Lefert (NASTAD) at 202-434-7138 or at alefert@nastad.org or William McColl (AIDS Action), at 202-530-8030 ext. 3096 or at wmccoll@aidsaction.org.

The following organizations endorse the recommendations in the *HIV/AIDS Community Consensus on the Future of the Ryan White HIV/AIDS Treatment Modernization Act:*
(Note: 282 organizations have signed on as of July 22, 2009. They are arranged alphabetically by State, Territory and the District of Columbia)

Alabama
AIDS Alabama, Birmingham, AL
Southern AIDS Coalition, Birmingham, AL

Alaska
HIV/AIDS Services for African Americans in Alaska, Anchorage, AK

Arizona
HIV/AIDS Law Project, Phoenix, AZ

Arkansas
Jefferson Comprehensive Care System, Inc., Pine Bluff, AR

California
AIDS Housing Alliance, San Francisco, CA
AIDS Legal Referral Panel of the San Francisco Bay Area, San Francisco, CA
AIDS Project Los Angeles, Los Angeles, CA
Alameda and Contra Costa Counties Collaborative Community Planning Council Transitional Grant Area Oakland, CA
AltaMed Health Services, East Los Angeles, CA
Asian & Pacific Islander American Health Forum, San Francisco, CA
Asian & Pacific Islander Wellness Center, San Francisco, CA
Bienestar Human Services, Los Angeles, CA
Black Coalition on AIDS, San Francisco, CA
Catholic Charities CYO, San Francisco, CA
Common Ground – the Westside HIV Community Center, Santa Monica, CA
County of Los Angeles Department of Public Health, Office of AIDS Programs and Policy, Los Angeles, CA
Desert AIDS Project, Palm Springs, CA

Face to Face/Sonoma County AIDS Network, Santa Rosa, CA
Food Bank of Contra Costa and Solano, Concord, CA
HIV ACCESS, Alameda County, CA
Los Angeles Gay & Lesbian Center, Los Angeles, CA
Mendocino County AIDS Volunteer Network, Ukiah, CA
Project Inform, San Francisco, CA
Project Open Hand, San Francisco, CA
Sacramento HIV Health Services Planning Council, Sacramento, CA
San Francisco AIDS Foundation, San Francisco, CA
San Francisco HIV Health Services Planning Council, San Francisco, CA
Solano County Health and Social Services Department, Vallejo, CA
Sonoma County Commission on AIDS, Santa Rosa, CA
Southern California HIV Advocacy Coalition (SCHAC), Los Angeles, CA
Strong Consulting, Crescent City, CA
Transgender Law Center, San Francisco, CA

Colorado
Colorado AIDS Project, Denver, CO
Denver Health HIV Primary Care Clinic, Denver, CO
Northern Colorado AIDS Project, Fort Collins, CO
Project Angel Heart, Denver, CO
The Empowerment Program, Women's AIDS Project, Denver, CO
Western Colorado AIDS Project, Grand Junction, CO

Connecticut
Connecticut AIDS Resource Coalition, Hartford, CT

Delaware
AIDS Delaware, Wilmington, DE
Delaware HIV Consortium, Wilmington, DE

District of Columbia
ADAP Advocacy Association (aaa+), Washington, DC
AIDS Action Council, Washington, DC
AIDS Alliance for Children, Youth & Families, Washington, DC
American Academy of HIV Medicine, Washington, DC
American Dental Education Association, Washington, DC
American Psychological Association, Washington, DC
Association of Nutrition Services Agencies (ANSA), Washington DC
CAEAR Coalition, Washington, DC
CAEAR Foundation, Washington, DC
Community Access National Network, Washington, DC
Food & Friends, Washington, DC
Hispanic Federation, Washington, DC
Human Rights Campaign, Washington, DC
National AIDS Fund, Washington, DC
National Alliance of State and Territorial AIDS Directors, Washington, DC
National Association of Community Health Centers, Washington, DC
National Association of Counties, Washington, DC
National Association of County and City Health Officials (NACCHO), Washington, DC

National Association of People With AIDS, Washington DC
National Black Gay Men's Advocacy Coalition, Washington, DC
National Center for Transgender Equality, Washington, DC
National Coalition for LGBT Health, Washington, DC
National Gay and Lesbian Task Force Action Fund, Washington, DC
National Minority AIDS Council, Washington, DC
Parents, Families, and Friends of Lesbians and Gays (PFLAG) National, Washington, DC
Sexuality Information and Education Council of the United States (SIECUS), Washington, DC
The Women's Collective, Washington, DC
Us Helping Us, Washington, DC

Florida
Broward House, Inc., Fort Lauderdale, FL
Dab the AIDS Bear Project, Jacksonville, FL
Okaloosa AIDS Support and Informational Services, Inc., Ft. Walton Beach, FL
South Beach AIDS Project, Miami, FL
The AIDS Institute – Tampa, FL/Washington, DC

Georgia
AID Atlanta, Atlanta, GA
AID Gwinnett, Duluth, GA
AIDS Athens, Athens, GA
AIDS Research Consortium of Atlanta, Atlanta, GA
AIDS Resource Council, Rome, GA
Aniz, Atlanta, GA
Community Foundation for Greater Atlanta, Atlanta, GA
Georgia AIDS Coalition, Snellville, GA
Georgia Equality, Atlanta, GA
Georgia Ryan White Working Group, Atlanta, GA
Grady Health System Infectious Disease Program, Atlanta, GA
Health STAT, Atlanta, GA
Living Room, Atlanta, GA
Metro Atlanta Ryan White Planning Council, Atlanta, GA
My Brothaz Home, Savannah, GA
North Georgia AIDS Alliance, Gainesville, GA
Open Hand, Atlanta, GA
Positive Impact, Atlanta, GA
SisterLove, Atlanta, GA
Someone Cares, Marietta, GA
Southern Crescent HIV Center, Riverdale, GA
The Phoenix Group Foundation, Inc., Atlanta, GA
Travelers Aid of Metropolitan Atlanta, Atlanta, GA
What Would Jesus Do HIV Health Ministry, Atlanta, GA

Hawaii
Hawaii Island HIV/AIDS Foundation, Keaau, HI
Malama Pono Kauai AIDS Project, Lihue, Kauai, HI
Maui AIDS Foundation, Wailuku, HI

Idaho
The O! Zone, Boise, ID

Illinois
AIDS Foundation of Chicago, Chicago, IL
AIDS Legal Council of Chicago, Chicago, IL
Asian Human Services, Chicago, IL
Austin Health Center of Cook County, Chicago, IL
BEHIV, Chicago, IL
CBC Initiative, Austin Health Center of Cook County, Chicago, IL
Center on Halsted, Chicago, IL
Chicago House and Social Service Agency, Chicago, IL
Heartland Alliance for Human Needs & Human Rights, Chicago, IL
HIV/AIDS Community Clinic Network, College of Medicine, University of Illinois at Chicago, Chicago, IL
Howard Brown Health Center, Chicago, IL
Illinois Caucus for Adolescent Health, Chicago, IL
International Association of Physicians in AIDS Care (IAPAC), Chicago, IL
New Age Services, Chicago, IL
Open Door Clinic, Elgin, IL
Ruth M. Rothstein CORE Center, Chicago, IL
South Side Help Center, Chicago, IL
Southern Illinois AIDS Walk, Carbondale, IL
The Children's Place Association, Chicago, IL
Vital Bridges NFP, Inc., Chicago, IL

Indiana
Harm Reduction Institute, Indianapolis, IN
Tri-State Alliance, Inc., Evansville, IN

Iowa
AIDS Project of Central Iowa, Des Moines, IA
Community HIV/Hepatitis Advocates of Iowa Network (CHAIN), Des Moines, IA
Wilson Resource Center (WRC), Arnolds Park, IA

Kansas
Douglas County AIDS Project, Lawrence, KS
United Methodist Mexican-American Ministries, Garden city, KS

Kentucky
AIDS Interfaith Ministries of Kentuckiana, Inc. (AIM), Louisville, KY
House of Ruth, Inc. , Louisville, KY
Volunteers of America, Inc. (VOA), Louisville, KY

Louisiana
NO/AIDS Task Force, New Orleans, LA
Office of Health Policy &AIDS Funding, New Orleans, LA

Maine
Frannie Peabody Center, Portland, ME
Maine AIDS Alliance, Portland, ME

Maine Community AIDS Partnership, Augusta, ME

Maryland
AIDS Action Baltimore, MD
Baltimore Behavioral Health, Baltimore, MD
Baltimore City Commission on HIV/AIDS, Baltimore, MD
Chase Brexton Health Services, Baltimore, MD
HIV/AIDS Volunteer Enrichment Network, Inc. (HAVEN), Annapolis, MD
Johns Hopkins AIDS Care Program, Baltimore, MD
LIGHT, Health and Wellness Comprehensive Services, Inc., Baltimore, MD
Manna House Inc, Baltimore, MD
Moveable Feast, Inc., Baltimore, MD
Park West Health System, Inc., Hidden Garden Program, Baltimore, MD

Massachusetts
AIDS Action Committee of Massachusetts, Boston, MA
Boston Health Care for the Homeless Program, Boston, MA
Cambridge Health Alliance-HIV Services, Cambridge MA
Catholic Charitable Bureau of the Archdiocese of Boston, Inc., Boston, MA
Community Research Initiative of New England, Boston, MA
Community Servings, Boston, MA
GAAMHA, Inc., Gardner, MA
Health Care of Southeastern Mass., Inc., Brockton, MA
HOPE: Hispanic Office of Planning and Evaluation, Inc., Boston, MA
JRI Health, Boston, MA
Latin American Health Institute, Boston, MA

Michigan
AIDS Partnership Michigan, Detroit, MI
CARES (Community AIDS Resource and Education Services), Kalamazoo, MI
HIV/AIDS Alliance of Michigan, Detroit, MI
HIV/AIDS Resource Center, Ypsilanti, MI
Lansing Area AIDS Network, Lansing, MI
Michigan HIV/AIDS Council, Lansing, MI
National Association of AIDS Education and Training Centers, Detroit, MI
Wellness AIDS Services, Inc., Flint, MI

Minnesota
Minneapolis Medical Research Foundation, i-MAC2 Clinics, Minneapolis, MN
Minnesota AIDS Project, Minneapolis, MN
Minnesota HIV Services Planning Council, Minneapolis, MN
Open Arms of Minnesota, Minneapolis, MN

Mississippi
A Brave New Day, Jackson, MS
Center of H.O.P.E., Jackson, MS

Missouri
Food Outreach, Inc. St. Louis, MO

Nebraska
Caring People Sudan, Omaha, NE

New Hampshire
AIDS Response Seacoast, Portsmouth, NH
AIDS Services for the Monadnock Region, Gilsum, NH
Southern NH HIV/AIDS Task Force, Nashua, NH

New Jersey
AIDS Coalition of Southern New Jersey, Bellmawr, NJ
African American Office Of Gay Concerns, Newark, NJ
Buddies of New Jersey, Inc., Hackensack, NJ
City of Passaic/ Passaic Alliance, Passaic, NJ
City of Paterson, NJ
Friends for Life, Fort Lee, NJ
Horizon Health Center, Jersey City, NJ
Hyacinth AIDS Foundation, New Brunswick, NJ
NJSHAC (New Jersey Statewide HIV/AIDS Coalition), East Brunswick, NJ
Paterson Counseling Center, Inc., Paterson, NJ
Puerto Rican Family Institute, Jersey City, NJ
Ryan White Part C grant VNACJ Community Health Center, Inc, Asbury Park, NJ
St. Mary's Hospital Early Intervention Program (EIP Clinic), Passaic, NJ
Visiting Nurse Association of Central Jersey, Red Bank, NJ

New Mexico
New Mexico AIDS Services Albuquerque, NM
OUTREACH New Mexico HIV Consummer Advocacy Network, Albuquerque, NM
Southwest CARE Center - Santa Fe, NM

New York
African Services Committee, New York, NY
AIDS Institute, New York State Department of Health, Albany, NY
AIDS Service Center NYC, New York, NY
AIDS Treatment Data Network, New York, NY
Albany Damien Center, Albany, NY
amfAR, The Foundation for AIDS Research, New York, NY
Asian & Pacific Islander Coalition on HIV/AIDS (APICHA), New York, NY
Bedford Stuyvesant Family Health Center, Inc. - Wellness Center, Brooklyn, NY
Center for Community Alternatives, Syracuse, NY/New York, NY
Central New York Health Systems Agency, Inc., East Syracuse, NY
Central New York HIV Care Network, East Syracuse, NY
Cicatelli Associates Inc., New York, NY
Gay Men's Health Crisis, New York, NY
George Santana Citiwide Harm Reduction, Bronx NY
God's Love We Deliver, New York, NY
Harlem United, New York, NY
Lower East Side Harm Reduction Center, New York, NY
Mid-Hudson Valley AIDS Task Force, Inc., Hawthorne, NY
Nassau-Suffolk HIV Health Services Planning Council, Long Island, NY
NY HIV Health & Human Services Planning Council, New York, NY

Positive SPACE, Copaigue, NY
The AIDS Network of Western New York, Inc., Buffalo, NY
The Family Center, New York, NY
The Recovery Center (HIV/AIDS Services Dept) Monticello, NY
The Sharing Community, Yonkers, NY
Village Care of New York, New York NY

North Carolina
Triad Health Project, Guilford County, NC

Ohio
AIDS Resource Center Ohio, Dayton, OH
AIDS Taskforce of Greater Cleveland, Cleveland, OH
Association of Nurses in AIDS Care, Akron, OH
Ohio AIDS Coalition, Columbus, OH
Ryan White Consortium # 5, Toledo, OH
Stark County Regional HIV Prevention & Education Planning Advisory Group, Canton, OH
Woodlands AIDS Task Force, Newark, OH

Oklahoma
Tulsa Community AIDS Partnership, Tulsa, OK

Oregon
Cascade AIDS Project, Portland, OR
OHSU/Partnership Project, Portland, OR

Pennsylvania
ActionAIDS, Inc, Philade PA
AIDS Care Group, Chester, PA
AIDSNET, Bethlehem, PA
Calcutta House, Philadelphia, PA
Family and Community Service of Delaware County, Media, PA
Family Service Association of Bucks County, Langhorne, PA
Family Service of Chester County, West Chester, PA
Family Services of Montgomery County, Eagleville, PA
Gaudenzia, Inc., Philadelphia, PA
Keystone Hospice and KeystoneCare LLC, PA
MANNA, Philadelphia, PA
Northeast Regional HIV Planning Coalition United Way of Wyoming Valley, Wilkes Barre, PA
Pennsylvania School for the Deaf/Center for Community and Professional Services, Philadelphia, PA
Philadelphia FIGHT, Philadelphia, PA
Pittsburgh AIDS Task Force, Pittsburgh, PA
Public Health Management Corporation, Philadelphia, PA
SHAC (Suburban HIV/AIDS Consortium), PA
Temple Comprehensive HIV Program, Temple University School of Medicine, Philadelphia, PA
The COLOURS Organization, Inc., Philadelphia, PA

Puerto Rico
Bill's Kitchen, Inc., San Juan, Puerto Rico
Pacientes de SIDA Pro-Politica Sana (PSPS)

Rhode Island
AIDS Care Ocean State, Providence, RI
Community HIV/AIDS Mobilization Project (CHAMP), New York, NY /Providence, RI
seaQuel (Southeast Asian Queers United for Empowerment and Leadership), Providence RI
Youth Student Movement (PrYSM), Providence, RI

South Carolina
South Carolina Campaign to End AIDS (SC-C2EA), Columbia, SC

Tennessee
Positive East Tennessean's, Knoxville, TN
Nashville CARES, Nashville TN
Tennessee AIDS Care and Treatment Improvement Coalition (TACTIC), Nashville, TN

Texas
AIDS Services of Austin, Austin, TX
Bexar County Department of Community Investment, San Antonio, TX
International AIDS Empowerment, El Paso, TX
Legacy Community Health Services, Inc. Houston,TX
North Central Texas HIV Planning Council, Fort Worth, TX
San Antonio AIDS Foundation, San Antonio, TX
South Texas Development Council, Laredo, TX
Triangle AIDS Network, Beaumont, TX

Vermont
Vermont People with AIDS Coalition, Montpelier, VT

Virginia
Fan Free Clinic, Richmond, VA
Health and Home Support Services, Inc., Newport News, VA
HIV Medicine Association (HIVMA), Arlington, VA
MediCorp Health System/ Infectious Disease Associates, Fredericksburg, VA
Ryan White Medical Providers Coalition, Arlington, VA
Williamsburg AIDS Network, Williamsburg, VA

Washington
Lifelong AIDS Alliance, Seattle, WA

Wisconsin
HIVictorious, Inc., Madison, WI
One Heartland, Milwaukee, WI
State of Wisconsin AIDS/HIV Program, Madison, WI

**Note: Original release of this document took place on March 10, 2009. Sign-ons to the document will be updated as needed. The internal content of later versions of the document, other than sign-ons, has not changed.*

COMMUNITIES ADVOCATING EMERGENCY AIDS RELIEF
CAEAR COALITION

Congressional Advocacy Talking Points: August 2009 Recess

TWO KEY MESSAGES FOR ALL MEETINGS:

- **Extension of the Ryan White Program is a TOP PRIORITY**
- **Community Funding Requests for the Ryan White Program are Needed to Meet Growing and Unmet Needs**

Extension Request and Update

- The Ryan White Program expires on September 30, 2009. We must ensure that the program is extended for three years to guarantee uninterrupted access to care and treatment. Passing the extension needs to be a TOP PRIORITY in the House and Senate.

- At the request of Congressional leaders, the AIDS community has come together to develop consensus recommendations for the extension. **Over 275 organizations from 45 states, DC and Puerto Rico have signed-on.**

- **Neither the** House nor the Senate has taken formal action to extend the Ryan White Program.

Funding Requests and Update

Part A—Cities and Communities

- 82% of AIDS cases reported in 2007 were in large U.S. metropolitan areas. **$766.1 million** will partially address the current unmet need for medical care and some support services for uninsured and underinsured people living with HIV/AIDS in these hard-hit communities.

Part B—AIDS Drug Assistance Program

- **$1.08 billion** is needed to reduce and prevent cost containment measures and to allow all state ADAPs to provide the full range of antiviral medications and treatments for infections and side effects.

Part C—Community Health Centers and Clinics

- Over 230,000 persons living with HIV/AIDS receive medical care in Part C–funded community health centers and clinics each year. **$268.3 million** would allow the clinics to provide outpatient medical care to the 30,000+ people living with HIV expected to enter care at those sites next year.

Part F—AIDS Education and Training Centers

- **$50 million** would support training of health care providers to care for growing patient caseloads and address the growing complexities of care.

The House has already voted passage of the Labor-HHS spending bill with levels far below community requests. The Senate Appropriations Committee has also voted on bill with levels far below community requests, including flat funding for Part A and Part F AETCs. The full Senate will vote after the recess. See attached chart for funding levels.

The Need for HIV/AIDS Care and Treatment is Growing

- CDC has significantly increased efforts to expand HIV testing in hard-hit communities to help people living with HIV learn their status and enter care.

- The CDC raised its estimated rate of annual new HIV infections from 40,000 to 56,300.

- 45% of HIV-infected people in the U.S. for whom antiretroviral therapy would likely be recommended are not-accessing treatment – together, primary medical care and medications are key to helping people living with HIV maintain their health.

The Ryan White Program Works

- The OMB's Program Assessment Rating Tool (PART) found that the Ryan White Program has contributed to the decline in the number of new AIDS cases and deaths due to HIV/AIDS.

- The PART assessment gave the program a score of 100% in Program Results and Accountability, making it one of only seven out of 1,016 federal programs to receive that score.
- The program addresses disparities in access to HIV treatment and care—the program serves women and racial and ethnic minorities in significantly higher proportions than their representation among reported AIDS cases.

REQUESTED ACTIONS

House of Representatives

- Actively support the community consensus request for a three-year extension of the Ryan White Program that includes legislative fixes supported by over 275 HIV/AIDS organizations in 45 states, DC and Puerto Rico. Members of the Energy and Commerce Committee should take swift action on the extension and others should urge their colleagues on the committee to make this a top priority as soon as Congress returns from recess.

- Support community's Ryan White Program funding requests in the conference process that reconciles the difference between the House and Senate versions of the Labor-HHS spending bill.

Senate

- Support the community consensus request for Ryan White Program extension that includes legislative fixes supported by over 275 HIV/AIDS organizations in 45 states, DC and Puerto Rico.. Members of the HELP Committee should take swift action on the extension and others should urge their colleagues on the committee to make this a top priority.

- Support Ryan White Program funding requests when the FY2010 Labor/HHS bill comes to the Senate floor.

COMMUNITIES ADVOCATING EMERGENCY AIDS RELIEF

CAEAR COALITION

Ryan White Program Appropriations: FY2010 Request

Program	FY 2009 Omnibus	CAEAR Coalition FY 2010 Request	President's FY 2010 Budget Request	House FY 2010 Bill	Senate Approps Committee FY 2010 Mark-up
Part A	**$663.1m (+$35.9m)**	**$766.1m (+$103m)**	**$671.1m (+$8m)**	**$679.1 (+16m)**	**$663.1m (+0)**
Part B Base	$408.8 (+$7.9m)	$514.2m (+$105.4m)	$418.8m (+$10m)	$418.8 (+$10m)	$418.8m (+$10m)
Part B ADAP	**$815.0m (+$20.6m)**	**$1,083.6m (+$268.6m)**	**$835.0m (+$20m)**	**$835.0m (+$20m)**	**$835.0m (+$20m)**
Part C	**$201.9m (+$3.1m)**	**$268.3m (+$66.4m)**	**$211.9m (+$10m)**	**$206.82m (+$4.9m)**	**$206.88m (+$5.0m)**
Part D	$76.8m (+$3.2m)	$134.6m (+$57.8m)	+$76.8m (+0)	$78.7m ($+1.9m)	$76.8m (+0)
Part F AETC	**$34.4m (+$0.3m)**	**$50.0m (+$15.6m)**	**$38.4m (+$4m)**	**$35.2m (+$0.8)**	**$34.4m (+0)**
Part F Dental Reimb.	$13.4m (+$0.6m)	$19.0m (+$5.6M)	$15.4m (+$2m)	$13.8m (+$0.3m)	$13.4m (+0)

Legislative Affairs & Intergovernmental Relations

Los Angeles County

Legislative Update

September 16, 2022

Greetings,

Below is an update on Federal and State legislative items of interest to the County of Los Angeles.

COUNTY ADVOCACY POSITIONS

- FUNDING TO COMBAT COVID-19 AND MONKEYPOX

  Send a five-signature letter to President Biden, Senate Majority Leader Schumer, Senate Minority Leader McConnell, House Speaker Pelosi and House Minority Leader McCarthy, with a copy to the Senate and House Appropriations Committee Chairs and Ranking Members, and the Los Angeles County Congressional Delegation, urging them to work with urgency and expediency to pass a Continuing Resolution that provides $22.4 billion in additional COVID-19 relief funding, as well as $3.9 billion to combat the Monkeypox outbreak. More details regarding this motion can be found here.

- ESTABLISHING A COUNTYWIDE RV ENCAMPMENT PILOT PROGRAM

  Secure State and Federal dollars for the 36-month RV encampment pilot program by advocating through the annual State and Federal budget processes and applying for existing State and Federal grant opportunities created to support such programs including the United States Department of Housing and Urban Development's 2022 Special Notice of Funding Opportunity to Address Unsheltered and Rural Homelessness, which is being coordinated locally by the Los Angeles Homeless Services Authority, as well as Congress' Congressionally Directed Spending Requests. More details regarding this new policy are available here.

- ENHANCING GUN REGULATION IN LOS ANGELES COUNTY

  Advocate in support of Federal and State Legislation that would prohibit persons who are on the United States Federal Bureau of Investigations' No Fly List from purchasing or possessing a firearm. More details regarding this motion can be found here.

- USE OF MODIFIED HYDROFLUORIC ACID AT REFINERIES IN LOS ANGELES COUNTY

  Send a five-signature letter to the Administrator of the United States Environmental Protection Agency (US EPA), Michael S. Regan and send a copy to President Biden, urging the proposed Risk Management Program regulations to be strengthened to prevent a catastrophic Modified Hydrofluoric Acid and/or Hydrofluoric Acid (MHF/HF) release; specifically, that the US EPA require a third-party review of industry-conducted Safer Technologies and Alternatives Analysis, and require conversion from MHF/HF to safer alternative technologies with all due haste. More details regarding this new policy are available here.

- EMERGENCY MOBILITY OPTIONS IN THE SANTA CLARITA VALLEY

  Advocate in support of Federal and State funding and appropriations requests for congestion relief and climate resiliency projects along The Old Road. More details regarding this new policy are available here.

STATE ADVOCACY

In addition, the County is advocating on the following proposals:

- SUPPORT SB 774 (HERTZBERG) - EMOTIONAL SUPPORT DOGS

  This bill would modify AB 468 from 2021 to exempt individuals who are verified to be homeless from the requirement of needing to have a 30-day existing relationship with a health care practitioner before being able to obtain a certification for an emotional support dog. Additional details available here.

- SUPPORT SB 1076 (ARCHULETA) - LEAD-BASED PAINT

  This bill would require the California Department of Public Health to review and amend its regulations governing lead-related construction work, including training and certification for workers and accreditation for trainers in lead-safe work practices to comply with existing state regulations and with the United States Environmental Protection Agency's Lead Renovation, Repair, and Painting Rule. More details regarding this motion can be found here.

2022 GREATER LOS ANGELES HOMELESS COUNT RESULTS

Last week the Los Angeles Homeless Services Authority (LAHSA), a joint powers authority of the city and county of Los Angeles, released the results of the 2022 Homeless Count. The results of the point-in-time count, conducted over three nights in February, estimated that 69,144 people were experiencing homelessness in LA County at that time, a 4.1% rise from 2020, and 41,980 people were experiencing homelessness in the City of LA, up 1.7% from 2020. (A count was not conducted in 2021 due to the COVID pandemic.)

To view the press release, slide deck, presentation or data summaries, click here.

LEGISLATIVE AFFAIRS RESOURCES

- County's Legislative Policies & Priorities
- Federal & State Legislation of Interest
- Contact Legislative Affairs

Chief Executive Office.

LEGISLATIVE AFFAIRS AND INTERGOVERNMENTAL RELATIONS
500 West Temple Street, Room 723
Los Angeles, California 90012

legislativeaffairs@ceo.lacounty.gov

https://ceo.lacounty.gov/legislative-affairs-and-intergovernmental-relations/

Stop Discrimination in Health Care!

Section 1557, known by some as the “Health Care Rights Law,” is the main nondiscrimination provision of the Affordable Care Act (ACA). **It prohibits discrimination in health care based on factors like race, ethnicity, language, age, disability, and sex – including pregnancy, sexual orientation, and gender expression. And it is particularly important for people who live at the intersection of multiple identities!**

Right now, the Biden Administration is considering changes that would strengthen Section 1557 protections and help improve care for millions of people across the country. Your story can help turn these proposals into reality so you and your loved ones can access the health care you need free from discrimination or prejudice. Share your story and help the Biden Administration strengthen nondiscrimination protections. Your comment will be sent directly to Regulations.gov and the National Health Law Program will retain a copy.

Who Should Comment?

- People who have experienced discrimination in health care
- LGBTQ+ folks, trans people, queer folk, and intersex people
- Black, Indigenous, and People of Color
- People with disabilities
- Older adults and caregivers
- Pregnant people, people who have had a miscarriages or abortions
- Non-English speaking people
- People at the intersection of multiple identities

How to Comment

Use the form to submit a comment and tell the government why you support the new rule.

Feel free to tell a little about yourself and share why health care free from discrimination and prejudice is important to you.

Click here (https://whymycarecounts.org/1557-resources/) for more Sec. 1557 resources

Comment*

The Biden administration has just proposed changes to the regulations implementing Section 1557 that would restore and strengthen nondiscrimination protections and improve access to care for millions of people.

If these proposed changes are adopted, they will promote the health equity of

First Name*

Last Name*

City*

State*

Choose one...

Country*

United States

Zip Code*

Email Address*

Nondiscrimination in Health Programs and Activities

Regulations.gov Document ID
HHS-OS-2022-0012-0001 (https://www.regulations.gov/document?D=HHS-OS-2022-0012-0001) (download PDF (https://downloads.regulations.gov/HHS-OS-2022-0012-0001/content.pdf))

Agency
HHS

Comment Period
Aug 4, 2022 to Oct 3, 2022

☑ Please keep me informed of the organization's efforts

AGN. NO.

MOTION BY SUPERVISORS HOLLY J. MITCHELL AND HILDA SOLIS 8/2/2022

RESPONDING TO LOS ANGELES COUNTY'S SEXUALLY TRANSMITTED DISEASE CRISIS

The rate and number of sexually transmitted diseases (STD) have been increasing in Los Angeles County (County) for over a decade. STDs are a type of disease or infection caused by a pathogen (bacterium, virus, or other microorganism) that can be transmitted or acquired via direct sexual contact from person to person. Congenital syphilis and syphilis, STDs that were nearly eradicated in the early 2000s, have increased at especially alarming rates. Syphilis, left untreated, can lead to serious health complications including heart disease, stroke, and infertility. Untreated syphilis amongst pregnant mothers can be passed on to the infant at birth. Known as congenital syphilis, the Centers for Disease Control and Prevention (CDC) estimates that up to 40% of babies born with congenital syphilis are stillborn or die at an early age. Infants can also experience short- and long-term complications including blindness, deafness, and liver and spleen complications.

In the County, congenital syphilis rates increased by 1300% and syphilis rates increased by 450% amongst women and 250% amongst men within the last 10 years. By 2018, in light of the sharp uptick in syphilis and congenital syphilis cases, the County Board of Supervisors (Board) allocated $5 million to the expansion of STD treatment and

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services and directed the Department of Public Health (DPH) to provide quarterly updates on the County's STD crisis. Since then, the ongoing COVID-19 pandemic has exacerbated challenges to the County's delivery of STD services. In 2020, the National Coalition of STD Directors reported that 78% of the STD/HIV health department workforce had redirected their priorities towards the pandemic. Therefore, on September 28, 2021, the Board directed DPH to provide an updated plan of action to address the STD crisis.

DPH's report back, submitted to the Board on April 1, 2022, recognizes that the decade-long increase in STD rates stems from systemic funding inequities predating the pandemic. Local public health departments and family planning clinics, which spearhead STD control efforts, are supported through a fragmented network of local, state, and federal funds. Unfortunately, federal funding sources for sexual health services have been cut or remained stagnant over the last decade. President Joseph Biden's budget proposal for Fiscal Year (FY) 2023 allocates a flat amount towards STD control, despite STDs like congenital syphilis increasing by 279% within 4 years nationally. The Title X Family Planning Program, a federal fund for clinics providing reproductive health services such as Planned Parenthood, has also received stagnant funding.

Inflation places an additional constraint on services. The CDC STD Prevention Budget decreased in purchasing power by 40% between FY 2003 and FY 2018 due to inflation. With consumer prices increasing by 8.6%, the fastest increase in 4 decades, the operational costs to provide sexual health services will increase, forcing providers to do more with less. DPH's existing STD programming prioritizes the most vulnerable populations needing sexual health services, including uninsured individuals, those without a regular primary care provider, and people experiencing homelessness or at-risk of becoming homeless. Given the growing rate of STDs, DPH and other local community health partners cannot address the STD crisis alone. As asserted in DPH's recommendations, a sustainable path forward requires participation and partnership across multiple sectors, agencies, providers, and advocates.

Private and public health insurance plans, in particular, are considered the largest payors for sexual health services including gynecological exams, birth control, and other services. An overwhelming majority of the County's residents are covered through their employer or a Medi-Cal managed care plan. Yet, despite being one of the largest payors

for sexual health services, current performance metrics for providers do not include comprehensive STD measures. The Healthcare Effectiveness Data and Information Set (HEDIS), managed by the National Committee for Quality Assurance, is the industry standard for evaluating the performance of insurance plans. HEDIS allows consumers to compare the performance of various health plans (Commercial, Medicare, and Medicaid) based on their ability to address significant public health issues such as cancer and heart disease. The data used to develop HEDIS measurements currently includes a limited range of STD measures. For example, chlamydia screening is included in HEDIS data, however, syphilis is not. Furthermore, HEDIS only collects STD rates among women. These gaps in data must be addressed, for providers and plans to adequately meet the needs of their members and improve the quality of their sexual health services.

Furthermore, as mandated through the California Healthy Youth Act (CHYA), school districts are also responsible for providing comprehensive sexual health education—including information on STDs—to middle and high school students. DPH reports that young people under the age of 25 have the highest risk for STDs. In 2016, youth represented the largest proportion of gonorrhea and chlamydia cases in the County. On a national level, young people ages 15 to 24 accounted for 22% of all reported syphilis cases, 42% of all gonorrhea cases, and 62% of all chlamydia cases despite making up only 13% of the population in 2018. Although considered an at-risk demographic for STDs, CYHA does not have a mechanism to ensure or assess whether school districts are disseminating up-to-date and accurate sexual health education in an effective and regulatorily compliant way.

A coordinated and collaborative response that engages partners in addition to local health departments is necessary to effectively address the STD crisis. California will pay a major cost if further action is not taken. One study, provided by the California Health Benefits Review Program (CHBRP), reports that each case of congenital syphilis costs an estimated $8,743 in direct costs and $78,396 in indirect costs for a total of $28.7 million for 329 cases in California (adjusted to 2021 dollars). The CHBRP also estimates that each case of syphilis would cost $742 per case in direct costs and $145 in indirect costs, translating to a total of $22.2 million in California for 25,344 cases in California (adjusted to 2021 dollars).

Moreover, untreated STDs can lead to serious short-term and long-term issues, and chronic health conditions that cause additional long-term costs, including costs of medical care, lost wages, and education. These long-term costs are disproportionately experienced by historically underrepresented and marginalized communities. This includes low-income persons, youth (ages 15-24), pregnant women and infants, transgender individuals, men who have sex with men, the prison population, individuals with substance use disorders, individuals in the child welfare system, and communities of color. In 2019, the National Association of County & City Health Officials (NACCHO) found that the rate of gonorrhea was 8.5 times higher in black men compared to white men and 6.9 times higher in black women than white women. Furthermore, NACCHO found that the rate of reported chlamydia cases is 5 times higher among black women relative to white women and 6.8 times higher amongst black men compared to white men. In the County, congenital syphilis and syphilis have disproportionately affected low-income communities of color. In 2020, Service Planning Areas (SPA) 4 and 6, which comprise Central and South Los Angeles, experienced the highest case of syphilis cases amongst females. Furthermore, a greater percentage of SPA 4 and 6 women diagnosed with syphilis did not receive treatment following their diagnosis. As we continue adapting to present health challenges, we must engage all partners in addressing an over decade long crisis.

I THEREFORE MOVE THAT THE BOARD OF SUPERVISORS:

1. Direct the Directors of the Department of Public Health (DPH), Department of Health Services (DHS), Department of Mental Health (DMH), and the Chief Executive Officer (CEO), to work with the Alliance for Health Integration, CEO's Anti-Racism, Diversity, and Inclusion Initiative, the CEO's Legislative Affairs and Intergovernmental Relations Branch, and relevant community stakeholders to:
    a. Appeal to the federal Department of Health and Human Services and to Congress to increase the federal investment for sexually transmitted disease (STD) Control efforts, including through, but not limited to services supported by the following agencies and funding streams, such as:

i. The Centers for Disease Control and Prevention and resources targeted for STD prevention and control that remain inadequate to address the high and growing level of STD morbidity;

ii. The Substance Abuse and Mental Health Services Administration and their State block grants given the strong nexus between substance use and STD risk and morbidity;

iii. The Health Resources and Services Administration through its grants to support Federally Qualified Health Centers (Bureau of Primary Health Care) and the Ryan White Program (HIV/AIDS Bureau) given the intersection of populations at risk for syphilis who are also at elevated risk for HIV.

b. Identify, with relevant stakeholder community-based advocacy organizations, additional opportunities to jointly advocate for more local, state, and federal funding, including STD policy proposals that prioritize communities or demographics that are disproportionately impacted by the STD epidemic.

c. Assess the impact workplace vacancies have on the delivery of STD-related programming, outreach, surveillance, and engagement administered through the County;

2. Direct the Director of DPH, the CEO, and the Executive Director of the Los Angeles County Youth Commission in coordination with the Superintendent of the Los Angeles County Office of Education, Superintendent of the Los Angeles Unified School District, and other relevant stakeholders to assess and report back in 60 days in writing on the implementation of the California Healthy Youth Act (CHYA).

a. This report should include, but not be limited to:

i. Available statistics on how often sexual health education is provided to middle school and high school students by school district;

ii. Available statistics on student attendance and participation including the number of students who opt-out of receiving sexual health education at the request of a parent or guardian;

iii. Strategies for ensuring curriculum is medically accurate, unbiased, up-to-date, inclusive, and adheres to all other requirements mandated by CHYA;
iv. Peer-led approaches which are promising or effective at delivering sexual health education; and
v. Input from family members, students, and instructors who have delivered sexual health education in compliance with CHYA.

b. Based on the findings in 2a above, this report should also specify any implementation challenges and recommendations for improvement related to CHYA including, but not limited to:
i. Funding needed, with cost estimates, to administer sexual health education in compliance with the CHYA;
ii. Feedback from educators, families, and students regarding CHYA and the effectiveness of sexual health education; and
iii. Limitations in the delivery or content of sexual health education being administered.

3. Instruct the Directors of DHS and DPH in partnership with managed care plans, and other relevant stakeholders to design a pilot program that implements antenatal syphilis point of care testing for pregnant mothers at-risk of syphilis and report back in writing in 60 days.
4. Instruct the Directors of DHS and DPH to identify the benefits and challenges of including STD testing (including oral, anal, and urine testing, blood tests, and bundled testing) within DHS-operated urgent care centers and emergency room settings, especially those located in high STD-incidence regions, and report back in writing in 60 days.
5. Direct the Directors of DPH and DHS to review their existing processes for sexual health screening and identify challenges and solutions to delivering screenings as it relates to asymptomatic people, young people, people with no pre-existing health conditions, and other target demographics who may not visit a provider or clinic frequently.

6. Direct the Directors of DPH, DHS and DMH in partnership with local managed care plans to improve messaging to increase Pre-Exposure Prophylaxis uptake.
7. Direct the Directors of DPH, DHS and DMH, in coordination with the Alliance for Health Integration, local managed care plans, and other relevant stakeholders to identify opportunities for improving Healthcare Effectiveness Data and Information Set measures or other related metrics tied to evaluating a health provider's provision of medically appropriate STD services, and report back in writing in 60 days.
8. Direct the Director of DPH to include reports on implementation progress in its quarterly STD updates.

# # # #

(KM/YV)

AGN. NO.

MOTION BY SUPERVISORS HILDA L. SOLIS August 2, 2022

Advocating for Federal and State Resources to Combat the STI Epidemic

Los Angeles County is in the midst of an ongoing sexually transmitted infections (STI) crisis that has seen case rates skyrocket over the past decade, with the highest ever annual reported case of syphilis, congenital syphilis, gonorrhea, and chlamydia. Recent data from the Los Angeles County Department of Public Health (Public Health), Division of HIV and STI Programs (DHSP) show a 450% increase in syphilis rates among females and a 235% increase in males in the last decade. Congenital syphilis rates have increased by 1100% in less than a decade, with 113 congenital syphilis cases reported in 2020 compared to 88 in 2019, and just 10 in 2010. In response to the September 28, 2021 Board-approved motion introduced by Supervisor Hilda L. Solis titled *Addressing the STI Crisis in Los Angeles County*, the Department of Public Health (Public Health), in collaboration with the Department of Health Services (DHS), Department of Mental Health (DMH), the Alliance for Health Integration (AHI), and the Chief Executive Office's (CEO) Anti Racism, Diversity and Inclusion Initiative (AHI) provided a report back with an updated plan of action and additional recommendations

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to address the STI Crisis in Los Angeles.

Pursuant to the motion, the County provided an analysis of funding streams to address the STI response, established a framework and timeline to end the STI crisis, created a planning process to ensure coordination of efforts including the creation of an STI workgroup, are developing a publicly facing STI dashboard, and worked with community partners to provide an analysis of community capacity and infrastructure needs to respond to the crisis, including identifying communities disproportionately impacted such as African American and Latinx residents, persons experiencing homelessness, and newborns.

Regrettably, despite the yearly increases in STI rates that have now reached record levels across the United States, California, and locally, there has not been the necessary increase in revenue to combat this epidemic. Despite continued efforts on behalf of the County, STI advocacy on the federal and state levels have not had the same level of success as compared to the HIV epidemic, the opiate epidemic, or the COVID pandemic. Key funding to combat the HIV epidemic over the last three decades and the recent funding dedicated to combat COVID-19 and opioid overdoses has shown that given the proper investment, significant progress can be made in combating public health crises faced by the County.

On the federal level, the County applauds the recently released Federal STI Strategic Plan, which sets forth a vision for the nation with goals, objectives, and strategies to meaningfully prevent and control STIs in the United States. The plan sets out goals to prevent new STIs, improve the health of people by reducing adverse outcomes of STIs, accelerates progress in STI research, technology, and innovation,

reduces STI-related health disparities and health inequities, and seeks to achieve integrated, coordinated efforts to address the STI epidemic. This strategic plan represents an important step in addressing the crisis, but currently lacks a large infusion of resources to bring to scale the interventions needed to meet the objectives outlined.

On the State level, the Governor's budget includes the continuation of $7 million for STI treatment and prevention services. And Governor Newsom signed into law SB 306, the STD Coverage and Care Act, which allows for a more comprehensive approach to addressing California's rising STI crisis. The new law expands access to testing and treatment and sets out to create a more equitable health system, requiring health plans to cover at-home tests, increasing providers who provide testing in the community, and requiring syphilis screening during both the first and third trimesters in pregnancy. However, there are further opportunities for funding and to improve compliance and tracking with respect to existing policies and tools in place to combat the spread of STIs. In 2016, the state legislature passed the California Healthy Youth Act, which has the California Department of Education partner with school districts to provide students with the knowledge and skills necessary to protect their sexual and reproductive health from HIV and other sexually transmitted diseases and unintended pregnancy. Although a recent study found most districts in compliance with the law, many continue to resist and enforcement of compliance remains requires clarity and improvement.

I THEREFORE MOVE that the Board of Supervisors instruct the Chief Executive Office (CEO) Legislative Affairs team, in collaboration with the Departments of Public Health, Health Services, and Mental Health, to send a five-signature letter to

the Department of Health and Human Services (HHS) Secretary Xavier Becerra requesting the following:

a. Support an STD Control Pilot Program for LA County that helps accelerate progress towards meeting four of the fourteen indicators and targets identified in the Federal STI Strategic Plan;
b. Launch the Ending the STD Epidemic Initiative: A Plan for America, modeled after the recently launched Ending the HIV Epidemic Initiative and that enlists a renewed commitment from federal agencies, States, Counties and Cities, public and commercial health plans, the biotech sector and the vast network of Federally Qualified Health Centers and Community Health Centers to combat the STD crisis; and
c. Appeal to the National Clinical Quality Association (NCQA) to adopt new incentives to improve compliance with the health plan HEDIS measure tied to annual chlamydia screening for young sexually active women ages 16 to 24. Furthermore, given the growing rates of chlamydia among young men and gonorrhea among both men and women, appeal for NCQA's adoption of new HEDIS measures to enhance screening in these areas and among these disproportionately impacted sub-populations.

I FURTHER MOVE that the Board of Supervisors instruct the Chief Executive Office (CEO) Legislative Affairs team, in collaboration with the Departments of Public Health, Health Services, and Mental Health, to send a five-signature letter to Governor Gavin Newsom, California Health and Human Services Secretary Mark Ghaly, and State Superintendent of Public Instruction Tony Thurmond, requesting the following:

a. Request the Department of Education develop and implement a systematic tracking system to monitor compliance with the 2016 California Healthy Youth Act (CHYA) and implement strategies to address non-compliance with a focus on areas with the highest numbers and rates of chlamydia and gonorrhea;
b. Request Health and Human Services develop and implement a tracking system to monitor compliance with the recommendations outlined in the November 16, 2021 Dear Colleague letter related to the expansion of HIV and syphilis testing for pregnant patients and the newly enacted SB 306; and
c. Request appropriate funds to support the enhancement of California's STD Control Infrastructure to fully operationalize an STD Master Plan that includes congenital syphilis elimination, a reduction of syphilis morbidity to at least 2010 levels, enhanced STD surveillance, geo-mapping and cluster detection capacity, novel STD screening, diagnosis and treatment models and expansion of home testing modeled after the COVID-19 response.

I FURTHER MOVE that the Board of Supervisors direct the CEO Legislative Affairs and Intergovernmental Relations division, in collaboration and consultation with the Department of Health Services Housing for Health (HFH), to advocate to the state and federal government to increase funding for street medicine interventions to ensure that people experiencing homelessness receive care for STIs.

I FURTHER MOVE that the Board of Supervisors direct the Departments of Public Health, Health Services, and Mental Health to incorporate STI education and resources into outreach efforts of *promotoras*/community health workers.

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AGN. NO.

REVISED MOTION BY SUPERVISORS HILDA L. SOLIS July 26, 2022

AND HOLLY J. MITCHELL

Confronting the Drug Overdose Epidemic

The United States, including Los Angeles County (LAC), is experiencing the worst drug overdose crisis in national and local history. The County has experienced increases in accidental drug overdoses since 2011, with 2,425 overdose deaths in 2020. Much of this increase has been attributable to a rise in methamphetamine, the illicit manufacturing of the powerful synthetic opioid called fentanyl, and the increasingly common combination of illicitly manufactured fentanyl in counterfeit pills and other drugs. The COVID-19 pandemic also contributed to drug overdoses given increased stressors related to finances, social isolation, and personal loss, among other variables.

Furthermore, overdose deaths disproportionately impact disenfranchised populations. Drug overdoses have become the leading cause of death among people experiencing homelessness (PEH), and African Americans are the racial group with the highest rate of accidental drug overdose death in LAC. Overdose rates rose 44 percent in 2020 for Black people and 39 percent for American Indian and Alaska Native people,

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compared to 22 percent for white people, largely related to not having access to substance use treatment. And since 2017, the opioid mortality rate for Latino residents in California has reached its highest level. Reports have also indicated that Black and Latino residents experience greater difficulty accessing Medication-Assisted treatment, and many Latino residents report bilingual treatment programs are hard to find.

Addressing the disparities and complexities of the drug overdose crisis requires targeted efforts focused on prevention, early intervention, and access to evidence-based, low barrier, non-judgmental substance use disorder (SUD) treatment services. It also requires evidence-based public health approaches like harm reduction to successfully engage the 95% of individuals with a SUD who either do not want or think they need treatment services[1].

The LAC Department of Public Health's Division of Substance Abuse Prevention and Control (DPH-SAPC) and the Department of Health Services (DHS) lead the County's response to the overdose crisis. The County's response to date has increased access to life-saving harm reduction strategies, including one of the nation's largest community education and naloxone distribution programs. Harm reduction services are a critical component to a comprehensive response to the overdose crisis by offering low-barrier, evidence-based, and participant-centered interventions that are proven to reduce the incidence of overdoses, soft tissue infections, sexually transmitted infections, hepatitis C, and HIV/AIDS, and most importantly support the health and wellness of people who use drugs. These include syringe service safety programs (SSP) that

[1] National Survey on Drug Use and Health; 2020. https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf

distribute naloxone and fentanyl testing strips and provide mobile outreach to vulnerable populations. DPH-SAPC has also launched media campaigns that increase awareness of the risks of fentanyl and methamphetamine and is working to expand the availability of Medication-Assisted Treatment (MAT). In addition, the launch of the Drug Medi-Cal Organized Delivery System (DMC-ODS) has significantly expanded the continuum of SUD treatment available to County residents and the linkage of people who use drugs (PWUD) to treatment.

DHS manages the Overdose Education and Naloxone Distribution (OEND) program to provide training, technical assistance and distribution of naloxone and other harm reduction supplies to county staff, DHS hospitals and clinics, and community-based organizations serving PWUD, particularly those with justice system involvement and PWUD experiencing homelessness across the County. Moreover, DPH-SAPC and DHS are coordinating with emergency departments to offer MAT and naloxone to patients who have recently overdosed to reduce the likelihood of subsequent overdose and death.

Despite these comprehensive efforts, drug overdose deaths across the County continue to rise and additional collaborative efforts are needed to save lives. Calls to action by community health advocates, including those led by members of *The Act Now Against Meth Coalition*, have helped draw attention to the immediate actions needed to address the emerging drug crisis, and demonstrate that the human and societal impact of the ongoing overdose crisis has had a devastating and destabilizing impact on communities across the County.

I THEREFORE MOVE that the Board of Supervisors direct the Departments of Public Health, in partnership with the Department of Health Services, and the Department of Mental Health, the Alliance for Health Integration, the Medical Examiner-Coroner, the Alternatives to Incarceration Initiative, the Department of Children and Family Services, the Los Angeles County Homeless Services Authority (LAHSA), the Homeless Initiative, the Los Angeles County Office of Education, the Chief Executive Office, other applicable entities, and community stakeholders, to report back within 120 days and biannually thereafter with an updated plan of action to address the growing crisis of overdose deaths related to methamphetamine, fentanyl, opioids, and other substances. Considerations in this plan should include, but are not limited to:

1. Build on current planning processes and strategies established by DPH-SAPC and DHS in partnership with CEO's Anti-Racism, Diversity & Inclusion initiative to ensure coordination with relevant County Departments, the Alliance for Health Integration, and key stakeholders such as community-based organizations, faith-based organizations, Federally Qualified Health Centers (FQHC), hospitals, County jails, Probation camps and halls, and managed care plans, County mental health plans, and County SUD plans tasked with implementing various Statewide initiative such as DMC-ODS and CalAIM, to support shared goals around reducing the risk of drug overdoses;
2. Ensure strategies to address the drug overdose epidemic among populations disproportionately impacted by overdoses, including persons of color, individuals who are justice-involved, PEH, and LGBTQ+ residents;
3. Work with the housing system to expand the housing continuum and availability

of permanent, interim, and emergency housing options throughout the County, including recovery-oriented and Housing First models, with particular focus on unhoused individuals with justice involvement who use drugs;

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;
5. Provide recommendations to expand harm reduction efforts including but not limited to developing a plan to establish safer consumption sites in LAC, expanded distribution of fentanyl strips, naloxone, drug checking, and low-threshold MAT, including in carceral facilities for adults and youth, and exploring the feasibility of funding for prevention case management.
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 PrEP/PEP;
7. Implement evidence-based, age-appropriate substance use curricula for students K-12 and for those in Probation camps and halls and their parents/guardians;
8. Expand the accessibility of contingency management interventions;
9. Expand efforts to explore and offer MAT options for methamphetamine and other substance use disorders;
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;

11. Develop a framework and timeline, including key metrics and milestone goals, to define success related to addressing the overdose epidemic in LAC;
12. Assess the funding in each Department's budget that is used to serve PWUD 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 Office on strategies to address those gaps; and
13. Direct the Chief Executive Office Legislative Affairs team and County advocates in Sacramento and Washington, D.C. to coordinate with the Departments of Public Health, Health Services, and Mental Health to advocate with the Governor, 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.

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THE WALL
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ActNOW
Against Meth

LOS ANGELES COUNTY PLATFORM ADDRESSING THE METH EPIDEMIC

2022

RESEARCH PARTNER

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LOS ANGELES COUNTY PLATFORM ADDRESSING THE METH EPIDEMIC 2022

Table of Contents

HISTORY OF ACT NOW AGAINST METH

In the summer of 2005, as the Los Angeles County Department of Public Health moved slowly to address the crystal methamphetamine (meth) outbreak, The Wall Las Memorias created the Act Now Against Meth Coalition. The aim of the coalition was to demand a strong public health response to rapidly increasing meth use in vulnerable communities across LA County. The coalition consisted of a variety of community-based organizations, private businesses, public high schools, and community leaders, including the Asian Pacific AIDS Intervention Team (APAIT), Being Alive, Lincoln High School, Midtowne Spa, and the Metropolitan Community Church.

The Act Now Against Meth Coalition developed a petition demanding funding be allocated specifically for meth use prevention projects. Coalition members held support groups, educational meetings, community forums, and media conferences to increase public awareness of meth and its impact on the community at large. The coalition conducted outreach at a variety of venues such as night clubs, festivals, high schools, and public spaces.

By September 2006, the coalition had gathered over 10,000 petition signatures. A press conference was held on the steps of the Los Angeles County Hall of Administration prior to presenting the petition to the LA County Board of Supervisors.

As a result of the coalition presenting the petition, the members of the Board of Supervisors introduced a motion to allocate $1.5 million to fund new prevention and treatment programs. This was a major accomplishment in which the community advocated and received action upon a request.

In 2020, following the arrest of Ed Buck and reports of crystal meth use back on the rise, The Wall Las Memorias reinitiated Act Now Against Meth to meet the dire need to confront the meth epidemic in Los Angeles County. Community members were invited to attend virtual roundtable meetings to discuss the current state of meth and listen to community concerns about the meth crisis. As a result of this grassroots outreach, a new coalition was formed, with 15 community partners committing their support.

Following a virtual Act Now Against Meth Community Summit in March 2021, the coalition established a workgroup to draft the Los Angeles County Platform Addressing the Meth Epidemic. The workgroup met for over 54 cumulative hours to draft a list of recommendations to better address crystal meth in LA County, reflecting the needs community stakeholders have expressed throughout the past two years. **We are delighted to submit the following platform, which details recommendations for meth prevention, treatment, and policy.**

RECOMMENDATIONS RELATED TO PREVENTION

It is self-evident that preventing the initiation of methamphetamine use offers optimal individual and community benefits. The Act Now Against Meth Coalition, henceforth referred to as ANAM, explicitly acknowledges that social stressors, unmet necessities, ignorance, denial of the problem, and blaming the user all impede prevention efforts. A robust, LA County-wide strategy to tackle methamphetamine use must address the social determinants of health through investment in our public health and social services infrastructure, effective services that follow harm reduction principles, awareness and education, and grassroots community engagement.

ANAM offers the following methamphetamine use prevention recommendations:

1. **We call upon the LA County Board of Supervisors to: 1) Improve coordination among the Los Angeles Department of Health Services, Department of Public Health, Department of Mental Health, Department of Children and Family Services, Department of Probation, Sheriff's Department, Homeless Services Authority, Department of Public Social Services, and other affiliated agencies, and 2) Direct the County of Los Angeles Alliance for Health Integration to help support and facilitate this coordinated approach across County Agencies.** The multiple needs of people at risk of using meth require concerted coordination among County agencies to ensure a comprehensive approach to primary and secondary meth use prevention. As part of this coordinated effort, all County departments that provide services to the public should be required to include substance use navigation services in their contracts to the extent feasible. Additionally, all County department personnel should be trained on the various substance use resources that are available in the community.

2. **We call upon the LA County Department of Mental Health to allocate Prevention and Early Intervention (PEI) funds for meth prevention activities and implement holistic prevention efforts in collaboration with the Department of Public Health's Substance Abuse Prevention and Control (SAPC) program**. Meth use frequently intersects with mental health disorders. It is critical that the Department of Mental Health and SAPC provide collaborative leadership to address the meth crisis in LA County.

3. **Improve coordination among community-based organizations, prevention providers, treatment programs, medical providers, and community health centers/Federally Qualified Health Centers.** As people at risk for meth use or currently using meth engage with community organizations and service providers across the County, it is imperative that they encounter a coordinated service system to ensure continuity of support. To that end, LA County should

require funded organizations to demonstrate that they work collaboratively with service providers to prevent and address methamphetamine and other drug use.

4. **Expand housing capacity for unhoused residents in LA County.** Homelessness is strongly correlated with methamphetamine use. In addressing the root causes of methamphetamine use, housing opportunities for residents of LA County regardless of drug use status or the ability to pay rent must be expanded to decrease the likelihood of methamphetamine use and to promote the dignity of the person.

5. **Expand and promote access to navigation services for unhoused people who are placed into temporary housing facilities.** Navigation services are critical to expanding access to substance use prevention and treatment services for unhoused people, which will increase the health and wellness of both the individual and the community. It is essential that these services be provided to unhoused people where they are located to ensure accessibility.

6. **Prioritize funding for prevention case management as part of harm reduction efforts.** Linking individuals at risk of using or currently using meth to the services they need to establish stable housing, food security, employment, health care, and substance use and mental health support is critical to primary and secondary meth use prevention efforts. Prioritizing funding for prevention case management is essential to addressing the meth epidemic.

7. **Ensure substance use prevention and treatment referrals are offered to clients accessing HIV, STI, and viral hepatitis screening, as well as HIV Pre-Exposure Prophylaxis/Post-Exposure Prophylaxis (PrEP/PEP) services, to promote a holistic approach to wellness**. When using meth and other drugs, individuals often engage in sexual behaviors that are primary risk factors for HIV transmission. Sexual health screening and PrEP programs offer prime opportunities for referrals to substance use prevention and treatment services.

8. **Incorporate comprehensive HIV, STI, and viral hepatitis screening, as well as PrEP/PEP navigation services, in substance use prevention and treatment programs through collaboration with clinical service providers across LA County**. Despite substance use being a key risk factor for and frequent comorbid condition with HIV, individuals in meth and other substance use prevention and treatment programs are not routinely offered prevention or screening services for HIV and related conditions. Incorporating these auxiliary services is critical to optimizing meth use prevention efforts.

9. **Increase the availability and accessibility of effective mental health services across Los Angeles County.** Mental illness is a key contributor to initial and continued methamphetamine use. Therefore, LA County should pursue a robust approach to addressing mental illness alongside

meth use. Mental health services must be culturally proficient and provide appropriate assessment, diagnosis, and treatment. Further, mental health intake services should be available to methamphetamine users within three business days of initial contact to support tertiary prevention and ensure urgent needs are addressed.

10. **Improve cultural proficiency among County departments and service providers.** County departments and service providers must be culturally proficient in the areas of race, ethnicity, language, sexual orientation, gender identity, and religious beliefs. These characteristics each intersect with methamphetamine use in unique ways that service providers should be aware of and be competent to address. County departments and service providers should be required to receive annual training in these areas to ensure that clients receive culturally proficient services. Training should follow curricula approved by the Los Angeles County Center for Health Equity.

11. **Continue and increase support for those returning to the community after incarceration.** Those returning to the community after a period of incarceration are at risk for meth and other substance use. These individuals should have a menu of services that they can access to improve their health and wellness. Reentry services must include navigation support to assist clients with proper referrals to housing, workforce placement, and substance use and mental health prevention and treatment programs. Additionally, all individuals exiting incarceration should receive education on fentanyl and overdose prevention, including provision of Naloxone and fentanyl test kits to help prevent overdoses.

12. **Provide evidence-based, age-appropriate substance use curricula from K-12.** Substance use prevention must be addressed from K-12 and should not be delayed until middle or high school. Early education is essential to promote the importance of connections with others and address the needs of children who may experience the harms of meth use by caretakers or parents. Youth involvement in collaborative learning during K-12 or engagement in making social connections with others who have prosocial behaviors will slow the use of meth and other drugs. Students should learn about harm reduction concepts and strategies, in addition to abstinence, that will empower them to make healthy choices for themselves and others regarding substance use.

13. **Fund community-based, grassroots prevention efforts that specifically address methamphetamine.** It is essential for public health to value the work of grassroots organizations that are grounded in the community and work with the target population daily. Therefore, funding must be prioritized to support community-based, grassroots, locally developed programs that focus on preventing meth use.

RECOMMENDATIONS RELATED TO TREATMENT

When it comes to treating meth dependency, effective treatment must encompass a "macro" approach that moves away from blaming the person with a substance use disorder for their behavior and toward addressing the factors that are negatively impacting their health and wellbeing.

ANAM offers the following methamphetamine treatment recommendations:

1. **Fund, invest in, and promote the use and expansion of evidence-based behavioral and interventions to treat methamphetamine addition.** Currently, evidence-based behavioral treatment options for methamphetamine addiction include contingency management, cognitive behavioral (individual and group counseling) interventions, motivational enhancement therapy, and community reinforcement. Very few places currently offer contingency management, which has the strongest evidence of success. Investing in these evidence-based approaches to treating methamphetamine use disorder is critical to addressing the methamphetamine epidemic in Los Angeles County

2. **Expand efforts to explore, formalize, and fund biomedical treatments.** Biomedical treatment options are just now coming on-line. Two clinical trials support the use of mirtazapine (30 mg per day), and one large trial demonstrates positive outcomes for a combination of extended-release naltrexone and high-dose bupropion, for reducing methamphetamine use over placebo (Trivedi et al, New England Journal of Medicine 2021). According to Dr. Steve Shoptaw at UCLA, "The agreement between the two trials of mirtazapine is impressive. The combination of Vivitrol and high-dose bupropion is outstanding. These findings require us as a community to make available mirtazapine and/or extended-release naltrexone plus high-dose bupropion to help people reach their methamphetamine use goals."

3. **Require physicians, counselors, behavioral health providers, social workers, educators, judicial system, law enforcement officers, and others across the County service system to participate in annual trainings on trauma-informed approaches to addressing methamphetamine use.** Many individuals who use meth have experienced significant trauma. Individuals who experience negative interactions with County services when seeking care may disengage in care and have detrimental outcomes. Successful treatment of methamphetamine use requires a holistic, trauma-informed approach to care across the County service system.

4. **Promote and normalize the use of naloxone, fentanyl strips, syringe services and other harm-reduction measures as meth treatment tools across the County.** These evidence-based harm-reduction tools have been proven effective and must be readily available to all who need them.

5. **Implement harm reduction principles.** It is crucial for LA County to require and promote harm reduction principles in all meth treatment programs to prevent and reduce the negative individual and community consequences of meth use. To that end, all meth treatment services across the County must be delivered in accordance with training in harm reduction principles and trauma-informed care.

6. **Fund, invest in, and increase the number of certified detox facilities throughout each Service Planning Area, and ensure no patient shall be turned away due to lack of financial ability.** Clients are often unable to access services when ready due to lack of service availability or limited financial resources. Additional, subsidized services must be made available across the County.

7. **Fund, invest in, and increase coordination of treatment efforts between mental health and substance use providers.** We call upon the Los Angeles County Department of Public Health and Department of Mental Health to streamline and implement coordinated services to adequately address co-occurring disorders impacting those using meth. When services are managed by different departments in silos, clients are less likely to have their health needs met.

8. **Ensure meth treatment programs address the complex, holistic needs of marginalized racial and ethnic communities by investing in and expanding the capacity of service providers who reflect the racial and ethnic identities of those communities.** Increasing the capacity of service providers from Latinx, Black, Asian, Native Hawaiian and other Pacific Islander, Indigenous, and other marginalized racial and ethnic communities is critical to improving the engagement and outcomes of clients from these communities.

9. **Invest in and increase the number of LGBTQ+ meth treatment centers specifically designed for LGBTQ+ patients in all Service Planning Areas to ensure treatment services are culturally and linguistically proficient and accessible to people of all identities within the LGBTQ+ community.** These centers should employ staff that are knowledgeable about the higher rates of meth and other substance use due to societally imposed obstacles that LGBTQ+ populations encounter daily. Co-occurring disorders common to the LGBTQ+ community such as anxiety, depression, self-harming tendencies, suicide/suicide attempts, compulsive sexual behavior, and trauma resulting from sexual abuse and assault must be addressed during treatment to support and sustain health and wellbeing.

RECOMMENDATIONS RELATED TO POLICY

Legislative and regulatory barriers impede wide-scale implementation and sustainable funding of more expansive prevention and treatment services for methamphetamine use. Effectively addressing the current crisis will require active engagement and support from federal, state, and local government officials to amend or eliminate these statutory and regulatory barriers.

At the same time, government officials must commit the resources and additional funding that will be needed to effectively scale up programs and services for communities affected by methamphetamine use. This effort includes ensuring adequate, sustainable funding for outreach and education, provider training, evidence-based interventions, harm reduction services, and low-barrier treatment options.

ANAM offers the following key policy recommendations to expand access to effective prevention and treatment options and develop a more robust, compassionate response to the methamphetamine crisis in LA County:

1. **Increase access to comprehensive health coverage.** Ensuring that all LA County residents, regardless of legal status, have access to affordable, high-quality health care and achieving universal health care coverage are among the most important steps to effectively address methamphetamine use. Policymakers must ensure that both public and private payors cover and provide adequate reimbursement for effective prevention and treatment interventions, including contingency management.

2. **Expand access to contingency management services.** Contingency management is an evidence-based intervention for methamphetamine use that encourages positive behavior through the use of rewards or incentives. The California Department of Health Care Services (DHCS) recently received approval to cover contingency management in the Medi-Cal program through a pilot that will run from July 1, 2022, through March 31, 2024. DHCS will launch the contingency management benefit in select Drug Medi-Cal Organized Delivery System (DMC-ODS) counties using county-contracted providers. We urge the LA County Board of Supervisors to fully participate in the pilot program and develop a robust network of County-contracted providers so that contingency management services are widely available. Further, we urge LA County to develop an effective communications and outreach strategy so that impacted communities are aware of this new benefit for Medi-Cal beneficiaries.

3. **Support the creation of a new safe harbor provision to the federal anti-kickback statute.** Despite its demonstrated effectiveness in reducing methamphetamine use, contingency management is rarely available, due in part to federal policy limiting the type and allowable cash

value of incentives that can be used. The Biden-Harris administration's drug policy platform cites the need to end "policy barriers related to contingency management interventions (motivational incentives) for stimulant use disorder" as part of its effort to expand evidence-based treatment. Establishing a safe harbor for contingency management, with guardrails in place to ensure its appropriate use, would allow for the further implementation of these effective programs.

4. **Increase funding for effective prevention and treatment interventions**. Increased funding to support effective prevention and treatment interventions is paramount to addressing methamphetamine use in LA County. Funding must also be allocated to support provider education and training on evidence-based, culturally responsive approaches to methamphetamine use. In 2020, the Substance Abuse and Mental Health Services Administration (SAMHSA) announced that State Opioid Response Grant dollars could be used to support evidence-based prevention, treatment, and recovery support services to address methamphetamine use. It will be critical for LA County to maximize these federal and state resources while addressing any remaining funding gaps.

5. **Increase funding for low-barrier harm reduction services, including syringe service programs, and work to increase public awareness of the effectiveness of harm reduction to reduce stigma**. Harm reduction organizations, including syringe service programs, are often the first point of contact for people who use drugs. These programs offer lifesaving services including Naloxone, sterile syringes, and testing for HIV, STIs, and other communicable diseases. Harm reduction organizations are also trusted community partners, and they remain critical resources to connect people who use drugs with treatment, recovery services, and health care. Increased funding is needed to support the further expansion of low-barrier harm reduction services across LA County. Increasing public awareness of the effectiveness of harm reduction will help to reduce the stigma and change the public perception of harm reduction to reflect its important role as a tool to curb problematic drug use.

6. **Continue to support statewide and local efforts to authorize and establish supervised consumption services.** Supervised consumption services are designated overdose prevention services where people can use pre-obtained drugs under the supervision and support of trained personnel. These programs have been extensively researched and shown to reduce health and safety problems associated with drug use, including overdose deaths. Senate Bill 57, by Senator Scott Wiener (D-San Francisco), would give LA County the ability to implement and evaluate these promising programs. We applaud the LA County Board of Supervisors for supporting this important legislation and urge the Board to continue moving toward establishing supervised consumption services.

7. **Support efforts to decriminalize drug possession and increase diversion programs.** Data from the U.S. and around the world indicate that treating drug use as a health issue, instead of as a criminal issue, is a more successful model for keeping communities healthy and safe. Using diversion programs aimed at addressing drug use in place of criminal prosecution for drug possession would save money by reducing prison and jail costs, free up law enforcement resources to be used for effective prevention and treatment services and prioritize health and safety over punishment for people who use drugs. Oregon recently became the first state in the nation to decriminalize drug possession, including methamphetamine. We support these efforts and urge the LA County Board of Supervisors to take appropriate steps toward decriminalizing drug possession.

8. Advance racial equity policy and legislation. The War on Drugs of the 1970s and '80s and its continued legacy of discriminatory policies has had a profoundly disproportionate impact on Black, Indigenous, and People of Color (BIPOC) communities. Higher arrest and incarceration rates for these communities are not reflective of increased prevalence of drug use, but rather of law enforcement's focus on communities of color. At the same time, BIPOC communities experience disparate access to health care, differential treatment, and poorer health outcomes. We urge policymakers at all levels of government to take steps to advance racial equity policy and legislation to address the harmful effects of the War on Drugs and eliminate health inequities in BIPOC communities.

9. Endorse legislation to declare methamphetamine an emerging drug threat. In 2021, Senators Dianne Feinstein (D-CA) and Chuck Grassley (R-IA) and Representatives Scott Peters (D-CA) and John Curtis (R-UT) introduced the Methamphetamine Response Act, a bill declaring methamphetamine an emerging drug threat which would require the Office of National Drug Control Policy (ONDCP) to develop, implement, and make public a national emerging threats response plan that is specific to methamphetamine. The plan would be required to be updated annually and include short- and long-term goals, performance measures, and the funding needed to implement the plan. We urge the LA County Board of Supervisors to endorse this important legislation.

10. Create a Meth Awareness Day in the County of Los Angeles. Greater awareness efforts are needed to educate LA County residents about the dangers of methamphetamine use. A countywide Meth Awareness Day would allow community-based organizations and LA County residents to have conversations about the impacts of methamphetamine use and increase awareness of available prevention and treatment services.

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Approved by the Act Now Against Meth Coalition on December 8, 2021.

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