LOS ANGELES COUNTY
COMMISSION ON HIV

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COMMISSION ON HIV
Virtual Meeting

Thursday, December 10, 2020

9:00AM -1:00PM (PST)

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

REGISTER + JOIN VIA WEBEX ON YOUR COMPUTER OR SMART PHONE:

https://tinyurl.com/yyqgdrx5
**Link is for members of the public only*

JOIN VIA WEBEX ON YOUR PHONE:

1-415-655-0001 US Toll
Access Code: 145 197 9652

PUBLIC COMMENTS

Public Comments will open at the time referenced on the meeting agenda. For those who wish to provide live public comment, you may do so by joining the WebEx meeting through your computer or smartphone and typing PUBLIC COMMENT in the Chat box. For those calling into the meeting via telephone, you will not be able to provide live public comment. However, you may provide written public comments or materials by email to hivcomm@lachiv.org. Please include the agenda item and meeting date in your correspondence. All correspondence and materials received shall become 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 (COH)

MAIN (213) 738-2816 / FAX (213) 637-4748

EMAIL: hivcomm@lachiv.org WEBSITE: http://hiv.lacounty.gov

Thursday, December 10, 2020 | 9:00 AM – 1:00 PM

To Register/Join by Computer: https://tinyurl.com/yyqgdrx5

**link is for members of the public*

To Join by Telephone: 1-415-655-0001 Access code: 145 197 9652

AGENDA POSTED: December 4, 2020

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 hivcomm@lachiv.org or leave a voicemail at 213.738.2816.

Los servicios de interpretación para personas con problemas de audición y los servicios de traducción para otros idiomas además del inglés están disponibles sin cargo con al menos 72 horas de anticipación antes de la fecha de la reunión. Para coordinar estos servicios, comuníquese con la oficina de la Comisión en hivcomm@lachiv.org o deje un mensaje de voz al 213.738.2816.

SUPPORTING DOCUMENTATION can be obtained at the Commission on HIV Website at: http://hiv.lacounty.gov. Currently all County buildings are closed to the public due to the COVID-19 public emergency until further notice. To request information, please contact the Commission office via email at hivcomm@lachiv.org or by leaving a voicemail at 213.738.2816.

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 and Roll Call		9:00 AM – 9:03 AM
1.	**ADMINISTRATIVE MATTERS**		
	A. Approval of Agenda	**MOTION #1**	9:03 AM – 9:05 AM
	B. Approval of Meeting Minutes	**MOTION #2**	9:05 AM – 9:07 AM
2.	**WELCOME, INTRODUCTIONS AND VIRTUAL MEETING GUIDELINES**		9:07 AM – 9:15 AM
3.	**REPORTS - I**		
	A. Executive Director/Staff Report		9:15 AM – 9:20 AM
	(1) County/COH Operational Updates		
	(2) 2020 Accomplishments and Reflection		
	(3) 2021 Commission Work Plan and Activities		
	B. Co-Chair Report		9:20 AM – 9:30 AM
	(1) Meeting Management Reminders		
	(2) November 12, 2020 Annual Meeting Follow Up & Feedback		
	(3) Recognition of Service		
	(4) Executive At-Large Member Open Nominations | ONGOING		
	(5) 2020 Holiday Meeting Schedule		
	C. California Office of AIDS (OA) Report		9:30 AM – 9:40 AM
	(1) California HIV Planning Group (CPG) Update		
	D. LA County Department of Public Health Report		9:40 AM – 10:00 AM
	(1) Division of HIV/STD Programs (DHSP) Updates		
	(a) Programmatic and Fiscal Updates		
	(b) Ending the HIV Epidemic (EHE) Activities & Updates		
	(c) Epidemic Modeling Updates		
	E. Housing Opportunities for People Living with AIDS (HOPWA) Report		10:45 AM – 10:50 AM
	F. Ryan White Program Parts C, D, and F Report		10:50 AM – 10:55 AM
	G. Cities, Health Districts, Service Planning Area (SPA) Reports		10:55 AM – 11:00 AM

4. REPORTS - II

A. Standing Committee Reports 11:00 AM – 12:30 PM

(1) Operations Committee

(a) Membership Management

- Alexander Luckie Fuller |Provider Representative #4 **MOTION #3**
- Damontae Hack |Unaffiliated Consumer, At Large #2 **MOTION #4**
- Ernest Walker | HIV Stakeholder Representative #3 **MOTION #5**
- Guadalupe Velazquez |Unaffiliated Consumer, At-Large #1 **MOTION #6**
- Resignation | Aaron Fox
- Seat Change | Frankie Darling Palacios to Part C Representative
- Alternate Seat Review

(c) Mentorship Program Update

(d) 2020 Virtual Training Summary

(3) Planning, Priorities and Allocations (PP&A) Committee

(a) DHSP Fiscal Expenditure Reports

(b) Prevention Planning Updates

(2) Standards and Best Practices (SBP) Committee

(a) Child Care Services Standards of Care | UPDATE

(b) Universal Standards of Care | UPDATE

(c) Patient Bill of Rights

(3) Public Policy Committee

(a) County, State, and Federal Legislation & Policy

(b) County, State, and Federal Budget

B. Caucus, Task Force and Work Group Report 12:30 PM – 12:45 PM

(1) Aging Task Force | January 25, 2021 @ 9am-11am

(a) Draft Recommendations

(2) Black African American Community (BAAC) Task Force | January 25, 2021 @ 1-3pm

(b) Commitment Statement

(3) Consumer Caucus | January 14, 2021 (following COH meeting)

(4) Women's Caucus | January 18, 2021 @ 2-4pm

(5) Transgender Caucus | January 26, 2020 @ 10am-12pm

5. MISCELLANEOUS

A. Public Comment 12:45 PM – 12:50 PM

Opportunity for members of the public to address the Commission of items of interest that are within the jurisdiction of the Commission. For those who wish to provide live public comment, you must register and join WebEx through your computer or smartphone. For those calling into the meeting via telephone, you will not be able to provide live public comment. However, you may provide written public comments or materials by email to hivcomm@lachiv.org.

B. Commission New Business Items 12:50 PM – 12:55 PM

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.

C. Announcements 12:55 PM – 1:00 PM

Opportunity for members of the public to announce community events, workshops, trainings, and other related activities. Announcements will follow the same protocols as Public Comment.

Adjournment and Roll Call 1:00 PM

Adjournment for the meeting of December 10, 2020.

PROPOSED MOTION(S)/ACTION(S)	
MOTION #1:	Approve the Agenda order, as presented or revised.
MOTION #2:	Approve the Minutes, as presented or revised.
MOTION #3:	Approve New Member Application for Alexander Luckie Fuller for Provider Representative #7 and forward to the BOS for appointment; as presented or revised.
MOTION #4:	Approve New Member Application for Damontae Hack for an Alternate seat and forward to the BOS for appointment; as presented or revised.
MOTION #5:	Approve New Member Application for Ernest Walker for HIV Stakeholder Representative #1 seat and forward to the BOS for appointment; as presented or revised.
MOTION #6:	Approve New Member Application for Guadalupe Velazquez to Unaffiliated Consumer, At Large #1 seat and forward to the BOS for appointment; as presented or revised.

COMMISSION ON HIV MEMBERS:			
Al Ballesteros, MBA, Co-Chair	Bridget Gordon, Co-Chair	Miguel Alvarez (Alternate*)	Everardo Alvizo, MSW
Danielle Campbell, MPH	Raquel Cataldo	Pamela Coffey (Alasdair Burton, Alternate **)	Michele Daniels
Erika Davies	Kevin Donnelly	Jerry D. Gates, PhD	Felipe Gonzalez
Grissel Granados, MSW	Karl Halfman, MA	Diamante Johnson (Kayla Walker-Heltzel, Alternate**)	Joseph Green
Thomas Green (Alternate *)	William King, MD, JD, AAHIVS	Lee Kochems, MA	David P. Lee, MPH, LCSW
Anthony Mills, MD	Carlos Moreno	Derek Murray	Paul Nash, CPsychol, AFBPsS FHEA
Katja Nelson, MPP	Frankie Darling-Palacios	Mario J. Pérez, MPH	Juan Preciado
Joshua Ray (Eduardo Martinez, Alternate **)	Ricky Rosales	Nestor Rogel (Alternate*)	Harold San Augstin, MD
Martin Sattah, MD	Tony Spears (Alternate*)	LaShonda Spencer, MD	Kevin Stalter
Maribel Ulloa	Justin Valero	Amiya Wilson	
MEMBERS:	**39**		
QUORUM:	**20**		

LEGEND:

LoA = Leave of Absence; not counted towards quorum

Alternate*= Occupies Alternate seat adjacent a vacancy; counted toward quorum

Alternate**= Occupies Alternate seat adjacent a filled primary seat; counted towards quorum in the absence of the primary seat member

LOS ANGELES COUNTY
COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov

VISION

A comprehensive, sustainable, accessible system of prevention and care that empowers people at-risk, living with or affected by HIV to make decisions and to maximize their lifespans and quality of life.

MISSION

The Los Angeles County Commission on HIV focuses on the local HIV/AIDS epidemic and responds to the changing needs of People Living With HIV/AIDS (PLWHA) within the communities of Los Angeles County.

The Commission on HIV provides an effective continuum of care that addresses consumer needs in a sensitive prevention and care/treatment model that is culturally and linguistically competent and is inclusive of all Service Planning Areas (SPAs) and Health Districts (HDs).

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CODE OF CONDUCT

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

All participants and stakeholders should adhere to the following:

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

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

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TO END HIV, WE MUST END RACISM

On the behalf of the Los Angeles County Commission on HIV, the Black/African American Community (BAAC) Task Force recognizes that these are extremely difficult, disturbing and painful times for us and our communities. We remain steadfast in solidarity with our Black/African American communities and vehemently condemn the pervasive, systemic racism that continues to plague our communities. “Without reckoning with our history of racial injustice and violence we will continue to be haunted by its ugly and painful legacy.” (Equal Justice Initiative [EJI].)

Racism IS a public health emergency and impacts us all. Racism impacts access to and the quality of health care and it dictates when, how and by whom health care is given or withheld. Medical mistrust by our Black/African American communities and implicit biases of the health care system are rooted in historical, institutional and socialized racism. It is without question we cannot end the HIV epidemic without dismantling these systems that continue to perpetuate the injustices that result in disproportionately poorer outcomes in our Black/African American communities. Our HIV community must remain diligent and committed to actively engaging in policy and action that promote health equity, eliminate barriers and address 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; and income/wealth gaps.

As HIV advocates, we cannot sit idly by and allow these inequities to continue. We must act now by centering ALL of our work and conversations around the intersection of racism and the unequal burden of HIV on our Black/African American communities. The Commission is committed to taking action.

We stand in memoriam of Breonna Taylor, George Floyd, Tony Mc Dade, Ahmaud Arbery, and all those who have lost their lives to senseless acts of violence, police brutality and HIV/AIDS. We stand with you, we hurt with you, and we will take action to address these inequities and heal with you.

In Solidarity,

Los Angeles County Commission on HIV
Black/African American Community (BAAC) Task Force

#EndBlackHIV #KnowYourStatus #EndingtheEpidemic #VOTE

“Injustice anywhere is a threat to justice everywhere. We are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly, affects all indirectly.” - Martin Luther King, Jr.

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

COMMISSION ON HIV MEETING MINUTES

SECONDARY TELECONFERENCE SITE:
California Department of Public Health, Office of AIDS
1616 Capitol Avenue, Suite 74-616, Sacramento, CA 95814

October 8, 2020

COMMISSION MEMBERS PRESENT	COMMISSION MEMBERS PRESENT *(cont.)*	COMMISSION MEMBERS ABSENT	DPH/DHSP STAFF
Al Ballesteros, MBA, *Co-Chair*	David P. Lee, MPH, LCSW	Frankie Darling-Palacios	Julie Tolentino, MPH
Bridget Gordon, *Co-Chair*	Anthony Mills, MD	Diamante Johnson	
Miguel Alvarez *(Alt.)*	Carlos Moreno	*(F to Walker-Heltzel)*	**COMMISSION STAFF/CONSULTANTS**
Danielle Campbell, MPH	Derek Murray	Eduardo Martinez *(Alt. to Ray)*	
Raquel Cataldo	Paul Nash, CPsychol AFBPsS FHEA	Tony Spears *(Alt.)*	Cheryl Barrit, MPIA
Stephanie Cipres, MPH	Katja Nelson, MPP	Amiya Wilson	Carolyn Echols-Watson, MPA
Pamela Coffey/Alasdair Burton	Mario Pérez, MPH		Dawn McClendon
Michele Daniels	Juan Preciado		Jane Nachazel
Erika Davies	Joshua Ray, RN *(F. to Martinez)*		James Stewart
Kevin Donnelly	Nestor Rogel *(Alt.)*		Sonja Wright, MS, Lac
Aaron Fox, MPM	Ricky Rosales		
Jerry D. Gates, PhD	Harold San Agustin, MD		
Felipe Gonzalez	Martin Sattah, MD		
Grissel Granados, MSW	LaShonda Spencer, MD		
Joseph Green	Kevin Stalter		
Thomas Green *(Alt.)*	Maribel Ulloa		
Karl Halfman, MS	Justin Valero, MA		
William King, MD, JD, AAHIVS	Kayla Walker-Heltzel, MPH		
Lee Kochems, MA	*(Alt. to Johnson)*		

PUBLIC			
Alejandra Aguilar-Avelina	Ignacio Alvarez	Everardo Alvizo	Luis Argueta
Laurie Aronoff	Martin Becerra	Paulina Buenrostro	Leopoldo Cabral
Andiver Castellano	Carlos Catano	Geneviéve Clavreul, RN, PhD	Eric Daar, MD
Maria Diaz	Ayana Elliott	Dahlia Ferlito	Felipe Findley
Thelma Garcia	Becky Gonzales	Joaquin Gutierrez	Damontae Hack
Marc Haupert	Damilola Jolayemi	Uyen Kao, MPH	Joseph Leahy

PUBLIC *(cont.)*			
Lorayne Lingat	Daisy Nip	LCDR Jose Antonio Ortiz, MPH	Meyerer Perez
Tara Raoufi	George Reynolds	Rosario Rivas	Sandra Robinson, MBA
Elena Rosenberg-Carlson, MPH	Kai Smith	Preeti Sodhi	Peter Soto
Jennifer Torres	Octavio Vallejo, MD, MPH	Lizette Villanueva	Deborah Wafer
Ernest Walker	Greg Wilson		

*Some participants may not have been captured electronically. Attendance can be corrected by emailing the Commission.

CALL TO ORDER AND ROLL CALL: Mr. Ballesteros opened the meeting at 9:05 am and Ms. Gordon read the Commission on HIV Code of Conduct which is also available for review in the meeting packet.
Roll Call (**Present)**: Alvarez, Campbell, Cataldo, Cipres, Coffey/Burton, Daniels, Davies, Donnelly, Fox, Gates, Gonzalez, Granados, Green (Joseph), Halfman, King, Kochems, Lee, Mills, Moreno, Murray, Nash, Nelson, Pérez, Preciado, Ray, Rogel, Rosales, San Agustin, Sattah, Spencer, Stalter, Ulloa, Valero, Walker-Heltzel, Ballesteros, Gordon.

1. ADMINISTRATIVE MATTERS

A. APPROVAL OF AGENDA

MOTION #1: Approve the Agenda Order, as presented ***(Passed by Consensus)***.

B. APPROVAL OF MEETING MINUTES

MOTION #2: Approve the 9/10/2020 Commission on HIV Meeting Minutes, as presented ***(Passed by Consensus)***.

2. WELCOME, INTRODUCTIONS, AND VIRTUAL MEETING GUIDELINES

- Ms. Gordon welcomed all to the meeting and noted the agenda and materials were on the Commission's website.
- She reminded attendees that live public comments can only be provided by those registered with WebEx and attending via computer or smart phone. Public comments are limited to two minutes per person and will be taken under that item.
- Please be mindful of on-camera activity and screen backgrounds or turn off video. Please also refrain from phone calls.
- Use WebEx Q&A to ask questions or make a comment about an agenda item and the Chat Box for WebEx technical issues.
- Those attending via telephone can email written comments or materials to hivcomm@lachiv.org. Please include the meeting date and agenda item. Correspondence received will become part of the meeting's official public record.
- If connecting both through a computer and by telephone, please mute the computer audio to avoid echo.
- A video and audio recording of this meeting will be posted on the Commission's website at http://hiv.lacounty.gov.
- Please refer to the Commission's Code of Conduct which may be found in the meeting packet after the agenda. It applies to all attendees. Ms. Gordon also reviewed the Commission's Vision and Mission which were also in the packet.
- On behalf of the Commission, she thanked Eric S. Daar, MD for today's presentation on the intersection of COVID-19 and HIV; and Commissioner Danielle Campbell, MPH for arranging this presentation.

3. REPORTS - I

A. EXECUTIVE DIRECTOR/STAFF REPORT

- Ms. Barrit thanked all who came and echoed appreciation for Dr. Daar's presentation and Ms. Campbell's coordination of it.
- The Commission was holding Daniela Hernandez in strength and healing thoughts as she recovers in the hospital from the horrific transphobic attack in McArthur Park on 10/4/2020. She is a volunteer at The TransLatin Coalition and has attended several Commission and Transgender Caucus meetings. The Commission has sent a letter of support. Bamby Salcedo, President and Chief Executive Officer, The TransLatin Coalition, put out a press release on the attack and the 10/7/2020 *Los Angeles Times* carried an article on it. Individuals may also reach out to Bamby Salcedo with care and support.

(1) County/Commission Operational Updates

- Ms. Barrit reported the Commission continues to work with the Board of Supervisors (Board), Executive Office (EO), and guidance from the Department of Public Health (DPH) to maintain safety and protection of public health during the COVID-19 pandemic. Consequently, LAC facilities and Commission offices remain closed to the public.
- Commission staff person Ms. Wright continues her Disaster Services Worker (DSW) assignment as a DPH contact tracer.

- Meanwhile, in preparation for the staff's eventual phased return to work in the office, Ms. Barrit met with the facilities manager on 9/29/2020. An on-site assessment of the Commission's offices was done on issues such as occupancy limits, Plexiglas dividers, and other safety measures that must be addressed before returning to the space.
- The EO employs a square footage formula for how many people can fit into a room per social distancing guidelines. Using that formula, the office conference room previously used for committee meetings can now only accommodate four people. This is an example of the logistical challenges that need to be met before returning to in-person meetings.

(2) 2020 Presidential Election Assistance

- The EO has begun mobilizing LAC staff as DSWs for the election. Ms. McClendon will work as a DSW for five days.
- Ms. Barrit sent an email earlier regarding the opportunity to serve as an election worker. Several Commissioners have indicated they have signed up or are in the process. People still interested can go to LAVote.net for more information.

(3) Unaffiliated Consumer Member Stipends

- Ms. Barrit noted the Commission's Ordinance and Bylaws define it as one of the few Planning Councils (PCs) in the country that allow Unaffiliated Consumers (UCs) to receive stipends. A UC is defined as a PLWH who receives services from a Ryan White Part A funded provider and is not an officer, employee, or consultant of any Part A funded provider.
- The Ordinance and Bylaws allow up to $150 per month provided a UC Commissioner attends the full meeting, the member's primary committee assignment, and the Consumer Caucus; and, $150 for a UC Alternate who meets requirements while serving as a Commissioner for a month in which either the Commissioner is incapacitated or there is no Commissioner; or, $100 for a UC Alternate who meets the requirements while serving as an Alternate.
- The Commission increased stipends in 2020 to the maximums allowed by Ordinance and Bylaws of $150 for those who meet requirements as UC Commissioners, $150 for UC Alternates serving as Commissioners, and $100 for UC Alternates. Policy/Procedure #09.7201 on this topic was in the packet for review.

(4) Feedback on Proposed Ending the HIV Epidemic (EHE) and Commission Activities

- The document provided to the 9/24/2020 Executive Committee for feedback was in the packet. Some people have already provided feedback. Others were encouraged to do so.
- ➲ Email additional questions, concerns or thoughts to Ms. Barrit by 10/9/2020.

(5) 11/12/2020 Annual Meeting Preparation

- The same document provided to the 9/24/2020 Executive Committee noted above also includes a section on Annual Meeting Ideas for feedback as well.
- ➲ Email additional questions, concerns or thoughts to Ms. Barrit by 10/9/2020.

B. CO-CHAIR REPORT

- Mr. Ballesteros thanked the Commission staff for all of their work under these difficult times.

(1) Welcome New Commission Members:

- Ms. Gordon noted the new Commission Members and invited them to introduce themselves:
  Stephanie Cipres, MPH, Part D She has worked at the University of Southern California (USC) Maternal Child and Adolescent/Adult Center (MCA) for two and a half years. She was excited to join the Commission.
  Kevin Donnelly, Unaffiliated Consumer, Service Planning Area (SPA) 8 He thanked the body for its confidence in returning him to the Commission for the second time and looked forward to working with all the Commissioners. He is a life-long Los Angeles County (LAC) resident. In 1983, his physician told him to be on the lookout for new diseases among the gay population. Since 1996, he has lived with HIV in his body. He looks forward to ending the HIV epidemic.
  Paul Nash, CPsychol AFBPsS FHEA, HIV Stakeholder Representative #2 He is an Instructional Associate Professor in Gerontology at the USC Leonard Davis School of Gerontology. He has worked on a bicoastal study on HIV as well as on the intersection of aging and HIV. Originally from the United Kingdom (UK), he was learning about the LAC and United States health care systems. He is grateful to be able to bring his areas of expertise to the table.
- Ms. Gordon encouraged new Commissioners to reach out to staff or other Commissioners for any help in acclimating to the work of the Commission. She emphasized that they and their service are appreciated.

(2) 2021 Commission Co-Chair Nominations and Election

- Mr. Stewart noted nominations were opened at the September meeting. Terms are two years starting in January.
- Ms. Granados nominated Mr. Lee and he accepted the nomination. Mr. Ballesteros had been nominated at the September meeting when he deferred a decision. He chose to decline in light of Mr. Lee's acceptance, but offered to be a resource to assist as needed. There were no other nominations.

- Mr. Lee thanked Ms. Granados for the nomination. He has had the privilege of being involved in three HIV PCs - first in Houston, then Seattle, and the Commission for the past three years. He served on the Washington State Governor's Advisory Council for HIV/AIDS for eleven years and served as its chair for two years. He is Associate Director, Drew Center for AIDS Research, Education and Services, at the Charles R. Drew University. He is happy to serve.

MOTION #2A: Elect David P. Lee, MPH, LCSW as Commission on HIV Co-Chair, as elected ***(Passed by Consensus)***.

(3) Executive At-Large Member Open Nominations - ONGOING

- Mr. Stewart reminded the body that two of the three At-Large seats remained open. One is held by Michele Daniels.
- Those holding the Executive At-Large positions sit on both the Operations and Executive Committees. This permits them to act as a liaison with the Executive Committee, and through Executive with the full body, for the Operations Committee which is in charge of recruitment, leadership development, and community engagement.
- Joseph Green nominated Justin Valero, MA and he accepted.

MOTION #2B: Elect Justin Valero, MA as Executive At-Large Member, as elected ***(Passed by Consensus)***.

C. LOS ANGELES COUNTY (LAC) DEPARTMENT OF PUBLIC HEALTH (DPH) REPORT

(1) Division of HIV/STD Programs (DHSP) Updates

- Mr. Pérez, Director, congratulated Mr. Lee on behalf of DPH and DHSP on his election as Commission Co-Chair. He also thanked Mr. Ballesteros for his ongoing service and commitment. His Commission Co-Chair term will end 12/31/2020.
- This two-part DHSP update includes Ms. Tolentino with EHE Draft Plan information and gathering Commission input.
- DHSP submitted its Ryan White Part A annual application and has received confirmation of its acceptance by the Health Resources and Services Administration (HRSA). The score and funding level to finance Part A services are expected in February or March 2021. He thanked the DHSP team for their hard work and Commissioners for their in-depth review.
- Emergency Financial Assistance (EFA) services were expected to roll out by 11/1/2020. Arrangements with two local partners were being finalized. A training will be provided in October for Medical Care Coordination (MCC) partners.
- DHSP still has some 80% of staff deployed to one of five or six COVID-19 related assignments. While LAC daily COVID-19 case reports had been declining, 10/7/2020 showed a jump back up to the highest number in the last six weeks. Consequently, the likelihood of DHSP continuing to serve in COVID-19 related assignments remains high.
- On 10/5/2020, the Centers for Disease Control and Prevention (CDC) issued a health alert highlighting the potential for an HIV outbreak among People Who Inject Drugs (PWID) in a COVID-19 environment. The State relayed the notice as part of the California Health Alert Network and LAC did the same on 10/7/2020. There has been no indication of a LAC outbreak or cluster of HIV among PWID. Such new infections have been fairly stable for the last few years at about 6%.

D. CALIFORNIA OFFLICE OF AIDS (OA) REPORT

- Mr. Halfman, Chief, HIV Care Branch, highlighted items from the October 2020 *OA Voice* in the packet, as noted:
  - Page 6: The six counties of the California Consortium were shifting from the planning to the implementation phase of the EHE initiative. The counties are: Alameda, Orange, Riverside, Sacramento, San Bernardino, and San Diego. OA will meet with the CDC in early October to coordinate activities.
  - Page 4: OA executed an agreement for participation in the Building Healthy Online Communities (BHOC) TakeMeHome in-home testing program. OA is piloting the program with the six Consortium counties.
  - Page 5: OA's Harm Reduction Unit released a brief, *Smoking Supplies for Harm Reduction*, on the public health research and legal framework for providing smoke pipes and snorting materials to reduce HIV and hepatitis C transmission.
- Ms. Robinson, Chief, AIDS Drug Assistance Program (ADAP) Branch, highlighted additional items from the October 2020 *OA Voice* in the packet, as noted:
  - Page 1: OA has launched a new four-person Pre-Exposure Prophylaxis Assistance Program (PrEP-AP) Unit to better address access to PrEP, Post-Exposure Prophylaxis (PEP). Sexually Transmitted Infection (STI) treatment, and related health services. Just one specialist previously addressed PrEP and that person left in January 2020. With over 4,000 current PrEP-AP clients, OA paused to build a new Unit with a manager, specialist, and two analysts.
  - Page 4: Current insurance program data is in the table, but open enrollment has begun so numbers will be changing.
- Dr. Mills noted approval of new ADAP and PrEP-AP sites has been on hold for some six months and asked when they will restart. Ms. Robinson replied OA has been reviewing how to best bring on new sites with so many people working virtually. It has also been updating the forms and process. The hope was to start application review for new sites in a month or so.
- Mr. Ballesteros asked if individuals are able to complete PrEP-AP applications virtually. Ms. Robinson affirmed that they are. Most Enrollment Workers are working virtually and OA has provided guidance ensuring security and confidentiality.

- Ms. Gordon noted re-enrollment/recertification was waived and asked if that has ended. Ms. Robinson replied the waiver has ended so individuals will revert to their next action date. That should not be an issue because the process is virtual.

➲ Mr. Halfman will relay to OA leadership Mr. Pérez' suggestion to collaborate on a cost reduction for TakeMeHome kits.

(1) California HIV Planning Group (CPG) Updates: Due to COVID-19, the annual meeting was replaced with a four-day virtual meeting starting 10/5/2020 with the second CPG Leadership Academy. Remaining meetings on 10/12/2020, 10/16/2020, and 10/22/2020, 1:00 to 4:00 pm, are open to the public and offer an opportunity for comment. For more information, go to the website or contact loris.mattox@cdph.ca.gov.

4. DISCUSSION

A. ENDING THE HIV EPIDEMIC (EHE) DRAFT PLAN DISCUSSION *(Special focus on harnessing Commission input on the Draft Plan)*

- Ms. Tolentino's presentation included the PowerPoint and materials in the packet. She noted the first EHE Steering Committee meeting was 10/1/2020. Members introduced themselves and related their backgrounds, experiences, and interests while staff provided an overview of DHSP. The body engaged in a brainstorming session on the LAC EHE Draft Plan.
- The EHE Steering Committee Member Roster and biographical sketches were in the packet. A seat was reserved for a not yet determined Commission representative who will function as a liaison between the bodies.
- DHSP will hold a Spanish-language event in collaboration with the Commission and the Prevention through Active Community Engagement (PACE) Team on 10/28/2020, 2:00 to 3:00 pm. This event is in response to a Consumer Caucus request for more Spanish-speaking community input on the LAC EHE Draft Plan.
- A Spanish-language EHE Town Hall will also be hosted by CDR Michelle Sandoval-Rosario, DrPH, MPH, Director, PACE, Region 9. This 10/13/2020 event will present a broader overview of EHE including regional partners from San Diego.
- Mr. Valero asked about accessibility and usage of at-home testing, e.g., whether it is increasing and is useful.
- Mr. Pérez replied there a few different mechanisms to access home HIV test kits. APLA Health and Wellness has been making them available so their program information could be requested. Separately, DHSP was supporting two methods.
- The National Alliance of State and Territorial AIDS Directors (NASTAD) is spearheading a national program that allows people to request a test kit. NASTAD will collect demographic and surveillance information to provide to the more than 20 participating jurisdictions across the country including LAC. Jurisdiction-specific data will be available in about six months.
- In addition, DHSP is purchasing home test kits with EHE funds for distribution to partners countywide. Those kits should be available soon. That usage and experience information will come back to DHSP which will report out to the Commission.
- Ms. Tolentino noted LAC first developed the Integrated Comprehensive HIV Plan which was succeeded by the Los Angeles County HIV/AIDS Strategy (LACHAS) released in November 2017. EHE was announced in February 2019 providing the opportunity to develop a broader plan with increased surveillance based on federal partners, resources, and EHE funding. LACHAS and EHE Plan goals are essentially the same - decrease infections, increase diagnoses, increase viral suppression - while aligning with the four EHE pillars (diagnose, treat, prevent, respond) and four indicators identified by federal partners.
- DHSP held a Virtual Town Hall weeks ago on the EHE, as reflected in the PowerPoint, and opened a 30-day public comment.
- Meanwhile, Ms. Tolentino encouraged people to visit the new www.GetProtectedLA.com, a sexual health information hub.
- Ms. Campbell, Co-Chair, Black African American Community (BAAC) Task Force, said successful work must center the daily lives and health needs of Black individuals living in LAC. The BAAC Task Force has promulgated a set of recommendations.
- Dr. Sattah was encouraged to see the home testing and pilot testing of the incentive program to increase treatment adherence especially among patients with higher needs. He hoped the latter could be expanded to patients who were undetectable and maintaining serologic suppression. He recommended directing attention and resources to improving provider-patient communication to ask the right questions in order to identify and recruit high risk patients to PrEP.
- Mr. Murray asked if there was data on whether people belonging to two or more high-risk groups are at greater risk, e.g., would there be increased risk for an African American living with HIV who is not housed. Mr. Pérez replied there is no doubt that a client with multiple co-morbidities faces worse outcomes. A person experiencing homelessness who is also challenged by mental illness and substance use will not fare as well as someone facing just one of those issues.
- It is possible to look at data on co-morbidities among racial groups, but the number may be too small to infer a trend among some racial groups. The topic underlines how important complete client level information is, especially for the Ambulatory Outpatient Medical (AOM) and MCC systems, to better understand population needs.
- Mr. Murray also asked if there was a DHSP commitment to work with local municipalities to encourage collaboration with partners implementing Syringe Services Programs (SSPs). Ms. Tolentino noted, prior to COVID-19, DHSP planned to expand staff including SSP and PWID subject matter experts. That is not possible now, but DHSP is identifying partnerships. Mr.

Pérez added there is an existing set of SSPs supported by LAC and the City of Los Angeles that he felt need to be enhanced. He would also like additional sites to better serve the full geographic area though some cities prefer not to have SSPs.

- Mr. Rosales continued that over the past 25 years there have been just a few SSPs in the City of Los Angeles and later expanding into LAC. He has tried to add more and has recently certified one new provider mainly focused on Skid Row.
- Mr. Gonzalez felt HIV testing should be as common as cholesterol testing. All physicians should also be capable of discussing HIV and PrEP regardless of whether they provide pertinent services or referral to services. Ms. Tolentino noted the EHE Plan identifies work with medical professional training programs to make HIV a normal part of medical careers. DHSP was also working towards an upcoming detailing project with providers.
- Mr. Valero highlighted private providers who offer the bulk of care. Mr. Ballesteros agreed and noted a knowledge disconnect between private and Ryan White providers and health plans. He felt that, e.g., LA Care with two million members, should be required to do some HIV educational activities with clients. Mr. Pérez added that the Commission has a Local Health/Hospital Planning Agency Representative seat designed to help inform this discussion, but it is vacant. Typically, only a few cause-driven health care providers, centers, or plans help with routine HIV testing. The rest test due to a financial incentive or mandate. He felt the latter would be most effective, i.e., if the state required it.
- One attendee felt stigma was a major issue. These conversations usually occur where they are expected like at health providers, but not in the general community like at schools or other gathering spaces. He did not learn about HIV until college. Ms. Tolentino noted significant feedback regarding stigma, especially with younger people. DHSP is working to identify how best to work on stigma in general and especially with the younger population.
- Dr. Mills noted 50% of PLWH are not connected to care in Columbia, South Carolina, where he is from. That is not for lack of racially sensitive Federally Qualified Health Centers (FQHCs) and providers of color. But there a lack of a safe space for, e.g., a gay man or transgender woman, to talk openly about who they are. In LAC, we like to think we are better than that. Yet, after many patients with Blue Shield some years back, he reached out to develop a relationship. After two months, he connected on a call with the California director of insurance services. He said, "HIV? That's not even on my radar screen."
- He commended LA Care for trying. They ensure patients have an LGBTQ referral source and. Dr. Mills has given lectures on, e.g., HIV, the transgender population, and other topics. But we have to elevate these issues as countywide standards.
- Mr. Hack urged more racial diversity in the health care work force to foster better relationships in health care spaces.
- Mr. Valero recommended auditing private health care capacity. Often suburban providers have only a handful of physicians familiar with HIV which limits patient ability to access appointments or to review matters fully, e.g., laboratory results.

➲ Ms. Tolentino will provide a 10/28/2020 event flyer to the Commission for distribution shortly.
➲ Overall LAC EHE Draft Plan public comment is due 10/16/2020, but DHSP will incorporate Spanish-language event input.
➲ In response to a query about feedback on the new STI National Strategic Plan, Mr. Pérez will forward both DHSP's original input on development of the Plan and its feedback on the initial Plan. Mr. Halfman will also check on OA feedback.
➲ Ms. Tolentino will review the BAAC Task Force recommendations for potential incorporation into the EHE Plan.
➲ DHSP will review and report back on www.GetProtectedLA.com activity especially regarding any potential spike. Ms. Tolentino will also forward her notes from a recent webinar on a study of the CDC virtual "Keep It Up" program intervention. The CDC was experiencing recruitment issues despite the virtual nature of the program.

5. PRESENTATION

A. INTERSECTION OF COVID-19 AND HIV:

Eric S. Daar, MD, Chief, Division of HIV Medicine, Harbor-UCLA Medical Center; Investigator, Lundquist Institute

- Dr. Daar, a former Commissioner, was pleased to return and present on the PowerPoint in the packet.
- Based on limited data available now, PLWH with CD4 counts over 200 are likely not at higher risk of poor COVID-19 outcomes unless they have other co-morbidities known to increase risk for poor outcomes in the general population.
- Guidance for PLWH does suggest general cautions like maintaining an ample supply of medications or getting them by mail to reduce excess trips, keeping vaccinations current, and delaying discretionary visits such as laboratory monitoring.
- There is currently no indication that changing Antiretroviral Therapy (ART) is warranted. Some have questioned whether some antiretroviral medications might be therapeutic, but there is currently no evidence of that.
- Vaccine development commonly takes a decade. To address this pandemic, all steps are being followed in a compressed fashion to speed development, e.g., the manufacturing process has begun on promising vaccines that are not yet proven.
- Multiple vaccines are in development at the same time both in hopes that one will work and to facilitate production. Billions of doses are needed worldwide with over 300 million for the United States alone. Most also require two doses.

- Some Phase I/II trials did not allow PLWH to participate, but Phase III trials are now including PLWH as well as people at higher risk such as seniors and communities of color with diabetes and hypertension. It is important to test that a vaccine works in these populations. Further, the end point is to show that vaccinated people are less likely to develop symptomatic disease and these populations most likely to get symptomatic disease can more readily demonstrate efficacy.
- Phase III trials require large numbers, e.g., 30,000, in order to accumulate a sufficient number of people who get sick to determine efficacy as quickly as possible - hopefully by the end of 2020 or early 2021.
- The Lundquist Institute is now enrolling for its study. For more information or to enroll go to www.helpstopcovid.la.
- Transmission risk is high after a significant exposure. A large proportion of exposed people will have no symptoms, but some of those will later develop mild, moderate, or severe disease. Usually only those with severe disease are hospitalized.
- There is a high level of virus early on which causes much of the disease. As the level of virus goes down, people can get sicker in response to the body's inflammatory response to the virus especially with severe lung disease. Consequently, treatment strategy is to use antivirals early and inflammatory response modifiers for the latter very severe disease.
- Because time is critical, initial treatments have been medications already approved for other purposes. Remdesivir was not previously approved, but had been developed for diseases like Ebola. The first studies were on these available medications.
- A Federal Drug Administration (FDA) Emergency Use Authorization (EUA) permits use of a product pending FDA approval for treatment of a condition because other options are unavailable. The product only needs to meet a "might be effective" standard and have a favorable risk-benefit ratio. To date, Remdesivir, an antiviral, is the only medication with an EUA. Convalescent plasma has also received an EUA, but there have been no randomized trials to document benefit.
- A 11,500 person study in 175 UK National Health System hospital organizations randomized patients to usual care or one of several treatments. Dexamethasone showed a potential benefit at the other end of the spectrum in reducing mortality.
- Dr. Mills reported Anthony Mills Medical, Inc. expects to institute a site in about one week for the Janssen COVID-19 vaccine trial located at its new facility on Santa Monica Boulevard one-half block from the West Hollywood City Hall. They are making a strong effort to recruit from the Black and Brown communities, PLWH, and those with co-morbidities.
- They are also doing a Remdesivir trial for those with mild to moderate COVID-19 disease. So far, it has only been shown effective for severe disease. Recruitment referrals are welcome. Contact Dr. Mills for more information on either trial.
- Mr. Burton asked about persistence of antibodies post-recovery. Dr. Daar replied that was being studied. Some people, especially those not becoming as ill, may have a less robust immune response and be more vulnerable to re-infection. Even those with more robust responses see immune response wane after a time. To date, there are only a couple of well documented cases of clear re-infection after recovery. Various groups are being followed to study immune persistence.
- That question is also pertinent to vaccines and different vaccines may provide immunity for different lengths of time.
- Mr. Murray asked about the risk to PLWH of co-infection with influenza and COVID-19. Dr. Daar said there was little data regardless of HIV status. The early part of the pandemic overlapped with the influenza season yet co-infections, and even overall influenza cases, were few - likely due to universal precautions in response to COVID-19. It is likely that clinical co-infection would be worse than either alone. On the macro level, it would strain hospitals to have to meet the needs of both.

B R E A K

6. REPORTS - II

A. HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS (HOPWA)

- Ms. Ulloa reported HOPWA was waiting for City Council approval to begin processing rental assistance applications funded by the Coronavirus Aid, Relief, and Economic Security (CARES) Act. She will offer more details next month.
- HOPWA released a Request For Proposals (RFP) on 9/28/2020. The virtual proposers conference will be today at 2:00 pm on hcidla.contractsprocurement@lacity.org. She cannot answer questions since the procurement process has begun.

B. RYAN WHITE PROGRAM PARTS C, D, AND F REPORTS

- *Part D* Ms. Cipres reported childcare focus groups will be 10/23/2020, 10/28/2020, and 10/29/2020. Flyers will be out soon.
- Maternal Child and Adolescent/Adult Center (MCA) Part D resources are funding gift cards for those impacted by COVID-19.
- *Part F* Dr. Gates, AIDS Education and Treatment Center (AETC), reported their new provider will start 11/1/2020.

C. CITIES, HEALTH DISTRICTS, SERVICE PLANNING AREA (SPA) REPORTS

- *City of Los Angeles* Mr. Rosales said contract amendments for this Fiscal Year (FY) were approved by the Mayor's Office and the Chief Administrative Office, but were stuck somewhere. He was trying to dislodge them so he could pay contractors.

- The new budget cycle has begun. The AIDS Coordinator's Office (ACO) is General Fund funded so is subject to the City's cuts. So far, the ACO has taken a 3% cut. It has been directed to budget an additional 3% cut and more may be called for later.
- *City of Long Beach* Mr. Kochems reported the Long Beach Comprehensive HIV Planning Group will meet 10/14/2020, 12:00 noon to 2:00 pm. It has its own strategic plan so the meeting offers the opportunity to talk about LACHAS and the EHE Plan. He will be attending along with Mr. Donnelly, Mr. Valero, and others. All were invited.

D. STANDING COMMITTEE REPORTS

(1) Planning, Priorities and Allocations (PP&A) Committee: *Commission Members stated their Conflicts of Interest.*

- The next meeting will be 10/20/2020, 1:00 to 4:00 pm. HOPWA will present on the Consolidated Plan. All are welcome.

(a) Program Directives for Maximizing Ryan White (RW) Part A and Minority AIDS Initiative (MAI) Funds for RW Program Years (PYs) 30, 31, and 32

- Mr. Ballesteros reported PP&A approved the Program Directives for maximizing Ryan White in the packet at its last meeting. They reflect the overarching areas PP&A is highlighting. Some recommendations are already in progress.
- Ms. Barrit commented the first page focuses on data from the surveillance report. The Directives went through a strong refinement process including feedback from DHSP reflecting ongoing programmatic work.
- Priority populations are also reflected including incorporation of Black African American Community (BAAC) Task Force recommendations and continued work with the Aging Task Force to refine those recommendation.
- To ensure full exploration of the Directives, the Co-Chairs read each item for individual review.
- ➲ Page 4, Item 5: Delete extra letter "a" in last sentence in order to read, "...for housing specialists... ."

MOTION #3: Approve Program Directives for Maximizing Ryan White (RW) Part A and Minority AIDS Initiative (MAI) Funds for RW Program Years (PYs) 30, 31, and 32, as presented or revised ***(Passed: 25 Ayes; 0 Opposed; 2 Abstentions)***.

(2) Operations Committee

(a) Membership Management

- Operations welcomes Commissioners appointed by the Board of Supervisors (Board) on 9/29/2020: Kevin Donnelly and Stephanie Cipres, MPH, both assigned to PP&A; and Paul Nash, CPsychol AFBPsS FHEA, assigned to SBP.
- Ms. Cipres is the new Part D Representative so Dr. Spencer was moved to the Provider Representative #4 seat.
- Ms. Campbell was selected by Supervisorial District 2 as its representative so will be moved to that seat.
- Two new member applications will be considered at the next Operations meeting. Three interviews were also conducted earlier in the week and the applicants will be placed on the next Operations agenda for consideration.
- Mr. Preciado thanked all those who participated in interviews and Operations overall for the work.
- Joseph Green noted all Operations Members have been asked to attend local Consumer Advisory Boards (CABs) as part of the Committee's community engagement efforts.
- An Application Work Group composed of Messrs. Alvarez, Burton, and Moreno is simplifying the document.

(i) New Membership Application - Everardo Alvizo, City of Long Beach Representative Seat

- The application was in the packet for review.

MOTION #4: Approve new Member Application for Everardo Alvizo to occupy the City of Long Beach Representative seat, as presented or revised, and forward to the Board of Supervisors for appointment ***(Passed by Consensus)***.

(b) Mentorship Program Implementation

- Joseph Green said the Mentorship Program was being renamed Peer Collaborative Program to reflect youth input.
- A mentorship meeting was scheduled for 11/19/2020, 1:00 to 2:30 pm. Commissioners who have agreed to serve as mentors are: Mr. Burton, Mr. Gonzalez, Ms. Nelson, Ms. Walker-Heltzel, Joseph Green, and Mr. Preciado.

(c) 2020 Virtual Training Schedule - REMINDER: Joseph Green noted the schedule in the packet on page 139. The next training on 10/29/2020, 10:00 to 11:30 am, will be on the Priority Setting and Resource Allocation (PSRA) Process.

(3) Standards and Best Practices (SBP) Committee

(a) Child Care Services Standards of Care (SOC) - UPDATE: Ms. Davies reported SBP feedback has already been incorporated into this SOC. Further action has, however, been put on hold pending consideration of feedback from community focus groups on child care hosted by DHSP.

(c) Universal SOC - UPDATE: Telehealth was being incorporated into this SOC. It was hoped it would be ready for the Commission next month.

(4) Public Policy Committee

(a) County, State, and Federal Legislation and Policy

- Ms. Nelson reported President Trump declared a public health emergency in March 2020 that allows certain emergency facilities to be put in place, e.g., expanded telehealth services. The United States Department of Health and Human Services (HHS) also has to declare a public health emergency to activate the facilities. The declaration must be extended every 90 days, as has been done, and the administration just extended it through January 2021.
- On 9/22/2020, the United States Citizenship and Immigration Services (USCIS) updated its website to state that, retroactive to 2/24/2020, public charge is again implemented. Protecting Immigrant Families (PIE) has a helpful information packet on the topic on its website at https://protectingimmigrantfamilies.org.
- President Trump has put forward a Supreme Court of the United States (SCOTUS) nominee, but it was unknown if she will be confirmed before the election. Notably, SCOTUS will hear Texas v. California on 9/10/2020. The case pertains to whether or not zeroing out the individual mandate invalidates the entire Affordable Care Act (ACA).
- President Trump signed an Executive Order in September 2020, Combating Race and Sex Stereotyping, that prohibits use of federal funds for training such as implicit bias and critical race theory.
- The Public Policy Committee will also be following developments regarding the new STI National Strategic Plan.
- California added a new COVID-19 equity metric for counties with populations over 106,000. In order to move to a lower tier, such counties must reflect positivity rates in disadvantaged communities commensurate with other areas in order to combat the disproportionate impact of COVID-19 in disadvantaged communities.
- Supervisor Mark Ridley-Thomas announced at a recent Board meeting that the LAC Chief Executive Office has launched a search for a Racial Equity Executive Director. They have also launched an anti-racist, diversity, and inclusion initiative website for the public to share ideas for addressing institutional racism. LAC will also develop a strategic plan and policy platform. The goal is to complete the platform by June 2021.
- The California End The Epidemics (ETE) Racial Justice Working Group released a statement on police brutality that was discussed at the Public Policy and Executive Committees. It was in the packet, page 35, to offer the reflection developed by another body to use in its work. Several people thanked Public Policy for presenting the statement.
- Co-Chairs Kochems and Nelson will present at the BAAC Task Force this month on an overview of Public Policy Committee work in order to help identify how best to incorporate BAAC Task Force recommendations.

(i) 2020 Commission Legislative Docket - UPDATES

- Ms. Nelson reported nine bills on the Docket reached Governor Gavin Newsom's desk and he signed eight: AB 732, AB 890, AB 2077, AB 2218, AB 2275, SB 132, SB 932, SB 1255. He vetoed AB 2405 basically due to funding issues. It would declare that the state's policy is everyone has the right to safe, decent, affordable housing.
- SB 145, SB 406, and SB 741 were added to the Docket later. Governor Newsom signed the first two. The third was returned to the Senate in consideration of a veto by the Governor.
- Information on all bills as well as measure and proposition recommendations were on the Docket in the packet. Measure and proposition positions were not forwarded to the Board as it had already taken positions.

(ii) Housing Saves Lives: Housing and Urban Development (HUD) Rule Change Serving Transgender Persons: The Commission submitted public comment, page 140 of the packet, on a proposed HUD rule that would allow emergency shelters to deny transgender individuals access according to their gender identity. HUD received 66,000 comments. Review is required so implementation has been delayed for the time being.

(b) County, State, and Federal Budget: Ms. Nelson noted Congress passed a Continuing Resolution to fund the federal government until 12/11/2020.

E. CAUCUS, TASK FORCE, AND WORK GROUP REPORTS

(1) Aging Task Force: 10/26/2020, 9:00 - 11:00 am: Mr. Ballesteros reported a rough draft of recommendations has been developed and was reflected in the PP&A report. The next meeting will further refine the recommendations.

(2) Black/African American Community (BAAC) Task Force: 10/26/2020, 1:00 - 3:00 pm

- Ms. Campbell reported the Task Force met on 9/28/2020. Discussion included: Task Force structure, responsibilities, co-chair terms, development of a membership interest or application form, recruitment strategies, ongoing development of a coordinated commitment statement, guidance to Committees on implementing recommendations, and contract/procurement recommendations to streamline the process and offer cost savings.
- The next meeting will focus on collaboration with the Public Policy Committee and implementation of BAAC Task Force recommendations. Attendees are invited who reflect the Black African American Diaspora.

(3) Consumer Caucus: 10/8/2020, 3:00 - 5:00 pm (English) and 5:30 - 7:00 pm (Spanish)

- Mr. Gonzalez said the Caucus has had initial training on the PSRA process. The full Commission training on the topic will be 10/29/2020, 10:00 am to 11:30 am.
- The main topic for today's English- and Spanish-language meetings will be focus groups on child care. All are welcome.

(4) Women's Caucus: 11/16/2020, 2:00 - 4:00 pm

- Ms. Gordon reported the Caucus provided feedback on the Child Care SOC for SBP and was working with DHSP to recruit participants for the child care focus groups to inform DHSP's upcoming child care RFP.
- The Caucus developed women-centric recommendations which were incorporated into PP&A's Program Directives.
- The Caucus has partnered with WeCanStopSTDsLA on its new CDC project. It will help recruit young women of color for a CAB to identify sustainable interventions to address Social Determinants of Health (SDH) and prevent STDs/STIs.
- A special training was being scheduled to provide guidance on how to use WebEx.
- The Caucus has decided to meet every other month. Work will continue between meetings with email updates.

(a) Virtual Lunch + Learn: Special Women Centered 4-Part Series - 10/14/2020

- These sessions have been largely successful with an average of 50 attendees each.
- The next in the series will be 10/14/2020, 12:00 noon to 1:30 pm. Elizabeth Lee, LCSW, Director of Housing, Downtown Women's Center, will co-present with three Caucus members on economics and housing.

(5) Transgender Caucus: 10/27/2020, 10:00 am: Ms. Barrit said Public Policy Co-Chairs Kochems and Nelson presented at the last meeting on an overview of Public Policy Committee work and how they might collaborate on transgender legislation.

7. MISCELLANEOUS

A. PUBLIC COMMENT: OPORTUNITY TO ADDRESS COMMISSION ON ITEMS OF INTEREST WITHIN COMMISSION JURISDICTION (To provide live public comment, register and join WebEx via computer or smartphone. Those joining via telephone cannot provide live public comment, but may submit written comments or materials via email to hivcomm@lachiv.org.): Mr. Soto, ACO, City of Los Angeles, noted the Los Angeles 2020 Real Abilities Virtual Film Festival will be 10/16-18/2020. The disability-focused event showcases new and classic films with full audio description and closed captioning. Screenings, panels, and Q-and-As are donation-based. A flyer was sent to the Commission or go to Real Abilities Los Angeles website for more information.

B. COMMISSION NEW BUSINESS ITEMS: OPPORTUNITY FOR COMMISSION MEMBERS TO RECOMMEND NEW BUSINESS ITEMS FOR FULL BODY OR COMMITTEE DISCUSSION ON FUTURE AGENDAS, OR MATTERS REQUIRING IMMEDIATE ACTION DUE TO AN EMERGENCY, OR WHERE NEED TO TAKE ACTION AROSE SUBSEQUENT TO POSTING THE AGENDA: There were no items.

C. ANNOUNCEMENTS: REGARDING COMMUNITY EVENTS, WORKSHOPS, TRAININGS, AND OTHER RELATED ACTIVITIES (Provision of announcements will follow the same protocol as that listed for public comments above.): No announcements.

ADJOURNMENT AND ROLL CALL: The meeting adjourned at 1:30 pm in memory of Timothy Ray Brown, the "Berlin patient" and first person cured of HIV/AIDS, who passed away due to leukemia on 9/29/2020. Mr. Donnelly said, while Mr. Brown's bone marrow and stem cell transplants were not a treatment that could readily be duplicated, that someone was cured and lived gave him hope. Bless the memory of Timothy Ray Brown.
Roll Call (**Present)**: Alvarez, Burton, Daniels, Davies, Donnelly, Gates, Gonzalez, Granados, Green (Joseph), Kochems, Murray, Nelson, Pérez, Preciado, Rosales, San Agustin, Ulloa, Ballesteros, Gordon.

MOTION AND VOTING SUMMARY		
MOTION 1: Approve the Agenda Order, as presented.	***Passed by Consensus***	**MOTION PASSED**
MOTION 2: Approve the 9/10/2020 Commission on HIV Meeting Minutes, as presented.	***Passed by Consensus***	**MOTION PASSED**
MOTION #2A: Elect David P. Lee, MPH, LCSW as Commission on HIV Co-Chair, as elected.	***Passed by Consensus***	**ELECTED UNOPPOSED**
MOTION #2B: Elect Justin Valero, MA as Executive At-Large Member, as elected.	***Passed by Consensus***	**ELECTED UNOPPOSED**
MOTION #3: Approve Program Directives for Maximizing Ryan White (RW) Part A and Minority AIDS Initiative (MAI) Funds for RW Program Years (PYs) 30, 31, and 32, as presented or revised.	***Ayes***: Alvarez, Campbell, Cataldo, Cipres, Coffey, Davies, Donnelly, Fox, Gates, Gonzalez, Granados, Green (Joseph), Kochems, Lee, Murray, Nash, Nelson, Preciado, Rosales, San Agustin, Ulloa, Valero, Walker-Heltzel, Ballesteros, Gordon ***Opposed***: None ***Abstentions***: Halfman, Pérez	**MOTION PASSED** **Ayes**: 25 **Opposed:** 0 **Abstentions**: 2
MOTION #4: Approve new Member Application for Everardo Alvizo to occupy the City of Long Beach Representative seat, as presented or revised, and forward to the Board of Supervisors for appointment.	***Passed by Consensus***	**MOTION PASSED**

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COMMISSION ON HIV

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

November 12, 2020 Annual Meeting Evaluation Summary
Total number of participants: 114 (32 Commissioners)
Number of Survey Responses: 24 (6 Commissioners; 18 Community Members)

I. Please state 3 things that you liked the most about the event?

1. I enjoyed the meeting. Good to hear that black people are important and we give allot to the world, we need more HIV Newly diagnosis population for black people cause most of us don't have family.
2. It was smoothly run; It was informative; It was ultimately productive.
3. The overview of federal and local efforts around EHE during these times. Naina Khana's presentation that clearly outlined what racism is and isn't.
4. Discussions towards fixing the problems
5. People involved, topics discussed, everyone's honesty
6. Racisms presentation
7. Guest presentations, attention to historical context, and social justice dialogue
8. the information presented, professionalism, how easy it was to understand everything.
9. The very first presentation was stellar, loved the information and the open dialogue
10. Naina Khanna!!!! Naina's presentation. The way Naina handled the presentation. I actually also liked Jeffrey's comment about having data presented on one group at a time and to explore what that means without talking about any other demographic
11. Topics, presenters, ability to let people join the conversation
12. I loved the gratitude show to [redacted] for all of his hard work. I liked the discussion on reaching out to the younger generation and POC to sit at the tables. Lastly, I loved when black leaders acknowledged the racism in the room and to a stance.
13. Update about HIV testing at home.
14. Presentation on race and racism. Discussion on the race/racism. Connecting that to the EHE.
15. That the meeting went forth even in a virtual setting.
16. The take home kit for women and men
17. Learned a lot. Trying to understand racism, anti-racism, and racial justice through the lens of others.
18. I love how we dived into conversations that needed to be had. I love how everyone felt safe to speak up. I like that this event made folks check themselves.
19. How to end the stigma of HIV, Take me home kit, The information of supportive groups
20. Easy access to presentation materials. Easy communication with the chat feature. Everyone kept respectful of opinions and time

II. Please state 3 things that you disliked about the event?

1. Too long, couldn't see the info being presented on the screen. I didn't hear anything about the HIV- population and how this disease affects them emotionally and physically and those who have negative statuses that date HIV+ persons.
2. Just a few glitches. I tad bit confrontational around race. Revealing
3. Discussions aimed at fixing the blame
4. People sometimes spoke many words, but not really saying much, had trouble getting online Need more open hearts and more love/understanding at the table
5. N/A
6. n/a
7. Nothing
8. I do not believe that we should be spending close to an hour making non-poc comfortable with a conversation about POC where the numbers of HIV infection are centered around POC being the highest group. Education is key but you cannot teach compassion.
9. The comments that [redacted] and [redacted] made and how much of the meeting was taken up with the same comments.
10. I disliked the White Privilege attendee that tried to devalue the words of any POC. I disliked that once again POC had do the labor of teaching and explaining. I disliked the tension of the group being my first time.
11. Uncontrolled conversations that did not help the objectives of the meeting. - Chairs and guest speaker should be able to measure and control the audience otherwise the conversation is out of control and useless.
12. That you saved what we always know will be one of the most important conversations until the end and thus ensuring that is would feel uncomfortable, mtg had to be extended, and then it feels rushed.
13. Not enough time. Wish we were in person. Would've liked the presentation slides ahead of time.
14. I didn't like that some people thought the conversations held were distractions when indeed they weren't; they were needed.
15. No comments because all that is said is helpful for someone
16. The meeting was long with no lunch break. Not all materials were available online beforehand. No mention of sex workers in the conversation

III. Overall, how satisfied were you with the event?

Neutral = 4 Very satisfied = 7 Satisfied = 10 Very dissatisfied = 3

IV. Did the event help you with new learnings or knowledge? Yes = 25

V. Do you have any other comments/suggestions that would help us make future events better?

1. Fix the logging in issues, it's very frustrating when your rejected to joining a meeting.

2. Racial issues seem hard to manage without causing some level of discomfort and confrontation.
3. Addressing the racist attacks from [redacted] that continue to happen over and over without any consequences.
4. Perhaps a speaker who can emphasise/train us to better empathise with others, rather than alienating groups or playing groups against each other ...
5. Encourage succinctness in comments
6. Let's do it again.
7. Thank you
8. Thank you
9. N/A
10. Bring Naina back for a deeper dive to help the group talk about who is not at the table and how can we get them to the table. Not in an accusatory manner, but coming from a genuine place of inclusion and how can we make it work instead of maybe why it isn't.
11. Since clearly there are racist that attend this group maybe it's time to have more uncomfortable discussions.
12. Racism and planning council work is an excellent topic that needs to be revisited and considering the audience is necessary to establish ways to moderate effectively the conversation. Thanks!
13. As an attendee I didn't have a video option when everyone else on commission did.
14. Don't set an agenda to include critical conversation towards the end. We need to be mindful of the fact that avoidance doesn't make a hard thing go away, it just prolongs the inevitable and suggests that you don't care enough to tackle it.
15. None
16. Best Commission meeting thus far.
17. No I don't
18. Include a lunch break and more opportunity for PUBLIC comments as my question about sex workers was never addressed.

From: lac-ppwg@googlegroups.com on behalf of DPH-dhspdirector
To: DPH-dhspdirector
Subject: World AIDS Day - December 1, 2020
Date: Tuesday, December 1, 2020 12:54:03 PM
Attachments: Ending the HIV Epidemic Plan-LA County-Executive Summary.pdf

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As we commemorate World AIDS Day 2020 and remember and reflect on the thousands of lives impacted by HIV in Los Angeles County, the Division of HIV and STD Programs (DHSP) is pleased to share the following: (1) Dear Colleague Letter and our *Undetectable=Untransmittable (U=U) Provider Kit,* (2) the *Ending the HIV Epidemic (EHE) Plan for Los Angeles County - Executive Summary*, and (3) information on the new HIV self-test kit program.

Dear Colleague Letter and U=U Provider Kit
Undetectable = Untransmittable, or U=U, conveys what science has already demonstrated; that people living with HIV who maintain an undetectable viral load for at least six months cannot transmit HIV to their sexual partners. The U=U message has the potential to change what it means to live with HIV and the *U=U Provider Kit* includes resources to ensure that this message gets shared at every opportunity. Access the *U=U Provider Kit* at http://publichealth.lacounty.gov/dhsp/U=U_Provider_Kit.htm

Ending the HIV Epidemic Plan (EHE) in Los Angeles County – Executive Summary (enclosed)
Ending the HIV Epidemic is a five-year federal initiative focused on reducing HIV across the U.S. by 75% in 2025 and 90% by 2030 by focusing on four key pillars: (1) diagnosing people with HIV as early as possible, (2) treating people with HIV rapidly and effectively, (3) preventing new HIV transmissions, and (4) responding quickly to HIV outbreaks to get needed prevention and treatment services to people who need them. DHSP understands the importance of community involvement in the EHE Initiative and hopes the Executive Summary will be a useful tool for sharing information about EHE, as well as engaging both traditional and non-traditional partners in the movement towards an AIDS-free generation. For more information on EHE in Los Angeles County, visit www.LACounty.HIV.

HIV Home/Self-Test Kits
An HIV diagnosis as close to the period of infection as possible is a crucial first step to achieving good HIV-related health outcomes and reducing the likelihood of HIV transmission to others. HIV diagnosis is a key pillar in the Ending the HIV Epidemic Initiative. In an effort to expand the availability of HIV testing in non-traditional health care settings, DHSP has partnered with Take Me Home to offer free self-test kits to Los Angeles County residents. For more information or to order a kit, visit https://takemehome.co/.

Thank you for your continued partnership, service, and commitment in the fight against HIV.

Sincerely,

Mario J Pérez, MPH, Director
Division of HIV and STD Programs
Los Angeles County Department of Public Health

EMERGENCY FINANCIAL ASSISTANCE

Please know that need-based and short-term financial assistance is now available to assist Ryan White Program-eligible individuals.
Rental assistance are rent payments will be made on behalf of the tenant.
Other expenses can be covered as well, please see the list below.
Individuals can apply for a maximum total of $5,000 over a 12-month period.

Eligibility Requirements:

- Los Angeles County Resident
- HIV-positive
- Current income ≤ 500% FPL
- Not currently receiving any other form of emergency financial assistance

Eligible Services Include:

- Housing assistance
  - Move-in assistance (including security deposit and first month's rent)
  - Short-term rental assistance (including assistance with late rental payments)
- Utilities (including electricity, water and gas, Wi-Fi, cell phone)
- Food
- Transportation

How to Apply:

Contact your DHSP-supported Medical Care Coordination Team through your HIV medical provider and they will help determine eligibility and apply via Housing for Health or Alliance for Housing and Healing.

This program is supported with funds from the Health Resources and Services Administration awarded to the Los Angeles County Department of Public Health as part of the Ending the HIV Epidemic effort.

COUNTY OF LOS ANGELES
DEPARTMENT OF PUBLIC HEALTH

WORK ORDER SOLICITATION (WOS)

FOR COMMUNITY ENGAGEMENT AND RELATED SERVICES

Project Title: **COMMUNITY ENGAGEMENT FOR ENDING THE HIV EPIDEMIC IN LOS ANGELES COUNTY**

WOS Number: CES-WOS-003

Prepared by:

CONTRACTS AND GRANTS DIVISION

WORK ORDER SOLICITATION
COMMUNITY ENGAGEMENT FOR ENDING THE HIV EPIDEMIC IN LOS ANGELES COUNTY

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WORK ORDER SOLICITATION
COMMUNITY ENGAGEMENT FOR ENDING THE HIV EPIDEMIC IN LOS ANGELES COUNTY

ATTACHMENTS

1.0 INTRODUCTION

1.1 GENERAL INFORMATION

Request for Statement of Qualifications

On July 23, 2019, the County of Los Angeles (County) Department of Public Health (hereafter DPH or Department), released a Request for Statement of Qualifications (RFSQ) to solicit Statements of Qualification (SOQ) from organizations with expertise in local issues and who are known in their local communities to ensure successful programs, services, and policy-making that are sensitive to the needs of their communities. In addition, this Master Agreement will also be available to organizations that can serve as fiscal sponsors to smaller, local community groups, giving them the opportunity to do the outreach directly to residents. Some of these smaller, local community groups may not be able to meet the administrative requirements of County contracts but are trusted by community members and therefore best qualified for performing community engagement services. As a result of the RFSQ process, Master Agreements were executed with vendors determined to be qualified to provide community engagement and related services in any of the following community engagement categories and related services:

a. Community Outreach/Engagement

Community outreach/engagement includes planning, implementing and managing community outreach events of various sizes to hold discussions on community needs, share pertinent information with community stakeholders, or obtain input on the County's proposed policies, ordinances, and plans. This may require various approaches such as convening large or small groups, door-to-door contact, interviews, street teams and/or mobile units, and press events to promote community outreach activities. This also may include encouraging people to attend public hearings and other meetings where input from community members is needed in order to inform key decisions.

b. Managing Multi-Stakeholder Collaboration

The management of multi-stakeholder collaboration entails leading or managing a collaboration with multiple stakeholders, comprised of diverse individuals and organizations that jointly address a community priority. This includes developing and sustaining relationships with external stakeholders such as cities, community-based organizations, faith-based organizations, and/or businesses. This also includes providing fundamental support and advancing the work of collaborations

through activities such as coordinating and mobilizing resources while managing multi-stakeholder collaboration.

c. Community-Based Communication Strategies

Community-based communication strategies can be conducted through various methods such as electronic surveys, in-person group meetings or social media. The strategies that best suit the population should be utilized. Communication through social media platforms including, but not limited to Twitter, Instagram, and Facebook should be employed to share information and encourage participation in upcoming community engagement activities. The ability to compile and analyze the activity on these accounts is also required.

d. Meeting Facilitation

Effective meeting facilitation is important to ensure successful meeting outcomes. A meeting facilitator is a neutral party who actively listens to community concerns, suggestions, and recommendations, and asks questions but does not seek to move a meeting toward any particular outcome. The value of having a meeting facilitator is to help guide groups which may have different points of view to work effectively to solve problems, build consensus and resolve conflicts through single meetings or a series of meetings.

e. Strategic Planning

Strategic planning is a process to set priorities and focus resources according to community needs. This includes, but is not limited to, gathering information through various means such as surveys or interviews. A strategic plan includes goals, objectives and strategies that are time-bound, actionable and measurable and reflect community input translated into clear, concrete intended outcomes and action items. Engaging a large segment of an organization's staff or constituency is an important part of the strategic planning process.

f. Community Engagement Training

The County workforce or community stakeholders also conduct community engagement services. Trainers with expertise in community engagement skills are needed to train the workforce and community stakeholders in key community engagement skills. Training topics include meeting facilitation skills; meeting and agenda design; community outreach best practices, including culturally sensitive practices; managing multi-stakeholder collaborations; and group decision-making.

Related Services:

As part of the Community Engagement Services, Related Services may be required but are not limited to:

- Providing simultaneous interpretation services while conducting presentations and meetings
- Producing and/or translating existing materials in multiple languages as needed for different audiences
- Providing transportation, childcare, refreshments, stipends, and/or space and rental services

Pursuant to the RFSQ, Master Agreement Contractors are not guaranteed any minimum or maximum amount of utilization of services, and Contractors may or may not be utilized, at the County's sole discretion.

Work Order Solicitation (WOS)

As stated in the RFSQ, qualified Community Engagement and Related Services Master Agreement Contractors will be solicited under competitive conditions via WOS, to provide services.

Services requested under this WOS are for the following category:

☒ Community Outreach/Engagement

☐ Managing Multi-Stakeholder Collaboration

☐ Community-Based Communication Strategies

☐ Meeting Facilitation

☐ Strategic Planning

☐ Community Engagement Training

Master Agreement Work Order (MAWO)

Department will use a pre-determined set of evaluation criteria to award a MAWO to selected Community Engagement and Related Services Master Agreement Contractor(s) who respond to this WOS.

1.2 OBJECTIVE/PROJECT TITLE

The objective of this WOS is to award one (1) MAWO to a Community Engagement and Related Services Master Agreement Contractor to provide Community Engagement Services, as described above in Section

1.11, Required Services; Attachment A, Statement of Work; and Attachment B, Scope of Work.

1.3 PROJECT BACKGROUND

The Division of HIV and STD Programs (DHSP) is seeking to secure a qualified vendor to conduct community engagement, outreach, and mobilization throughout the County to help implement the strategies and help reach the goals of the national initiative, Ending the HIV Epidemic (EHE): A Plan for America. The community engagement vendor will be responsible for mobilizing and empowering local stakeholders and community members to help rethink, innovate, develop, organize, and sustain novel and enhanced HIV prevention and care efforts to meet EHE goals.

Los Angeles County (LAC) has been battling the HIV/AIDS epidemic for nearly four decades. Despite advances in HIV medicine and a growing awareness that persons living with HIV (PLWH) who maintain an undetectable HIV viral load will not sexually transmit HIV to others, not all are benefiting from these advances or knowledge. Significant HIV-related health disparities persist among a number of populations, including men who have sex with men, Black, Latinx, and American Indian/Alaskan Native communities. Additionally, young people are less likely to be engaged in care and young men aged 20-29 years had the highest HIV diagnosis rates in 2018 (78 per 100,000). In addition, HIV-related stigma, racism and a myriad of social determinants of health influence individual HIV prevention and treatment access patterns.

With renewed energy from existing federal, state and local partners, readiness of new partners, and an ongoing appetite for innovation, DHSP is committed to finding and partnering with stakeholders with fresh perspectives and solutions that can reinvigorate efforts to address a range of challenges and obstacles that prevent an end to the HIV epidemic. DHSP plans to conduct widespread and meaningful engagement through a community engagement vendor that will expand the reach and active participation of new voices empowering residents to affect change in their own communities through a community-led approach.

<u>Ending the HIV Epidemic Federal and Local Partners</u>

Federal partners guiding and advancing EHE efforts include the Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), Indian Health Service, Substance Abuse and Mental Health Services Administration (SAMHSA), Housing and Urban Development (HUD), and the Office of the Assistant Secretary of Health. In LAC various entities have received funding from HRSA, CDC, and NIH to support EHE goals and

strategies, including the Department of Public Health, federally qualified health centers, AIDS Education Training Centers, and academic institutions partners.

Ending the HIV Epidemic Goals and Strategies

Nationally, EHE seeks to reduce the number of new HIV infections in the United States by 75 percent by 2025 and at least 90 percent by 2030. The initiative focuses on four (4) key pillars to end the epidemic:

1) Diagnose people as early as possible,
2) Treat people rapidly and effectively,
3) Prevent new HIV transmissions, and
4) Respond quickly to HIV outbreaks.

The County efforts will include mobilization of community stakeholders and residents to advance projects centered on three (3) of the four (4) EHE pillars:

1) Diagnose,
2) Treat, and
3) Prevent.

Mapping the Los Angeles County Epidemic

LAC spans over 4,000 square miles and includes 88 cities, 26 health districts, and a mix of urban, suburban and rural areas. At year-end in 2017, 57,500 people were living with HIV in LAC with an estimated 1,700 new HIV transmissions. In 2018, Latinx men represented 24.3% of the general population (n=2,502,487), while representing 39.8% of people living with HIV (PLWH) (n=20,680). Black/African American men represented approximately 4% of the LAC population (n=408,620), but represent 16% of PLWH in LAC (n=8,545). Moreover, the highest HIV incidence rates by race/ethnicity was among the Black population (54 per 100,000) followed by the Latinx population (21 per 100,000), White population (12 per 100,000), and Asian/Pacific Islander population (6 per 100,000). With regard to age, the highest HIV incidence is among persons aged 25-34 years (43 per 100,000) followed by ages 13-24 (25 per 100,000), ages 35-44 (24 per 100,000), and ages older than 55 (4 per 100,000).

The EHE initiative description and epidemiological profile are provided solely as background information and context designed to increase the Proposer's understanding of the magnitude of the HIV epidemic in LAC and EHE's goals for addressing it. For further information on the EHE initiative, please visit https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview

1.4 PROJECT TERM/PERIOD

The MAWO will be effective upon execution through July 31, 2023 with a provision for two (2) additional one-year periods through July 31, 2025, subject to performance and availability of funds.

1.5 MASTER AGREEMENT WORK ORDER RATES

Payment for all work performed under any resultant MAWO shall be on a Cost Reimbursement basis.

Proposer must complete and submit a budget for the proposed services and adhere to the Budget Instructions (Attachment C) attached hereto. Proposals that do not clearly indicate the maximum total cost to complete the project may, at the discretion of the County, be rejected. No other budget forms or template shall be accepted.

Exhibit V, Budget, shall be in the following format and include:

Cost Reimbursement

a) Salaries

b) Employee Benefits – At a minimum, the benefit package must include FICA, Health Insurance (Basic Health and Dental must be 100% covered by the Contractor/Employer), Unemployment Insurance, Disability Insurance, and Workers Compensation. Benefits shall include County observed Holiday days.

c) Travel – Some positions will be required to travel to different locations throughout the project period as outlined in Attachment A, Statement of Work. Budget should include funding for local mileage and parking and out of town travel reimbursement. County's current mileage reimbursement rate is 55 cents per mile.

d) Supplies/Materials

e) Consultant/Contractual

f) Other

g) Indirect Costs

No other budget forms or templates shall be accepted.

1.6 COUNTY'S ESTIMATED FUNDING AVAILABILITY

DPH anticipates awarding one (1) MAWO in an amount not to exceed $1,000,000 for Period 1 (date of execution through July 31, 2021); $1,000,000 for Period 2 (August 1, 2021 through July 31, 2022); and $1,000,000 for Period 3 (August 1, 2022 through July 31, 2023); 100 percent funded by Ending the HIV Epidemic grant funds.

The County reserves the right to adjust the funding amount and allocation of funds. The amount of funding available to support these services is also subject to the availability of funds from local, State, and federal resources.

1.7 COUNTY RIGHTS & RESPONSIBILITIES

1.7.1 DPH has the right to amend this WOS by written addendum at any time. The County is responsible only for that which is expressly stated in the WOS document and any authorized written addenda thereto. DPH will make such addendum available to each Community Engagement and Related Services Master Agreement Contractor that has a current Community Engagement and Related Services Master Agreement for the services requested under this WOS, as identified in Section 1.1, Work Order Solicitation (WOS). Should such addendum require additional information not previously requested, failure to address the requirements of such addendum may result in the Proposal not being considered, as determined in the sole discretion of the County. The County is not responsible for and shall not be bound by any representations otherwise made by any individual acting or purporting to act on its behalf.

1.7.2 Responses to this WOS shall become the exclusive property of the County. The County shall not, in any way, be liable or responsible for the disclosure of any such record or any parts thereof, if disclosure is required or permitted under the California Public Records Act or otherwise by law.

1.7.3 In addition, the County reserves the right to make changes to the Master Agreement and its appendices and exhibits, including the MAWO, at its sole discretion.

1.8 CONTACT WITH COUNTY PERSONNEL

Any contact regarding this WOS or any matter relating thereto must be submitted in writing by electronic mail (e-mail) to the County Contact Person identified below:

José Cueva, Contract Analyst
County of Los Angeles – Department of Public Health
Email address: jcueva@ph.lacounty.gov

If it is discovered that a Proposer contacted and received information regarding this solicitation from any County personnel other than the person specified above, County, in its sole determination, may disqualify their Proposal from further consideration.

1.9 FINAL AWARD BY THE BOARD OF SUPERVISORS

Notwithstanding a recommendation from DPH, the County Board of Supervisors retains the right to exercise its judgment concerning the final selection of a work order proposal and to determine whether the proposal best serves the interest of the County. The County Board of Supervisors is the ultimate decision-making body and may make the final determinations necessary to arrive at a decision to award, or not award, a MAWO.

1.10 MINIMUM MANDATORY REQUIREMENTS

Interested Proposers who meet all the following minimum mandatory requirements stated below by the date on which the proposals are due may submit a Proposal in response to this WOS.

Proposers must provide a completed Exhibit III, Proposer's Affidavit of Adherence to Minimum Mandatory Requirements, to validate meeting the minimum mandatory requirements.

1.10.1 Master Agreement

Proposer **must** have a current executed DPH Master Agreement for Community Engagement and Related Services.

1.10.2 Contract Status

Proposers **must** not be debarred, suspended, or excluded from securing United States Federal Government (federal), State of California (State) and/or County contracts at the time of the proposal submission due date.

1.10.3 Unresolved Disallowed Costs

If a Proposer's compliance with a County contract has been reviewed by the Department of the Auditor-Controller within the last 10 years, Proposer **must not** have unresolved questioned costs identified by the Auditor-Controller in an amount over

$100,000 that are confirmed to be disallowed costs by the contracting County department and remain unpaid for a period of six months or more from the date of disallowance, unless such disallowed costs are the subject of current good faith negotiations to resolve the disallowed costs, in the opinion of the County .

County will verify that Proposer does not have unresolved disallowed costs.

1.10.4 **Experience (Community Engagement and Mobilization)**

Proposer must have a minimum of three (3) years experience within the last five (5) years implementing community engagement and mobilization programs focused on health equity and social justice.

1.10.5 **Recruitment Experience**

Proposer must have a minimum of two (2) years of experience within the last five (5) years recruiting cohorts to participate in a community engagement project related to improve health outcomes related to identified public health issues.

1.10.6 **Recruitment Approach Experience**

Proposer must have a minimum of one (1) year of experience within the last three (3) years utilizing the Community Based Participatory Research (CBPR) approach and/or Youth Participatory Action Research (YPAR) framework.

1.11 REQUIRED SERVICES AND TARGET POPULATIONS

DPH is seeking a Community Engagement and Related Services Master Agreement Contractor to provide the services described in this WOS (including Attachment A, Statement of Work and Attachment B, Scope of Work). Attachment A, Statement of Work, provides a detailed description of the services and/or deliverables to be performed under this work order. Attachment B, Scope of Work, provides a detailed “road map” of the project objectives, activities, timeline, and deliverables to ensure that the service needs are met.

1.11.1 Required Services

The County is seeking a single Contractor to implement Community Engagement for Ending the HIV Epidemic in LAC Projects.

1.11.2 Target Populations

The target populations for this Community Engagement contract is comprised of residents and organizations of LAC including but not limited to:

- Youth (12-29 years old)
- Black/African American
- Latinx
- Transgender persons
- Gay and Bisexual men
- Substance abusers/users

1.11.3 Location of Services

The location of services for this Community Engagement contract must be focused on geographic areas of high HIV burden and disproportionately affected target populations. (see Section 1.11.2)

1.12 COUNTY'S PREFERENCE PROGRAMS

Overview of County's Preference Programs

1.12.1 The County of Los Angeles has three preference programs. The Local Small Business Enterprise (LSBE), Disabled Veterans Business Enterprise (DVBE), and Social Enterprise (SE). The Board of Supervisors encourages business participation in the County's contracting process by continually streamlining and simplifying our selection process and expanding opportunities for these businesses to compete for County opportunities.

1.12.2 The Preference Programs (LSBE, DVBE, and SE) require that a business must complete certification prior to requesting a preference in a solicitation.

1.12.3 In no case shall the Preference Programs (LSBE, DVBE, and SE) price or scoring preference be combined with any other County preference program to exceed fifteen percent (15%) in response to any County solicitation.

1.12.4 Sanctions and financial penalties may apply to a business that knowingly, and with intent to defraud, seeks to obtain or maintain certification as a certified LSBE, DVBE, or SE when not qualified.

Note: Cost is not a determining factor in this solicitation process; as such no preference will be applied. However, LSBE Proposers are

encouraged to apply for certification to take advantage of the LSBE Prompt Payment Program further identified in Paragraph 1.14 - Local Small Business Enterprise Prompt Payment Program.

1.13 LOCAL SMALL BUSINESS ENTERPRISE (LSBE) PREFERENCE PROGRAM (INTENTIALLY OMITTED)

1.14 LOCAL SMALL BUSINESS ENTERPRISE (LSBE) PROMPT PAYMENT PROGRAM

It is the intent of the County that Certified LSBEs receive prompt payment for services they provide to County Departments. Prompt payment is defined as fifteen (15) calendar days after receipt of an undisputed invoice.

1.15 SOCIAL ENTERPRISE (SE) PREFERENCE PROGRAM (INTENTIALLY OMITTED

1.16 DISABLED VETERAN BUSINESS ENTERPRISE (DVBE) PREFERENCE PROGRAM (INTENTIALLY OMITTED)

1.17 CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION – LOWER TIER COVERED TRANSACTIONS (45 C.F.R. PART 76)

1.17.1 Pursuant to federal law, the County is prohibited from contracting with parties that are suspended, debarred, ineligible, or excluded or whose principals are suspended, debarred or excluded from securing federally funded contracts. At the time of Contractor's response to a WOS, Contractor must submit the Certification Regarding Debarment, Suspension, Ineligibility & Voluntary Exclusion – Lower Tiered Covered Transactions, as set forth in Exhibit VII attesting that neither it, as an organization, nor any of its owners, officers, partners, directors, or other principals is currently suspended, debarred, ineligible, or excluded from securing federally funded contracts. Should a response to any WOS identify prospective subcontractors, or should Contractor intend to use subcontractors in the provision of services under any subsequent contract, Contractor must submit a certification, completed by each subcontractor, attesting that neither the subcontractor, as an organization, nor any of its owners, officers, partners, directors, or other principals is currently suspended,

debarred, ineligible, or excluded from securing federally funded contracts.

1.17.2 Failure to provide the required certification may eliminate Contractor's response to a WOS from consideration.

1.17.3 In the event that Contractor and/or its subcontractor(s) is or are unable to provide the required certification, Contractor instead shall provide a written explanation concerning its and/or its subcontractor's inability to provide the certification. Contractor's written explanation shall describe the specific circumstances concerning the inability to certify. It further shall identify any owner, officer, partner, director, or other principal of the Vendor and/or subcontractor who is currently suspended, debarred, ineligible, or excluded from securing federally funded contracts. Finally, the written explanation shall provide that person's or those persons' job description(s) and function(s) as they relate to the services to be performed under this WOS.

1.17.4 The written explanation shall be examined by the County to determine, in its full discretion, whether further consideration of the response to a WOS is appropriate under the federal law.

1.18 DEPARTMENT OPTION TO REJECT WORK ORDER PROPOSALS OR CANCEL WORK ORDER SOLICITATION

The Director of DPH may, at her sole discretion, reject any or all work order proposals submitted in response to this WOS at any time. In addition, this WOS process may be canceled at any time when County, at its sole discretion, determines that such a cancellation is in the best interest of the County. The County shall not be liable for any costs incurred by the Proposer in connection with the preparation and submission of any proposal. DPH, in its sole discretion, may elect to waive any error or informalities in the form of a proposal or any other disparity, if, as a whole, the proposal substantially complies with the WOS's requirements.

1.19 PROTEST POLICY REVIEW PROCESS

1.19.1 Under Board Policy No. 5.055 (Services Contract Solicitation Protest), any prospective Proposer may request a review of the requirements under a solicitation for a Board-approved services MAWO, as described in Section 1.18.3 (Department Levels of Review) below. Additionally, any actual Proposer may request a

review of a disqualification or of a proposed MAWO award under such solicitation as described respectively in the Section below. It is the responsibility of the Proposer challenging the decision of a County Department to demonstrate that the Department committed a sufficiently material error in the solicitation process to justify invalidation of a proposed MAWO award.

1.19.2 Throughout the review process, the County has no obligation to delay or otherwise postpone an award of MAWO based on a Proposer protest. In all cases, the County reserves the right to make an award when it is determined to be in the best interest of the County of Los Angeles to do so.

1.19.3 **Department Levels of Review**

Unless state or federal statutes or regulations otherwise provide, the level of review under the protest policy are as follows:

- Work Order Solicitation Requirements Review (Reference Sub-paragraph 2.2 in the Proposal Submission Requirements Section)
- Disqualification Review (Reference Section 3.3 in the Proposal Review and Selection Process Section)
- Department's Proposed Contractor Selection (Reference Section 3.6 in the Proposal Selection Review and Selection Process Section)

1.20 NOTICE OF THE PUBLIC RECORDS ACT

1.20.1 Responses to this WOS shall become the exclusive property of the County. Absent extraordinary circumstances, the recommended Proposer's proposal will become a matter of public record when (1) MAWO negotiations are complete; (2) DPH receives a Letter of Intent from the recommended Proposer's authorized officer that the negotiated MAWO is the firm offer of the recommended Proposer; and (3) DPH releases a copy of the recommended Proposer's proposal in response to a Notice of Intent to Request a Proposed Contractor Selection Review under Board Policy 5.055.

1.20.2 Notwithstanding the above, absent extraordinary circumstances, all proposals will become a matter of public record when the Department's Proposer recommendation appears on the County's Board Correspondence.

1.20.3 Exceptions to disclosure are those parts or portions of all proposals that are justifiably defined as business or trade secrets, and plainly

marked by the Proposer as “Trade Secret”, “Confidential”, or “Proprietary”.

1.20.4 The County shall not, in any way, be liable or responsible for the disclosure of any such record or any parts thereof, if disclosure is required or permitted under the California Public Records Act or otherwise by law. A blanket statement of confidentiality or the marking of each page of the proposal as confidential shall not be deemed sufficient notice of exception. The Proposers must specifically label only those provisions of their respective proposal which are “Trade Secrets”, “Confidential”, or “Proprietary” in nature.

2.0 PROPOSAL SUBMISSION REQUIREMENTS

This Section contains key project dates and activities as well as instructions to Proposers on how to prepare and submit their proposal.

2.1 WORK ORDER SOLICITATION TIMETABLE

Release of WOS ..... December 1, 2020

Request for a Solicitation Requirements Review Due ... December 8, 2020

Proposers' Written Questions Due.....3:00 PM, December 8, 2020

Questions and Answers Released..... December 18, 2020

Proposal Due .....3:00 PM, January 8, 2021

All times as listed above and throughout this WOS are Pacific Time (PT).

2.2 WORK ORDER SOLICITATION REQUIREMENTS REVIEW

Any eligible Community Engagement and Related Services Master Agreement Contractor may seek a Solicitation Requirements Review by submitting Attachment E - Transmittal Form to Request a Work Order Solicitation Requirements Review to DPH as described in this Section. A request for a WOS Requirements Review may be denied, in the Department's sole discretion, if the request does not satisfy all of the following criteria:

1. The request is made within the time frame specified in Section 2.1, Work Order Solicitation Timetable, and contact person identified in WOS, Section 1.8, Contact with County Personnel;

2. The request includes documentation (e.g., letterhead, business card, etc.), which identifies the underlying authority of the person or entity to submit a proposal;

3. The request itemizes in appropriate detail, each matter contested and factual reasons for the requested review; and

4. The request asserts that either:

    a. application of the minimum requirements, evaluation criteria and/or business requirements unfairly disadvantages the person or entity; or

b. due to unclear instructions, the process may result in the County not receiving the best possible responses from prospective Proposers.

The WOS Requirements Review shall be completed and the Department's determination shall be provided to the requesting person or entity, in writing, within a reasonable time prior to theproposal due date.

2.3 PROPOSERS' QUESTIONS

Proposers may submit written questions regarding this WOS by e-mail with a subject line of "**CES-WOS-003 Questions**" by the deadline specified in Section 2.1, Work Order Solicitation Timetable, to the contact person identified in WOS, Section 1.8, Contact With County Personnel.

All questions, without identifying the submitting company, will be compiled with the appropriate answers and issued as an addendum to this WOS. When submitting questions, please specify the WOS section number, paragraph number, and page number, and quote the language that prompted the question. County reserves the right to group similar questions when providing answers.

Questions may address concerns that the application of minimum requirements, evaluation criteria and/or business requirements would unfairly disadvantage Proposers or, due to unclear instructions, may result in the County not receiving the best possible responses from Proposer.

2.4 PROPOSERS' CONFERENCE

A Proposers' Conference <u>will not</u> be conducted for this WOS. Proposers may submit written questions regarding this WOS as described in Section 2.3, Proposers' Questions.

2.5 PREPARATION OF THE PROPOSAL

Proposal must be submitted in the prescribed format as further described in section 2.6, Proposal Format, below. Any proposal that deviates from this format may be rejected without review at the County's sole discretion. County shall not be liable for any costs incurred by any Proposer in connection with the preparation, submission, or presentation of any proposal submitted in response to this WOS.

2.6 PROPOSAL FORMAT

Proposal must be in black type of not less than eleven (11) point Arial style font with top, bottom, left and right margins of not less than one (1) inch.

No other templates shall be accepted. Where applicable, Proposer must adhere to the required page limits, as any response/section, etc. that exceeds the page limit will not be considered. Proposers are advised that

evaluators will disregard and not evaluate any information provided past the page limit. Proposers should respond to each question, as each question that does not have a response (e.g., no response, blank, etc.) will result in zero points for each instance where a response was not provided. Proposer must read this WOS carefully and follow all instructions, giving consideration to all requirements and requested documents as set forth herein when submitting their proposals to ensure that errors or omissions do not cause Proposers to be deemed non-responsive and disqualified.

Proposer is admonished not to alter any Attachments, Exhibits, or any information provided either in hardcopy or electronic format, with the exception of filling in blanks in applicable response forms or complying with directions provided in said forms. If County determines that Proposer has altered or modified any County-provided forms or data in any other manner whatsoever, County may, in its sole discretion, determine the Proposer's submission to be non-responsive, and disqualified. In preparing the written proposal, the Proposer should do so in its own words and not copy the language in the WOS.

Proposal must be organized by titled paragraph sections as described herein, numbered sequentially throughout from beginning to end, and arranged in the prescribed order:

- Table of Contents
- Section A – Proposer's Qualifications
  - ✓ Proposal Submission Checklist (Exhibit I)
  - ✓ Proposer's Transmittal Form (Exhibit II)
  - ✓ Proposer's Affidavit of Adherence to Minimum Mandatory Requirements (Exhibit III)
- Section B – Proposer's Experience
- Section C – Proposer's Approach to Required Services
- Section D – Proposer's Staffing Plan (Exhibit IV)
- Section E – Proposer's Social Distancing Plan
- Section F – Proposer's Data Reporting Plan
- Section G – Proposer's Evaluation and Quality Management Plan
- Section H – Required Forms
  - ✓ Proposer's Budget (Exhibit V)
  - ✓ Acceptance of Terms and Conditions Affirmation (Exhibit VI)
  - ✓ Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower Tier Covered Transactions (45 C.F.R. Part 76) (Exhibit VII)

2.6.1 Table of Contents

The table of contents shall include a detailed and complete outline of material included in the proposal, identified by proposal titled sections and page numbers.

2.6.2 Proposal Content

The proposal must include the following:

A. Proposer's Qualifications (SECTION A)

This section shall be identified as "SECTION A" of the proposal and shall include the following:

1. Proposal Submission Checklist (Exhibit I)

Proposer is to provide a completed Exhibit I, Proposal Submission Checklist. The purpose of the document is to ensure that the Proposer has submitted all applicable sections, forms, exhibits, attachments, etc. with its Proposal.

2. Proposer's Transmittal Form (Exhibit II)

Proposer must provide a completed Exhibit II, Proposer's Transmittal Form. The purpose of the document is to identify the WOS by title and number and the Proposer's name, address, and telephone number. Indicate whether or not the Proposer intends to solely perform the duties of the MAWO; and that the Proposer will bear sole and complete responsibility for all work as defined in Attachment A, Statement of Work and Attachments B, Scope of Work. In addition, the Proposer's Transmittal Form should include the name, title, business address, telephone number, fax number, and e-mail address of the following individuals: a) Proposer's authorized representative who is authorized to sign on behalf of the Proposer, able to make representations for the Proposer during contract negotiations, and able to legally bind the Proposer to any resultant MAWO; and b) Proposer's contact person, who will serve as the Proposer's main contact with the County for any matters related to this WOS.

3. Proposer's Affidavit of Adherence to Minimum Mandatory Requirements (Exhibit III)

Proposer must demonstrate the ability to satisfy each of the Minimum Mandatory Requirements as outlined in WOS, Section 1.10 by completing and signing Exhibit III, Proposer's Affidavit of Adherence to Minimum Mandatory Requirements.

B. Proposer's Experience (Community Engagement and Mobilization) (SECTION B) (150 points)

This section shall be identified as "SECTION B" of the proposal. Section B must not exceed **three (3) pages** and shall include the following:

1. Describe Proposer's experience mobilizing and coordinating local residents, stakeholders and cohort groups targeting Youth (12-29 years old), Black/African American, Latinx, Transgender Persons, and/or gay and bisexual men, and persons who use methamphetamine/inject drugs in three (3) of the last five (5) years. Proposer's answer should include:

    a. Any related experience with grassroots community mobilization and recruitment, and outline Proposer's recruitment approach;

    b. Experience in planning, developing and implementing innovative programs designed to improve health-related outcomes in specific populations;

    c. A description of experience in advancing strategies and activities related to health equity and social justice as it relates to specific public health issues.

C. Proposer's Approach to Required Services (Section C) (400 points)

This section shall be identified as "SECTION C" of the proposal. Section C must not exceed **three (3) pages** and shall include the following:

1. Describe in detail how Proposer plans to conduct community engagement, outreach, recruitment, and mobilization efforts throughout LAC that support the goals and strategies of EHE. Proposer's answer should include:

    a. Approach the Proposer will employ (i.e. Community Based Participatory Research (CBPR) and/or Youth Participation Action Research (YPAR) framework) to identify and recruit partnering community members and stakeholders who are innovators that can bring fresh perspectives, creative thinking, and solutions to address HIV prevention and treatment. Please include any experience in utilizing Community Based Particpatory Research (CBPR) and/or Youth Participation Action Research (YPAR) framework;

    b. Examples of how Proposer will provide outreach to ensure that the community is aware of and educated on EHE goals;

    c. Approach the Proposer will use to ensure that individuals recruited for this initiative have an understanding of and focus on health disparities and social justice as part of the larger effort to meet EHE goals;

    d. How Proposer will sustain engagement among community members and stakeholders in helping achieve the EHE goals; and

    e. The use of online virtual meetings and chats, social media, and/or other newer technologies and communication methods.

D. Proposer's Staffing Plan (Section D) (150 points)

This section shall be identified as "SECTION D" of the proposal. Section D must not exceed **one (1) page** (not including attachments) and shall include the following:

1. **Organizational Chart** – Proposer must provide an organizational chart for each Community Engagement office/site, detailing the positions to be funded for Community Engagement Services. Please clearly identify

and define staff and staff roles and number of full-time equivalent (FTE) staff dedicated to each role, particularly if staff are serving in multiple capacities and/or in multiple service delivery sites (e.g. serving in the multiple offices). See listing of required positions outlined in the Scope of Work, Attachment B.

2. **Resumes** – Resumes must be provided, at a minimum, for each staff person providing Community Engagement Services at the time of proposal submission. If any of the additional staff, beyond the respective Project Manager, have not yet been hired, then a list of staff and duties submitted in this section will be sufficient with resumés required by the date of contract execution. Resumés must include names, titles, experience, education, roles and responsibilities and other evidence demonstrating experience, certification, licensure, and ability to successfully perform the required services.

E. Proposer's Social Distancing Plan (SECTION E) (50 points)

This section shall be identified as "SECTION E" of the proposal. Section E must not exceed **one (1) page** and shall include the following:

1. Describe Proposer's social distancing plan to ensure that Cohort groups can meet safely while effectively providing Community Engagement Services. Proposer's answer should include a detailed description of how:

    a. Proposer promotes social distancing;
    b. Proposer determines the importance of convening an in-person meeting of any size;
    c. Proposer encourages/facilitates use of virtual meetings, social media, mobile/computer apps, and/or mobile texting; and
    d. Proposer ensures that online meetings stay secure from unauthorized access.

F. Proposer's Data Reporting Plan (SECTION F) (100 points)

This section shall be identified as "SECTION F" of the proposal. Section F must not exceed **one (1) page** and shall include the following:

1. Describe Proposer's plan for collecting, analyzing and providing data on an ongoing basis to DHSP for the EHE initiative.

G. Evaluation and Quality Management Plan (SECTION G) (150 points)

This section shall be identified as "SECTION G" of the proposal. Section G must not exceed **two (2)** pages* and shall include the following:

1. Describe Proposer's evaluation and quality management plan for the community engagement effort in order to evaluate program efficacy and ensure that services provided are reflective of overall EHE initiative goals and strategies. Proposer's plan should include a detailed description of how Proposer will utilize a qualified subcontractor to provide evaluation services as described in the Scope of Work to assess participant involvement with regard to empowerment, knowledge of HIV-related issues, and leadership skills.

H. Required Forms (SECTION H)

This section shall be identified as "SECTION H" of the proposal and shall include the following:

EXHIBIT V	Proposer's Budget
EXHIBIT VI	Acceptance of Terms and Conditions Affirmation
EXHIBIT VII	Certification of Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower Tier Covered Transactions (45 C.F.R. PART 76)

2.7 PROPOSAL SUBMISSION

2.7.1 Proposing Entity Limitations

Only one (1) proposal per Community Engagement and Related Services Master Agreement Contractor will be considered in response to this WOS. Proposer's cannot perform as subcontractors on other proposals.

2.7.2 Submission Requirements

It is the sole responsibility of the submitting Proposer to ensure that its proposal is received before the submission deadline. Proposal are due by 3:00 p.m., Pacific Time, on or before the date specified in Sub-paragraph 2.1, WOS Timetable, by **e-mail transmission** to the person identified in this WOS, Paragraph 1.8, Contact with County Personnel.

2.7.2.1 Proposer shall submit one (1) copy of the proposal in response to this WOS in the format prescribed herein and clearly marked “Proposal Submission for CES-WOS-001”, in the subject line of the e-mail transmission.

2.7.2.2 All proposals must be submitted in the prescribed format and order. Any proposal that deviates from this format may be rejected without review at the Director of DPH’s sole discretion.

2.7.2.3 At the Director's sole discretion, late proposals received after the due date may be considered, in the order received, if a determination is made that there is a specific unmet need.

2.7.3 Acceptance of Terms and Conditions Affirmation

Proposers understand and agree that submission of a proposal and Exhibit VI, Acceptance of Terms and Conditions Affirmation, constitutes an acknowledgement and acceptance of, and a willingness to comply with all terms and conditions of this WOS, any addenda, the MAWO, and the Master Agreement.

In addition, the County reserves the right to make changes to the Master Agreement and its appendices and exhibits, including the MAWO, at its sole discretion.

3.0 PROPOSAL REVIEW AND SELECTION PROCESS

3.1 SELECTION PROCESS

DPH reserves the sole right to judge the contents of the work order proposals submitted in response to this WOS and to review, evaluate, and select the successful proposals. The selection process will begin upon the response deadline identified in this WOS, Section 2.0, Proposal Submission Requirements, Sub-section 2.1, Work Order Solicitation Timetable. The evaluation process will be conducted in three (3) stages:

Stage 1: Adherence to Minimum Mandatory Requirements

Stage 2: Proposal Evaluation

Stage 3: Proposer's Final Review and Selection

Evaluation of the proposals will be made by an Evaluation Committee selected by DPH. The Evaluation Committee will evaluate the proposals and will use the evaluation approach described herein to select the prospective Contractor. All proposals will be evaluated based on the criteria listed below. All proposals will be ranked from highest to lowest score. Evaluators will not evaluate proposals beyond the page limits listed.The highest-ranking Proposal shall be recommended for an award of a MAWO. However, the County retains the right to select a Proposal other than the Proposal receiving the highest number of points if County determines, in its sole discretion, another Proposal is the most overall qualified, cost-effective, responsive, responsible and/or in the best interest of the County.

The available funds identified in Paragraph 1.6, County's Estimated Funding Availability, the allocation of funds, and the number of MAWOs to be awarded are estimates and are subject to change.

The County retains the right to select a Proposal other than the Proposal receiving the highest number of points if County determines, in its sole discretion, another Proposal is the most overall qualified, cost-effective, responsive, responsible and/or in the best interest of the County.

The County also reserves the right to waive any informality, minor irregularities, or immaterial defects in proposals as determined by County if the sum and substance of the Proposal is present. Where County waives any informality, minor irregularities, or immaterial defects, such waiver shall in no way modify WOS specifications, and other MAWO requirements, if the Proposer is awarded any resultant MAWO.

3.2 STAGE 1: ADHERENCE TO MINIMUM MANDATORY REQUIREMENTS

DPH shall review Exhibit III, Proposer's Affidavit of Adherence to Minimum Mandatory Requirements and the Statement of Experience to determine if the Proposer meets each of the Minimum Mandatory Requirements as outlined in WOS, Section 1.10, Minimum Mandatory Requirements.

Proposer must "Pass" each of the Minimum Mandatory Requirements outlined in the WOS. Proposals that "Fail" this section of the review shall be deemed non-responsive and shall be disqualified from further consideration.

3.3 DISQUALIFICATION REVIEW

A proposal may be disqualified from consideration because the Department determined it was a non-responsive proposal at any time during the review/evaluation process. If the Department determines that a proposal was disqualified due to non-responsiveness, the Department shall notify the Proposer in writing.

Upon receipt of the written determination of non-responsiveness, the Proposer may submit a written request for a Disqualification Review within the timeframe specified in the written determination.

A request for a Disqualification Review may, in the Department's sole discretion, be denied if the request does not satisfy all of the following criteria:

1. The request for a Disqualification Review is submitted timely (i.e., by the date and time specified in the written determination); and

2. The request for a Disqualification Review asserts that the Department's determination of disqualification due to non-responsiveness was erroneous (e.g. factual errors, etc.) and provides factual support on each ground asserted as well as copies of all documents and other material that support the assertions.

The Disqualification Review shall be completed and the determination shall be provided to the requesting Proposer, in writing, prior to the conclusion of the evaluation process.

3.4 STAGE 2: PROPOSAL EVALUATION

DPH shall comply with the County Board of Supervisors Policy 5.054, Evaluation Methodology for Proposals, to ensure a consistent process for the evaluation of proposals.

Proposer's responses provided in Sections B, C, D, E, F and G will be evaluated and scored with a total maximum point of 1000.Evaluators will not evaluate proposals beyond the page limits listed.

Section B: Experience (150 points)

Section C: Proposer's Approach to Required Services (400 points)

Section D: Proposer's Staffing Plan (150 points)

Section E: Proposer's Social Distancing Plan (50 points)

Section F: Proposer's Data Reporting Plan (100 points)

Section G: Evaluation and Quality Management Plan (150 points).

3.5 STAGE 3: FINAL REVIEW AND SELECTION

3.5.1 Proposals will be ranked from highest to lowest score.

3.5.2 One (1) MAWO will be awarded to the highest score proposal.

3.5.3 No work is guaranteed to any person or organization based on the existence of a Media Master Agreement with the County of Los Angeles.

3.5.4 After "Recommended Proposer" has been selected, DPH and the Recommended Proposer will negotiate the final MAWO for inclusion into that Contractor's Community Engagement and Related Services Master Agreement with the County. If a satisfactory MAWO cannot be negotiated, the County may, at its sole discretion, begin MAWO negotiations with the next qualified Proposer who submitted a proposal, as determined by the County. DPH recommendation to award a MAWO will not bind the Board to award a MAWO to the Recommended Proposer. The Board is the ultimate decision-making body that may make the final determinations necessary to arrive at a decision to award or not award a MAWO.

3.5.5 Upon completion of negotiations with the Work Order Proposer whose proposal submission is selected, DPH shall obtain a Letter of Intent from an authorized officer of the Work Order Proposer stating that the negotiated MAWO is a firm offer of the selected Work Order Proposer, which shall not be revoked by that Work Order Proposer pending DPH completion of the Protest and Review Process (described below).

3.5.6 A Proposer whose proposal is selected by the Director of DPH and authorized by the Board shall not begin work on the project until the MAWO has been fully executed by DPH and incorporated into the selected Proposer's Community Engagement and Related Services Master Agreement with the County of Los Angeles.

3.6 DEPARTMENT'S PROPOSED CONTRACTOR SELECTION REVIEW

3.6.1 Departmental Debriefing Process

Upon completion of the evaluation, DPH shall notify the remaining Proposers in writing that DPH is entering negotiations with another Proposer. Upon receipt of the letter, any non-selected Proposer may submit a written request for a Debriefing within the timeframe specified in the letter. A request for a Debriefing may, in the Department's sole discretion, be denied if the request is not received within the specified timeframe.

The purpose of the Debriefing is to compare the requesting Proposer's response to the solicitation document, with the evaluation document. The requesting Proposer shall be debriefed only on its response. Because contract negotiations are not yet complete, responses from other Proposers shall not be discussed although the Department may inform the requesting Proposer of its relative ranking.

During or following the Debriefing, DPH will instruct the requesting Proposer of the manner and timeframe in which the requesting Proposer must notify DPH of its intent to request a Proposed Contractor Selection Review (see subsection 3.6.2 below), if the requesting Proposer is not satisfied with the results of the Debriefing.

3.6.2 Proposed Contractor Selection Review

3.6.2.1 Upon completion of the selection process, County shall notify the remaining Proposers in writing that DPH is entering into negotiations with another Proposaer. Upon receipt of the letter, any non-selected Proposer may submit a written notice of intent to request a Proposed Contractor Selection Review within the timeframe specified by County.

3.6.2.2 Any Proposer that has timely submitted a notice of its intent to request a Proposed Contractor Selection Review (as described in section 3.6.2.1) may submit a written request for a Proposed Contractor Selection Review, in the manner and timeframe as shall be specified by County.

3.6.2.3 A request for a Proposed Contractor Selection Review may, in the department's sole discretion, be denied if the request does not satisfy all of the following criteria:

1. The request for a Proposed Contractor Selection Review is submitted timely (i.e., by the date and time specified by the department);

2. The person or entity requesting a Proposed Contractor Selection Review asserts in appropriate detail with factual reasons one or more of the following grounds for review:

   a. The department materially failed to follow procedures specified in its solicitation document. This includes:

      i. Failure to correctly apply the standards for reviewing the proposal format requirements.
      ii. Failure to correctly apply the standards, and/or follow the prescribed methods, for evaluating the proposals as specified in the solicitation document.
      iii. Use of evaluation criteria that were different from the evaluation criteria disclosed in the solicitation document.

   b. The department made identifiable mathematical or other errors in evaluating proposals, resulting in the Proposer receiving an incorrect score and not being selected as the recommended contractor.

   c. A member of the Evaluation Committee demonstrated bias in the conduct of the evaluation.

   d. Another basis for review as provided by state or federal law; and

3. The request for a Proposed Contractor Selection Review sets forth sufficient detail to demonstrate that, but for the department's alleged failure, the Proposer would have been the lowest cost, responsive and responsible bid or the highest-scored proposal, as the case may be.

Upon completing the Proposed Contractor Selection Review, the department representative shall issue a written decision to the Proposer within a reasonable time following receipt of the request for a Proposed Contractor Selection Review, and always before the date the contract award recommendation is to be heard by the Board. The written decision shall additionally instruct the all Proposer of the manner and timeframe for requesting a County Independent Review (see Section 3.7 below).

3.7 COUNTY INDEPENDENT REVIEW PROCESS

Any Proposer that is not satisfied with the results of the Proposed Contractor Selection Review may submit a written request for a County Independent Review in the manner and timeframe specified by DPH written decision regarding the Proposed Contractor Selection Review.

A request for a County Independent Review may, in the County's sole discretion, be denied if the request does not satisfy all of the following criteria:

1. The request for a County Independent Review is submitted timely (i.e. by the date and time specified by the DPH); and

2. The person or entity requesting the County Independent Review has limited the request to items raised in the Proposed Contractor Selection Review as listed in Section 3.6 (Proposed Contractor Selection Review) above.

Upon completion of the County Independent Review, the County Internal Services Department will forward the report(s) to the DPH, which will provide a copy to the Proposer.

4.0 MASTER AGREEMENT WORK ORDER AWARD

4.1 Upon completion of negotiations with the Work Order Proposer whose proposal submission is selected, DPH shall obtain a Letter of Intent from an authorized officer of the Work Order Proposer stating that the negotiated MAWO is a firm offer of the selected Work Order Proposer.

4.2 A Proposer whose proposal is selected by the Director of DPH and authorized by the County Board of Supervisors shall not begin work on the project until the MAWO has been fully executed by DPH and incorporated into the selected proposer's Community Engagement and Related Services Master Agreement with the County of Los Angeles.

4.3 DPH recommendation to award a MAWO will not bind the County Board of Supervisors to award a MAWO to the recommended Proposer.

4.4 No work is guaranteed to any contractor based on the existence of a Community Engagement and Related Services Master Agreement with the County of Los Angeles.

ATTACHMENT A – STATEMENT OF WORK

COMMUNITY ENGAGEMENT FOR ENDING THE HIV EPIDEMIC IN LOS ANGELES COUNTY

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ATTACHMENT A

STATEMENT OF WORK
FOR
COMMUNITY ENGAGEMENT FOR ENDING THE HIV EPIDEMIC IN LOS ANGELES COUNTY

1.0 DESCRIPTION

The County of Los Angeles (County), Department of Public Health (DPH), Division of HIV and STD Programs (DHSP) received grant funding for Ending the HIV Epidemic (EHE): A Plan for America, a national initiative that seeks to reduce the number of new HIV infections in the United States by 75 percent within five (5) years and at least 90 percent within 10 years. EHE focuses on four key pillars to end the epidemic:

1) Diagnose people as early as possible,
2) Treat people rapidly and effectively,
3) Prevent new HIV transmissions, and
4) Respond quickly to HIV outbreaks.

To meet the grant deliverables, Contractor shall conduct community engagement, outreach, and mobilization throughout Los Angeles County (LAC) to support the goals and strategies of EHE. Contractor will be responsible for mobilizing and empowering local stakeholders, community members as well as new voices in the community to innovate, develop, organize and sustain efforts to address HIV prevention and care related issues aligned with EHE goals and strategies. Community residents will focus on advancing projects focused on three of the four EHE Pillars:

1) Diagnose,
2) Treat, and
3) Prevent.

1.1 DHSP Program Goal and Objectives

Contractor is required to achieve the DHSP Goal and Objectives described in Table 1 below:

TABLE 1 - GOALS AND OBJECTIVES FOR COMMUNITY ENGAGEMENT FOR ENDING THE HIV EPIDEMIC IN LOS ANGELES COUNTY	
PRIMARY GOAL	Reduce the number of new HIV infections by 75 percent within five (5) years and at least 90 percent within ten (10) years in LAC by diagnosing people as early as possible, treating people rapidly and effectively, and preventing new transmissions.
PROGRAM GOALS	A. Empower community members to advance HIV-related projects aimed at accomplishing the Primary Goal within their respective communities, utilizing a community-led approach.
	B. Increase knowledge and awareness among LAC communities of HIV and HIV-related issues, including populations disproportionately affected by HIV/AIDS.

	C. Develop partnerships with organizations and businesses to support EHE efforts.
	D. Reduce HIV-related stigma among LAC residents.
OBJECTIVES	1. **Cohort Recruitment:** Contractor shall recruit community members from areas or populations within LAC that are disproportionally affected by the HIV/AIDS epidemic to form a minimum of ten (10) cohorts (teams) with a minimum of six (6) members per cohort to advance an HIV-related project oriented to accomplishing the Primary Goal within their community.
	2. **Cohort Meetings:** Contractor shall facilitate a minimum of fifteen (15) cohort meetings per cohort group for a total of one hundred and fifty (150) cohort group meetings within twelve (12) months.
	3. **HIV Education Activities:** Contractor shall ensure each cohort group conducts five (5) formal or informal HIV education activities (i.e. presentations, workshops and/or trainings) to educate individuals and communities on Ending the HIV Epidemic's goals and strategies, the impact of HIV in LAC, and other HIV-related information.
	4. **Stakeholder Engagement:** Contractor shall work with cohort groups to identify and engage key stakeholders in various sectors that will support and participate in implementation of community-led projects at identified partner sites.

2.0 DEFINITIONS

2.1 **Cisgender**: A person whose gender identify corresponds with the sex the person had or was identified as having at birth.

2.2. **Community Engagement:** The process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the wellbeing of those people.

2.3 **County's Project Director**: Person designated by County with authority for County on contractual or administrative matters relating to this Contract that cannot be resolved by the County's Project Manager.

2.4 **County's Project Manager**: Person designated by County's Project Director to manage the operations under this Contract. Responsible for managing inspection of any and all tasks, deliverables, goods, services and other work provided by the Contractor.

2.5 **Day(s)**: Calendar day(s) unless otherwise specified.

2.6 **Ending the HIV Epidemic (EHE)**: A federally funded plan for America that aims to end the HIV epidemic in the United States within 10 years.

2.7 **Fiscal Year**: The twelve (12) month period beginning July 1st and ending the following June 30th.

2.8 **Men Who Have Sex with Men (MSM)**: Term used to categorize men who have sex with men but who may identify their sexuality as either gay, straight, bisexual, same gender loving, down low, pansexual, etc. or some other identity.

2.9 **Project Manager**: The Contractor's designee responsible to administer the Contract operations and to liaise with the County after the Contract award.

2.10 **Transgender person**: A person who identifies with or expresses a gender identity that differs from the sex they were assigned at birth.

2.11 **Youth**: Persons of all racial and ethnic backgrounds aged 12-29 years old.

3.0 RESPONSIBILITIES

The County's and the Contractor's responsibilities are as follows:

COUNTY

The County will administer the Contract according to Master Agreement, Paragraph 6.0, ADMINISTRATION OF MASTER AGREEMENT – COUNTY.

3.1 Personnel

3.1.1 Monitoring the Contractor's performance in the daily operation of this Contract.

3.1.2 Providing direction to the Contractor in areas relating to policy, information and procedural requirements.

3.1.3 Preparing Amendments in accordance with the Contract, Paragraph 8.0, Standard Terms and Conditions, Sub-paragraph 8.1 Amendments.

CONTRACTOR

The Contractor will administer the Contract according to Master Agreement, Paragraph 7.0, ADMINISTRATION OF MASTER AGREEMENT – CONTRACTOR.

3.2 Contractor Requirements

1) **Experience (Community Engagement and Mobilization) –** Contractor must have a minimum of three (3) years of experience within the last five (5) years implementing community engagement and mobilization programs focused on healthy equity and social justice.

2) **Provision of Services (Target Populations)** – Contractor must focus Community Engagement efforts on residents and organizations of LAC with an emphasis on:

   a) Youth (12-29 years old)
   b) Black/African American
   c) Latinx
   d) Transgender persons
   e) Gay and Bisexual men
   f) Substance abusers/users

3) **Recruitment Experience** – Contractor must have a minimum of two (2) years of experience within the last five (5) years recruiting cohorts to participate in a community engagement project to improve health outcomes related to an identified public health issue.

4) **Recruitment Approach Experience** – Contractor must have a minimum of one (1) year of experience within the last three (3) years utilizing the Community Based Participatory Research (CBPR) approach and/or Youth Participatory Action Research (YPAR) framework.

5) **Sub-Contract Evaluation Services** – Upon contract execution, Contractor must subcontract evaluation services, as described in the Scope of Work, to assess participant's knowledge of HIV-related issues, leadership skills, empowerment, and more.

3.3 Personnel

3.3.1 **Project Manager (1.0 FTE)**

3.3.1.1 Contractor shall provide a full-time Project Manager and designated alternate to act as a central point of contact with the County. County must have access to the Contractor's Project Manager during normal working hours as designated in Section 7.0, Days/Hours of Work. Contractor shall provide a telephone number where the Project Manager may be reached on an eight (8) hour per day basis during those hours.

3.3.1.2 The Project Manager must have three (3) years of experience within the last five (5) years developing, implementing, and monitoring community engagement services.

3.3.1.3 Contractor's Project Manager shall act as a central point of contact with the County. Project Manager/alternate shall have full authority to act for Contractor on all matters relating to the daily operation of the Contract. Project Manager/alternate shall be

able to effectively communicate, in English, both orally and in writing.

3.3.1.4 The Project Manager shall be charged with oversight of the Community Engagement Programmatic activities, the Project Manager, Project Coordinators, and all additional staff involved in program development and implementation.

3.3.1.5 Project Manager must be physically located at the Contractor's office location within Los Angeles County.

3.3.2 **Project Coordinators (5.0 FTE)**

3.3.2.1 Contractor shall provide five (5) full-time Project Coordinators to act as liaisons to the community and coordinate community engagement efforts. Each coordinator shall be responsible for the day-to-day management and facilitation of two (2) cohorts.

3.3.2.2 Project Coordinators must have experience with community engagement and mobilization, specifically with community-led approaches such as the Community Based Participatory Research (CBPR) framework, Youth Participatory Action Research (YPAR) framework, coalition building, or the Health Promotora model.

Project Coordinators must have experience working on sensitive public health issues and diverse populations.

Project Coordinators must be physically located at the Contractor's office location within Los Angeles County and be able to travel to program activities including Cohort group meetings as well as formal and informal Cohort group trainings/workshops throughout Los Angeles County.

3.4 Staffing

3.4.1 Contractor shall assign a sufficient number of employees to perform the required work. At least one (1) employee on site shall be authorized to act for Contractor in assuring compliance with contractual obligations at all times.

3.4.2 All staff and subcontracted staff shall be appropriately licensed or certified to provide services in their respective specialty fields, as required by federal, State, and local laws.

3.4.3 Contractor is responsible for ensuring that all staff and subcontracted staff remain in good standing, with proper certification and licensing updated as required by law.

3.4.4 Contractor's staff and subcontractors shall display non-judgmental, culture-affirming attitudes.

3.4.5 Contractor shall be required to perform background checks of their employees as set forth in Administration of Master Agreement, Sub-paragraph 7.5 – Background & Security Investigations, of the Contract. All costs associated with the background and security investigation shall be borne by the Contractor.

3.4.6 Prior to employment or provision of services, and annually (12 months) thereafter, Contractor shall obtain and maintain documentation of tuberculosis screening for each employee, volunteer, subcontractor and consultant providing direct MSS, according to the Master Agreement, Sub-paragraph 9.15, Guidelines for Staff Tuberculosis Screening.

3.4.7 Contractor shall provide County with a roster of all administrative and program staff, including titles, degree(s) and contact information within thirty (30) days of the effective date of the contract.

3.4.8 Contractor shall ensure annual performance evaluations are conducted on all staff budgeted and performing services under the proposed contract to ensure program staff are meeting job duties as required.

3.4.9 Contractor shall ensure all staff and subcontracted staff perform duties in accordance with DPH's COVID-19 recommendations and guidelines, including but not limited to limiting in-person meetings, wearing face coverings when in the presence of others and practicing physical distancing at all times, and following all handwashing and sanitizing protocols. Further information can be found at http://publichealth.lacounty.gov/media/coronavirus/guidances.htm#business

3.5 Training of Contractor's Staff

3.5.1 Contractor shall ensure that all new employees and staff receive appropriate DHSP and/or State of California approved training as well as continuing in-service training for all employees mandated by the terms and conditions of the Contract.

3.5.2 Contractor shall ensure health care providers/network of providers, consultants, and subcontractors shall maintain up-to-date knowledge and skill levels in accordance with their respective roles in community engagement and with the rapidly expanding literature and information regarding prevention and treatment approaches in the HIV field.

3.5.3 All employees shall be trained in their assigned tasks and in the safe handling of equipment as applicable when performing services under this contract. All equipment shall be checked daily for safety. All employees must wear safety and protective gear according to OSHA standards.

3.6 Approval of Contractor's Staff and Subcontractors

3.6.1 County has the absolute right to approve or disapprove all of Contractor's staff performing work hereunder, and any proposed changes in Contractor's staff, including, but not limited to, Contractor's Program Director.

3.6.2 Contractor and Subcontractor shall remove and replace personnel performing services under the Contract within thirty (30) days of the written request of the County. Contractor and/or Subcontractor shall send County written confirmation of the removal of the personnel in question.

3.6.3 County has the absolute right to approve or disapprove all of Contractor's subcontractor(s) or consultant(s) performing work hereunder and any proposed changes in subcontractor(s).

3.6.4 Contractor shall obtain approval of DHSP Director or his designee prior to signing any subcontractor(s) or consultant(s) agreement and shall give DHSP Director fifteen (15) days prior notice to review proposed subcontract or consultant agreement.

3.6.5 Subcontractor(s) shall remove and replace personnel performing services under this Contract within thirty (30) days of the written request of the County. Contractor shall send County written confirmation of the removal of the personnel in question.

3.6.6 Contractor shall notify County if/when MSS network provider agreements are dissolved.

3.7 Uniforms/Identification Badges

3.7.1 Dress code is business professional as defined by the Contractor.

3.7.2 Contractor shall ensure their employees are appropriately identified as set forth in Sub-paragraph 7.4, Contractor's Staff Identification, of the Master Agreement.

3.8 Materials, Supplies and/or Equipment

3.8.1 The purchase of all materials, supplies, and or equipment to provide the needed services is the responsibility of the Contractor. Contractor shall use materials, equipment, and or supplies that are safe for the environment and safe for use by the employee. Such materials, supplies, equipment, etc., must have been clearly identified in the program budget and must have been approved in advance by the DHSP Director in order to be eligible for cost reimbursement.

3.8.2 In no event shall the County be liable or responsible for payment for materials or equipment purchased absent the required prior written approval.

3.8.3 Any and all materials and equipment purchased under the Contract are the property of the County and must be returned to County in good working order at the end of the Term of the Contract.

3.8.4 The County will not provide the Contractor with any materials, supplies, and/or equipment.

3.9 Contractor's Office

Contractor shall maintain a physical office location with a telephone in the company's name where Contractor conducts business. The office shall be staffed during the hours of 8 a.m. to 5 p.m., Monday through Friday, by at least one employee who can respond to inquiries and complaints which may be received about the Contractor's performance of the Contract. When the office is closed, an answering service shall be provided to receive calls. The Contractor shall answer calls received by the answering service within twenty-four (24) hours of receipt of the call.

3.10 Guidelines on Materials Review

3.10.1 Contractor shall obtain written approval from DHSP's Director or designee for all administrative and educational materials utilized in association with the delivery of services for the program prior to use in

order to ensure that such materials adhere to community norms and values and are in compliance with all Contract requirements.

3.10.2 Contractor shall comply with federal, state, and local regulations regarding HIV or STD educational materials. Instructions on which educational materials need to be submitted for materials review can be found at the Interim Revision of the Requirements for Content of AIDS-related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments and Educational Sessions located on the web at http://www.cdc.gov/od/pgo/forms/hiv.htm.

3.10.3 Additional information about materials review and related guidelines can be found at: http://publichealth.lacounty.gov/dhsp/InfoForContractors.htm#MATERIALS

3.11 County's Data Management System

3.11.1 The County's data management system is used to standardize reporting and billing/invoicing, support program evaluation processes, and to provide DHSP and Contractor with information relative to the HIV and STD epidemic in Los Angeles County. Contractor shall ensure data quality, and compliance with all data submission requirements provided in writing by DHSP.

3.11.2 Contractor may enter data directly into the County's data management system or send data electronically to the County's data management system via an electronic data interface (EDI) monthly.

3.12 Emergency Medical Treatment

3.12.1 Contractor shall arrange immediate transport for any client receiving services who requires emergency medical treatment for physical illness or injury.

3.12.2 Contractor shall have written policies for staff regarding how to access emergency medical treatment for clients. Such written policies must be provided to DHSP.

3.13 County's Commission on HIV

All services provided under the Contract should be in accordance with the standards of care as determined by the County of Los Angeles Commission on HIV (Commission). Contractor shall actively view the Commission website (http://hivcommission-la.info/) and where possible participate in the deliberations and respectful dialogue of the Commission to assist in the planning and operations of HIV prevention and care services in Los Angeles County.

3.14 Provide Culturally Appropriate and Linguistically Competent Services

3.14.1 Contractor shall provide Community Engagement Services with non-judgmental, culturally affirming attitudes that convey a culturally and linguistically competent approach that is appropriate and attractive to the client.

3.14.2 Contractor shall maintain a proven, successful track record serving RWP clients by effectively addressing treatment and concerns within the appropriate social context for each client.

4.0 SPECIFIC WORK REQUIREMENTS

Primary responsibilities and/or services to be provided by the Contractor shall include, but not be limited to, those activities as listed in Attachment B, Scope of Work for Community Engagement for Ending the HIV Epidemic in Los Angeles County.

5.0 ADDITION/DELETION OF FACILITIES, SPECIFIC TASKS AND/OR WORK HOURS

5.1 Contractors must obtain permission from Director, DHSP or his designee at least sixty (60) days prior to the addition/deletion of service facilities, specific tasks and/or work hour adjustments.

5.2 All changes must be made in accordance with Sub-paragraph 8.1, Amendments, of the Master Agreement.

6.0 HOURS/DAY OF WORK

The Contractor shall provide Community Engagement Services during the hours that are the most effective and convenient for the population served. Hours may be the standard Monday through Friday, between 8:00 a.m. to 5:00 p.m., but may also include alternate hours such as evenings, late nights, and weekends. Contractor is not required to work on the following County recognized holidays: New Year's Day; Martin Luther King's Birthday; Presidents' Day; Cesar Chavez Day; Memorial Day; Independence Day; Labor Day; Indigenous Peoples Day; Veterans' Day; Thanksgiving Day; Friday after Thanksgiving Day; and/or Christmas Day.

7.0 WORK SCHEDULES

7.1 Contractor shall maintain a work schedule for each location/facility and submit to the County Project Manager upon request. Said work schedules shall be set on an annual calendar identifying all the required on-going maintenance tasks and

task frequencies. The schedules shall list the time frames of the tasks to be performed by day of the week and morning, afternoon, and/or evening hours.

7.2 Contractor shall notify County Project Manager when actual performance differs substantially from planned performance. Said revisions shall be submitted to the County Project Manager within thirty (30) working days prior to scheduled time for work.

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
COMMUNITY ENGAGEMENT FOR ENDING THE HIV EPIDEMIC IN LOS ANGELES COUNTY

SCOPE OF WORK

CONTRACTOR NAME: _____

MASTER AGREEMENT NUMBER: _____ **WORK ORDER NUMBER:** _____
(County Use Only)

WORK ORDER SOLICITATION NUMBER: CES-WOS-003

TERM: Upon Master Agreement Work Order (MAWO) execution through July 31, 2023

OBJECTIVE	IMPLEMENTATION ACTIVITIES	TIMELINE	DOCUMENTATION/TRACKING MEASURES
1. Hire one (1) Full Time Equivalent (FTE) Project Manager	1.1 Identify, recruit, and hire qualified (defined in Section 3.3, Statement of Work) staff member to serve as Project Manager	1.1 Within 3 months of MAWO execution	1.1 Documentation of recruitment efforts (e.g. job descriptions, job postings) and resume of hired staff to be kept on file
2. Hire five (5) FTE Project Coordinators	2.1 Identify, recruit, and hire qualified staff (defined in Section 3.3, Statement of Work) to serve as Project Coordinators who will oversee a minimum of two (2) teams each.	2.1 Within 3 months of MAWO execution	2.1 Documentation of recruitment efforts (e.g. job descriptions, job postings) and resumes of hired staff to be kept on file
3. **County Meetings/Trainings:** Participate in DHSP identified trainings, webinars, conference calls, etc.	3.1 Designated Project Manager and Project Coordinators will participate in all required trainings, webinars, and conference calls as required by DHSP. Trainings include, but are not limited to: a. Contractor orientation b. The science behind community action and mobilization, i.e. community based participatory research (CBPR) or youth participatory action research (YPAR), Health Promotora Model	3.1 Upon MAWO execution	3.1 Summary of participation will be kept on file (includes copies of agendas and/or certificates of completion)
	3.2 Designated staff will participate in Ending the HIV Epidemic webinars and trainings hosted by federal and State partners	3.2 Upon MAWO execution	3.2 Summary of participation will be kept on file (includes copies of agendas and/or certificates of completion)

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SCOPE OF WORK

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(County Use Only)

WORK ORDER SOLICITATION NUMBER: CES-WOS-003

TERM: Upon Master Agreement Work Order (MAWO) execution through July 31, 2023

OBJECTIVE	IMPLEMENTATION ACTIVITIES	TIMELINE	DOCUMENTATION/TRACKING MEASURES
4. **Cohort Recruitment:** Project Coordinators will recruit community members to form at least ten (10) cohorts with a minimum of six (6) participants per cohort.	4.1 Develop and submit for approval a recruitment plan outlining steps and timeline for recruiting participants. Cohorts must include a broad representation of the community, such as Black/African Americans, Latinx people, Youth (ages 12 – 29) of all racial and ethnic backgrounds, and/or consumer advisory boards. 4.2 If working with youth under 18 years, collect parent/guardian permission slips and/or authorization documentation. If working with youth, create cohort(s) that are solely youth participants and cohort(s) that are solely adult focused.	4.1 Within 4 months of MAWO execution 4.2 Within 4 months of MAWO execution	4.1 DHSP approval and copy of the recruitment plan to be kept on file. Cohort rosters with contact information to be kept on file 4.2 If working with minors, permission slips and/or authorization documentation to be kept on file
5. **Cohort Orientation:** Provide orientation to members of each community cohort.	5.1 Develop orientation materials and submit for approval. At minimum, content covered must include an overview of: a. Basic HIV information and relevant data b. EHE initiative and Pillars c. HIV prevention and treatment education (e.g. Pre-Exposure Prophylaxis (PrEP), Undetectable = Untransmittable) d. Options for HIV testing e. HIV-related stigma	5.1 Within 4.5 months of MAWO execution	5.1 DHSP approval and orientation materials to be kept on file

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
COMMUNITY ENGAGEMENT FOR ENDING THE HIV EPIDEMIC IN LOS ANGELES COUNTY

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(County Use Only)

WORK ORDER SOLICITATION NUMBER: CES-WOS-003

TERM: Upon Master Agreement Work Order (MAWO) execution through July 31, 2023

OBJECTIVE	IMPLEMENTATION ACTIVITIES	TIMELINE	DOCUMENTATION/TRACKING MEASURES
	f. Intersection between HIV, social determinants of health, and other health related issues (e.g. homelessness, drug use) g. Process and importance of community-led projects (focus on CBPR, YPAR, or coalition building)		
6. **Cohort Meetings**: Project Coordinators will meet with their assigned cohorts a minimum of fifteen (15) times per cohort in this term. Youth teams will meet a minimum of twenty-five (25) times in this term to build trust and increase commitment.	6.1 Develop meeting plans and materials. Submit for approval. 6.2 Plan and schedule meetings. Maintain a calendar of meeting locations (i.e. online virtual platform), dates and times. 6.3 Conduct, facilitate, and guide cohort meetings.	6.1 Within 5 months of MAWO execution 6.2 Within 5 months of MAWO execution 6.3 Upon MAWO execution	6.1 DHSP approval and meeting materials on file 6.2 Detailed calendar of meeting information (online platform utilized, meeting date, meeting time) on file 6.3 List of meeting participants on file

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
COMMUNITY ENGAGEMENT FOR ENDING THE HIV EPIDEMIC IN LOS ANGELES COUNTY

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TERM: Upon Master Agreement Work Order (MAWO) execution through July 31, 2023

OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	DOCUMENTATION/TRACKING MEASURES
7. **Cohort Focus:** Project Coordinators will guide cohort participants to identify their primary project focus and secondary project focus	7.1 Conduct needs assessments via community mapping exercises and discussions during cohort meetings. Based on results and cohort interest, select primary and secondary project focuses and submit for approval. Potential areas of focus include: a. Pillar 1: Diagnose (HIV testing, knowing your HIV status, stigma) b. Pillar 2: Treat (increasing knowledge of and access to services, implementing changes in a clinic to support clients and reduce stigma when connecting to care, undetectable = untransmittable) c. Pillar 3: Prevent PrEP promotion and uptake, Post Exposure Prophylaxis, syringe services programs)	7.1 Within 5.5 months of MAWO execution	7.1 DHSP approval of primary and secondary areas of focus for cohort-led projects on file Meeting summaries (date and time, meeting participants, brief description of topics discussed) and materials reviewed or completed during project selection process to be kept on file

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SCOPE OF WORK

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TERM: Upon Master Agreement Work Order (MAWO) execution through July 31, 2023

OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	DOCUMENTATION/TRACKING MEASURES
8. **Develop Cohort Project Plan:** Project Coordinators shall guide cohorts to identify public health approaches that will educate the community and/or reach outcomes	8.1 Cohorts develop a project plan in support of their project and potential outcomes. Project examples include, but are not limited to: a. Pillar 1: Diagnose (hosting workshops to implement HIV education and reducing HIV-related stigma, partnering with barbershops/salons to encourage HIV testing, advocating to city officials the importance of routine testing) b. Pillar 2: Treat (partnering with medical colleges/universities to implement HIV-related trainings, partnering with a church to promote messaging of undetectable = untransmittable, partner with a clinic to develop youth-friendly campaign) c. Pillar 3: Prevent (conducting widespread education on the importance of PrEP, working with non-Ryan White clinics to offer PrEP to clients, creating a PrEP social media campaign)	8.1 Within 6 months of MAWO execution	8.1 DHSP approval and detailed project plan on file

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OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	DOCUMENTATION/TRACKING MEASURES
9. **Cohort Research**: Project Coordinators guide and support cohorts in researching selected areas of focus by gathering information and analyzing data	9.1 Cohorts select research method(s) to gain the necessary information needed for their project focus. a. Project Coordinators provide cohorts with the tools and information needed to conduct assessments, surveys, etc. b. Project Coordinators guide cohorts in analyzing data collected information and data to inform next steps in project.	9.1 Within 8 months of MAWO execution	9.1 Meeting summaries (date and time, meeting participants, brief description of topics discussed) and materials reviewed or completed to be kept on file
10. **Identify Partners and Key Stakeholders:** Project Coordinators will guide and facilitate cohorts conducting outreach to key stakeholders and community members to identify and recruit partners on the issue	10.1 Contractor assists cohorts to identify key stakeholders in the community as potential partners on the selected area of focus. Stakeholders may include non-HIV providers, colleges or universities, faith leaders, business owners, community groups and agencies. 10.2 Project Coordinators will support cohorts in identifying a site or organization that will support implementation of the project. A minimum of 1 site per cohort is required.	10.1 Within 6 months of MAWO execution 10.2 Within 6 months of MAWO execution	10.1 List of stakeholders, dates of outreach, and method of outreach to be kept on file 10.3 List of site or organization to be kept on file

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OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	DOCUMENTATION/TRACKING MEASURES
11. **Building Community Power:** Project Coordinators guide cohorts in conducting community education based on their project and what they've learned from their own research	11.1 Contractor assists cohorts in developing presentations, based on their research findings, to educate the community and gain buy-in on projects. Presentation topics may include: a. Overview of Ending the HIV Epidemic b. Overview of HIV data in the local community or LA County as a whole c. Details on cohort-led project, potential outcomes, and how stakeholders can support or get involved.	11.1 Within 10 months of MAWO execution	11.1 Presentations and related documents to be kept on file
12. **Cohort Final Presentation:** Project Coordinators facilitate each cohort conducting a minimum of one (1) presentation to key stakeholders at each identified project site(s) to share the findings from their research to bring about necessary changes and/or improvement.	12.1 Cohorts present their key findings to key stakeholders and decision makers on their selected area of focus and possible outcomes that will support EHE efforts. Presentations may be formal presentations (i.e. PowerPoint and/or video presentations to elected officials) or informal presentations (one-on-one meetings with stakeholders, etc.).	12.1 Within 11 months of MAWO execution	12.1 Meeting summaries (date and time, meeting participants) and materials reviewed or completed to be kept on file

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OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	DOCUMENTATION/TRACKING MEASURES
13. **Project Outcomes:** Support implementation efforts and document outcomes related to individual, community and/or institutional changes based on the project.	13.1 Provide the resources, tools, and/or necessary partnerships to implement changes within the community based on the project.	13.1 MAWO end date	13.1 Provide project updates on monthly reports Submit year-end narratives summarizing project outcome(s)
14. **HIV Community Education Activities:** Project Coordinators support cohorts in conducting a minimum of five (5) education and/or awareness activities on HIV prevention and treatment to the broader community.	14.1 With support from Contractor, cohorts conduct activities such as workshops, hosting booths at events, social media campaigns. Target audiences may include other community members, peers, family and/or other community stakeholders to advance EHE efforts. Topics include, but are not limited to: a. Overview of HIV and EHE initiative b. Promotion and/or distribution of HIV testing and HIV home test kits c. Promotion and/or distribution of free condoms d. Promotion of PrEP and PEP and locations on where the medication can be accessed	14.1 MAWO end date	14.1 List of activities (meeting dates, participants, topics covered) and related documents on file Number of participants reached on file

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TERM: Upon Master Agreement Work Order (MAWO) execution through July 31, 2023

OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	DOCUMENTATION/TRACKING MEASURES
15. **Program Evaluation:** Contractor shall conduct impact and outcome evaluations to assess program efficacy.	15.1 Conduct pre/post evaluations on education and awareness activities. 15.2 Engage with a qualified subcontractor to evaluate individuals within cohorts on impact of participation in program/project. Methods may include pre/post self-assessments, mid-year evaluations, focus groups, listening sessions, etc. Evaluation research questions may cover HIV knowledge and awareness, leadership skills, feelings of empowerment, ability to implement projects, etc.	15.1 MAWO end date	15.1 Evaluation instruments, completed questionnaires, pre/post-tests, mid-year evaluations, etc. to be kept on file 15.2 Year-end formal case study report submitted to DHSP

BUDGET INSTRUCTIONS

COMMUNITY ENGAGEMENT FOR ENDING THE HIV EPIDEMIC IN LOS ANGELES COUNTY CES – WOS – 003

These Budget Instructions provide Proposers direction for completing the budget forms provided in Exhibit V of Attachment D – Required Forms. The budgets must include all expenses required to complete the objectives, activities, and deliverables set forth in the Master Agreement, Statement of Work (Attachment A), and Scope of Work (Attachment B). Proposer must submit a budget for each of the three periods, which are separated into 3 tabs on the Excel spreadsheet provided. Pursuant to WOS Section 1.1.3, Availability of Funding, the budgets should not exceed the following amounts per period:

- Period 1: $1,000,000
- Period 2: $1,000,000
- Period 3: $1,000,000

Proposer must use the budget forms/Excel spreadsheet provided with this WOS. No other budget forms or templates shall be accepted. Proposer may add additional rows on the Excel spreadsheet as necessary, however the budget must be formatted and provide all the information as required in the template and budget instructions. Proposers must also ensure that formulas/calculations are accurate. All amounts are to be rounded to the nearest dollar. Budgets submitted in excess of the budget limits listed above may be deemed non-responsive and may be disqualified from further consideration.

Proposers must include all costs associated with the budget categories listed below:

Budget Categories

A. Full-time and Part-time Salaries

At a minimum, the budget should include the following required full-time personnel:

- **One (1) Project Manager (1.0 Full-time Equivalent (FTE))**
- **Five (5) Project Coordinators (5.0 FTE)**

Full-time Salaries: List the position title and name of each full-time employee that will provide services under the proposed project. A "full-time employee" is an individual who works 40 hours per week for the Proposer and is determined by the fact that Proposer reports and pays payroll taxes (SUI, FICA, etc.) and pays employee's income taxes as basic legal requirements. Specify "vacant" for the employee's name if the employee has not been identified and/or hired.

- Monthly Salary: For each full-time position, enter the employee's monthly salary.
- Number of Months: For each full-time position, enter the budgeted number of months each employee will work under the proposed project.
- Percentage (%) of Time: Enter the total percentage of time that each full-time employee will work under the proposed project. If all of an employee's time will be spent under the proposed project, enter 100% (100% means 40 hours per week). If less than 40 hours per week will be spent on the proposed project, enter the appropriate percentage of time. If an employee is a part-time staff member

(working for the Proposer less than 40 hours a week) list the employee under part-time staff.

- Total: The salary amounts should automatically calculate in the Total column on the Excel spreadsheet provided. (For each full-time position, the monthly salary should be multiplied by the number of months and by the percentage of time.) This amount should be automatically entered in the Total column.
- Subtotal Full-time Salaries: The subtotal amounts for Full-time salaries should be automatically added and entered in the Total column.

Part-time Salaries: List the position title and name of each part-time employee that will provide services under the proposed project. A "part-time employee" is an individual who works for the Proposer on a part-time basis only and is paid on an hourly basis. Specify "vacant" for the employee's name if the employee has not been identified and/or hired. (Note: If an employee works 40 hours per week but only 40% of the employee's time is charged to the project and 60% charged to another project, the employee should be listed under full-time staff.)

- Hourly Salary: For each part-time position, enter the employee's hourly rate.
- Number of hours worked annually: For each part-time position, enter the budgeted number of hours each employee will work annually under the proposed project.
- Percentage (%) of Time: Enter the total percentage of time that each part-time employee will work under the proposed project.
- Total: The salary amounts should automatically calculate in the Total column. (For each part-time position, the hourly rate should be multiplied by the number of hours worked annually and by the percentage of time.) This amount should automatically be entered in the Total column.
- Subtotal Part-time Salaries: The subtotal amounts for Part-time salaries should automatically be added and entered in the Total column.

Total Salaries: The Total Salaries should automatically calculate in the Total Salaries row. (The Subtotal Full-time Salaries and Subtotal Part-time Salaries should be automatically added). Proposer must ensure that formulas/calculations are accurate.

B. Employee Benefits

- Full-time Employee Benefits Rate: Enter the estimated total full-time employee benefits percentage (%) rate for which the Proposer is responsible (e.g., FICA, SUI, Workers' Compensation, retirement, etc.). The total amount of full-time employee benefits should automatically calculate in the Total column. (The Full-time Employee Benefits Rate should be multiplied by the Subtotal Full-time Salaries.)
- Part-time Employee Benefits Rate: Enter the estimated total part-time employee benefits percentage (%) rate for which the Proposer is responsible (e.g., FICA, SUI, Workers' Compensation, retirement, etc.). The total amount of part-time employee benefits should automatically calculate in the Total column. (The Part-time Employee Benefits Rate should be multiplied by the Subtotal Part-time Salaries.)
- Employee Benefits Totals: The total amount of Employee Benefits should automatically calculate in the Amount column. (The amount of Full-time Employee Benefits and the amount of Part-time Employee Benefits should be automatically added.)

Total Salaries & Employee Benefits: The Total Salaries & Employee Benefits amount should automatically calculate in the Total Salaries & Total Employee Benefits row. (The Total Salaries amount, and the Total Employee Benefits amount should be automatically added.) Proposer must ensure that formulas/calculations are accurate.

C. Operating Expenses

Identify the type of expense (e.g., office or facility rent/lease, office supplies, printing/reproduction, general liability insurance, equipment, computers, telephone expenses, etc.) that will be required for the provision of services under the proposed project. Proposer must also provide a short description of the expense and/or methodology for arriving at the expense amount. Enter the total cost of the expense item in the Amount column. The costs for operating expenses should conform to the proposed project's objectives. Please note, there will be no reimbursement for mortgage expenses for property owned by the Proposer.

D. Mileage and Travel

Identify the costs of mileage required for the provision of services under the proposed project. This may be calculated by multiplying the estimated number of miles each employee will be required to travel by the **lower** of the Proposer's current mileage rate or the County's prevailing rate (Los Angeles County mileage reimbursement rate is currently 55 cents per mile). Proposer must also identify the travel costs required for the proposed project (e.g., parking fees). Provide a short description of the expense and/or methodology for arriving at the expense amount (e.g., indicate the total number of miles and mileage rate used) and enter the total cost of the expense item in the Amount column.

E. Other Costs (including Consultants/Subcontractors)

Identify other costs required for the provision of services under the proposed project (e.g., Oral Health Summit expenses, venue fees, catering costs, food and beverages, costs of printing and distributing reports, and oral health incentives [e.g., toothbrushes, floss, toothpaste]). The cost of oral health incentives must not exceed $50 in value, per person per year and must not include gift cards that can be used to purchase tobacco or alcohol products. Proposer may also include costs of hiring subcontractors and/or consultants (e.g., event planners, translators, subject matter experts, graphic design artists, etc.). Provide a short description of the expense and/or methodology for arriving at the expense amount (e.g., provide the type of consultant/subcontractor and indicate their hourly rate) and enter the total cost of the expense item in the Amount column.

F. Total Direct Costs (Categories A through E)

The Total Direct Costs should automatically calculate in the Amount column. (The total amounts of categories A through E should be automatically added.) Proposer must ensure that formulas/calculations are accurate.

G. Indirect Costs

Enter indirect costs required for the provision of services under the proposed project. Indirect costs are costs that are incurred for a common or joint purpose benefiting more than one cost objective, and not readily attributable to any particular project or service. These costs may include salaries, wages, and fringe benefits of administrative personnel whose effort benefits more than one cost objective; operational and maintenance costs that benefit more than one cost objective; and/or expenses such as rent for percentage of space occupied by administrative personnel, etc.

Indirect costs should not exceed 15% of total salaries and benefits.

H. Total Term Budget

The Total Term Budget for the respective period should automatically calculate in the Amount column. (The amount of Total Direct Costs and Total Indirect Costs should be automatically added.) Proposer must ensure that formulas/calculations are accurate.

I. Total Budget Cost (Total Bid Amount)

The Total Budget Cost (Total Bid Amount) should automatically calculate in the Cumulative Budget worksheet (tab 4 of the budget form Excel spreadsheet). (The Total Term Budget amounts for Periods 1, 2, and 3 should be automatically added.) Proposer must ensure that formulas/calculations are accurate. The Total Budget Cost will represent Proposer's Total Bid Amount requested for the proposed project.

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
COMMUNITY ENGAGEMENT FOR ENDING THE HIV EPIDEMIC IN LOS ANGELES COUNTY
WORK ORDER NUMBER: CES-WOS-003

REQUIRED FORMS

EXHIBIT I	Proposal Submission Checklist
EXHIBIT II	Proposer's Transmittal Form
EXHIBIT III	Proposer's Affidavit of Adherence to Minimum Mandatory Requirements
EXHIBIT IV	Proposer's Personnel
EXHIBIT V	Proposer's Budget
EXHIBIT VI	Acceptance of Terms and Conditions Affirmation
EXHIBIT VII	Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower Tier Covered Transactions (45 C.F.R. Part 76)

EXHIBIT I

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
COMMUNITY ENGAGEMENT FOR ENDING THE HIV EPIDEMIC IN LOS ANGELES COUNTY
WORK ORDER NUMBER: CES-WOS-003

PROPOSAL SUBMISSION CHECKLIST

PROPOSER'S NAME:	

The purpose of this document is to ensure that Proposer has submitted all applicable sections, forms, exhibits, attachments, etc. with its proposal. Please check the appropriate box:

Proposer has completed and submitted the following:		
Section 2.7.2	One (1) electronic copy of entire proposal.	☐ Yes ☐ No
Section 2.6.1	Table of Contents	
Section 2.6.2	Proposal Content, Section A – Proposer's Qualification • Proposal Submission Checklist (Exhibit I) • Proposal Transmittal Form (Exhibit II) • Proposer's Affidavit of Adherence to Minimum Mandatory Requirements (Exhibit III)	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Section 2.6.2	Proposal Content, Section B – Proposer's Experience (3 pages max)	☐ Yes ☐ No
Section 2.6.2	Proposal Content, Section C – Proposer's Approach to Required Services (3 pages max.)	☐ Yes ☐ No
Section 2.6.2	Proposal Content Section D – Proposer's Staffing Plan (1 page max) • Proposer's Personnel (Exhibit IV)	☐ Yes ☐ No ☐ Yes ☐ No
Section 2.6.2	Proposal Content, Section E – Proposer's Social Distancing Plan (1 page max)	☐ Yes ☐ No
Section 2.6.2	Proposal Content, Section F – Proposer's Data Reporting Plan (1 page max)	☐ Yes ☐ No
Section 2.6.2	Proposal Content, Section G – Proposer's Evaluation and Quality Management Plan (2 pages max)	☐ Yes ☐ No
Section 2.6.2	Proposal Content, Section H – Required Forms • Exhibit V, Proposer's Budget • Exhibit VI, Acceptance of Terms and Conditions Affirmation • Exhibit VII, Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower Tier Covered Transactions (45 C.F.R. Part 76)	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

_____ _____
Signature of Authorized Representative of Vendor/Contracting Entity — Date

_____ _____
Print Name — Title

EXHIBIT II

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
COMMUNITY ENGAGEMENT FOR ENDING THE HIV EPIDEMIC IN LOS ANGELES COUNTY
WORK ORDER NUMBER: CES-WOS-003

PROPOSER'S TRANSMITTAL FORM

PROPOSER'S NAME: _____

PROPOSER'S ADDRESS: _____
Street Suite

_____
City State Zip Code

PROPOSER'S AUTHORIZED REPRESENTATIVE: Please provide the below information as it relates to Proposer's authorized representative. Proposer's authorized representative must be authorized to sign on behalf of the Proposer, able to make representations for the Proposer during contract negotiations, and able to legally bind the Proposer to any resultant MAWO.

Authorized Representative: _____

Title: _____

Address: _____
Street Suite

_____
City State Zip Code

TELEPHONE NUMBER: _____ FAX NUMBER: _____

EMAIL ADDRESS: _____

PROPOSER'S CONTACT PERSON: Please provide the below information as it relates to Proposer's contact person. Proposer's contact person will serve as the Proposer's main contact with the County for any matters related to this WOS.

Contact Representative: _____

Title: _____

Address: _____
Street Suite

_____
City State Zip Code

TELEPHONE NUMBER: _____ FAX NUMBER: _____

EMAIL ADDRESS: _____

CONTRACTING AFFIRMATION:

☐	Proposer intends to **solely perform** the duties of the MAWO as defined in Attachment A (Statement of Work) and Attachment B (Scope of Work); **OR**
☐	Proposer intends to act as a **fiscal sponsor** and duties of the MAWO as defined in Attachment A (Statement of Work) and Attachment B (Scope of Work) will be performed by the Service Provider. Service Provider Name: _____ Duties: _____ Service Provider Name: _____ Duties: _____ Service Provider Name: _____ Duties: _____

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
COMMUNITY ENGAGEMENT FOR ENDING THE HIV EPIDEMIC IN LOS ANGELES COUNTY
WORK ORDER NUMBER: CES-WOS-003

PROPOSER'S AFFIDAVIT OF ADHERENCE TO MINIMUM MANDATORY REQUIREMENTS

NOTE: Completion of this form without sufficient details to substantiate that Proposer meets the minimum mandatory requirements as outlined in Section 1.10, Minimum Mandatory Requirements and/or any inconsistencies or inaccuracy in the information provided in this form, or this form and your proposal, may subject your bid to disqualification or other action, at the sole discretion of the County.

Proposer acknowledges and certifies that on the day on which the proposals are due, it meets and will comply with all of the Minimum Mandatory Requirements listed In Section 1.10 - Minimum Mandatory Requirements, of this Work Order Solicitation (WOS), as listed below.

Please check the appropriate boxes:		
Section 1.10.1	**Master Agreement:** Proposer must have a current executed DPH Master Agreement for Community Engagement Services and Related Services **DPH Master Agreement Number:** _____	☐Yes ☐No
Section 1.10.2	**Contract Status:** Proposer **must** not be debarred, suspended, or excluded from securing United States Federal Government (federal), State of California (State) and/or County contracts at the time of the proposal submission due date	☐Yes ☐No
Section 1.10.3	**Unresolved Disallowed Costs:** If a Proposer's compliance with a County contract has been reviewed by the Department of the Auditor-Controller within the last 10 years, Proposer **must not** have unresolved questioned costs identified by the Auditor-Controller in an amount over $100,000 that are confirmed to be disallowed costs by the contracting County department and remain unpaid for a period of six months or more from the date of disallowance, unless such disallowed costs are the subject of current good faith negotiations to resolve the disallowed costs, in the opinion of the County. County will verify that Proposer does not have unresolved disallowed cost. ☐ Proposer **does not** have unresolved disallowed costs as explained above. ☐ Proposer **has** unresolved disallowed costs as explained above.	

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
COMMUNITY ENGAGEMENT FOR ENDING THE HIV EPIDEMIC IN LOS ANGELES COUNTY
WORK ORDER NUMBER: CES-WOS-003

PROPOSER'S AFFIDAVIT OF ADHERENCE TO MINIMUM MANDATORY REQUIREMENTS

Section 1.10.4	**Experience (Community Engagement and Mobilization:** Proposer must have a minimum of three (3) years experience within the last five (5) years implementing community engagement and mobilization programs focused on health equity and social justice.

Check the appropriate box:

☐ **Yes.** Proposer does meet the experience requirement stated above.

☐ **No.** Proposer does not meet the experience requirement stated above.

Proposer must document their experience below that clearly demonstrates ability to meet the above-referenced requirement. Provide dates, names of agencies/departments in which Proposer provided the required service that substantiates Proposer meets the above-referenced requirement (attach additional sheets as necessary).

Indicate Years of Experience from _____ to _____

mm/yr. mm/yr.

Describe experience here.

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
COMMUNITY ENGAGEMENT FOR ENDING THE HIV EPIDEMIC IN LOS ANGELES COUNTY
WORK ORDER NUMBER: CES-WOS-003

PROPOSER'S AFFIDAVIT OF ADHERENCE TO MINIMUM MANDATORY REQUIREMENTS

Section 1.10.5	**Recruitment Experience:** Proposer must have a minimum of two (2) years of experience within the last five (5) years recruiting cohorts to participate in a community engagement project related to improve health outcomes related to identified public health issues.

Check the appropriate box:

☐ **Yes.** Proposer does meet the experience requirement stated above.

☐ **No.** Proposer does not meet the experience requirement stated above.

Proposer must document their experience below that clearly demonstrates ability to meet the above-referenced requirement. Provide dates, names of agencies/departments in which Proposer provided the required service that substantiates Proposer meets the above-referenced requirement (attach additional sheets as necessary).

Indicate Years of Experience from _____ to _____

mm/yr. mm/yr.

Describe experience here.

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
COMMUNITY ENGAGEMENT FOR ENDING THE HIV EPIDEMIC IN LOS ANGELES COUNTY
WORK ORDER NUMBER: CES-WOS-003

PROPOSER'S AFFIDAVIT OF ADHERENCE TO MINIMUM MANDATORY REQUIREMENTS

Section 1.10.6	**Recruitment Approach Experience:** Proposer must have a minimum of one (1) year of experience within the last three (3) years utilizing the Community Based Participatory Research (CBPR) approach and/or Youth Participatory Action Research (YPAR) framework.

Check the appropriate box:

☐ **Yes.** Proposer does meet the experience requirement stated above.

☐ **No.** Proposer does not meet the experience requirement stated above.

Proposer must document their experience below that clearly demonstrates ability to meet the above-referenced requirement. Provide dates, names of agencies/departments in which Proposer provided the required service that substantiates Proposer meets the above-referenced requirement (attach additional sheets as necessary).

Indicate Years of Experience from _____ to _____

mm/yr. mm/yr.

Describe experience here.

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
COMMUNITY ENGAGEMENT FOR ENDING THE HIV EPIDEMIC IN LOS ANGELES COUNTY
WORK ORDER NUMBER: CES-WOS-003

PROPOSER'S AFFIDAVIT OF ADHERENCE TO MINIMUM MANDATORY REQUIREMENTS

Proposer further acknowledges that if any false, misleading, incomplete, or deceptively unresponsive statements in connection with this Proposal are made, the Proposal may be rejected. The evaluation and determination in this area shall be at the Director's sole judgment and his/her judgment shall be final.

On behalf of (Proposer's Name) _____

I, (Proposer's Authorized Representative) _____

hereby certify that this Proposer's Affidavit is true and correct to the best of my information and belief.

Signature _____ Title _____

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
COMMUNITY ENGAGEMENT FOR ENDING THE HIV EPIDEMIC IN LOS ANGELES COUNTY
WORK ORDER NUMBER: CES-WOS-003

PROPOSER'S PERSONNEL

PROPOSER'S NAME:	

Please provide the information below that specifically identifies the Proposer's Project Manager, Evaluation Services subcontractor and other key individuals assisting in this project, including any other proposed subcontractors. Proposer may assign up to two (2) subcontractors (optional) to provide the requested Community Engagement Evaluation Services and or as needed services. Proposer must assign personnel who possess the background and experience necessary to successfully complete this project. Please refer to Attachment A, Statement of Work for experience requirements. Attach additional pages if necessary. There is no page limit.

Please provide the following information as it pertains to the personnel (please specify if personnel is contractor or consultant personnel**:**	
Project Manager's Name:	**Title:**
Years of Experience from _____ **to** _____ mm/yr mm/yr	
Describe experience:	
Percentage of time on requested services: _____ **Phone Number:** _____ **Email Address:** _____	
Subcontractor Evaluation Services Name:	**Title:**
Years of Experience from _____ **to** _____ mm/yr mm/yr	
Describe experience:	
Percentage of time on requested services: _____ **Phone Number:** _____ **Email Address:** _____	

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
COMMUNITY ENGAGEMENT FOR ENDING THE HIV EPIDEMIC IN LOS ANGELES COUNTY
WORK ORDER NUMBER: CES-WOS-003

Subcontractor (optional) Name:	**Title:**
Years of Experience from _____ **to** _____ mm/yr mm/yr	
Describe experience:	
Percentage of time on requested services: _____ **Phone Number:** _____ **Email Address:** _____	
Name:	**Title:**
Years of Experience from _____ **to** _____ mm/yr mm/yr	
Describe experience:	
Percentage of time on requested services: _____ **Phone Number:** _____ **Email Address:** _____	

Attach resumes for each assigned staff including any subcontractor(s) and subcontractor's personnel proposed for this project, which includes project descriptions and other evidence demonstrating experience and ability to successfully perform the required services.

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH **EXHIBIT V**

COMMUNITY ENGAGEMENT SERVICES FOR ENDING THE HIV EIPDEMIC IN LOS ANGELES COUNTY

PERIOD 1: DATE OF EXECUTION THROUGH JULY 31, 2021

Proposer Name:						
Budget Period 1	**MONTH/DAY**	**YEAR**		**MONTH/DAY**	**YEAR**	
(period):	**Date of Execution**	**2020**	**THROUGH**	**JULY 31,**	**2021**	

A. FULL-TIME AND PART-TIME SALARIES				
Full-time Salaries (Position Title and Name)	**Monthly Salary**	**No. of Months**	**% of Time**	**Total**
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
			Subtotal Full-time Salaries	$ -

Part-time Salaries (PositionTitle and Name)	**Hourly Salary**	**No. of hours worked annually**	**% of Time**	**Total**
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
			Subtotal Part-time Salaries	$ -
			TOTAL SALARIES:	$ -

B. EMPLOYEE BENEFITS		**Amount**
	enter % rate	
Full-time Employees Benefits Rate:		$ -
Part-time Employees Benefits Rate:		$ -
	Total Employee Benefits:	$ -
	TOTAL SALARIES & EMPLOYEE BENEFITS (A & B):	$ -

C. OPERATING EXPENSES		
Expense Type	Short Description	Amount
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
	TOTAL OPERATING EXPENSES:	$ -

D. MILEAGE AND TRAVEL		
Expense Type	Short Description	Amount
Mileage		$ -
Travel		$ -
	TOTAL MILEAGE & TRAVEL:	$ -

E. OTHER COSTS		
Expense Type	Short Description	Amount
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
	TOTAL OTHER COSTS:	$ -

F. CONSULTANT/SUBCONTRACTOR		
Expense Type	Short Description	Amount
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -

TOTAL CONSULTANT/SUBCONTRACTOR:						$ -
G. TOTAL DIRECT COSTS (A - F)						$ -
H. INDIRECT COSTS (should not exceed 15% of Total Salaries & Employee Benefits)						
TOTAL INDIRECT COSTS:						$ -
I. TOTAL PERIOD BUDGET (Period 1 of 3)						**$ -**

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH **EXHIBIT V**

COMMUNITY ENGAGEMENT SERVICES FOR ENDING THE HIV EIPDEMIC IN LOS ANGELES COUNTY

PERIOD 2: AUGUST 1, 2021 THROUGH JULY 31, 2022

Proposer Name:						
Budget Period 2	**MONTH/DAY**	**YEAR**		**MONTH/DAY**	**YEAR**	
(period):	**AUGUST 1,**	**2021**	**THROUGH**	**JULY 31,**	**2022**	
A. FULL-TIME AND PART-TIME SALARIES						
Full-time Salaries (Position Title and Name)			**Monthly Salary**	**No. of Months**	**% of Time**	**Total**
						$ -
						$ -
						$ -
						$ -
						$ -
						$ -
						$ -
						$ -
						$ -
						$ -
						$ -
						$ -
						$ -
						$ -
						$ -
				Subtotal Full-time Salaries		$ -
Part-time Salaries (PositionTitle and Name)			**Hourly Salary**	**No. of hours worked annually**	**% of Time**	**Total**
						$ -
						$ -
						$ -
						$ -
						$ -
						$ -
						$ -
						$ -
						$ -
						$ -
						$ -
				Subtotal Part-time Salaries		$ -
					TOTAL SALARIES:	$ -
B. EMPLOYEE BENEFITS						**Amount**
				enter % rate		
Full-time Employees Benefits Rate:						$ -
Part-time Employees Benefits Rate:						$ -
					Total Employee Benefits:	$ -
					TOTAL SALARIES & EMPLOYEE BENEFITS (A & B):	$ -

C. OPERATING EXPENSES		
Expense Type	Short Description	Amount
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
	TOTAL OPERATING EXPENSES:	$ -

D. MILEAGE AND TRAVEL		
Expense Type	Short Description	Amount
Mileage		$ -
Travel		$ -
	TOTAL MILEAGE & TRAVEL:	$ -

E. OTHER COSTS		
Expense Type	Short Description	Amount
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
	TOTAL OTHER COSTS:	$ -

F. CONSULTANT/SUBCONTRACTOR		
Expense Type	Short Description	Amount
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -

TOTAL CONSULTANT/SUBCONTRACTOR:						$ -
G. TOTAL DIRECT COSTS (A - F)						$ -
H. INDIRECT COSTS (should not exceed 15% of Total Salaries & Employee Benefits)						
TOTAL INDIRECT COSTS:						$ -
I. TOTAL PERIOD BUDGET (Period 2 of 3)						**$ -**

Proposer Name:						
Budget Period 3	MONTH/DAY	YEAR		MONTH/DAY	YEAR	
(period):	AUGUST 1,	2022	THROUGH	JULY 31,	2023	

A. FULL-TIME AND PART-TIME SALARIES				
Full-time Salaries (Position Title and Name)	Monthly Salary	No. of Months	% of Time	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Subtotal Full-time Salaries				$ -

Part-time Salaries (PositionTitle and Name)	Hourly Salary	No. of hours worked annually	% of Time	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Subtotal Part-time Salaries				$ -
TOTAL SALARIES:				$ -

B. EMPLOYEE BENEFITS	enter % rate	Amount
Full-time Employees Benefits Rate:		$ -
Part-time Employees Benefits Rate:		$ -
Total Employee Benefits:		$ -
TOTAL SALARIES & EMPLOYEE BENEFITS (A & B):		$ -

C. OPERATING EXPENSES		
Expense Type	Short Description	Amount
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
	TOTAL OPERATING EXPENSES:	$ -

D. MILEAGE AND TRAVEL		
Expense Type	Short Description	Amount
Mileage		$ -
Travel		$ -
	TOTAL MILEAGE & TRAVEL:	$ -

E. OTHER COSTS		
Expense Type	Short Description	Amount
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
	TOTAL OTHER COSTS:	$ -

F. CONSULTANT/SUBCONTRACTOR		
Expense Type	Short Description	Amount
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -

					TOTAL CONSULTANT/SUBCONTRACTOR:	$	-
G. TOTAL DIRECT COSTS (A - F)						$	-
H. INDIRECT COSTS (should not exceed 15% of Total Salaries & Employee Benefits)							
					TOTAL INDIRECT COSTS:	$	-
I. TOTAL PERIOD BUDGET (Period 3 of 3)						**$**	**-**

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH **EXHIBIT V**

COMMUNITY ENGAGEMENT SERVICES FOR ENDING THE HIV EIPDEMIC IN LOS ANGELES COUNTY

CUMULATIVE BUDGET (PERIODS 1- 3)

Proposer Name:						
Cumulative Budget	**MONTH/DAY**	**YEAR**		**MONTH/DAY**	**YEAR**	
(period):	**Date of Execution**	**2020**	**THROUGH**	**July 31**	**2023**	
			Period 1	**Period 2**	**Period 3**	**Cumulative**
I. TOTAL BUDGET COSTS REQUESTED (PROPOSED AMOUNT)			$ -	$ -	$ -	$ -

EXHIBIT VI

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
COMMUNITY ENGAGEMENT FOR ENDING THE HIV EPIDEMIC IN LOS ANGELES COUNTY
WORK ORDER NUMBER: CES-WOS-003

ACCEPTANCE OF TERMS AND CONDITIONS AFFIRMATION

Proposer, _____ , hereby affirms that it understands
(Proposer's Legal Entity Name)
and agrees that a submission of a proposal response to the County of Los Angeles, Department of Public Health, Work Order Solicitation (WOS) for Community Engagement Services and Related Services, constitutes an acknowledgment and acceptance of, and a willingness to comply with, all terms and conditions of this WOS, any applicable addenda, and Master Agreement Work Order (MAWO).

I, the Official named below, hereby swear that I am duly authorized legally to bind the Proposer to the above described affirmation.

I, the Official named below, hereby swear that I am duly authorized legally to bind the Proposer to the above described affirmation.	
Name:	Title:
Signature (blue ink):	Date of Signature:

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
COMMUNITY ENGAGEMENT FOR ENDING THE HIV EPIDEMIC IN LOS ANGELES COUNTY
WORK ORDER NUMBER: CES-WOS-003

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION – LOWER TIER COVERED TRANSACTIONS (45 C.F.R. PART 76)

Instructions for Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower Tier Covered Transactions (45 C.F.R. Part 76)

1. This certification is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that Bidder knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

2. Bidder shall provide immediate written notice to the person to whom this bid is submitted if at any time Bidder learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

3. The terms “covered transaction,” “debarred,” “suspended,” “ineligible,” “lower tier covered transaction,” “participant,” “person,” “primary covered transaction,” “principal,” “bid,” and “voluntarily excluded,” as used in this certification, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this bid is submitted for assistance in obtaining a copy of those regulations.

4. Bidder agrees by submitting this bid that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 C.F.R. part 9, subpart 9.4, debarred suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.

5. Bidder further agrees by submitting this bid that it will include the provision entitled “Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower Tier Covered Transactions (45 C.F.R. Part 76),” as set forth in the text of the MAWO, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

6. Bidder acknowledges that a participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 C.F.R. part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. Bidder acknowledges that a participant may decide the method and frequency by which it determines the eligibility of its principals. Bidder acknowledges that each participant may, but is not required to, check the List of Parties Excluded from Federal Procurement and Non-procurement Programs.

7. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the required certification. The knowledge and

information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

8. Except for transactions authorized under paragraph 4 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 C.F.R. part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

9. Where Bidder and/or its subcontractor(s) is or are unable to certify to any of the statements in this Certification, Bidder shall attach a written explanation to its bid in lieu of submitting this Certification. Bidder's written explanation shall describe the specific circumstances concerning the inability to certify. It further shall identify any owner, officer, partner, director, or other principal of the Bidder and/or subcontractor who is currently suspended, debarred, ineligible, or excluded from securing federally funded contracts. The written explanation shall provide that person's or those persons' job description(s) and function(s) as they relate to the contract which is being solicited by this Work Order Solicitation.

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower Tier Covered Transactions (45 C.F.R. Part 76)

Bidder hereby certifies that neither it nor any of its owners, officers, partners, directors, other principals or subcontractors is currently debarred, suspended proposed for debarment, declared ineligible or excluded from securing federally funded contracts by any federal department or agency.

Dated: _____

_____
Signature of Authorized Representative

_____
Title of Authorized Representative

_____
Printed Name of Authorized Representative

ATTACHMENT E

TRANSMITTAL FORM TO REQUEST A WORK ORDER SOLICITATION REQUIREMENTS REVIEW

Proposers requesting a Solicitation Requirements Review must submit this form to the County within the timeframe identified in the solicitation document.

Proposer Name:	Date of Request:
Solicitation Title:	Solicitation No.:

A **Solicitation Requirements Review** is being requested because the Proposer asserts that they are being unfairly disadvantage for the following reason(s): *(check all that apply)*

- ☐ Application of **Minimum Requirements**
- ☐ Application of **Business Requirements**
- ☐ Due to **unclear instructions**, the process may result in the County not receiving the best possible responses

For each area contested, Proposer must explain in detail the factual reasons for the requested review. *(Attach supporting documentation.)*

Request submitted by:

_____ _____

(Name) *(Title)*

For County use only

Date Transmittal Received by County: _____ Date Solicitation Released:_____

Reviewed by: _____

DRAFT - COMMISSION MEETING 12/10/20

Los Angeles County Department of Public Health
Division of HIV and STD Programs
Ending the HIV Epidemic (EHE) Steering Committee

Proposed Activities and Potential Roles for Committee Members
As of 12/9/20

Proposed Activities in EHE Plan	Potential EHE Steering Committee Member Role	Name
Pillar 1 Diagnose		
Expand routine testing in Emergency Departments and community clinics	Work with DHSP to identify sites in high morbidity areas or work with clinics you already have relationships with; then work to meet with clinical leadership and advocate for expanded testing	Louise M. Jerry A.
Increased re-screening of clients with elevated HIV risk (recent STD, recent negative HIV test, PEP) get repeat HIV testing in 3-6 months	Work with DHSP funded HIV Testing Service (HTS) providers, clinics, or community-based organizations to develop protocols to improve rescreening	Bridget R. Luis G.
Home test kit programs (Take Me Home and kits given to HTS providers)	Identify and implement ways to increase uptake and use of home test kits to engage clients in future/ongoing HIV prevention	Javontae W. Zelenne C. Ty S. Barbara R. Raniyah C.
Other ideas?		
Pillar 2 Treat		
Rapid ART	Participate in planning meetings with DHSP, help identify any policy or other barriers	Ty S.
Same day linkage to HIV care	Work with DHSP funded Ryan White clinics and private HIV clinics on protocols to improve immediate linkage of new patients or those reengaging in care	Charles R. Matt B. Ty S.
Mental Health and SUD consultant to do a needs assessment for people living with HIV	Participate in planning meetings, help find a consultant, assist in framing assessment and interpretation of findings and recommendations	Jerry A. Bridget R. Charles R. Erin J-W.
Increase awareness of U=U in the community and among people living with HIV	Identify ways to communicate with HIV service providers and clients as way to improve engagement in care	Robbie R. Raniyah C.
Other ideas?		
Pillar 3 Prevent		
PrEP/PEP landscape analysis	Identify and work with community providers serving priority populations or in highly impacted areas of LAC who are not offering PrEP and PEP	Bridget R. Louise M. Luis G. Raniyah C. (maybe)
Improve PrEP uptake among priority populations, including AA MSM, Latinx MSM, TG, AA women	Identify and implement projects to increase uptake and use of PrEP initiation in priority groups	

Improve PrEP retention for clients at continued HIV risk	Work with DHSP funded PrEP Centers of Excellence or other PrEP providers on their protocols (how they deal with missed appts, lost clients, etc.) Identify and implement projects to improve retention	Bridget R. Matt B.
TelePrEP	Identify ways technology should be used to make PrEP as accessible and low barrier as possible	Devon R. Erin J-W.
PrEP support groups	Study and propose best case use for PrEP support groups as a way to potentially increase use and retention	
Syringe Services Programs (SSPs)	Participate in planning meetings to review SSPs programs and assist in expanding testing and referral to HIV prevention	Barbara R. Bridget R. Luis G.
Other ideas?		

Cross Cutting EHE Activities		
Proposed Activities	**Potential EHE Steering Committee Member Role**	**Name**
EHE Promotion	Distribute resources through networks, listservs, etc. (e.g. EHE Infographic, AHEAD Dashboard, LACounty.HIV website). Inform other groups that you are a part of about EHE (Boards, Committees, CABs, internal organization meetings, etc.)	All
Trainings/Presentations	HIV 101 and related trainings to reduce stigma, provide education on HIV and populations affected by HIV	Bridget R. Matt B. Devon R. Luis G.
Provider Trainings/Outreach	Train/Educate providers on implicit bias, trauma informed care, PrEP, routine HIV testing	Robbie R. Luis G.
EHE Champions and Partners	Identify EHE champions or partners (universities, faith-based institutions, medical associations, pharmacies/pharmacy associations)	All
Ryan White Promotion	Promote Ryan White program and services to network	
Identify Partners	Identify partners to join EHE efforts (universities, faith-based institutions, medical associations, pharmacies/pharmacy associations) Ensure leadership within organizations are aware of EHE and potential strategies to support	All
Identify Champions	Identify and empower EHE Champions to further educate and promote EHE and related strategies	All

Ending the HIV Epidemic in Los Angeles County

DRAFT PLAN - REVISED

Commission on HIV Meeting
December 10, 2020

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

LA County HIV

Ending the HIV Epidemic

Introduction

Ending the HIV Epidemic: A Plan for America (EHE) is a national initiative which focuses on four key pillars of interventions designed to help us reach the goal of reducing new HIV transmissions and acquisitions in the United States by 75 percent in five years (by 2025) and by 90 percent in ten years (by 2030).[1] The four EHE Pillars are: (1) **Diagnose** people living with HIV as early as possible, (2) **Treat** people living with HIV rapidly and effectively to achieve viral suppression, (3) **Prevent** new HIV transmissions using proven interventions, and (4) **Respond** quickly to HIV outbreaks and deliver prevention and treatment services to people who need them.

Through collaboration with key stakeholders and community partners, the Los Angeles County Department of Public Health (LAC DPH), Division of HIV and STD Programs (DHSP), plans to guide, implement and evaluate activities that enhance the current Los Angeles County HIV portfolio; align our efforts with the four pillars of EHE, and further advance efforts to both prevent new HIV infections and improve HIV-related health outcomes among persons living with HIV. EHE is built on the premise that the right data, the right tools, and the right leadership will be the drivers in achieving a generation not impacted by HIV/AIDS; this will require commitment, accountability, and transformational leadership across sectors.

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

In addition to the 58,000 persons living with HIV in LAC, there are nearly 1,700 new HIV infections each year and separately there are more than 6,000 undiagnosed persons living with HIV. For persons living with HIV, adherence to ART and achieving viral suppression is critical to promoting health and to ensuring that HIV is not sexually transmitted to others.[2] For persons who have HIV but are not yet diagnosed (e.g. unaware of their infection) or for persons who have been diagnosed but are experiencing challenges with both adherence to ART and maintaining viral load suppression, the scale up of existing effective interventions and the adoption of new interventions are necessary to achieve our Ending the HIV Epidemic goals. It has been well established that broad scale testing that allows persons with HIV to be diagnosed as close to the period of infection as possible and promptly linking newly HIV diagnosed persons to care and treatment services will not only improve overall individual health outcomes but will also have broad public health benefits. The support and access of new biomedical HIV prevention tools like PrEP (pre-exposure prophylaxis or a daily pill that prevents HIV transmission) for HIV-negative persons at elevated risk for HIV continues to be uneven across Los Angeles County. The underutilization of these low-cost or no-cost prevention tools in the most impacted areas of our County will require a renewed commitment of education, awareness and mobilization if we are to realize the full potential of this science, and end the HIV epidemic, once and for all.

[1] https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview

[2] https://www.cdc.gov/hiv/risk/art/index.html

Please note that the following EHE Plan for Los Angeles County is written and structured in accordance with the Centers for Disease Control and Prevention (CDC) requirements and guidelines for *Notice of Funding Opportunity (NOFO) PS19-1906: Strategic Partnerships and Planning to Support Ending the HIV Epidemic in the United States Component B*: *Accelerating State and Local HIV Planning to End the HIV Epidemic* and does not include descriptions of the entire existing LAC HIV portfolio.[3]

Section I: Engagement Process

Community engagement has been and will continue to be invaluable to the planning and development process for HIV prevention, care and treatment services throughout Los Angeles County (LAC). Prior to the launch of *Ending the HIV Epidemic: A Plan for America* (EHE), LAC developed and released its own jurisdictional plan in November 2017, the *Los Angeles County HIV/AIDS Strategy for 2020 and Beyond* (LACHAS), which offered a framework of policies, recommended strategies, and numerical targets that collectively we sought to achieve.

In February 2019, fifteen months after the release of LACHAS, the federal administration announced its plan to launch EHE, providing LAC with the opportunity to adapt and expand the goals and activities described in LACHAS and requiring LAC to align its current efforts with the national EHE initiative. LAC DPH elicited and secured input and guidance on services and activities critical to LACHAS and necessary for EHE implementation through a series of listening sessions and planning meetings with community stakeholders including the Los Angeles County Commission on HIV (Commission, which serves as the local Ryan White Program (RWP) planning body), , the California Department of Public Health Office of AIDS (California OA), the University of California at Los Angeles (UCLA) Center for HIV Identification, Prevention, and Treatment Services (CHIPTS), the local EHE Steering Committee, people living with HIV/AIDS (PLWH) and a broad network of community-based service providers. LAC DPH also engaged in meetings and site visits with multiple federal partners to inform local EHE efforts. Los Angeles County will continue to work to engage communities, especially those that are hardly reached, as we jointly implement the EHE Plan and are prepared to adapt our strategies, activities, and portfolio as EHE needs evolve throughout the years.

Local Prevention and Care Integrated Planning Body

The Los Angeles County Commission on HIV (Commission) is the local, federally mandated Ryan White Program community planning body that sets program priorities and funding allocations for HIV prevention, care and treatment services throughout the County. The Commission is comprised of 51 members (all appointed by the Board of Supervisors) who represent the diversity of LAC and communities impacted by HIV. LAC DPH has a long-standing partnership with the Commission and will rely on this and other partnerships as key community engagement efforts tied to EHE move forward.

After the release of the Los Angeles County HIV/AIDS Strategy (LACHAS), LAC DPH continued to collaborate with the Commission to disseminate, promote, and engage a broader set of community stakeholders to build knowledge and awareness of LACHAS strategies and goals, and to recruit new partners and voices into this effort. The Commission helped spearhead over a dozen call-to-action meetings, held in various communities and jurisdictions across the County to inform, engage, and empower community stakeholders and residents to participate in LACHAS implementation. As a result of outreach and promotion to the existing network of HIV planning, program and service partners, including special invites to key stakeholders and elected officials not traditionally engaged in HIV efforts, over 750 community stakeholders were reached through the call-to-action meetings. Summary reports

[3] A list of acronyms utilized throughout the Plan are included in Appendix A.

from the call-to-action meetings, including health district demographics, key takeaways, and top insights from the group discussions were developed and distributed to the community.[4] The Commission was integral in promoting LACHAS, encouraging the community to get involved, and identifying new non-traditional partners to join the movement to end the HIV epidemic. The ongoing community engagement and input conducted for LACHAS provided valuable perspectives on needed services and activities and helped drive the development of the EHE Plan.

In response to the announcement of EHE, the Commission held an all-day community meeting in November 2019 with over 190 participants to 1) directly hear from community partners on an EHE Plan for LAC, 2) determine the best way to engage the community moving forward as we transition from LACHAS to the EHE Plan, and 3) garner input on the leadership necessary to achieve EHE goals. The meeting included a panel of representatives from the California OA; LAC DPH leadership; the Office of Assistant Secretary of Health's Region IX Prevention through Active Community Engagement (PACE) Team; UCLA CHIPTS, among other important HIV stakeholders. Key takeaways included the importance of multi-sector commitment to achieve EHE goals, a commitment to being disruptively innovative with new and expanded interventions and policies, ensuring transparency and accountability from all partners, and lifting up voices of communities most impacted by HIV. The meeting agenda is included in Appendix B.

In January 2020, the Commission reinforced its commitment to EHE efforts by providing dedicated space for Commissioners and members of the public to participate in small group breakout sessions to discuss additional ideas related to community engagement and mobilization for EHE. With an understanding that LAC needs to be even more intentional, has to be disruptively innovative and must bring new voices to the table to end the HIV epidemic, participants broke out into small groups to discuss and address several key questions, including: 1) How can community members take individual action in EHE efforts, 2) Which sectors should partners for prioritize for new or increased mobilization around EHE, and 3) How can the development of a new LAC EHE Steering Committee be used to support efforts to recruit new perspectives, enlist change agents and spur more action. As a follow up to these community-driven discussions, the Commission is also working to increase membership on its planning body with persons representing pharmaceutical companies, commercial health plans and California's Medicaid program.

In September 2020, LAC DPH released the draft EHE plan to community stakeholders as part of a 30-day public comment period and partnered with the Commission to ensure individuals and communities were aware of the input opportunity. In addition, Commissioners were provided an opportunity to submit written feedback as a complement to the listening sessions facilitated by Commission staff. The Commission submitted 13 pages of public comments including recommendations from the Black/African American Community Taskforce to be considered for inclusion in the EHE Plan. Separately, Commission leaders continue to provide feedback on the content, strategies, and activities included in the EHE Plan.

Local Community Partners

In September 2020, LAC DPH formed an Ending the HIV Epidemic (EHE) Steering Committee as a strategy to identify new partners that could support the local implementation of new EHE strategies as well as serve as catalyst for collective action to end the HIV epidemic (Appendix C). To maximize the pool of potential Steering Committee candidates, LAC DPH launched an application process via an online survey platform, distributed the application across 11 distinct HIV and non-HIV specific listservs, and reached out to mission-aligned partners such as the Region IX PACE Program, the LAC DPH Center for Health Equity, and the LAC DPH Regional Health Offices to further amplify the application opportunity. A

[4] https://tinyurl.com/LACHASmeetings

review team from LAC DPH and the Executive Director of the Commission on HIV reviewed and scored over 85 applications that were received over a two-week period, and selected Committee members who reflect a broad range of disciplines and perspectives beyond HIV including health equity, social justice, substance use disorder, housing, and mental health. LAC DPH notified candidates in early September 2020 and announced Committee Members to the public at the Ending the HIV Epidemic Townhall on September 16, 2020. The first Steering Committee meeting was held on October 1, 2020 and a subsequent meeting was held on November 10, 2020. The EHE Steering Committee members will be integral in the development and implementation of the EHE Plan and have been tasked to not only provide their input on the proposed strategies and activities, but also assume roles as EHE ambassadors and help advance specific EHE projects in their organizations and/or communities.

Local community partners have also been engaged through recurring EHE updates at monthly Commission meetings and subcommittee meetings. In addition, the Commission currently has three official caucuses (Consumer Caucus, Women's Caucus, and Transgender Caucus) and two taskforces (Aging Taskforce and the Black/African American Communities Taskforce) that focus on specific populations disproportionately and/or highly impacted by HIV. After the COVID-19 pandemic forced the closure of most County offices in March 2020, the Commission switched all meetings to a virtual platform, allowing community partners to continue to participate in critical Commission deliberations. During that period, there has been a notable increase in community participation in these meetings, including an estimated 25% increase in new participants in the monthly meetings and a 50% increase in new participants at the Commission's recently-launched Virtual Lunch and Learn Series which reviews and promotes HIV services available across the County. The Commission's virtual platform has allowed participation from individuals who had not been able to attend meetings in the past due to competing priorities, logistical challenges or other barriers.

On September 16, 2020, LAC DPH hosted a virtual Ending the HIV Epidemic (EHE) Townhall to provide an overview of EHE efforts, describe how COVID-19 is impacting progress on EHE, and formally open a 30-day community public comment period on the EHE plan. The public comment opportunity was promoted both at the Townhall and through the same vehicles used to promote the EHE Steering Committee application and recruitment process. As a follow up to the EHE Townhall, LAC DPH hosted a virtual EHE Townhall in Spanish on October 28, 2020 in collaboration with the Commission and the Region IX PACE Program to provide space for the Spanish-speaking community to learn about EHE and provide input on the proposed plan. Through this exercise, LAC DPH gathered input from a diverse group of local community partners, service providers, and new voices which resulted in the submission of 26 public comments via the online feedback form (17 pages), 6 pages of comments from the EHE Steering Committee, and 2 pages of comments from the EHE Spanish-language event. The key themes that emerged from the Spanish-language event included the need to focus on communities most impacted by HIV; the need for increased educational opportunities for non-HIV-sector providers and community partners on implicit bias, trauma informed care, medical mistrust, sexual health, and Pre-exposure Prophylaxis (PrEP); and the need to implement rapid/same day ART and same day PrEP.

To further expand the reach and engagement of new voices and local community partners, LAC DPH plans to conduct widespread and meaningful engagement on EHE efforts in communities across the County by partnering with organizations that will empower residents to affect change in their own communities through a community-led approach. Community residents will focus on advancing projects related to the Diagnose, Treat, and Prevent EHE Pillars.

Local Service Provider Partners

Local service providers are represented and engaged through various committees, coalitions, working groups, and networks across Los Angeles County. There is a strong network of LAC DPH funded community-based organizations that serve people living with and affected by HIV in diverse communities across the County. In addition, there are several public facing listservs that disseminate information for trainings, webinars, and events related to HIV and the social determinants of health that impact HIV. Service providers are also represented on the Commission, the EHE Steering Committee, and Service Provider Networks (SPNs) in specific jurisdictions across the County. There are strong coalitions and groups in LAC such as the LAC PrEP/PEP Working Group and the Ending the Epidemics Statewide Coalition that addresses policy and advocacy on the intersection between HIV, sexually transmitted infections (STIs), and viral hepatitis. By actively working with these groups and coalitions, LAC DPH has been able to gain input and guidance on HIV prevention, care and treatment efforts. Service providers were actively engaged in the various community listening sessions and health district discussions that were facilitated as part of the development and release of LACHAS; and most have remained active in the development and refinement of the EHE Plan. LAC DPH continues to partner and collaborate with two city health departments that exist within the County (Long Beach Department of Health and Human Services and the Pasadena Public Health Department) to advance EHE strategies. We hope to align the existing HIV plans and programs goals in these jurisdictions (e.g. the Long Beach HIV/STD 2019-2022 Strategy) with the LAC EHE Plan as well.

In addition to the existing service provider network, LAC DPH has been working to enlist its five Regional Health Offices that oversee all public health issues in specific geographic service planning areas throughout the County as well as the LAC Community Prevention and Population Health Task Force which focuses on the social determinants of health but has not yet identified HIV as a priority public health issue. New potential EHE partners were also identified through the UCLA CHIPTS Regional EHE Coordination meeting held January 2020. In addition, LAC DPH will continue to work with the Los Angeles County Departments of Mental Health and Health Services to develop systems and processes that more effectively align goals, strategies, and programming to optimize HIV-related services for clients and communities. The PACE Program has been an important resource to help advance local EHE community engagement efforts. Separately, the LAC DPH HIV Medical Advisory Committee (which includes medical leadership from Ryan White Program-funded HIV Clinics across the County) and the Medical Care Coordination (MCC) Learning Collaborative (which provides feedback on all HIV prevention and treatment activities for high acuity clients in the MCC program) have also provided valuable feedback and perspectives tied to the EHE Plan.

Concurrence with Local Planning Council

The development of the EHE Plan was an iterative process designed to fully vet and refine the strategies and activities necessary to end the HIV epidemic in LA County (LAC). The approach for achieving concurrence included presenting drafts of the EHE Plan for review and input to the leadership of the Commission as well as providing the opportunity for Commissioners to submit feedback outside of the online public comment form to allow for flexibility in providing robust and overarching comments given the long-standing commitment and expertise of Commissioners. In addition, LAC DPH continues to provide space for Commissioners to provide ongoing EHE feedback at several monthly Commission committee and caucus meetings (i.e. Executive Committee which includes Commission leadership and Consumer Caucus meetings which includes consumers of HIV prevention and treatment services) and at the larger full Commission body monthly meetings. Consistent with the national and other jurisdictional

plans, the LAC EHE Plan is a living document and will continue to be updated based on progress as well as ongoing community engagement and guidance from key EHE stakeholders.

LAC DPH worked closely with the Commission to not only reach concurrence on the final plan, but to further engage the community and monitor progress of EHE strategies (Appendix D). LAC DPH values community voices as part of the planning, development, implementation, and evaluation of LAC HIV prevention, care and treatment efforts and is fortunate and grateful to the Commission for offering guidance and engaging community stakeholders in the development of the EHE Plan despite the COVID-19 impact on individuals and organizations across the County.

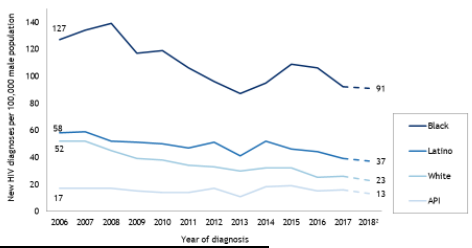
Section I: Epidemiologic Profile

Los Angeles County (LAC) spans over 4,000 square miles and includes 88 cities, 26 health districts, and a mix of urban, suburban, and rural areas. In 2018 there were an estimated 10.3 million people that resided in LAC with the Latinx population representing the largest population group (49%) followed by the White population (28%). The Black/African American (Black/AA) community represents 8% of the total LAC population. In contrast, the populations most impacted by the HIV epidemic are Latinx cisgender[5] men who have sex with men (cis MSM), who represent nearly 40% of all people living with HIV (PLWH) followed by White cis MSM (26%) and Black/AA cis MSM (16%). Combined, these three groups represent more than 80% of PLWH in LAC.

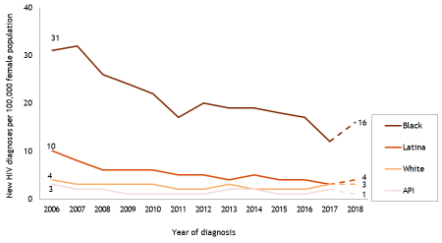
Epidemiological Profile – Pillar 1: Diagnose

In Los Angeles County (LAC), reducing new HIV infections and improving health outcomes for people living with HIV (PLWH) remains a challenge and a priority. In 2018, 1,660 persons aged 13 years and older were newly diagnosed with HIV infection with cisgender MSM representing 87% of those new HIV diagnoses (N=1,445). Cisgender women (cis women) (N=180; 11%) and transgender persons (N=35; 2%) represented a much lower number and proportion of persons newly diagnosed with HIV.[6] Again, the primary mode of HIV transmission for newly diagnosed cis men was having sex with other men (MSM; 92%), followed by combination of MSM and injection drug use (IDU; 4%), and IDU alone (3%). Among cis women newly diagnosed with HIV the primary modes of transmission were having sex with men (75%) and IDU (25%). The percentage of persons newly diagnosed with HIV who were unhoused at the time of diagnosis has more than doubled in recent years from 3.1% in 2010 to 7.5% in 2018. HIV diagnoses rates have also increased among persons experiencing homelessness in the past three years from 19 per 100,000 in 2015 to 24 per 100,000 in 2018. While HIV diagnoses rates have declined in general and across all racial and gender groups, key inequities persist. Black/AA cis men and cis women continue to have the highest rates of new diagnoses.[7]

HIV diagnoses rates among males aged ≥ 13 years by race/ethnicity, LAC 2006-2018



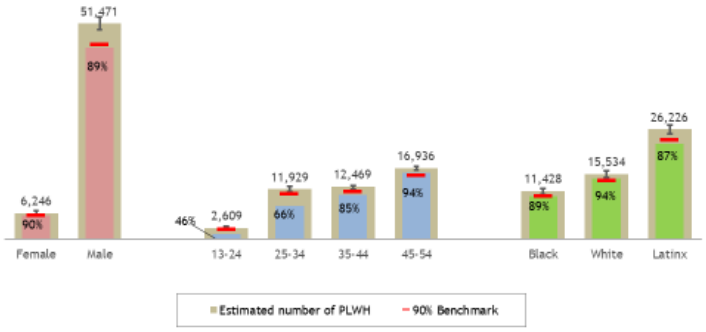
HIV diagnoses rates among females aged ≥ 13 years by race/ethnicity[1], LAC 2006-2018



[5] Defined as individuals whose current gender identity is the same as the sex they were assigned at birth.
[6] Transgender-specific data collected has been required by CDC since May 2013, however accurate information on gender identity may not be consistently documented or reported by providers which may result in an underrepresentation or lower count of persons identifying as transgender including transgender women, transgender men, non-binary persons, and people with other gender identities.
[7] Rates for transgender persons cannot be reported due to unreliable estimates of the total population.

In 2017, there were 57,717 PLWH of whom 51,317 (89%) were diagnosed and an estimated 6,400 (11%) were unaware of their HIV infection. The greatest disparities in awareness of HIV-positive serostatus were among young PLWH. Only 48% of PLWH aged 13-24 years and 66% of PLWH aged 25-34 years were aware of their HIV status, falling very short of the 95% target. Sero-status awareness disparities also existed for persons who inject drugs (PWID), with over one-third of PWID with HIV unaware of their HIV-positive status and only 55% of surveyed PWID having been tested for HIV in the past 12 months.

Awareness of HIV serostatus[1] among PLWH aged ≥ 13 years by gender, age group, and race/ethnicity, LAC 2017



It is well understood that diagnosis and treatment of PLWH needs to occur soon after HIV acquisition to ensure that viral suppression is achieved and sustained, and the forward transmission of HIV is interrupted. While the percentage of persons presenting with AIDS (the latest stage of HIV infection), at the time of diagnosis in LAC has been slowly decreasing, it has persisted at around 20% most recently. Almost half of Latinx cisgender men (48%) and 17% of Black/AA cis men were diagnosed with AIDS at the time of HIV diagnosis; compared to only 2% of White cis men, and 4% of Latinx and Black/AA cisgender women.

Meeting timely diagnosis benchmarks requires that people at ongoing and elevated risk of HIV test regularly. Across the three Centers for Disease Control and Prevention (CDC) National HIV Behavioral Surveillance (NHBS) survey populations, the highest levels of recent HIV testing (in the past 12 months) was reported among transgender (85%) and MSM (84%) participants. Among transgender participants, the highest levels of recent HIV testing were among Latinx (89%) and those aged 30 and younger (90%). Among MSM, 83% of Latinx, 83% Black/AA, and 90% of White MSM reported recent HIV testing. Among PWID, 55% reported recent HIV testing, with lowest levels reported among White PWID (47%). Among at-risk heterosexuals[8], the overall level of recent HIV testing was 30% and was lowest among Latinx (27%) and cis men (28%).

Data in Action: More work is needed to diagnose people living with HIV (PLWH) earlier or soon after HIV acquisition. Testing programs need to be scaled for groups with highest levels of undiagnosed HIV infection including youth between the ages of 13-34 and PWID. Latinx cis men are more likely to wait until they are sick to seek HIV testing services, highlighting the need to focus on improving early HIV diagnosis in this population. *Note: Data in Action sections serve to contextualize programmatic and policy implications for the local response to HIV.*

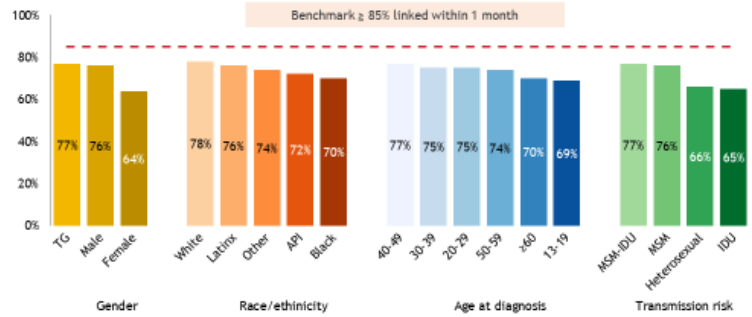
[8] Defined as persons who were born and identify as male or born as and identify as female, younger than 60 years of age, and reported vaginal or oral sex with a partner of the opposite sex in the past 12 months.

Epidemiological Profile – Pillar 2: Treat

The Ending the HIV Epidemic (EHE) Treatment Pillar focuses on treating people rapidly and effectively and includes two primary indicators to measure progress: (1) increasing the proportion of people diagnosed with HIV who are linked to HIV care within one month of diagnosis to 95% and (2) increasingthe proportion of diagnosed PLWH who are virally suppressed to 95%.

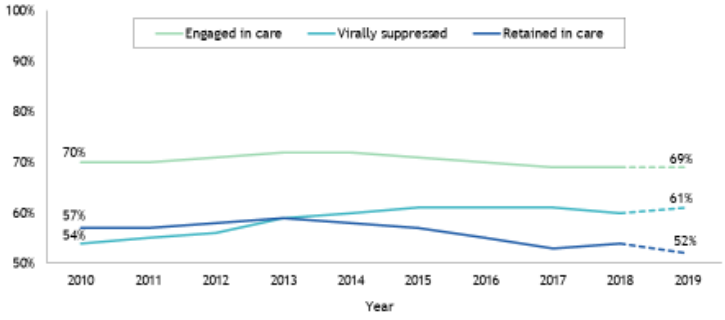
Linkage to Care: Ideally, linkage to care should occur within days of diagnosis to ensure optimal treatment for the individual and reduce transmission. In 2018, 75% of people aged 13 and older newly diagnosed with HIV in LAC were linked to care within one month of diagnosis. Populations with the lowest levels of linkage include cis women, Black/African American persons, youth ages 13-19, people over age 60, and individuals whose mode of HIV transmission was heterosexual sex or IDU.

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



HIV Care Continuum: Despite increased programming to improve HIV Care Continuum outcomes, there has been only modest improvement in engagement, retention, and viral suppression among PLWH in LAC since 2010. At the end of 2019, only 7 in 10 PLWH were engaged in HIV care (at least one HIV medical visit/year), 5 in 10 were retained in care (two or more HIV medical visits/year separated by 90 days) and 6 in 10 were virally suppressed (most recent viral load test <200 copies/ml). While 9 in 10 PLWH in HIV care achieved viral suppression, individuals not in care were unlikely to remain virally suppressed.

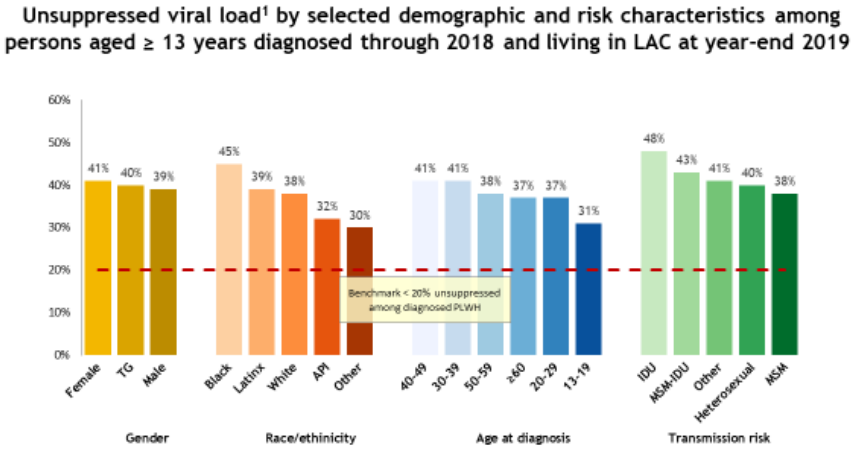
Trends in engagement, retention and viral suppression for persons aged ≥ 13 years diagnosed through 2018 and living in LAC at year-end 2019[1]



People whose mode of HIV transmission was IDU had the lowest levels of engagement in care (61%), retention in care (47%), and viral suppression (52%) compared with persons who report other modes of

HIV transmission. Compared to PLWH of other race/ethnicity groups, Black/African American persons have experienced the poorest care outcomes, with the lowest levels of engagement (66%) and retention in care (48%) and viral suppression (55%). Poor outcomes persist throughout the HIV care continuum for unhoused persons compared with housed persons, with greatest disparities observed in viral suppression at 45% and 61%, respectively.

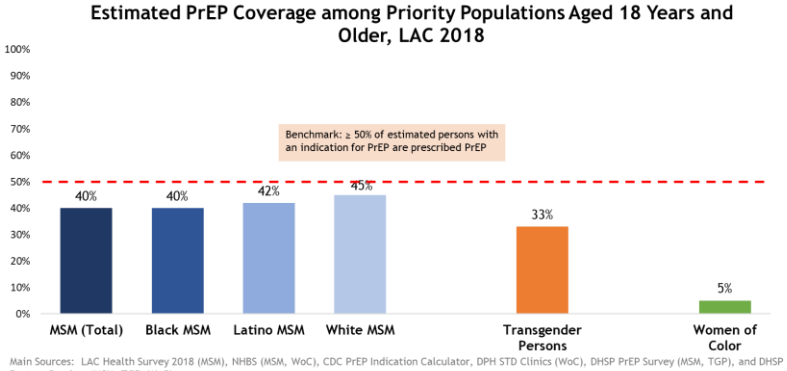
Data in Action: Groups with greatest disparities in the HIV care continuum are people who are unhoused at the time of HIV diagnosis, cis women, those with IDU transmission risk, and Black/AA PLWH. Client-centered interventions tailored to individual needs and that respond directly to the diverse challenges and needs of these populations are urgently needed for these groups.



Epidemiological Profile – Pillar 3: Prevent

The Ending the HIV Epidemic (EHE) Prevent Pillar focuses on preventing new HIV transmissions through proven interventions with the primary performance indicator to increase the proportion of persons prescribed PrEP in priority populations from 35% to at least 50% by 2025.

Pre-exposure Prophylaxis (PrEP): "PrEP coverage" is defined as the number of people aged 16 years and older prescribed PrEP divided by the number of people with an indication for PrEP, meaning that they were at elevated risk for HIV acquisition. Based on multiple data sources, an estimated 72,700 LAC residents had an indication for PrEP and approximately 25,500 had been prescribed PrEP in 2018; representing a 35% PrEP coverage level. In LAC, approximately 24% of MSM (42% of Latinx, 60% of Black/AA, and 12% White MSM), 21% of transgender persons, and 8% of cis women of color had an indication for PrEP. PrEP coverage among MSM was 40% with highest coverage among White MSM (45%) followed by Latinx (42%) and Black/AA MSM (40%). PrEP coverage among transgender persons was 33% while PrEP coverage for cisgender heterosexual Latinx and African-American women with an indication for PrEP was 5%.



Syringe Support Service Programs (SSP): Drug-using related risk behaviors and access to and use of prevention services among people who inject drugs (PWID) in LAC is monitored every three years through CDC's National HIV Behavioral Surveillance (NHBS) project. Recent cycles of NHBS among PWID have focused on recruiting younger PWID as they have more recently started injecting drugs and may better represent current trends in drug use and injection behaviors compared to older PWID. In 2018, 36% of the 511 PWID participants reported receptive sharing of syringes while 60% reported receptive sharing of other injection equipment (e.g., cookers, cotton, or water). Those who reported sharing syringes had an average of 4 sharing partners. Compared with PWID aged 30 and older, more PWID participants aged 18–29 years reported receptive syringe sharing (50% compared to 32%) and injection equipment sharing (74% compared to 56%).

Sixty-nine (69%) percent of PWID participants had obtained sterile syringes from LAC syringe exchange programs in the past 12 months. Other syringe sources included pharmacies (47%) and friends (32%). Approximately 26% of participants reported always disposing of used syringes safely. During the past 12 months, 75% had received clean injection equipment, 52% had received free condoms, and 27% had participated in an HIV behavioral intervention. Approximately 55% had taken medicines including methadone, buprenorphine, Suboxone or Subutex, to treat opioid use disorder.

Heroin was the most commonly injected drug among PWID, with 84% of participants reporting IDU in the past 12 months and 70% reported injecting heroin daily. While heroin use has remained relatively consistent over time, IDU of methamphetamine in the past 12 months among PWID participants increased from 29% in 2009 to 68% in 2018. This trend was observed specifically among younger PWID (aged 30 and younger), White PWID, unhoused PWID, and cis men who inject drugs.

Data in Action: Interventions to address suboptimal PrEP coverage, particularly among Black/AA MSM and cis women of color, are critically needed. Without broader and sustained interventions in this area, increased use of injection methamphetamine and higher risk injection behaviors represent a critical and emerging HIV and other infection outbreak risk among PWID in LAC.

Epidemiological Profile - Pillar 4: Respond

The use of individual-level information reported to LAC DPH to identify and target individuals for communicable disease contact tracing and linkage to services has a long precedent that continues during the current COVID-19 pandemic. All people newly diagnosed with HIV should receive a *Partner Services* interview to help them engage in HIV care and ensure that any sex or needle-sharing partner is tested for HIV and linked to PrEP and/or SSPs to prevent forward transmission. Unfortunately, in 2019, more than a quarter of newly diagnosed HIV-positive persons in LAC did not receive a Partner Services interview due to workload capacity of existing staff or refusal by the client. Among all the named sex or needle-sharing partners of persons diagnosed with HIV, Partner Services staff referred over 50% to PrEP services, but only confirmed subsequent HIV testing for 1 in 5 named partners.

Data-to-Care is a data-driven approach that uses HIV surveillance and other data sources to identify PLWH who are not in care, link those not in care to appropriate medical and social services, and ultimately move clients along the HIV care continuum to sustained viral suppression.[9] Despite increased focus on direct public health interventions to improve the HIV care continuum since 2013, linkage to and engagement in HIV medical care remain suboptimal. The lowest levels of linkage to care within one month of diagnosis was among cis women, Black/African Americans, and PWID newly diagnosed with HIV in 2018. At the end of 2019, approximate 1 in 3 PLWH had no evidence of HIV medical care in the

[9] https://tinyurl.com/DataToCare

past 12 months with the lowest levels of engagement in care among PWID (39%), Black/African American persons (34%), heterosexual persons (33%), persons aged 40-49 years (33%), and cis women (32%).

To further identify and prioritize individuals for public health interventions, the CDC has advanced two new approaches, HIV Molecular Cluster Detection and time-space cluster analyses to complement Data-to-Care activities. In 2018, LAC adopted the use of the CDC's HIV TRACE program to identify priority molecular clusters (defined as a group of 5 or more persons whose HIV genotype is identified as being highly similar and a transmission cluster requiring additional review and intervention). Because HIV has a high mutation frequency, individuals whose HIV genotypes are highly similar are likely connected through recent sexual or social networks where there is ongoing HIV transmission. In addition, there is a high likelihood that persons who may be part of new cluster are unaware of their HIV status or know their status but are not virally suppressed. LAC staff perform molecular cluster analysis of available surveillance and programmatic data to determine if the individuals are in care, virally suppressed, and if they need contact and engagement from linkage to care, re-engagement or partner services/notification teams. A total of 16 priority molecular clusters are currently being monitored and prioritized for public health action including 5 clusters identified by California OA and CDC that involve LAC cases. Upon investigation, approximately 25% of all cluster members were not virally suppressed and 35% had never received Partner Services. Direct intervention at the cluster-level resulted in 75% of all cluster members being contacted and offered partner services.

Time-space cluster analysis has been conducted monthly in LAC since January 2019 to monitor changes in the number of diagnoses by health district. No transmission clusters have been identified to date. This approach requires complete reporting of new diagnoses to LAC DPH which is estimated at 65% and currently limits the potential utility of this approach.

Data in Action: Groups with greatest disparities across the HIV care continuum are persons who are unhoused at the time of HIV diagnosis, those who report injection drug use transmission risk, cis women, and Black/AA PLWH. More work is needed to understand the structural and individual-level barriers to staying in care and how LAC DPH can address these barriers. Improvements in HIV case reporting completeness and timeliness are needed to effectively identify and respond to potential transmission clusters.

Section II: Situational Analysis & Needs Assessment

Situational Analysis & Needs Assessment - Pillar 1: Diagnose

An HIV diagnosis as close to the period of infection as possible is a crucial first step to achieving good HIV-related health outcomes and reducing the likelihood of HIV transmission to others. As mentioned previously, only 89% of PLWH in LAC are aware of their HIV status, meaning that approximately 6,400 people in LAC who are HIV-positive are unaware of their infection. To increase the proportion of people living with HIV who are diagnosed to at least 95%, LAC DPH, community health clinics, non-traditional community-based HIV testing partners, and other private and public entities must jointly support a robust and widespread HIV testing strategy, including testing in new and innovative ways. LAC DPH supports a cross-section of organizations to conduct HIV testing in a variety of settings, including non-clinical venues that serve the priority populations, community-based HIV/sexually transmitted diseases (STD) clinics, social and sexual network testing programs, and commercial sex venues. Overall, LAC DPH supports 42 HIV testing providers with annual goals to provide over 80,000 HIV tests and with the goal of diagnosing more than 800 individuals with HIV each year. In addition, LAC DPH staff directly provides

HIV testing in the LAC jails and County STD Clinics. These public-sector supported HIV testing and diagnosis efforts are an important complement to private sector HIV testing efforts supported by commercial health plans.

The Los Angeles County (LAC) Department of Public Health (DPH) has had a long-standing partnership with the LAC Department of Health Services and the Los Angeles County Sheriff's Department to ensure that clients have access to HIV testing and other sexual health related services, including those delivered in County correctional and juvenile detention centers. LAC DPH continues to strive to ensure that the HIV-related health needs of gay and bisexual men as well as transgender persons are also met. Notwithstanding our commitment to promoting the public's health, LAC DPH recognizes that there is necessary reform related to the criminal justice system, patterns of systemic racism and the treatment of communities of color. In that spirit, we understand the nature of the recent political and civil unrest witnessed and experienced in LAC and communities across the Nation. We pledge to do our part to confront harmful and racist practices perpetuated by racist systems as we continue to commit to ensuring that programs and services provided in these settings are client-centered and best support the client needs.

Routine HIV Testing

Expanding routine HIV testing within emergency departments, hospitals in highly HIV impacted geographic areas, federally qualified health centers (FQHCs), and other clinical settings is crucial to meet the HIV testing goals tied to EHE. While targeted testing often provides the highest positivity rate, implementing routine testing in health care settings is an important component to not only move towards destigmatizing HIV, but also allowing individuals who do not recognize their HIV risk to be tested for HIV. Opportunities to include HIV testing as a part of routine STD screenings and at substance use disorder treatment facilities persist. Routine testing in a subset of clinical settings can have an acceptable yield while leveraging multiple revenue streams, including public and private health plans, to cover testing costs. Despite these opportunities and benefits, launching new routine HIV testing programs in healthcare settings in LAC has been difficult. To catalyze routine HIV testing, a variety of policy changes are needed including changes that require low barrier reimbursement for HIV screening and strong annual screening mandates. In addition, we must address several non-financial routine HIV testing barriers, including broad scale training and technical assistance of routine HIV testing staff, broad scale adaptation of electronic medical records to incorporate HIV testing prompts and export critical HIV testing data, the development of protocols to ensure the immediate linkage of newly-diagnosed HIV-positive persons to care, and incentives to recruit and maintain a county-wide cadre of health care settings based routine HIV testing "champions." In LAC, fourteen FQHCs, all part of the local Community Clinic Association of Los Angeles County (CCALAC) network, received EHE funding to cover start-up costs and reduce barriers to adopting routine HIV testing, PrEP and other HIV prevention services within their clinics.

In the past, LAC DPH has conducted Public Health Detailing (a method of targeting and reaching providers who will benefit from a short, focused key public health message) related to *HIV*, *PrEP*, and *Syphilis among Women* to influence practice patterns for established community medical providers. This effective intervention, however, remains both resource and time intensive for a jurisdiction the size of LAC. A more targeted approach of connecting with medical schools and training programs, including residency programs, nurse practitioner and physician assistant training programs, may be a more cost-effective way to support sustained clinical practices with public health benefit. By reaching clinicians at the beginning of their healthcare training and careers, the importance of HIV prevention and HIV testing can be included as a fundamental element of routine clinical practice that spans the life of medical careers, and can be used to identify and development HIV champions.

Rescreening individuals with elevated HIV risk

Both national and local data indicate that many people at higher risk for HIV infection are not screened according to clinical guidelines. Among CDC's National HIV Behavioral Surveillance (NHBS) participants, 16% of MSM and 45% of PWID had not had a test in the past 12 months; and a lower proportion of persons with ongoing HIV risk received an HIV test every 3 or 6 months as recommended by the CDC.

The link between sexually transmitted diseases (STDs) and elevated HIV risk is clear, and we must ensure that health care providers are not missing opportunities to conduct HIV testing with clients who are seeking STD screening, diagnosis and treatment services. The wide-scale adoption of technology to allow HIV testing providers to track and communicate with clients via text or a secure portal when they are due for repeat testing in an automated fashion and could accelerate efforts to ensure that clients who are newly diagnosed are promptly linked to care. The adoption of this technology and the use of digital forms of communications is congruent with how younger individuals prefer to exchange information, particularly given their ease and the higher levels of confidentiality they provide.

Home Test Kits

Due to the COVID-19 pandemic, the use of preventive and diagnostic health care services has been negatively impacted, as evidenced by a steady decrease in the number of HIV tests provided in local healthcare settings. Alternative HIV testing approaches are necessary to ensure that HIV diagnoses continue among individuals who may be HIV-positive but who may be less inclined to seek in-person services. The U.S. Food and Drug Administration (FDA) has approved home HIV test kits, that while less sensitive than other rapid tests, provide an important low barrier option for individuals to confirm their HIV status. In response to this alternate testing strategy, LAC DPH has partnered with the National Association of AIDS Directors (NASTAD) and Building Healthy Online Communities and joined the multi-jurisdictional Take Me Home initiative. Take Me Home is a timely and innovative HIV home test kit ordering program that centralizes advertising, data collection, and test kit distribution to clients, relieving health departments from coordinating and hiring staff during the COVID crisis. As a strategy to promote linkage to care efforts, LAC DPH will also make available home HIV test kits to community-based partners who also offer video or phone assistance and support by trained test counselors and who prioritize providing linkage to care services to persons testing HIV-positive.

Additional HIV Testing Modalities

Although mobile HIV testing is often cited as an important HIV testing strategy for some individuals and communities, after years of supporting this modality, LAC DPH has noted a low positivity rate, lower than average linkage to care rates, and poor PrEP referral rates from mobile testing programs compared to health center or community-based organization-based testing programs. The average linkage to HIV medical care from these programs has been as low as 23% and no higher than 70% -- far below the goal of 95% linkage to care rates expected for newly diagnosed HIV positive persons. As a result of these performance disparities, the resources that have been used to support mobile testing programs have been repurposed to expand the number of programs that target high HIV impacted sexual and social networks throughout LAC. These testing modalities have reported a higher HIV positivity rate among testers as well as a higher linkage to care rate.

LAC looks forward to working with partners to further explore HIV testing opportunities that allows for the highest impact in increased testing access points, reduced barriers for clients, and integration of routine testing across syndemics such as viral hepatitis and sexually transmitted infections. LACDPH will continue to expand or support the existing HIV testing portfolio especially for populations where HIV rates are rising and is committed to partnering with agencies such as homeless service providers

conducting street outreach to further increase HIV testing opportunities, given their expertise of the communities and clients they serve.

Situational Analysis & Needs Assessment - Pillar 2: Treat

By leveraging a combination of federal, State, and local prevention, care and treatment funds, LAC DPH supports a network of HIV prevention providers and more than 30 LAC DPH funded HIV medical homes, where referrals, linkage assistance, medical care, and medications are available regardless of insurance status. Since the advent of "treatment as prevention," LAC DPH has worked with the Commission and its network of providers to reduce barriers to care so that PLWH can be readily linked to and retained in HIV medical care. Despite these efforts, at the end of 2019, linkage to care, engagement in care, and viral suppression rates remain far below targets for a significant subset of patients, as described in the Epidemiological Profile Section.

Linkage to care

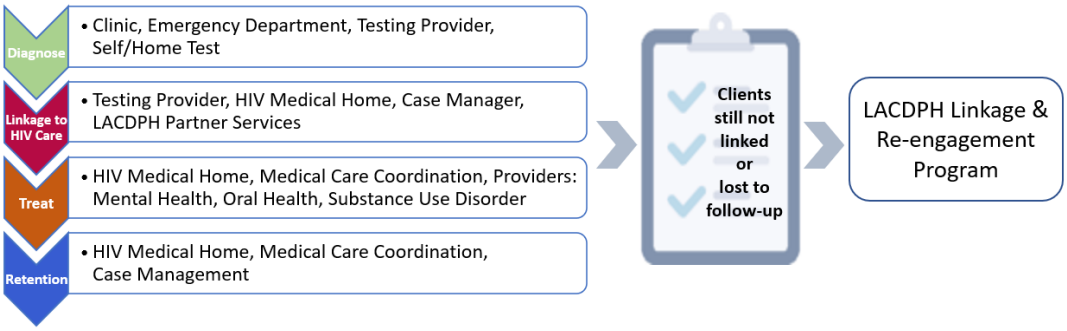
Since 2011, LAC DPH has incentivized timely linkage to HIV medical care for its network of community-based HIV testing providers. HIV testing providers assume primary responsibility for linking a newly diagnosed person to HIV care by setting up appointments and following up with the client until the first appointment is completed. While this incentive structure initially produced significant improvements in initial linkage to care, more recently performance has generally plateaued. This is likely due to a combination of factors, such as denial or competing life demands, and structural barriers, such as lengthy financial screening requirements and administrative paperwork. The current system must evolve to make rapid initiation of antiretroviral therapy (ART) the easiest choice for both the provider and the patient. LAC DPH, together with HIV prevention and medical providers, must restructure its approach to linkage to care, must treat new HIV diagnoses with more urgency, and must ensure that providers receive technical assistance to make same day linkage referrals a standard practice. In addition, LAC DPH will utilize its position as funder to provide technical assistance to clinics to reduce unnecessary administrative barriers for patients and improve the client experience (Appendix E).

Engagement and Retention in Care

In 2013, LAC DPH implemented the *Medical Care Coordination (MCC)* program in Ryan White Program-funded HIV medical homes with the goal of addressing the unmet psychosocial and medical needs of patients at risk for or already experiencing poor health outcomes. Comprised of a Registered Nurse, a Social Worker, a Case Manager, and a Retention Outreach Specialist, the MCC teams help patients with a range of psychosocial, behavioral, and medical issues that may impact their treatment adherence. A robust evaluation of the MCC program demonstrated that PLWH who utilize MCC services experience significantly improved health outcomes after 12 months. In 2016, DHSP established the *Linkage and Re-engagement Program (LRP)* as a complement to the MCC program to identify, reach, and re-engage patients who have fallen out of care. Based on these findings and experiences, LAC DPH expanded MCC to additional HIV clinics in 2017. Given that the path to consistent, ongoing HIV care and reaching viral suppression is not always a linear experience for clients (for multiple reasons), the Linkage and Re-engagement Program was developed as a specialty linkage program to work with clients who have had challenges linking to care or have fallen out of care and cannot be reached. LRP utilizes experienced DPH-based health navigators, who have access to a wide-range of LAC DPH and County data systems in order to locate and follow-up with clients who are often not well served by traditional medical and support service models, including those without a cell phone or who are unstably housed, or who have not been located or responsive to service providers' attempts to engage them in care. While the engagement and retention in care of clients remains a primary responsibility of the clinic, the LRP

program is intended to serve as a complementary option of last resort to focus efforts on locating and connecting with clients and subsequently facilitating a warm hand-off to clinics and MCC teams.

Figure 1. *Visual model of the comprehensive provider network available to link and re-engage clients in LAC, including the separate Linkage and Re-engagement Program that is available as a service of last resort for clients who are not in care despite efforts across the full network of provider services.*



LAC DPH understands that despite the availability of these programs, many PLWH struggling with financial concerns, housing instability, mental health diagnoses, and substance use disorders (SUD), also struggle to not only access care, but remain in care and achieve viral suppression over long periods of time. The current safety net in LAC to address these issues is fraught and complex. Navigating the healthcare system and identifying accessible and quality mental health and SUD services, particularly for low-income persons, can be difficult; at the same time, mental health services specifically designed for PLWH remain underutilized in parts of LAC. While methamphetamine is the primary drug of use for over 20% of clients admitted for SUD treatment in the LAC DPH Substance Abuse Prevention and Control (SAPC)-funded programs, only 47% of clients complete treatment.[10] To ensure that we improve the health outcomes of PLWH who have not achieved viral suppression, disruptive programming that provides supportive services with an emphasis on emotional support, trauma informed care, reducing stigma and improves the lives of people experiencing financial hardship, homelessness, mental illness, and SUD are greatly needed. New and unconventional programming, such as conditional financial incentives, also known as contingency management, must be expanded, as well as advances in antiretroviral therapy such as long acting injectables, particularly for individuals facing the most complex life circumstances. For communities most impacted by HIV, the importance of addressing barriers to care and ensuring PLWH are informed and able to easily access various programs and resources will be important.

Situational Analysis & Needs Assessment - Pillar 3: Prevent

Pre-exposure Prophylaxis (PrEP)

Increasing the number of people who take advantage of and have access to clinical preventive services, such as PrEP, continues to be a major public health challenge. Despite widely available PrEP resources and providers in LAC, fewer than a third of persons with an indication for PrEP report taking it. In California, significant progress has been made to limit PrEP associated costs as a barrier to uptake; most health insurance plans now cover most PrEP associate health care costs, with public and private programs available to cover out-of-pocket costs based on income.[11] Unfortunately, assistance programs require eligibility screening and paperwork, which can deter some clients. Clear and direct messaging about PrEP from the appropriate community stakeholders is greatly needed to address mistrust and

[10] Unpublished data, LAC DPH Substance Abuse Prevention and Control.
[11] www.PleasePrEPMe.org/payment

combat misleading information. Health care systems must adapt to make PrEP initiation and its continued use as easy as possible so that individuals with a continued indication are retained in care.

Mistrust of new pharmacologic interventions and medical providers in communities of color are understandable and justifiable given the history of Black Americans mistreatment as unwilling subjects of medical research and continued racial biases in access to and the delivery of health care services. Unsurprisingly, the uptake of PrEP among Black and Latinx MSM has consistently been lower compared to Whites. Unfortunately, this underutilization is compounded by the fact that potential side effects of PrEP have received undue and misdirected attention due to advertising by those seeking product liability lawsuits against the drug manufacturer. In addition, many individuals incorrectly believe that PrEP will be too expensive and therefore inaccessible. Federal, State, and local programs that support PrEP at low to no-cost remain; and community-based organizations, medical providers, and public health departments all have a role to play to help address misinformation and mistrust as a step towards deconstructing institutional racism and improving healthcare access patterns. The Commission's *Black/African American (AA) Community Task Force* has recommended increasing culturally sensitive PrEP advertising designed with input from the very communities it is attempting to reach, including Black/AA youth, cis women, transgender individuals, and gender nonconforming populations. In addition, voices of influential individuals through social media and marketing may help destigmatize both HIV and PrEP use and could potentially activate some individuals to take action. Lastly, PrEP support groups have the potential to create social support to promote PrEP initiation and retention and may be a particularly promising strategy for younger men who do not have much experience navigating the healthcare system.

For PrEP to reach the individuals who would most benefit from this prevention tool, health care partners across all sectors and disciplines must not only understand its clinical use, but, more importantly, be mindful and comfortable in their approach discussing sexual behaviors with patients, ideally in an open non-judgmental manner. The network of LAC PrEP Centers of Excellence was launched in 2016 with the goal of creating culturally competent access points where patients can also receive assistance navigating PrEP-related cost and health insurance coverage issues. Since the FDA approval of PrEP, the number of medical providers in LAC who report being a PrEP Provider has steadily increased.[12] Unfortunately, certain geographic areas of LAC have a low number of PrEP providers relative to the number of individuals at risk for HIV: eastern San Gabriel Valley near Pomona, High Desert, South Los Angeles, San Fernando Valley, and Long Beach. Recently, 14 Federally Qualified Health Centers (FQHCs) in LAC were funded directly through the federal Ending the HIV Epidemic initiative to expand their PrEP and HIV prevention efforts. Recent California legislation and policy changes have further expanded PrEP access points to include pharmacies and telemedicine providers.

An outstanding concern regarding PrEP uptake is its duration of use among individuals with continued risk. Discontinuation of PrEP is likely due to multiple factors, including pill fatigue, administrative barriers, and competing life demands. To ensure consistent, sustained access for clients at highest risk for HIV and other STDs in sexual health and prevention services and PrEP services, providers must develop more systematic and innovative ways of staying engaged with their clients. PrEP providers can reduce barriers to care for follow up appointments by offering telemedicine visits, allowing patients to come in only when laboratory work is needed. Expansion of technology to allow for accurate and sensitive home or self-collected HIV and STD tests will be significant step toward further minimizing the frequency and length of time for medical visits and ensuring PrEP adherence. Many clients, especially younger individuals, prefer digital forms of communication and care, yet many community health centers still lack secure technology platforms to facilitate easier communication with patients.

[12] www.PleasePrEPMe.org/find-a-provider

With the passing of California's Senate Bill 159, pharmacists are now allowed to directly provide PrEP and PEP. LAC DPH and stakeholders must continue to promote all PrEP access points to further increase uptake. Recent studies have demonstrated that the "2-1-1" PrEP regimen (where an individual takes two pills 2 to 24 hours before sex, one pill 24 hours after the initial dose, and one final pill 24 hours later), as well as long acting injectable PrEP options, are important alternatives to oral daily PrEP. These alternate regimens have the added benefit of being attractive for individuals with pill fatigue or those struggling with adherence issues. Lastly, providers must be aware of clients who have or continue to utilize Post-exposure Prophylaxis (PEP), the use of antiretroviral drugs for people who are HIV-negative after a single high-risk exposure to stop HIV acquisition. Clients utilizing PEP should be connected to PrEP service providers to further prevent HIV transmission and acquisition. Although providers must acknowledge that for some clients, repeated use of PEP overtime may be the most beneficial form of biomedical prevention.

Syringe Services Programs

Historical data in LAC have shown injection drug use (IDU) to be a consistent, but less common risk factor for HIV transmission, accounting for less than 5% of HIV cases annually. However, across the United States, and more recently in Seattle-King County, IDU-based HIV outbreaks have occurred, even in areas where syringe support programs are available.[13] The rise of conditions that contribute to drug use, such as economic inequality, homelessness, untreated mental illness, and opioid and methamphetamine use are pervasive in LAC, increasing our susceptibility to an IDU outbreak. The most recent National Behavior Surveillance Survey (NHBS) cycle among PWID in LAC, which surveyed more younger PWID than previous cycles, revealed higher levels of risky injection practices, methamphetamine use, exchange sex, and unstable housing.

Fortunately, syringe services programs (SSPs) are legal under California law, but programs in LAC experience fragmented or insufficient support from County and City of Los Angeles partners. In addition, LAC DPH funded SSPs continue to be small in scale, including only six agencies funded at modest levels through the LAC DPH Substance Abuse and Prevention Control Program (SAPC). Of the six currently funded SSP agencies, only three are funded to provide HIV, STD, and hepatitis C (HCV) testing. Unfortunately, there is limited data and an absence of an in-depth analysis to confirm the impact of the LAC DPH-supported SSP programs, including data tied to linking clients to testing, other HIV prevention and care resources as well as Hepatitis and substance use disorder services. As part of our EHE efforts, we aim to increase our investment in this area and enhance the SSP service portfolio.

Given the increased number of IDU HIV outbreaks reported nationally, the need to assess and address gaps in HIV prevention services targeted to PWID has become important. In 2019, the California legislature, recognizing the importance of SSPs and the effectiveness of a comprehensive, integrated approach to care for people who inject drugs, allocated increased funding to SSPs for expanded service provision and HCV screening. As a result, the LAC DPH's Division of HIV and STD Programs (DHSP), Substance Use and Prevention Control (SAPC), and the Acute Communicable Disease Control Program (ACDC) began preliminary work to expand HCV, HIV, and syphilis screening among SSP users. Unfortunately, the COVID-19 pandemic has put tremendous strain on all three LAC DPH Divisions. We remain eager to expand the bandwidth of County-based and community-based partners to accelerate efforts to expand SSP programming and services.

[13] MMWR Feb 2019 Seattle. https://www.cdc.gov/mmwr/volumes/68/wr/mm6815a2.htm.

Situational Analysis & Needs Assessment - Pillar 4: Respond

The use of client-level data reported to the public health department to identify and target HIV-positive individuals for contact tracing and linkage to services has a long precedent that continues during the current COVID pandemic. The use of this client data for expanded HIV prevention and outreach efforts, however, is relatively recent. For decades, national guidelines and state laws restricted access and use of client-level HIV surveillance data to traditional surveillance functions, such as generating aggregated reports to describe population-based trends among persons living with diagnosed HIV. While these limits on the use of surveillance data in the early days of the HIV epidemic as a way to protect privacy of PLWH were understandable, these laws severely limited the ability of public health staff to use available information to further advance outbreak investigation efforts.

Fortunately, we finds ourselves in a different era where data driven HIV public health strategies, such as data-to-care, the use of geospatial analysis, and molecular cluster analysis are available (and required) and can be leveraged to ensure that the HIV public health response is more timely, targeted and has the greatest impact. These activities require real-time access to client-level surveillance data and are expected to be carried out regularly as part of the Respond Pillar of the EHE strategy as a way to not only identify individuals who need enhanced services, but to also detect and rapidly respond to early clusters or outbreaks of HIV in the community. In addition, the development and growth of technology-based dating mechanisms has further complicated the issue of identifying and monitoring clusters and new HIV diagnoses. LAC DPH has three programmatic Respond activities: Partner Services, the Linkage Re-engagement Program, and HIV Molecular Cluster Detection, all described further below.

Partner Services

The CDC describes Partner Services as a public health activity of rigorously trained staff to "identify and locate the sexual contacts of infected people and other people at risk for behavioral or other risk factors 'contact tracing'- and then refer them for care and treatment, as appropriate."[14] While the Partner Services program in LAC has been successful in interviewing newly diagnosed clients, there is opportunity to further expand the program's capacity to ensure all newly diagnosed clients and their partners are being interviewed in a timely and more efficient manner. In LAC, improved data system integration, easier data access, and increased staffing will improve the ability of LAC DPH to reach all newly diagnosed persons with HIV. The latest estimate suggests that two-thirds of newly diagnosed persons with HIV in LAC receive an offer of Partner Services around the time of their diagnosis. There is an opportunity to build staff capacity within the Partner Services program as well as expand partnerships with providers at high volume HIV/STD clinical testing sites to 1) establish more on-site counseling and education for persons testing positive within clinics, 2) promote rapid linkage to care and treatment efforts, and 3) reinforce community driven service sites that support and empower clients to prioritize their wellness and connect identified partners with critical HIV testing and/or PrEP. In addition, Partner Services will need to adapt to new technologies in order to respond to the use of web-based platforms, mobile apps, and other internet-based modalities that facilitate identifying and connecting with partners to testing, prevention, or care.

Linkage Re-engagement Program

At LAC DPH, the Linkage Re-engagement Program (LRP) is staffed by a team of health navigators and supervised by a social worker. LRP provides intensive case management and longitudinal support to PLWH who are out of care, who are facing challenging life circumstances and who have multiple co-morbid, mental health or SUD conditions. While linkage and re-engagement activities are the primary contracted responsibility of clinics and organizations that provide direct services to clients, LAC DPH

[14] https://www.cdc.gov/std/program/partners.htm

offers LRP as a complementary service designed to locate and connect the hardest to reach clients to the health care system. The majority of clients served by LRP are referred by their medical provider after they have fallen out of care and have been lost to follow-up. Other clients in need of LRP services are identified through data-to-care analyses because they are high need for intensive case management such as pregnant women, individuals recently released from jail, and individuals who are identified as part of a growing HIV transmission cluster.

HIV Molecular Cluster Detection

In 2018, LAC adopted the use of the CDC's HIV TRACE program to identify priority molecular clusters (defined as a group of 5 or more persons whose HIV genotype is identified as being highly similar and a transmission cluster requiring additional review and intervention.) Because HIV has a high mutation frequency, individuals whose HIV genotypes are highly similar are likely connected through recent sexual or social networks where there is ongoing HIV transmission. In addition, there is a high likelihood that persons who may be part of new cluster are unaware of their HIV status or know their status but are not virally suppressed. LAC staff perform molecular cluster analysis of available surveillance and programmatic data to determine if the individuals are in care, virally suppressed, and if they need contact and engagement from linkage to care, re-engagement or partner services/notification teams. Given the novel nature of molecular cluster detection, in late 2019 LAC DPH launched an effort to engage community stakeholders regarding its use and assess potential unintended consequences. LAC DPH provided an overview of molecular surveillance to the Commission on HIV to provide background information, address community concerns, address misperceptions related to the use of data, and review the potential legal ramifications and privacy issues. Unfortunately, planned activities for further community dialogue have been put on hold due to the deployment of staff to the local COVID-19 response. As a part of continued community engagement and awareness on molecular cluster detection and the monitoring of cluster outbreaks, the development of a communication strategy for community members and organizations will be important and will resume in 2021.

More recently, LAC DPH has begun to identify emerging HIV diagnosis trends using a complementary methodology called time-space cluster analysis using case surveillance data. Time-space alerts determine whether the number of new cases in the prior 12 months is greater than expected baseline levels across different geographic areas and sub-populations, providing insight into where and among whom to prioritize early investigation and interventions to prevent onward transmission.

Looking forward

As we continue to move forward with EHE and develop new or strengthen existing partnerships with community stakeholders and service providers, LAC DPH will continue to adopt common language and improve understanding of the Respond Pillar. This will be important to advance strategies designed to support the adoption of this new technology, more efficiently serve clients in need, and prevent outbreaks. Successful EHE efforts are strongly dependent on the extensive partnerships between LAC's HIV medical homes, Medical Care Coordination teams, vast network of HIV support services providers, leaders from the most impacted communities, and a broad-based coalition of non-traditional service partners. An integrated data management system for case management and surveillance data is foundational to future programmatic enhancements. LAC DPH's Informational Technology branch intends to add HIV and STDs to its new surveillance data system for all communicable diseases in July 2021; the new system will offer large-scale improvements to overall data management, facilitate data linkages across diseases, and improve timely access to surveillance data for staff working with clients. Prior to the COVID-19 pandemic, there was broad LAC DPH-wide support to expand surveillance and program staff to support full implementation and optimization of LAC DPH EHE Respond Pillar activities. Since March 2020, most surveillance and program staff are reassigned to COVID-19 response, hindering

the capacity to fully plan and implement new EHE Respond Pillar activities. With no current timeline for changes in the COVID-19 staffing plan, LAC DPH may be forced to delay further changes and improvements. LAC DPH hopes the social acceptance of contact tracing for COVID-19, and the societal shift in understanding its importance in disease investigation will translate into improved HIV casefinding efforts under the Respond Pillar of EHE.

Priority Populations

Based on the epidemiologic profile, situational analysis and needs assessment in Los Angeles County, the key populations of focus selected for local Ending the HIV Epidemic activities to reduce HIV-related disparities include: **Black/African American MSM, Latinx MSM, women of color, people who inject drugs, transgender people, and youth under 30 years**. Although priority populations have been selected for EHE, the LAC HIV portfolio will continue to support all populations affected by HIV and will not diminish efforts to prevent, diagnose, and treat HIV for populations who remain a critical concern, including people over age 50 who account for over 50% of PLWH in the United States and people experiencing unstable housing or homelessness, among others.

Capacity Building & HIV Workforce

At the November 2018 Commission meeting, there was a resounding call from frontline HIV service providers of the need for providing the HIV workforce with the tools, resources, and support to maintain their health and wellbeing while continuing to diligently serve people affected by and living with HIV. LAC DPH is committed to exploring additional opportunities to support frontline workers by addressing staff burnout, identifying and addressing training needs, and supporting continued professional development and advancement, all of which will improve the quality of services and strengthen the local HIV response. LAC DPH will continue to work with the California Prevention Training Center to identify trainings to support the HIV workforce, with a particular focus on client-centered approaches to HIV care.

Prior to COVID-19, LAC was experiencing a massive affordable housing and homelessness crisis, which has continued to disproportionately impact Black/African American and Latinx communities. Coupled with the disproportionate impact of HIV/AIDS in the Black/African American community, worsening economic injustice, racial and social injustice amplified by the Black Lives Matter movement, and the COVID-19 pandemic, the emotional and physical capacity of individuals, organizations, and the HIV workforce including LAC DPH continues to be strained and tested. LAC DPH recognizes the need to support programs and services that 1) address intersectional issues that go beyond HIV prevention, care and treatment needs, 2) support PLWH with meeting basic human needs and 3) better support the LAC HIV workforce. LAC DPH will continue to encourage organizations to diversify the HIV workforce by hiring diverse employees to promote cultural competency, mirror the HIV epidemic, and combat systemic racism as we operationalize all EHE Pillars.

In the COVID-19 era, it is imperative that the strategies and activities outlined in the EHE Plan are adopted by organizations and the workforce beyond LAC DPH. LAC DPH plans on leveraging existing and new partnerships and will work closely with both the Long Beach Department of Health and Human Services as well as the Pasadena Public Health Department to achieve the EHE goals.

Section IV: Ending the HIV Epidemic Plan

The EHE Plan for LAC is a living document and includes proposed strategies and activities to be implemented within the first year (2021) and further expanded over the course of the next five years. It is commonly understood that the unprecedented COVID-19 pandemic has affected the timeline and implementation of proposed EHE efforts. LAC DPH received guidance and input during the 30-day public comment period from key community stakeholders on how to best navigate the current climate. The proposed strategies are complementary to the existing LAC HIV portfolio and will further expand existing prevention and care services available to people affected by and living with HIV/AIDS throughout the County. For a snapshot of all LAC DPH HIV prevention and treatment activities please see Table 2 (in development).

Overall Goal: Reduce the annual number of new HIV infections by 75% in five years (2025) and 90% in ten years (2030.)

Overall Strategy: Ensure strategies and activities of the Ending the HIV Epidemic Initiative in Los Angeles County address and improve health inequities, dismantle racism in all forms, and focus on the communities most impacted by HIV in a client-centered, people first approach.

EHE Plan - Pillar 1: Diagnose

Leading Indicators:

1) Increase the percentage of PLWH who are aware of their HIV status to 95%.
2) Reduce the number of undiagnosed persons living with HIV.

Strategy 1A: Expand or implement routine opt-out HIV screening in healthcare and other settings (such as emergency departments and community health centers) in high prevalence communities.

- Activity 1A.1: Assess and monitor the degree that HIV testing is occurring County-wide. Identify infrastructure and healthcare system issues to determine the feasibility of expanding routine opt-out testing.
- Activity 1A.2: Expand the number of emergency departments and community health centers in high prevalence communities performing routine opt-out HIV screening.
- Activity 1A.3: Identify additional opportunities in healthcare and non-healthcare settings where HIV testing can be included, such as routine STD screening sites and substance use treatment centers, among others.

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

- Activity 1B.1: Assess and monitor the degree that HIV testing is occurring County-wide (see Strategy 1A). Identify infrastructure and healthcare system issues to determine the feasibility of launching a countywide rapid HIV self-test program.
- Activity 1B.2: Develop guidance on HIV home testing, including a quality assurance protocol, and assess readiness of providers to implement home testing.
- Activity 1B.3: Expand use of HIV home testing among at risk individuals unlikely to receive traditional in-person HIV testing.

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

- Activity 1C.1: Develop provider-to-patient communication tools to support providers identify at risk clients who are due for HIV re-screening and increase systematic ways of maintaining communication with clients.
- Activity 1C.2: Develop a plan for evaluating impact of the provider-to-patient communication tools on client re-screening.
- Activity 1C.3: Expand implementation and use of provider-to-patient communication tools among LAC DPH funded HIV prevention providers.

Key Partners and HIV Workforce: FQHCs and Community Health Centers, Emergency Departments, HIV and STD Testing Providers, HIV prevention providers, private providers, academic medical provider training programs including colleges and universities, Building Healthy Online Communities-NASTAD, LAC Department of Health Services, LAC Department of Mental Health, LAC Sherriff's Department, homeless service providers, and City of Long Beach and City of Pasadena Health Departments, LAC DPH Substance Abuse Prevention and Control Division and other DPH programs and divisions.

Outcomes:

- Increased routine opt-out HIV screenings in healthcare and other institutional settings
- Increased local availability of and accessibility to HIV testing services
- Increased HIV screening and re-screening among persons at elevated risk for HIV infection
- Increased knowledge of HIV status
- Increased HIV diagnoses

Monitoring Data Sources: DHSP HIV Surveillance (eHARS)

EHE Plan - Pillar 2: Treat

Leading Indicators:

1) Increase the proportion of people diagnosed with HIV who are linked to HIV care within 1 month of diagnosis to 95%.
2) Increase the proportion of diagnosed PLWH who are virally suppressed to 95%.

Strategy 2A: Ensure rapid linkage to HIV care and antiretroviral therapy (ART) initiation for all persons newly diagnosed with HIV.

- Activity 2A.1: Increase county-wide capacity to provide same-day rapid linkage to care during expanded hours and days for persons newly diagnosed with HIV.
  Activity 2A.2: Develop a network of HIV care providers who offer same day appointments with rapid ART disbursement.

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

- Activity 2B.1: Comprehensively assess unmet mental health and SUD needs of PLWH and identify gaps and areas of improvement in the mental health and SUD treatment provider network in LAC.
- Activity 2B.2: Develop a report that summarizes critical gaps in current system and makes recommendations for improvement and investment of County resources, including Ryan White Program funds.

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

- Activity 2C.1: Assess how clients are currently learning about available RWP services. Identify existing and new resources to assist with promotion and educational outreach including, but not limited to, print materials and online resources.

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

- Activity 2D.1: Determine processes and program operations for financial assistance that are aligned with federal funding guidance and restrictions.
- Activity 2D.2: Identify potential partners positioned to serve PLWH and implement an emergency financial assistance program.

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

- Activity 2E.1: Conduct assessment to identify factors contributing to staff burnout and attrition as well as gaps in skills or knowledge around trauma informed care, stigma reduction, implicit bias, and medical mistrust.
- Activity 2E.2: Support programs or provide technical assistance in response to identified needs

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

- Activity 2F.1: Determine processes and program operations for housing assistance that are aligned with federal funding guidance and restrictions.
- Activity 2F.2: Identify potential housing partners positioned to serve PLWH and implement an expanded housing program.

Strategy 2G: Explore the impact of conditional financial incentives to increase adherence to treatment for high acuity out-of-care PLWH.

- Activity 2G.1: Develop processes and program operations for pilot program that acceptable to clients and are aligned with federal funding guidance and restrictions.
- Activity 2G.2: Identify potential clinical sites, train staff on pilot processes, and implement program.

- Activity 2G.3: Develop a robust evaluation plan to determine continued use of financial incentives and potential for expansion to other populations.

Key Partners and HIV Workforce: Ryan White Program-supported HIV service providers, HIV medical providers outside of Ryan White Program network, FQHCs and Community Health Centers, HIV and STD Testing Providers, HOPWA, LAC DHS Housing for Health program, Los Angeles County Homeless Services Authority (LAHSA), additional housing and homeless service providers, immigrant rights groups, public and private health plans, LAC Department of Mental Health, LAC Department of Health Services, City of Long Beach and City of Pasadena Health Departments.

Outcomes:

- Increased rapid linkage to HIV medical care
- Increased early initiation of ART
- Increased support to providers for linking, retaining, and re-engaging PLWH to care and treatment
- Increased utilization of RWHAP core care services among PLWH
- Increase viral suppression among PLWH

Monitoring Data Sources: HIV Casewatch, DHSP HIV Surveillance (eHARS), Medical Monitoring Project (MMP)

EHE Plan - Pillar 3: Prevent

Leading Indicator:

- Increase the proportion of persons prescribed PrEP in priority populations to at least 50%.
- Increase the number of syringe service programs by 50%.

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

- Activity 3A.1: Conduct an in-depth landscape analysis of current PrEP resources and services among primary care providers in high morbidity areas, among providers who serve transgender persons, women's health providers, and SUD providers.
- Activity 3A.2: Implement systematic and innovative strategies at LAC DPH-funded PrEP Centers of Excellence for enhanced client communication to promote retention in PrEP and sexual health services.
- Activity 3A.3: Increase capacity of LAC DPH staff to provide more robust PrEP Navigation services to clients served through County STD clinics, Partner Services, and those receiving PrEP/PEP at community pharmacies.
- Activity 3A.4: Disseminate simple fact-based social marketing PrEP messaging to increase knowledge and awareness of PrEP, alternatives to daily PrEP, and help combat misinformation regarding cost, access, and safety.
- Activity 3A.5: Work with local stakeholders to identify the potential role for PrEP support groups or PrEP ambassadors to support new and continued PrEP use in affected communities.

Strategy 3B: Increase availability, use, and access to comprehensive syringe services programs (SSPs).

- Activity 3B.1: Collaborate with the Los Angeles County Substance Abuse Prevention and Control Program to identify opportunities to improve the provision or linkage of SSP clients to HIV prevention and care services.
- Activity 3B.2: Explore ideas for alternate models of prevention service delivery (e.g., vouchers which can be taken to pharmacies in exchange for clean syringes and home HIV test kits).

Key Partners: FQHCs and Community Health Centers, PrEP Centers of Excellence, HIV and STD Testing Providers, LAC STD clinics, LAC DPH Substance Abuse Prevention and Control Division, Los Angeles County and City of Los Angeles funded SSPs, pharmacies, general practitioners and private healthcare providers, family planning clinics (including Planned Parenthood), schools and colleges, community leaders and advocates, Region IX PACE Program.

Outcomes:

- Increased referral and linkage of persons with indications for PrEP
- Increased PrEP prescriptions compared to number with indications overall and in areas with high HV diagnosis rates
- Decreased racial and ethnic disparities in PrEP uptake
- Increased capacity of SSP service providers to directly provide or link clients to HIV prevention and care services
- Reduced new HIV infections

Monitoring Data Source: Multiple PrEP monitoring and evaluation plans, DHSP HIV Surveillance (eHARS), National HIV Behavioral Surveillance (NHBS).

EHE Plan - Pillar 4: Respond

Leading Indicators:

1) Develop and maintain capacity for cluster and outbreak detection and response.
2) Increase the proportion of people newly diagnosed with HIV that are interviewed for Partner Services within 7 days of diagnosis to at least 85%.

Strategy 4A: Refine processes, data systems, and policies for robust, real-time cluster detection, time-space analysis, and response

- Activity 4A.1: Develop a protocol, training materials, and standard operation plan.
- Activity 4A.2: Continue community engagement regarding the use of HIV molecular surveillance for cluster detection to inform its best use and identify and mitigate any unintended consequences.
- Activity 4A.3: Expand routine epidemiological analysis of recent infection by person, place, and time will help to identify hot-spot locations and sub-populations associated with recent infection to inform rapid investigation and intervention.

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

- Activity 4B.1: Increase capacity of LAC DPH to provide Partner Services to all newly diagnosed persons in LAC.
- Activity 4B.2: Implement new STD surveillance system to enhance the identification and assignment of new HIV cases to LAC DPH staff for timely follow-up and Partner Services.

Key Partners: California Office of AIDS, City of Long Beach and City of Pasadena Health Departments, HIV and STD Service Providers

Outcomes:

- Increased number of newly diagnosed people with HIV interviewed by Partner Services
- Improved data systems and surveillance data for real-time cluster detection and response
- Improved policies and funding mechanisms to respond to and contain HIV clusters and outbreaks
- Improved knowledge of networks to contain HIV transmission clusters and outbreaks
- Increased number of testing providers offering HIV recent infection testing
- Increased new HIV diagnoses

Monitoring Data Source: Partner Services data (STD Casewatch), Local HIV clusters

LAC DPH Funding Sources specific to EHE: HRSA 078 Ending the HIV Epidemic ($3,083,808), CDC Ending the HIV Epidemic ($3,360,658), HRSA CARES Act ($1,000,000)

Table 1: Funding Sources and Allocations
The table below includes funding at the LAC DPH level as well as external funding that will play an important role in EHE Plan implementation. Please Note: This is not an exhaustive list.

Funding Source	Diagnose	Treat	Prevent	Respond
HRSA Ending the HIV Epidemic		X		X
CDC Ending the Epidemic Program Implementation (Component A)	X		X	
CDC Ending the Epidemic Planning (2019-2020)	X	X	X	X
HRSA CARES		X		
HRSA Ryan White Program Part A	X	X	X	
HRSA Ryan White Program Part B		X	X	
HRSA Ryan White Program Minority AIDS Initiative		X	X	
CDC Integrated HIV Surveillance and Prevention	X	X	X	X
CDC HIV Treatment Improvement Demonstration Project		X	X	
CDC National HIV Behavioral Survey and TG Supplement			X	
CDC Medical Monitoring Project		X		
State OA HIV Surveillance	X		X	
SAPC Non-Drug Medi-Cal	X		X	
County/City of LA SSP Funding			X	
EHE funding to Federally Qualified Health Centers	X	X	X	
EHE funding to Academic Institutions/Research	X	X	X	X
EHE funding to AIDS Education and Training Centers	X	X	X	

Table 2: Overview of LAC DPH HIV Prevention and Treatment Activities (in development)
The table includes existing programs and activities at the LAC DPH level that will play an important role in EHE despite not being mentioned in the EHE Plan. Please Note: This is not an exhaustive list.

[Include Table here]

Appendix A: Acronyms

ACDC	Acute Communicable Disease Control Program
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
CCALAC	Community Clinic Association of Los Angeles County
CDC	Centers for Disease Control and Prevention
CHIPTS	Center for HIV Identification, Prevention and Treatment Services
DHSP	Division of HIV and STD Programs
eHARS	Enhanced HIV/AIDS Reporting System (DHSP HIV Surveillance)
EHE	Ending the HIV Epidemic
FQHC	Federally Qualified Health Center
FDA	Food and Drug Administration
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for Persons with AIDS
IDU	injection drug use
LAC	Los Angeles County
LACHAS	Los Angeles County HIV/AIDS Strategy
LAC DPH	Los Angeles County Department of Public Health
LAHSA	Los Angeles County Homeless Services Authority
LRP	Linkage and Re-engagement Program
MCC	Medical Care Coordination
MMP	Medical Monitoring Project
MSM	Men who have Sex with men
NASTAD	National Association of AIDS Directors (formerly National Association of State and Territorial AIDS Directors
NHBS	National HIV Behavioral Surveillance
OA	Office of AIDS
OASH	Office of the Assistant Secretary for Health
PACE	Prevention through Active Community Engagement
PLWH	People Living with HIV
PrEP	Pre-Exposure Prophylaxis
PEP	Post Exposure Prophylaxis
PWID	Persons Who Inject Drugs
RWP	Ryan White Program
SAPC	Substance Abuse Prevention and Control
SSP	Syringe Service Programs
SUD	substance use disorders
STD/STI	Sexually Transmitted Disease/Sexually Transmitted Infection
WoC	Women of Color

Appendix B: Commission on HIV - November 2019 Meeting Agenda

LOS ANGELES COUNTY COMMISSION ON HIV

REVISED

2019 Annual Meeting Agenda

Thursday, November 14, 2019 | 9:00AM – 4:00PM

St. Anne's Conference Center | 155 North Occidental Blvd., Los Angeles CA 90026

RENEWED OPPORTUNITIES AND COLLABORATIONS IN TIME OF URGENCY TO END THE HIV EPIDEMIC

I.	**Registration**	8:30 AM – 9:00 AM
II.	**Call to Order, Roll Call & Approval of Agenda**	9:00 AM – 9:05 AM
III.	**Welcome, Opening Remarks & Meeting Objectives**	9:05 AM – 9:30 AM
	Cheryl A. Barrit, MPIA, Executive Director, Commission on HIV (COH) **Grissel Granados, MSW**, COH Co Chair & **Al Ballesteros, MBA**, COH Co Chair **Emily Gantz-McKay**, President/Managing Director EGM Consulting, LLC	
IV.	**Ending the HIV Epidemic: What Do We Know?**	9:30 AM – 11:15 AM
	Mario J. Pérez, MPH, Director, Division of HIV and STD Programs (DHSP), Los Angeles County Department of Public Health **Raphael J. Landovitz, MD, MSc** Co-Director, UCLA Center for HIV Identification, Prevention, and Treatment Services (CHIPTS) **Britt Skaathun, PhD, MPH**, Postdoctoral Fellow, Infectious Diseases & Global Public Health, School of Medicine, University of California San Diego (UCSD) **Marisa Ramos, PhD**, Interim Chief, Office of AIDS, California Department of Public Health **CDR Michelle Sandoval-Rosario**, Director, Prevention through Active Community Engagement (PACE) Program Region 9, Los Angeles **LCDR Jose Antonio Ortiz**, Deputy Director, Prevention through Active Community Engagement (PACE) Program Region 9, Los Angeles	
V.	**Facilitated Group Discussion**	11:15 AM – 11:45 AM
VI.	**Lunch**	11:45 AM – 12:15 PM
VII.	**Leadership to End the HIV Epidemic:** **Insights on Public Health and Community Partnerships and Sustained Action**	12:15 PM – 1:00 PM
	Barbara Ferrer, PhD, MPH, MEd, Director, Los Angeles County Department of Public Health **Jeffrey Gunzenhauser, MD, MPH**, Disease Control Bureau Director and Chief Medical Officer, Los Angeles County Department of Public Health **Louise McCarthy, MPP**, President and CEO, Community Clinics Association of Los Angeles County (CCLAC)	
VIII.	**Facilitated Group Discussion**	1:00 PM – 1:30 PM
IX.	**Break**	1:30 PM – 1:45 PM
X.	**Creating an Effective and Responsive Community Planning Structure**	1:45 PM – 2:45 PM
XI.	**Public Comments**	2:45 PM – 3:15 PM
XII.	**Summary, Closing Remarks & Roll Call**	3:15 PM – 3:30 PM
XIII.	**Networking Opportunity for Community Stakeholders**	3:30 PM – 4:00 PM

Appendix C: Ending the HIV Epidemic Steering Committee

Astrid Reina, PhD	Los Angeles County Department of Mental Health
Barbara Roberts	LAC DPH Substance Abuse and Prevention Control Program
Bridget Rogala, MPH	California State University Long Beach
Charles Robbins, MBA	Health Management Associates
Devan Rose	Translatin@ Coalition
Erin Jackson-Ward, MPH	Cedars-Sinai
Javontae Wilson	In the Meantime Men's Group
Jerry P Abraham, MD, MPH, CMQ	Los Angeles County Medical Association
Lindsey P. Horvath	City of West Hollywood
Louise McCarthy, MPP	Community Clinic Association of Los Angeles County
Luis Garcia, Ed.D, MSW	Weingart Center
Mariana Marroquin	Trans Wellness Center
Matthew Gray Brush, MPH	Advocate
Raniyah Copeland, MPH	Black AIDS Institute
Robbie Rodriguez	Equality California
Tyreik Gaffney-Smith	APLA Health
Zelenne L. Cardenas	Social Model Recovery Systems

Appendix D: Letter of Concurrence [TBD by Commission on HIV]

Appendix E: Rapid ART Resources

Department of Health and Human Services Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral in adults and adolescents living with HIV. Available at: https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/whats-new-guidelines.

Getting to Zero Rapid Committee. San Francisco Program for Rapid ART Initiation and Linkage to Care Standard Operating Procedures. Available at https://www.gettingtozerosf.org/getting-to-zero-resources/.

New York State Department of Health AIDS Institute Clinical Guidelines Program. When to Initiate Antiretroviral Therapy, With Protocol for Rapid Initiation. Available at: https://www.hivguidelines.org/antiretroviral-therapy/when-to-start-plus-rapid-start/.

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

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

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

What strategies will be implemented?

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

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

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

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

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

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

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

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

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

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

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

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

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

What strategies will be implemented?

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

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

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

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

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

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

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

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

What strategies will be implemented?

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

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

Ending the HIV Epidemic in Los Angeles County Next Steps

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

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

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

Research Letters

AIDS 2020, **34**:2325–2331

Can the 'Ending the HIV Epidemic' initiative transition the USA towards HIV/AIDS epidemic control?

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Using a dynamic HIV transmission model calibrated for six USA cities, we projected HIV incidence from 2020 to 2040 and estimated whether an established UNAIDS HIV epidemic control target could be met under ideal implementation of optimal combination strategies previously defined for each city. Four of six cities (Atlanta, Baltimore, New York City and Seattle) were projected to achieve epidemic control by 2040 and we identified differences in reaching epidemic control across racial/ethnic groups.

Progress towards addressing HIV/AIDS in the USA has stalled, spurring the 2019 declaration to 'End the HIV Epidemic' (EHE) in the USA, which aims for a 90% reduction in the number of incident infections by 2030 [1]. To generate international consensus, UNAIDS defined several metrics for HIV epidemic control [2–4]. Using surveillance data, Bosh *et al.* [5] found the USA to meet several, but not all control targets by 2015; however, their assessment obscures trends occurring at subnational levels and key population subgroups.

Our previous HIV epidemic modelling study identified optimal, city-specific combinations of evidence-based interventions to prevent, diagnose and treat HIV/AIDS in six USA cities accounting for 24% of all people living with HIV (PLHIV) [6–12]. We found that substantial reductions in HIV incidence (population-weighted average reduction of 63.5% across cities) could be achieved if interventions were implemented at ideal levels (90% target population coverage for each intervention) for 10 years [11], but that racial/ethnic disparities would persist [13]. Achieving epidemic control represents a critical benchmark on the path to ending HIV epidemics [3,4]. Given longstanding racial/ethnic [14] and regional disparities in HIV/AIDS, more detailed analysis on epidemic control is warranted, particularly as epidemics become increasingly concentrated among key subpopulations [4,5,15].

Our objective was to determine whether extending the ideal implementation of city-specific, combination implementation strategies identified in our prior research for 20 years could lead to meeting an established measure of epidemic control in six USA cities. We also sought to examine potential disparities in reaching control in key racial/ethnic and transmission groups.

We employed a calibrated and validated dynamic, compartmental HIV transmission model to simulate HIV microepidemics in six US cities: Atlanta, Georgia, Baltimore, Maryland, Los Angeles (LA), California, Miami, Florida, New York City (NYC), New York, and Seattle, Washington [11]. We previously identified optimal combination strategies for each city, which provided the greatest health benefits while remaining cost-effective. In this study, we extended the sustainment of these combinations implemented at 'ideal' levels (i.e. 90% target population coverage) from a 10-year to a 20-year time horizon (2020–2040) and stratified projected HIV incidence by racial/ethnic groups (also by HIV transmission risk groups for additional analysis). We defined HIV epidemic control as absolute HIV incidence of less than one infection per 10 000 adults per year (according to UNAIDS [2,4]) and conducted probabilistic sensitivity analysis.

Under ideal implementation, four out of six cities (Atlanta, Baltimore, NYC and Seattle) are projected to achieve epidemic control by 2030. We estimate that LA and Miami are unlikely to reach epidemic control within the study time horizon, with an estimated incidence rate of 1.77 [95% credible intervals (CI): 1.21–2.51] and 2.09 (95% CI: 0.98–5.19) per 10 000 adults in 2040, respectively (Fig. 1).

We also found differences in reaching epidemic control across racial/ethnic and risk groups by 2040. In Atlanta, Baltimore, NYC and Seattle, epidemic control was reached for the white population earlier than for Hispanic and black populations (Fig. 1). In all cities but Miami, the control target was reached among heterosexuals prior to 2020, while control was not achieved in any city among MSM by 2040 (results not shown).

Our findings suggest that implementing city-specific, optimal combination strategies can reach an international benchmark of epidemic control in four of the six USA cities in our study, but will require upfront investment, substantial increases in service access, and a long-term commitment to sustain these efforts. Although LA and Miami would not reach the control target by 2040, implementing the recommended combinations would narrow the racial/ethnic disparities in HIV incidence between white and black/Hispanic populations.

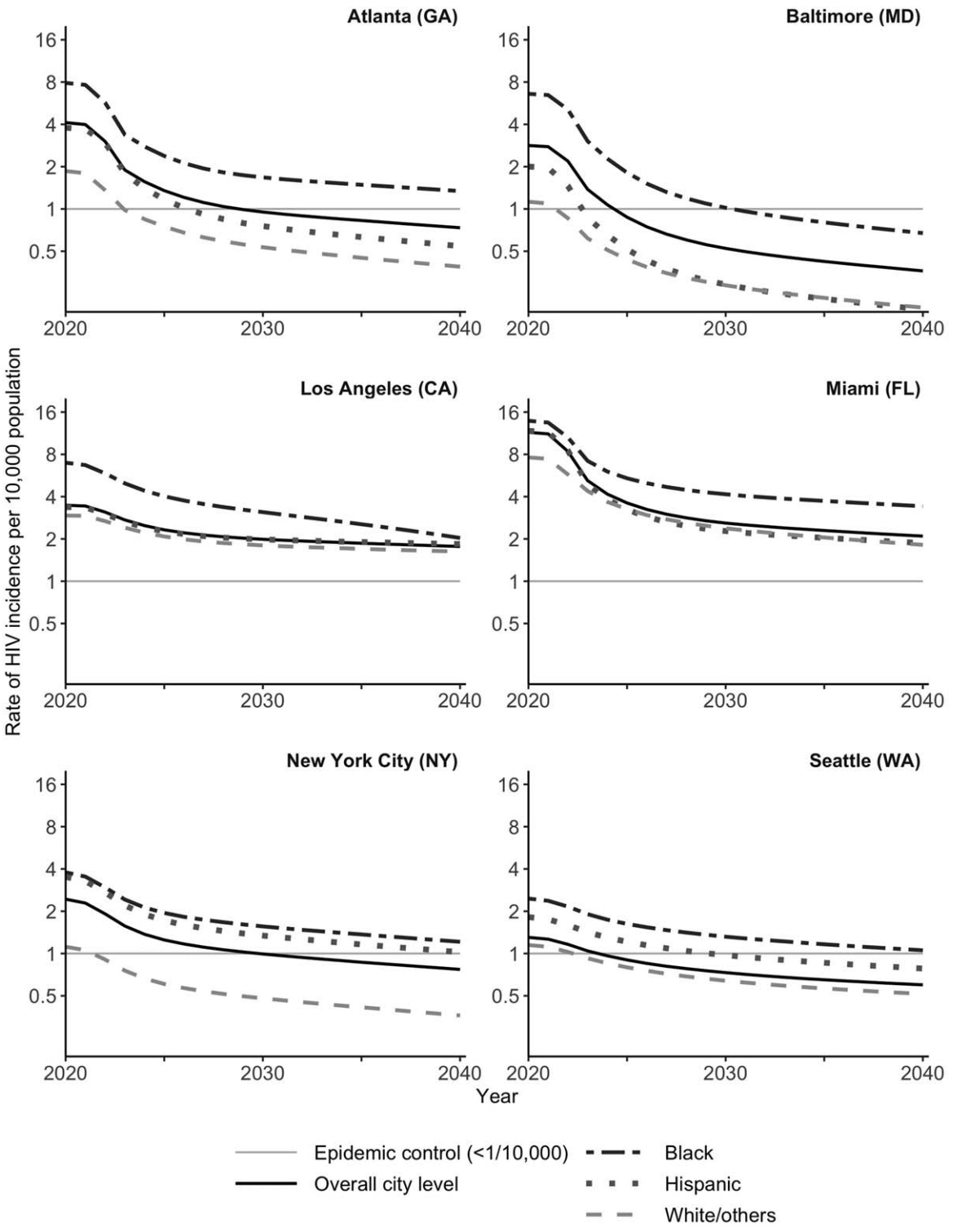

Fig. 1. Projected HIV incidence (per 10 000 adults, aged 15–64 years) between 2020 and 2040 under ideal implementation of combination strategies in six USA cities, in relation to the UNAIDS epidemic control target, overall and stratified by racial/ethnic groups. The *y*-axis is in the logarithmic scale with base 2.

Differences in reaching epidemic control between cities are driven by diverse factors, including disparities in available resources [16], the extent of sexual mixing between race/ethnic groups [17], as well as existing differences and projected shifts in the demographic composition of each city. On the latter point, increases in the relative size of the Hispanic population in Miami and Los Angeles in particular will challenge these cities'

responses without targeted, culturally sensitive approaches. NYC and Seattle, cities with the strongest political and funding support, already have low incidence that approaches the point of epidemic control (2.44 and 1.30 per 10 000 adults, respectively, in 2020). Further, the assortative sexual mixing between racial/ethnic groups accounted for in our model will likely exacerbate existing disparities in HIV incidence, as the impacts of interventions conferred to white populations will not extend to other racial groups, a barrier to reaching control and other targets. Authorities must respond to existing epidemic characteristics and anticipated demographic changes by targeting HIV-related services to black and Hispanic populations while engaging with the broader social/structural forces that shape these epidemics.

Our analysis assumed proportional scale-up of interventions by race/ethnicity from existing levels representing disparate barriers to care at baseline. Explicit efforts to reduce inequality and structural constraints in healthcare access are needed to reduce these barriers. Across diverse settings, programme uptake and engagement in care among PLHIV and susceptible populations are mediated by socioeconomic needs, including housing, transportation, employment, navigation support and substance use treatment and mental health services [18,19]. As disadvantaged populations are less likely to have these needs satisfied [20], intersectional approaches to service delivery may be warranted. Patient-centred delivery models that require funding recipients (states, metropolitan areas, community-based organizations) to detail their approach to reducing disparities have increased viral suppression and reduced disparities in care outcomes among key populations [21] and should be considered for expansion/replication.

This study features several limitations, which have been described in our prior publications on this topic [6,10–13]. The combination strategies we assessed and recommended should not be considered exhaustive, as more effective interventions, such as long-acting injectable PrEP modalities, are expected to come available in the near future and will accelerate efforts towards epidemic control.

This study highlights the importance of local, disaggregated assessment of epidemic control. Large increases in service access/delivery and sustained implementation of optimal combination strategies can lead to epidemic control, but inequitable results across race/ethnic and transmission risk groups will persist unless efforts to explicitly reduce these disparities are implemented.

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BN and XZ conceived the study. XZ and CM wrote the first draft. XZ, CM and EK performed the analysis. XZ, JM, EK and BN developed the underlying model. All authors provided critical review of the manuscript and approved the submitted draft. We acknowledge Benjamin Enns for assistance with manuscript preparation.

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Conflicts of interest

XZ, EK, CM, JEM, BDLM, DJF, BRS, LRM, SAS, CNB and BN declare no competing interests.

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Viral suppression rates in a safety-net HIV clinic in San Francisco destabilized during COVID-19

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The COVID-19 pandemic is expected to hinder US End the HIV Epidemic goals. We evaluated viral suppression and retention-in-care before and after

LOS ANGELES COUNTY
COMMISSION ON HIV

Ryan White HIV/AIDS Program Parts

The Ryan White HIV/AIDS Program is divided into five Parts, following from the authorizing legislation. Note that all Parts utilize the same service categories.

- **PART A** provides grant funding for medical and support services to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs). EMAs and TGAs are population centers that are the most severely affected by the HIV/AIDS epidemic.

- **PART B** provides grant funding to states and territories to improve the quality, availability, and organization of HIV health care and support services. Grant recipients include all 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and the 5 U.S. Pacific Territories. In addition, Part B also includes grants for the AIDS Drug Assistance Program (ADAP).

- **PART C** provides grant funding to local community-based organizations to support outpatient HIV early intervention services and ambulatory care. Part C also funds planning grants, which help organizations more effectively deliver HIV care and services.

- **PART D** provides grant funding to support family-centered, comprehensive care to women, infants, children, and youth living with HIV.

- **PART F** provides grant funding that supports several research, technical assistance, and access-to-care programs. These programs include:

    - **The Special Projects of National Significance Program**, supporting the demonstration and evaluation of innovative models of care delivery for hard-to-reach populations;

    - **The AIDS Education and Training Centers Program**, supporting the education and training of health care providers treating people living with HIV through a network of eight regional centers and three national centers;

    - **The Dental Programs**, providing additional funding for oral health care for people with HIV through the HIV/AIDS Dental Reimbursement Program and the Community-Based Dental Partnership Program; and

    - **The Minority AIDS Initiative**, providing funding to evaluate and address the impact of HIV/AIDS on disproportionately affected minority populations.

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October 2016.

HIV/STD STRATEGY 2019-2022

LONG BEACH
DEPARTMENT OF HEALTH
AND HUMAN SERVICES

CITY OF
LONG BEACH

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LA Biomedical Harbor UCLA

LA County Commission on HIV

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Long Beach Comprehensive Clinic

Long Beach Memorial

LA County Department of Mental Health

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CITY OF
LONG BEACH

In 2017, the Long Beach Comprehensive HIV Planning Group launched a comprehensive effort to develop a Long Beach HIV/STD strategy to significantly reduce the number of HIV and STD infections in the city.

The Planning Group, co-chaired by the City's Health Department and two community stakeholders, is comprised of key stakeholders including the LGTBQ+ community, Los Angeles County Division of HIV and STD Programs (DHSP) and policy representatives, medical care providers, substance abuse treatment centers, mental health agencies, social service agencies, community members, and other individuals or groups who support the mission of the city.

The new strategies outlined in this report come at a time when new HIV infections continue, although science has made it possible to stop HIV infections through PrEP, PEP and other treatments. In addition, our city has experienced significant increases in STDs since 2013. It is essential that we focus additional resources and the expertise of our Health Department, community-based organizations, and medical providers to reduce the number of new cases in Long Beach.

A special thank you to the Planning Group co-chairs Susan Alvarado (Health Department), Michael Buitron (St. Mary's CARE Center) and Cynthia Chavez (Safe Refuge) for leading the planning effort and to the Long Beach Health Department Director, Kelly Colopy and Health Officer Anissa Davis, MD and their team for serving as the lead agency for coordinating the important work of bending the curve on HIV and STDs in Long Beach.

The City of Long Beach looks forward to working with the Planning Group to achieve significant reductions in HIV and STDs in the years ahead.

Mayor Robert Garcia

EXECUTIVE SUMMARY

The Long Beach HIV/STD Strategy comes at a time with new HIV infections continue and STDs are rising in the face of declining resources to address the increasing rates.

HIV Rates

As of December 31, 2017, 4,520 Long Beach residents were diagnosed and living with HIV. Nationally, CDC estimated in 2016 that another 14% of people are living with HIV and are undiagnosed. This would indicate that approximately 730 people in Long Beach are living with HIV and undiagnosed. Although the number of new HIV diagnoses declined by 33% overall from 151 individuals in 2013 to 101 individuals in 2017, the rate of new infections in Long Beach (26 per 100,000) remains higher than in Los Angeles County (19 per 100,000) and the State of California (13 per 100,000).

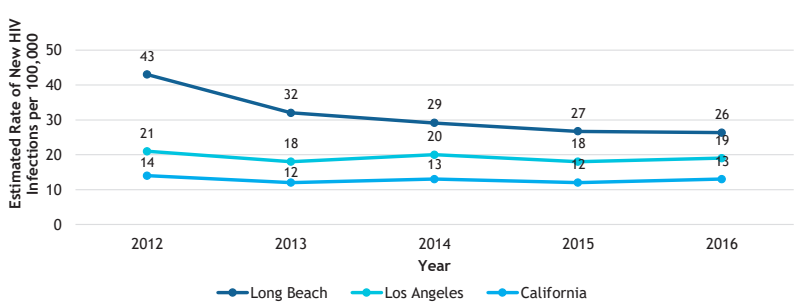
2017 HIV FACTS

101 NEW CASES OF HIV

4,520 INDIVIDUALS LIVING WITH HIV

NEWLY DIAGNOSED	**92%** MALE	**36%** PERSONS AGED 30-39	**41%** LATINX	**67%** MEN WHO HAVE SEX WITH MEN
LIVING WITH HIV	**90%** MALE	**35%** PERSONS AGED 50-59	**39%** WHITE	**80%** MEN WHO HAVE SEX WITH MEN
CARE CONTINUUM	**71%** IN HIV CARE	**57%** RETAINED IN CARE		**63%** VIRALLY SUPPRESSED

Incidence rates per 100,000 population of new HIV infections, Long Beach, Los Angeles, and California. 2012-2016



[1]Population data taken from California Department of Finance Demographic Research Unit Report P-3 State and County total population projections by race/ethnicity and detailed age; www.dof.ca.gov/Forecasting/Demographics/projections/.
[2]Long Beach HIV data taken from California Office of AIDS eHARS database.
[3]The latest available HIV data for Los Angeles County and California is for 2016. Therefore, 2012-20016 data was used for the figure to create a 5-year comparison.

STD Rates

Cities across the nation and in California have seen a reduction in funding and capacity over the past 15-20 years. Federal funding for STD Control efforts decreased by $21 million dollars between 2003 and 2016. The City of Long Beach has experienced significant increases in its STD rates. Since 2013, the Chlamydia rate increased by 88%, Syphilis by 143% and Gonorrhea increased by 267%.

2017 STD FACTS

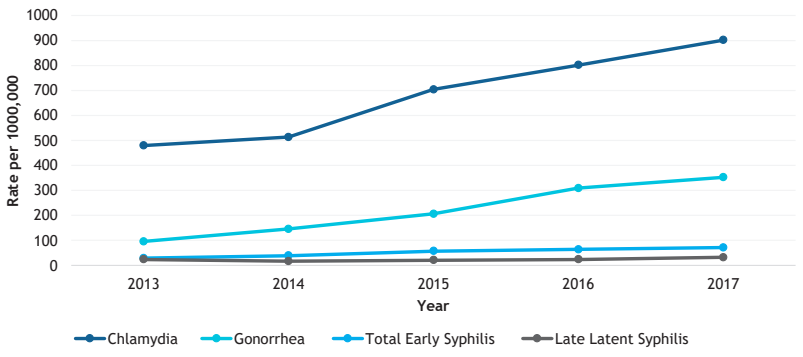
4, 321 CASES OF CHLAMYDIA

1,690 CASES OF GONORRHEA

499 CASES OF SYPHILIS

CHLAMYDIA	**60%** FEMALE	**52%** PERSONS AGED 15-24	**40%** LATINX	**2ND** HIGHEST RATES IN CA
GONORRHEA	**67%** MALE	**45%** PERSONS AGED 20-29	**38%** AFRICAN AMERICAN	**2ND** HIGHEST RATES IN CA
SYPHILIS	**91%** MALE	**23%** PERSONS AGED 35-44	**43%** LATINX	**3RD** HIGHEST RATES IN CA

Chlamydia, gonorrhea, total early syphilis, and late latent syphilis incidence rates per 100,000 population, Long Beach, 2013-2017



Note: Incidence rates are per 100,000 population.
Source: California Department of Public Health, STD Control Branch
State of California, Department of Finance, *California County Population Estimates and Components of Change by County*, July, 1, 2013-2017. Sacramento, California, December 2017.

In 2017, the Long Beach Comprehensive HIV Planning Group, began developing a Long Beach HIV/STD Strategy for 2019-2022. The Planning Group identified five priority areas with bold goals and strategies designed to reduce new HIV and STD infections. These goals are based on epidemiological data and trends in the City of Long Beach and take into consideration the specific needs and populations of the city, while aligning with Los Angeles County HIV/AIDS Strategy for 2020 and Beyond, Los Angeles County Department of Public Health Sexually Transmitted Disease Workplan, as well as the State's Laying a Foundation for Getting to Zero; California's Integrated HIV Surveillance, Prevention, and Care Plan.

To begin to turn the tide of STDs and HIV, the City and its partners must come together through system coordination and resources to implement these strategies. The recommended goals include building system capacity, educating providers and the community on HIV and STD testing and treatment, increasing testing and treatment availability, coordinating service provision, identifying undiagnosed persons with HIV, linking newly diagnosed persons to care, retaining persons who are living with HIV in HIV care, reducing the community viral load, and expanding the availability of PrEP (pre-exposure prophylaxis) and PEP (post-exposure prophylaxis) within the City to prevent HIV infections. Furthermore, new investment and funding for the Health Department and community-based organizations in the areas of surveillance, disease investigation, STD screening and treatment, PrEP/PEP and a visible focused campaign throughout the city is crucial to ensuring these goals are attained. The partners of this planning group recognize that no one organization can do this on its own and that this plan will only be effective if all organizations come together to decrease STDs and HIV.

GOAL 1: REDUCE HIV AND STD INFECTIONS IN LONG BEACH

Objective 1.:Reduce new HIV infections by 50%.
Objective 2: Increase proportion of Persons Living with HIV who are diagnosed to at least 90%.
Objective 3: Reduce new infections for gonorrhea, chlamydia and syphilis by 20%.

GOAL 2: STRENGTHEN CAPACITY TO ADDRESS HIV AND STDs IN LONG BEACH

Objective 1: Identify additional $2 million to strengthen the size and capacity of the HIV/STD system to meet the needs across the city to reduce infections.
Objective 2: Educate 100 providers each year in the standards of care for STDs and HIV to support a robust STD and HIV continuum of care.

GOAL 3: EDUCATE COMMUNITIES ON HIV/STD PREVENTION, TESTING AND TREATMENT

Objective 1: Conduct STD and HIV workshops to 4,000 adolescents and young adults (ages 15-29) per year.
Objective 2: Provide HIV and STD education at 30 community events per year.
Objective 3: Leverage and expand existing educational campaigns to increase awareness of HIV and STDs among populations who are disproportionately impacted.

GOAL 4: INCREASE ACCESS AND ENGAGEMENT IN CARE FOR HIV AND STD TREATMENT IN LONG BEACH

Objective 1: Increase the percentage of newly HIV diagnosed persons in Long Beach who access HIV medical care within 30 days of their HIV diagnosis to at least 85%.
Objective 2: Increase viral suppression of persons living with HIV (PLWH) to at least 90%.
Objective 3: Ensure an additional 10 high burden clinics carry/administer treatment for chlamydia, gonorrhea and syphilis.

GOAL 5: EXPAND PrEP AND PEP ACCESS IN LONG BEACH

Objective 1. Increase PrEP enrollment among HIV negative individuals to 4,550 individuals.
Objective 2. Train 500 service and medical providers on PrEP and PEP.

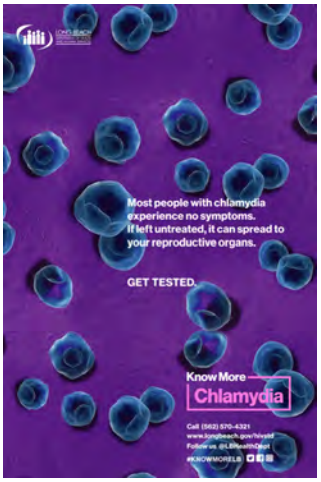
Table of Contents

LONG BEACH COMPREHENSIVE HIV PLANNING GROUP

The Long Beach Comprehensive HIV Planning Group (Planning Group) is the local body for the HIV and STD prevention and care program planning in the City of Long Beach. They have been meeting since 1999. The primary task of the Planning Group is to develop a comprehensive HIV and STD treatment and prevention plan that focuses efforts based on those populations experiencing the greatest increases in infection. Membership is open to all persons affected, afflicted, or working with HIV and STDs in the City of Long Beach. Key stakeholders include the LGTBQ+ community, Los Angeles County Division of HIV and STD Programs (DHSP) and policy representatives, medical care providers, substance abuse treatment centers, mental health agencies, social service agencies, community members, and other individuals or groups who support the mission of the Planning Group. In 2017, the Planning Group began the process of creating a working plan and established five goals in the areas of; capacity building, education, testing, treatment, and PrEP (Pre-Exposure Prophylaxis) to address HIV and STDs in Long Beach. In late 2018, with the continuous input by Planning Group members, the sub-groups began to finalize the goals and objectives of the plan to start implementation in 2019.

The Planning Group created the goals of this plan to establish priorities for the next four years (2019-2022) to prevent new HIV and STD infections and engage those who are affected into treatment. This plan is a living document that will be updated as changes in funding, prevalence, and the needs and barriers to care among highly impacted poulations occur. This plan is in keeping with both national and regional biomedical prevention priorities. These priorities take into consideration the specific needs and populations of the City of Long Beach, while aligning with Los Angeles County HIV/AIDS Strategy for 2020 and Beyond, Los Angeles County Department of Public Health Sexually Transmitted Disease Workplan, as well as the State's Laying a Foundation for Getting to Zero; California's Integrated HIV Surveillance, Prevention, and Care Plan. In joining the efforts of the State of California and Los Angeles County, the Planning Group is committed to reducing new HIV infections annually, increasing access to care to improve health outcomes for people living with HIV (PLWH), and expanding on biomedical services for the prevention of new infections.

This plan is data-informed and adaptable to the evolving HIV and STD incident landscape in the city and intends to leverage the capacities of existing public and private sector providers, current services and partnerships as well as identify and close gaps in services such as access to STD testing and treatment, PrEP and PEP. In addition, working closely with those most impacted by HIV and STDs and utilizing the STD/HIV Surveillance Report, this plan will support creating and implementing a system that provides equitable access and outcomes across the city. Such a system would allow the city and its partners to overcome barriers and challenges that impact access to HIV and STD services, such as stigma, transportation limitations, limited mental health services, homelessness and lack of culturally sensitive providers.



SETTING THE CONTEXT

Long Beach is a coastal and port city in the Harbor region of Los Angeles County (LAC). The City of Long Beach is the second largest city in LA County with nearly a half million people and an area size of 52 miles. It is also one of the top 10 most diverse cities in the country. This is a diversity of race, income, marital status, sexual orientation, and gender identity. Forty-five percent of the City's population is Hispanic/Latinx, 26% White, 12% Black and 12% Asian. (Data USA, 2019). Approximately 4,520 residents have been diagnosed and are living with HIV in Long Beach. 6,514 sexually transmitted infections (chlamydia, gonorrhea, and syphilis) were reported in 2017 (2017 STD/HIV Surveillance Report).

HIV continues to be a significant public health concern. Although the City of Long Beach has experienced a decrease in persons newly diagnosed with HIV, the City continues to have higher rates of newly diagnosed with HIV infection than Los Angeles County and the State of California. Through new testing technology, individuals can attain their results in minutes and be linked into HIV care in a timely manner to start treatment right away. The same behaviors and community characteristics associated with HIV also place individuals and communities at risk for STDs. STDs can increase the likelihood of HIV transmission and acquisition. STD infections such as gonorrhea, chlamydia and syphilis continue to have the greatest impact on young people aged 15-24, especially among young men, and young MSM of color, which have a higher chance of HIV infection compared to non-MSM youth.

The City of Long Beach has some of the highest chlamydia, gonorrhea and syphilis rates in the State of California. Many are not aware of the long-term health impacts of unidentified and untreated STDs. Syphilis is considered the most serious because the infection can spread to the brain and cause permanent loss of vision or hearing. Gonorrhea is among the Centers of Disease Control and Prevention's (CDC) top three urgent threats for developing drug resistance. Chlamydia and gonorrhea are the most commonly reported sexually transmitted bacterial infections in Long Beach, and when left untreated, can result in pelvic inflammatory disease (PID) and lead to serious outcomes in women such as infertility, ectopic pregnancy, and chronic pelvic pain.

It is recommended by the CDC that all adults and adolescents from ages 13-64 be tested at least once for HIV. For sexually active individuals with new or multiple partners, the recommendation is to be tested every 3-6 months. Many STDs do not have symptoms and people, unaware of their infection, can inadvertently transmit an STD to their partner. Therefore, increasing awareness of this issue in the community and to providers is essential to mitigate STD rates in Long Beach.

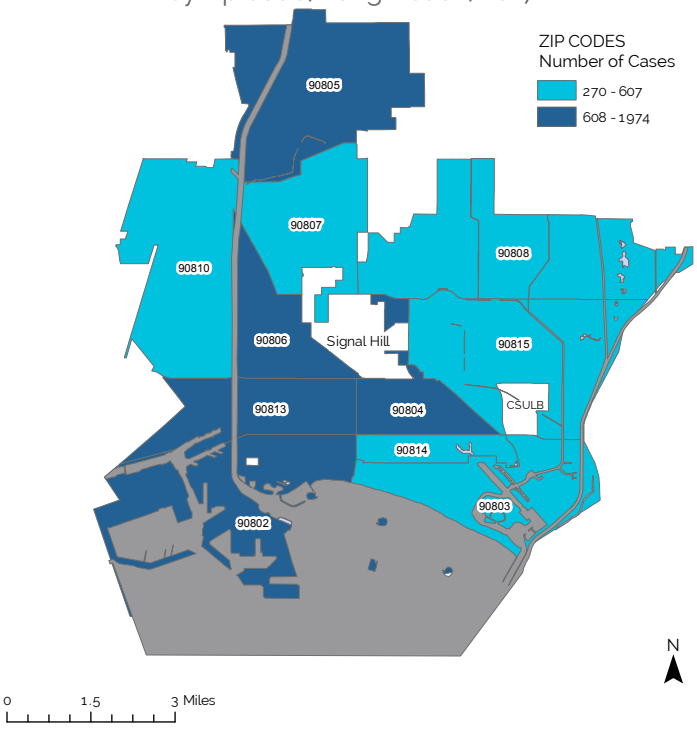
WHY ARE RATES INCREASING?

High rates of STDs have always been related to a complex web of social issues. Like so many other diseases, socioeconomic status and homelessness play a role. Stigma and discomfort in talking openly about sexual health also present major challenges. Many primary care providers are uncomfortable discussing sexual health with their patients and patients themselves are uncomfortable disclosing their risk to their primary care provider for fear of being judged. Other factors that may be contributing to the rise of gonorrhea, chlamydia and syphilis in the city, include changes in sexual behavior, increased social media access and use of social apps, decline in condom use (condom fatigue) and lack of appropriate and focused HIV and STD screening and treatment. It should also be noted that improved access to screening, testing services and care; increased awareness of the symptoms causing people to visit their provider for testing; and improved public health reporting may also be factors behind the increased rates—more people are being tested and positives are reported. Routine screening for STDs for patients on PrEP has identified more cases of gonorrhea, chlamydia and syphilis, especially among men who have sex with men (MSM).

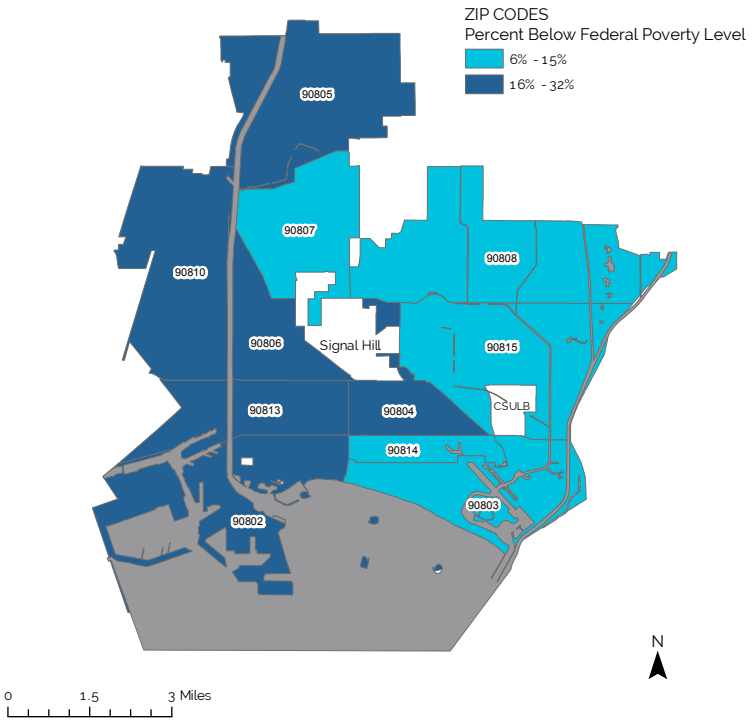
ADDRESSING HEALTH INEQUITIES

In the City of Long Beach, health outcomes are impacted by a person's gender, sexual orientation, race and ethnicity, socioeconomic status and neighborhood. These factors impact the risk of disease, access to care, as well as life expectancy overall. In the City of Long Beach, the highest rates of infection generally occur among people living in low-income communities, African-American and Latinx populations, and among men who have sex with men (MSM). The maps below show the zip codes in Long Beach that have the highest African-American and Latinx populations,poverty as well where we see the highest numbers of STD infections and those living with HIV.

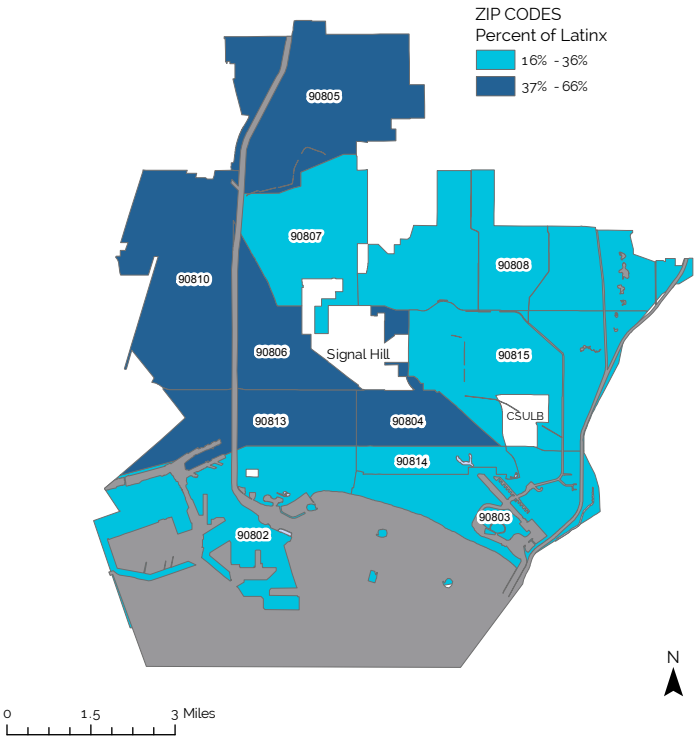
Chlamydia, gonorrhea, syphillis and HIV/AIDS Total cases by zip code, Long Beach, 2017



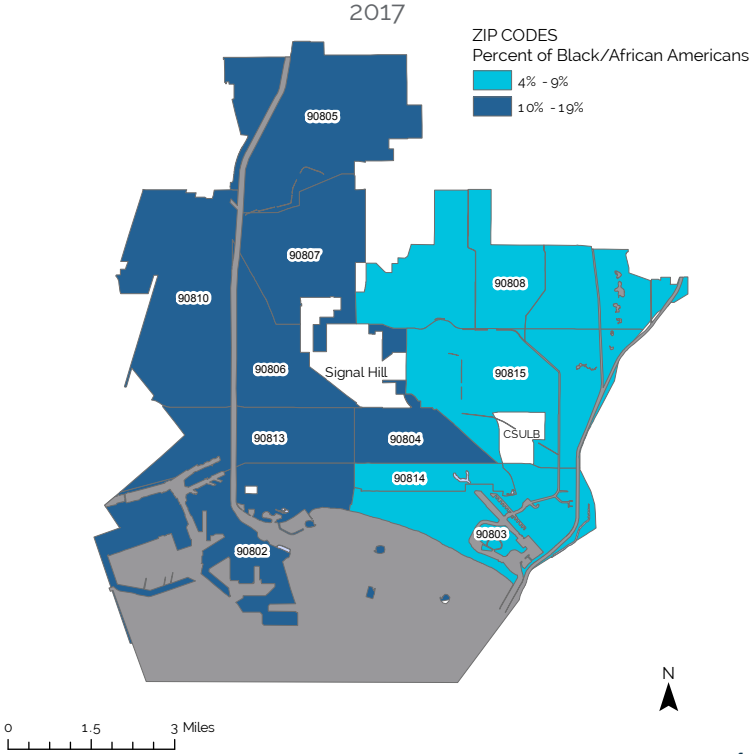
Percent Below Federal Poverty Level by zip code, Long Beach, 2017



Percent of Latinx by zip code, Long Beach, 2017



Percent of Black/African American by zip code, Long Beach, 2017



Long Beach has a number of testing and treatment sites; however, they do not feel accessible for many given their location, cultural humility of the providers and/or stigma. Low income neighborhoods tend to have less access to health information and to quality testing and treatment services that are easily accessible. This lack of access and lower quality of services in low-income communities, which in Long Beach, include higher proportions of African American and Latinx individuals, leads to a poor response to the health care needs of those individuals that are most impacted by HIV and STDs in the city. As the map demonstrates, zip code 90805 has the highest number of STD cases in the city, yet there are few providers to serve the population and is generally considered a sexual health desert due to the lack of access to services. Zip code 90813 is much more service rich but is located in the communities of highest poverty.

Some community organization and medical provider practices have environments that feel judgmental for patients, creating an unsafe space leading to an unwillingness to discuss sexual health practices and to ask important questions. This fosters an inconsistent relationship with a provider and reduces opportunity to engage in HIV/STD testing. Provider attitudes towards people of color or LGBTQ individuals also can have a negative impact on the individual's health. Moreover, providers may be insufficiently trained to conduct an adequate sexual health screening to make proper recommendations for HIV testing and STD screening and may be more reluctant to offer Patient Delivered Partner Theray (PDPT) which allows for treating the sex partners of patients diagnosed with chlamydia and gonorrhea by providing prescriptions or medications to the patient to take to their partner(s) without the health care provider first examining the partner. Limited and untimely follow-up with sexual partners can impact the identification and treatment of individuals with both HIV and STDs.

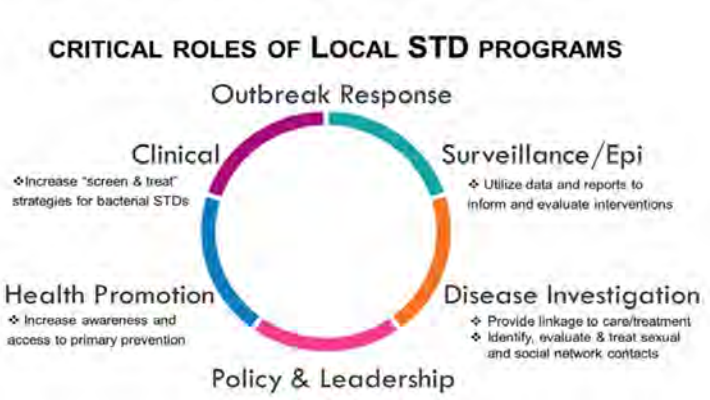
Stigma is higher not only in communities of color, but also among Latino and African-American LGBTQ individuals leading to less access to education and testing utilization. Among MSM and transgender individuals, homophobia, stigma, and threats to violence lead to disproportionate disease risk. These factors are also evident among LGTBQ youth, who experience higher rates of victimization and criminalization than their non-LGBTQ counterparts. Such experiences faced by LGBTQ youth also leads to limitations in accessing medical services that are adequate and culturally sensitive to their needs. MSM youth carry the burden of some of the highest rates of STDs nationally and locally and stigma and discrimination among providers prevents MSM youth from accessing STD and HIV services.

The persistent lack of sex positive sexual health messages among health care providers and community leaders throughout the community contributes to a lack of awareness, shame and stigma surrounding sexual health. Such stigma may also be geared towards individuals that lack the literacy skills to understand messaging around risk and prevention further making it inaccessible to seek sexual health services in the city.

This Plan outlines strategies to reduce the disparities in testing and treatment quality and access as well as reducing stigma related to HIV and STDs.

THE NETWORK OF PROVIDERS AND SERVICES

The City of Long Beach has a network of HIV and STD testing, treatment and care providers including an array of non-profit organizations, medical providers, hospitals and federally qualified health centers, and the Health Department. Access to PrEP and PEP is more limited, provided by only a few providers in the city. Resources to fund these services come from Federal, State, and County funding as well as the ability to bill insurance providers for services.

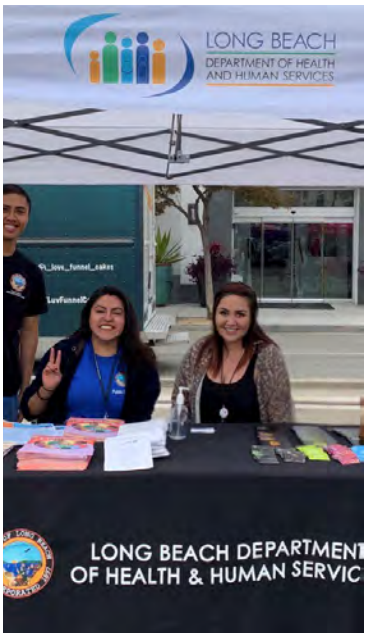


Health Department

As one of only three cities in California with its own Health Department, the City of Long Beach Department of Health and Human Services (Health Department) holds a unique place within Los Angeles County as its own local health jurisdiction. The Health Department is both the responsible body for collecting, analyzing, interpreting, and disseminating information to prevent and control the spread of disease, and a provider of direct medical care and support services. The Health Department serves as the coordinating organization for HIV/STD prevention, treatment and control for the City. The Department has the legal mandate to prevent the spread of HIV/STDs in our communities. It works in collaboration with community experts to ensure that people have access to testing and treatment, that their partners are tested, and that healthcare providers have the training and the support they need to provide good care.

The Health Department:

- Educates people across the city at community events, health fairs, in our high schools, and upon request about ways to prevent STD/HIV infection, importance of testing, and how to access testing and treatment. The Health Department partnered with the Pasadena Design School to develop the "Know More" campaign utilizing print and social media to educate those across the City about STD/HIV infections.



- Provides subject matter expertise to community providers and educates medical providers about appropriate testing and reporting protocols to ensure effective testing and reporting. With the increasing prevalence of syphilis, Health Department staff are working closely with health care providers to improve testing, diagnosis and treatment of syphilis as many providers are unfamiliar with the symptoms and the staging of syphilis.

- Conducts surveillance and case investigations. Disease Intervention Specialists (DIS) are trained to inform individuals affected by HIV and syphilis on the causes and spread of such diseases and are skilled in taking sexual histories, identifying and locating individuals who have been exposed to HIV and/or syphilis. DIS assist medical providers to locate individuals who have been tested but did not return for their positive results or engage in treatment.

The Health Department also provides testing and treatment for HIV and STDs in its clinics and on its mobile testing unit (MTU) which focuses on hard to reach communities such as injection drug users (IDU), sex workers, and homeless individuals to meet them in their settings in remote and underserved areas of the city. It also provides PrEP and PEP services for HIV prevention and is designated as a PrEP Center for Excellence.

Community-Based Providers

Key partnerships among agencies in Long Beach have been integral to addressing HIV and STDs in the City. Nonprofit organizations, such as St. Mary's Hospital and CARE Center, The LGBTQ Center of Long Beach, Safe Refuge, and APLA of Long Beach are among many organizations and medical providers who are actively involved in efforts to address HIV and STDs across the City. These agencies actively work to focus on the populations that need the most support in medical care, behavioral health, and HIV/STD testing and treatment.

The Center and APLA among others focus on the LGBTQ community, while St. Mary's CARE Center works closely, but is not limited to, individuals living with HIV. They serve 40% of the HIV positive population in Long Beach. Both APLA and The Center have programs specific to transgender individuals, providing culturally sensitive services for a community that continues to be stigmatized, especially around medical services. Each agency offers free HIV/STD testing and treatment, eliminating cost as a major barrier to services. APLA also works closely with St. Mary's CARE Clinic to link people into HIV treatment.

St. Mary's Hospital implemented a routine HIV testing program for all patients coming through the emergency room for services. Last year, they provided over 10,000 HIV tests. St. Mary's is the only hospital in the South Bay that provides routine opt-out HIV testing. Patients who test positive in their ED are immediately linked to services at the CARE Center, and started on antiretroviral therapy.

The CARE Center is a PrEP and PEP Center of Excellence. PEP is offered at no cost on a walk-in basis at the CARE Center, and 24/7 at the St. Mary Emergency Department. If someone has had a potential exposure to HIV, PEP will protect them from infection, but must be started within 72 hours of exposure.

The Long Beach Unified School District (LBUSD) and California State University Long Beach (CSULB) are also key partners in the work to reduce HIV and STD infections. LBUSD invited the Health Department and the Center to design a sexual health curriculum for their high school science classrooms, and to train science teachers to teach this curriculum. Over 70 teachers were trained.

In addition to providing HIV and STD testing at the student clinics, CSULB and its Center for Health Equity Research (CHER), is partnering with St. Mary Medical Center, The LGBTQ Center Long Beach, and Behavioral Health Services (BHS) to address an unmet need on the CSULB campus and in the Long Beach community to serve Black young men who have sex with men (YMSM) ages 18 to 24, at risk for HIV and hepatitis C (HCV) infection and substance use. The Peer Promotion of Wellness, and Enhanced Linkage to Resources Project (PPOWER) seeks to prevent and reduce substance use and provide community-level interventions, testing and linkage to care to prevent the transmission of HIV/HCV.

CAPACITY AND FUNDING

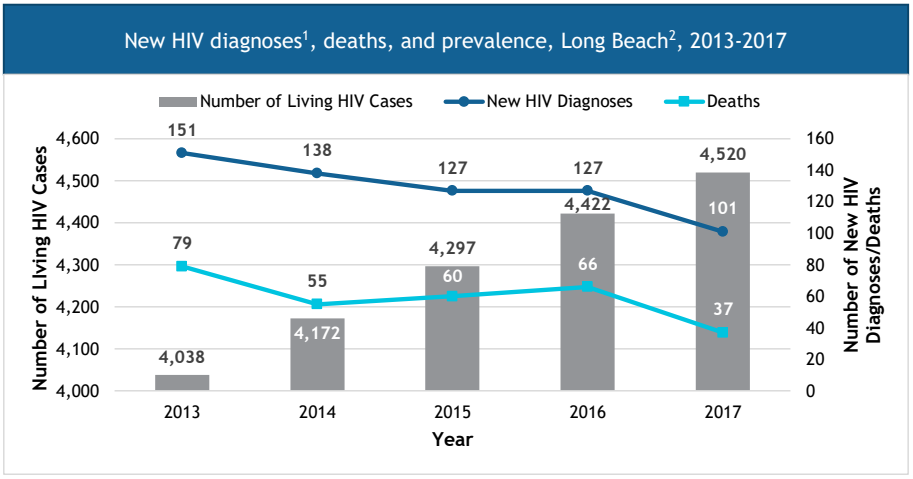
Cities across the nation and in California have seen a reduction in funding and capacity over the past 15-20 years. Federal funding for STD Control efforts decreased by $21 million dollars between 2003 and 2016. As an example, Federal and State funding for the Long Beach Health and Human Services Department provides approximately $3.5 million specifically for HIV prevention testing, treatment and care services and only $79,000 to test and treat for STDs. The increasing STD rates demonstrate this reduction in funding.

A primary source of funding for HIV prevention, testing and treatment is from the Centers for Disease Control and Prevention (CDC). LA County Division of HIV and STDs Program (DHSP) receives the funding for the City of Long Beach. In the most recent contract, DHSP awarded $1.8 million to organizations in Long Beach. Just over one-third of this was awarded to the Long Beach Health Department for HIV prevention and coordination and the remaining funding leverages and supports four non-profit organizations in Long Beach-The LGBTQ Center, St. Mary's CARE Center, APLA, and AIDS Healthcare Foundation-to expand HIV/STD testing and treatment in the city as well as promote PrEP/PEP. There remains a significant funding need within the City of Long Beach to end HIV new infections and stem the growing tide of STDs. Existing funds do not currently cover the core roles of the City's Health Department such as surveillance, disease investigations, linkage to care and community/provider education nor is there sufficient community capacity to provide robust testing and treatment across the city.

The reductions in funding and capacity across the state is requiring health departments to narrow their focus. At this time, the focus of funding and staffing is on preventing congenital syphilis (treating pregnant women who have syphilis to ensure their babies are not born with syphilis). Congenital syphilis can have long-term negative health impacts on the baby. Any additional resources are focused on investigating syphilis cases in heterosexual men and MSM. Investigations for Chlamydia and most Gonorrhea cases are unaddressed due to lack of resources. The Health Department has had to redirect staff from other programs to stay ahead of the most important STD cases, with little impact in the overall level of disease. Getting ahead of this unprecedented increase in STDs is possible but will require sustained funding to increase staffing and other resources.

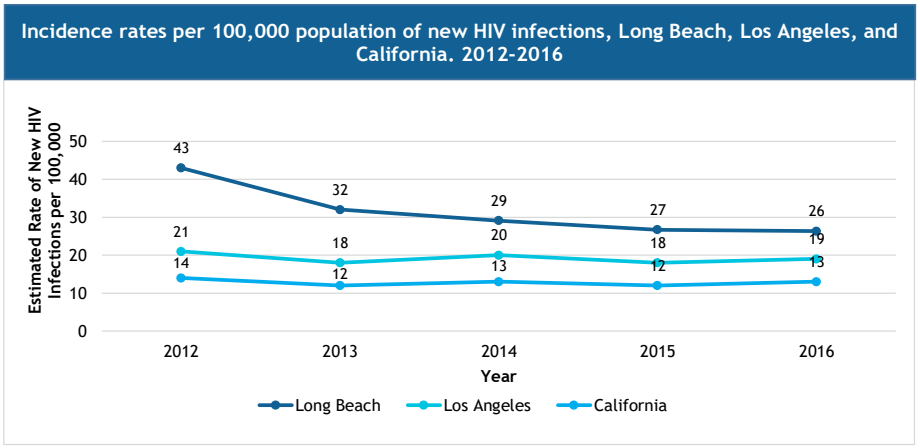
HIV Rates

As of December 31, 2017, there were 4,520 Long Beach residents diagnosed and living with HIV. Nationally, CDC estimated that, in 2016, another 14% of people are living with HIV and are undiagnosed. This would indicate that approximately 730 people in Long Beach are living with HIV and undiagnosed. The number of new HIV diagnoses declined by 33% overall from 151 individuals in 2013 to 101 individuals in 2017. A total of 37 recorded deaths were recorded in 2017. Eighty percent (80%) were diagnosed with only HIV, as opposed to HIV and later AIDS, or HIV and AIDS diagnosed simultaneously. Most persons living with HIV in Long Beach reside in the 90802 zip code.



[1] See Technical Notes "Date of Initial HIV Diagnosis."
[2] All HIV data taken from California Office of AIDS eHARS database.

In 2016, Long Beach had a rate of 26 new HIV infections per 100,000 population. This rate is higher than the new infection rates of Los Angeles County (19 per 100,000) and the State of California (13 per 100,000).

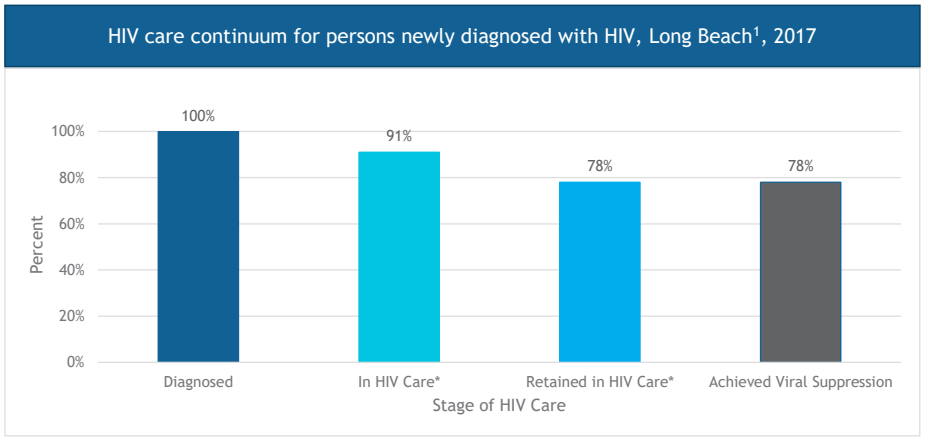


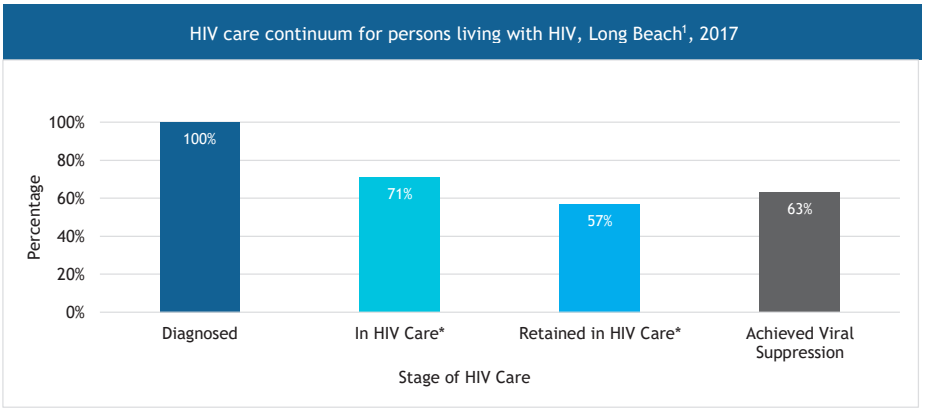
[1]Population data taken from California Department of Finance Demographic Research Unit Report P-3 State and County total population projections by race/ethnicity and detailed age; www.dof.ca.gov/Forecasting/Demographics/projections/.
[2]Long Beach HIV data taken from California Office of AIDS eHARS database.
[3]The latest available HIV data for Los Angeles County and California is for 2016. Therefore, 2012-20016 data was used for the figure to create a 5-year comparison.

HIV Care Continuum

In 2017, 78% of newly diagnosed HIV persons were retained in HIV care and 78% achieved viral suppression in the City of Long Beach. Asians and African Americans newly diagnosed with HIV had the lowest percentages of HIV care retention and viral suppression in 2017. For all persons living with HIV in Long Beach in 2017, 57% were retained in HIV care and 63% achieved viral suppression. In 2017, African Americans living with HIV had the lowest percentages of HIV care retention and viral suppression.

Achieving viral suppression for all individuals infected with HIV is crucial because people who are virally suppressed do not transmit HIV to their sexual partners. When people infected with HIV receive treatment right after their diagnosis, they not only improve their own health but the health of the community.





HIV Care Continuum Definitions:

- Diagnosed: Persons currently diagnosed and living with HIV.
- In HIV Care: Persons who have at least one CD4 or viral load or HIV-1 genotype test during the calendar year are engaged in care.
- Retained in HIV Care: Persons who have two or more CD4 or viral load or HIV-1 genotype tests that were performed at least 3 months apart during the calendar year are considered to be retained in care.
- Achieved Viral Suppression: Persons who have a most recent viral load test result <=200 copies/ml during the calendar year are virally suppressed for HIV.

2017 HIV FACTS

101
NEW CASES OF HIV

4,520
INDIVIDUALS LIVING WITH HIV

NEWLY DIAGNOSED

92%	36%	41%	67%
MALE	PERSONS AGED 30-39	LATINX	MEN WHO HAVE SEX WITH MEN

LIVING WITH HIV

90%	35%	39%	80%
MALE	PERSONS AGED 50-59	WHITE	MEN WHO HAVE SEX WITH MEN

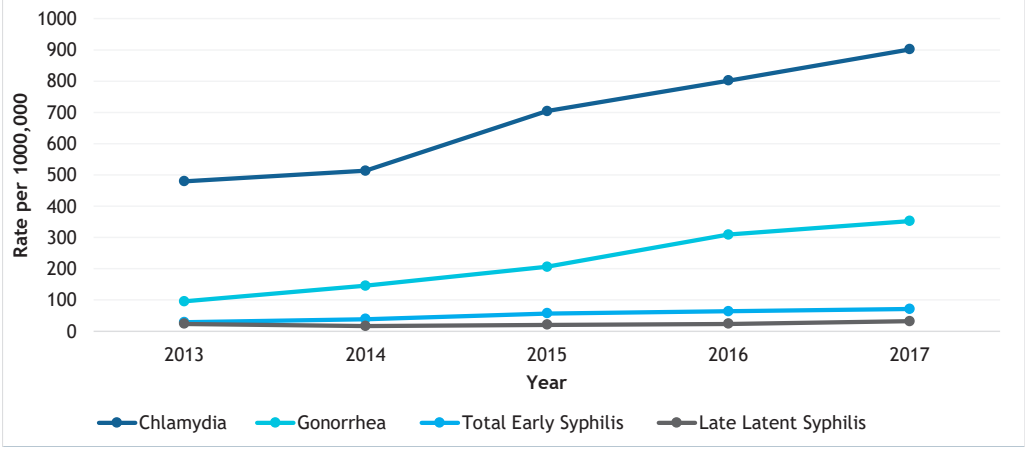
CARE CONTINUUM

71%	57%	63%
IN HIV CARE	RETAINED IN CARE	VIRALLY SUPPRESSED

Sexually Transmitted Diseases (STDs)

The rates for chlamydia, gonorrhea, and total early syphilis in Long Beach have seen an overall increase from 2013 to 2017. Most of sexually transmitted disease (STD) diagnoses in Long Beach are concentrated among young adults aged 15-29 years. Among those with available race/ethnicity data, African Americans had the highest rates of infection for chlamydia, gonorrhea, and total early syphilis in 2017. Most chlamydia cases occurred in the 90805-zip code; gonorrhea cases occurred most often in 90802 and 90805; and total early syphilis occurred most often in the 90802-zip code. For more information visit: www.longbeach.gov/hivstd.

Chlamydia, gonorrhea, total early syphilis, and late latent syphilis incidence rates per 100,000 population, Long Beach, 2013-2017

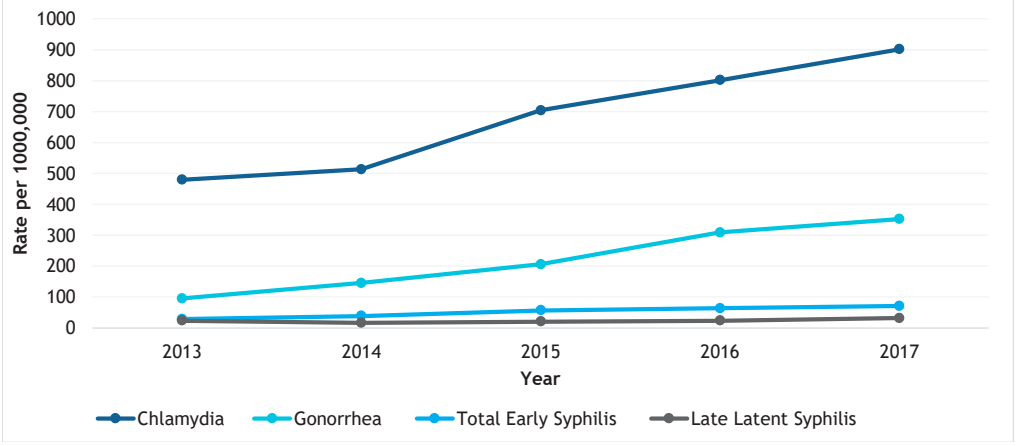


Note: Incidence rates are per 100,000 population.
Source: California Department of Public Health, STD Control Branch
State of California, Department of Finance, *California County Population Estimates and Components of Change by County*, July, 1, 2013-2017. Sacramento, California, December 2017.

Chlamydia

Chlamydia trachomatis is the most common reportable communicable disease in the City of Long Beach. Chlamydia rates in Long Beach have increased by 88% from 2013 to 2017. In 2017, Long Beach had the second highest rate of chlamydia in the State of California.

Chlamydia, gonorrhea, total early syphilis, and late latent syphilis incidence rates per 100,000 population, Long Beach, 2013-2017

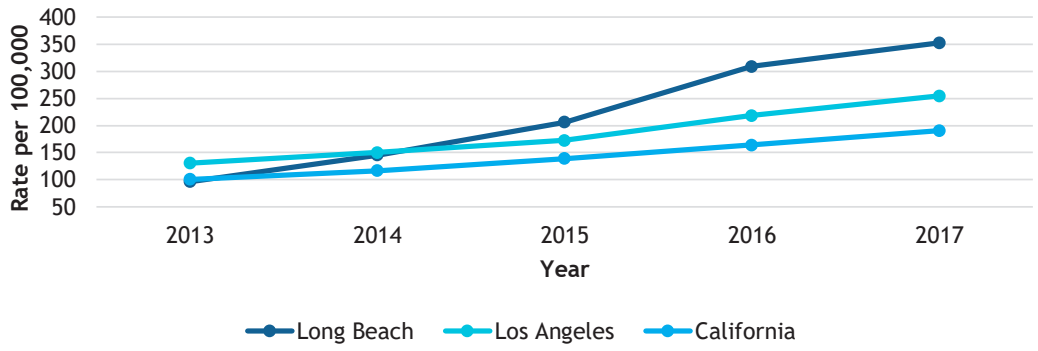


Note: Incidence rates are per 100,000 population.
Source: California Department of Public Health, STD Control Branch
State of California, Department of Finance, *California County Population Estimates and Components of Change by County*, July, 1, 2013-2017. Sacramento, California, December 2017.

Gonorrhea

Gonorrhea rates in Long Beach have increased by 267% from 2013 to 2017. In 2017, Long Beach had the second highest rate of gonorrhea in the State of California.

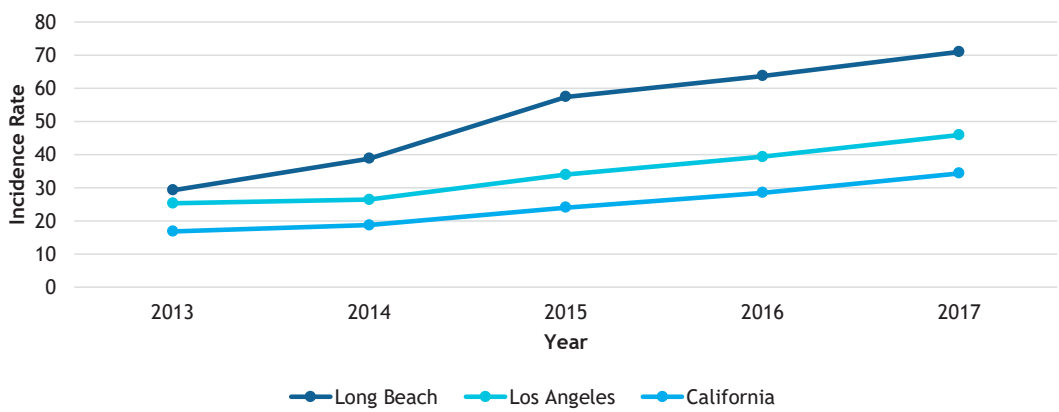
Gonorrhea incidence rates per 100,000 population, Long Beach, Los Angeles, and California, 2013-2017



Syphilis

Total early syphilis (primary, secondary, early latent syphilis) rates in Long Beach have increased by 143% from 2013 to 2017. In 2017, Long Beach had the third highest rate of total early syphilis in the State of California. Men who have sex with men (MSM) comprise 67% of syphilis cases in Long Beach; however, data for syphilis is incomplete so there may be an underestimation of syphilis among MSM. In the last three years (2014-2017) Long Beach has seen an increase in the number of women infected with syphilis. This is a concerning trend because pregnant women who are infected with syphilis can pass the disease to their unborn child. If their child contracts congenital syphilis, they can experience several poor health outcomes including stillbirth, neonatal death, blindness, deafness, and skeletal deformations. Women who are pregnant and infected with syphilis often require significant staff and community resources as they are on a strict treatment regimen and often have many barriers that must be overcome to get them treated.

Total early syphilis[1] incidence rates per 100,000 population, Long Beach, Los Angeles, and California, 2013-2017



2017 STD FACTS

4, 321
CASES OF CHLAMYDIA

1,690
CASES OF GONORRHEA

499
CASES OF SYPHILIS

CHLAMYDIA

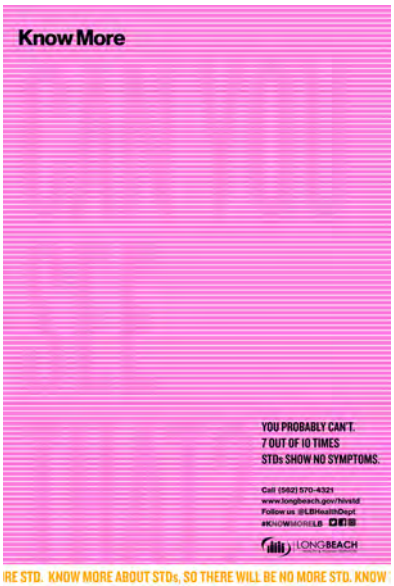
60% FEMALE	**52%** PERSONS AGED 15-24	**40%** LATINX	**2ND** HIGHEST RATES IN CA

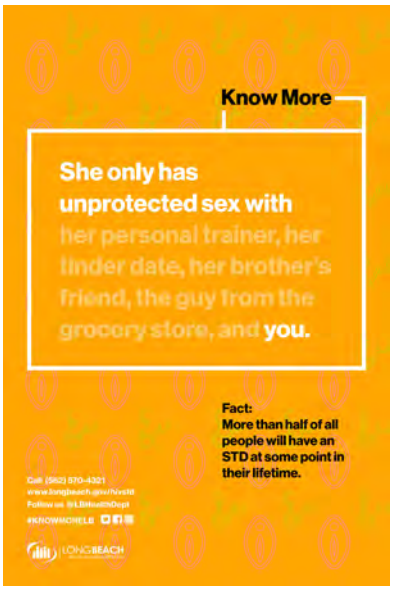
GONORRHEA

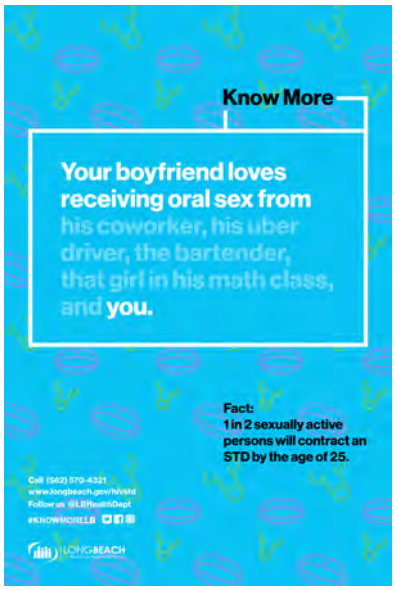
67% MALE	**45%** PERSONS AGED 20-29	**38%** AFRICAN AMERICAN	**2ND** HIGHEST RATES IN CA

SYPHILIS

91% MALE	**23%** PERSONS AGED 35-44	**43%** LATINX	**3RD** HIGHEST RATES IN CA







Based on epidemiological data and trends in the City of Long Beach, the Planning Group established five priority areas to address HIV and STDs. To begin to turn the tide of STDs and HIV, the City and its partners must come together through system coordination and resources to implement these strategies. The recommended goals include building capacity, educating providers and the community on HIV and STD testing and treatment, increasing testing and treatment availability, coordinating service provision, identifying undiagnosed HIV, linking newly diagnosed persons to care, retaining persons who are living with HIV in HIV care, reducing community viral load and expanding the availability of PrEP and PEP within the City to prevent HIV infections. In addition to working toward the goals to improve health outcomes, the Planning Group will prioritize strategies that meet the objectives of this plan. Furthermore, new investment and funding for the Health Department and community partners in the areas of surveillance, disease investigation, STD screening and treatment, PrEP/PEP and a visible focused campaign throughout the city is crucial to ensuring these goals are attained. The partners of this planning group recognize that no one organization can do this on their own and that this plan will only be effective if all the organizations come together to decrease STDs and HIV.

Goals

By 2022:

- **Reduce HIV and STD Infections in Long Beach**
- **Strengthen capacity to address HIV and STDs in Long Beach**
- **Educate communities on HIV/STD prevention, testing and treatment**
- **Increase access and engagement in care for HIV and STD treatment in Long Beach**
- **Expand PrEP and PEP access and engagement in Long Beach**

GOAL 1: REDUCE HIV AND STD INFECTIONS IN LONG BEACH

STD rates in the City of Long Beach are higher than nearly every county in California and although the rate of new infections for HIV declined in 2017, Long Beach remains higher than LA County and the State of California. Routine and comprehensive testing (extra genital testing-urethra, rectal and pharyngeal) for chlamydia and gonorrhea is essential for identifying those who have HIV or other STDs and linking them to important treatment services. Recent studies in Long Beach have found that while extra genital testing has increased significantly, it remains that only 14% of cases include extra genital tests. Relying on urinary testing leaves many people believing they are not infected.

Objective 1. Reduce new HIV infections by 50%.

Strategies

1a. Utilize mobile testing unit(s), co-location of services, and community and local partners within the City of Long Beach to reach clients in areas who have less access to testing and treatment centers. Increase the availability of HIV testing to include evening and weekend hours.

1b. Increase HIV prevention through testing and other support services (e.g., harm reduction or needle exchange programs for people who use and inject drugs).

1c. Focus on testing populations with the highest rates of infection--men who have sex with men, transgender persons, African American and Hispanic/Latino men and women, and men between the ages of 20-39.

1d. Expand access to condoms through educational institutions and community-based partners.

1e. Provide effective behavioral interventions such as client-centered counseling and group level interventions.

Objective 2: Increase proportion of Persons Living with HIV who are diagnosed to at least 90%.

Strategies

2a. Increase accessibility of HIV testing in communities disproportionately impacted. Cross promote all free, confidential, walk-in HIV and STD screening services to increase access points to testing and treatment.

2b. Improve ability to assess an individual's sexual risk to support recommendations for HIV testing, STD screening and provide risk reduction education to prevent and transmit such diseases.

2c. Utilize mobile testing unit(s), co-location of services, and community and local partners to reach clients in areas who have less access to testing and treatment centers. Increase the availability of HIV testing to include evening and weekend hours.

Objective 3: Reduce new infections for gonorrhea, chlamydia and syphilis by 20%.

Strategies

3a. Utilize mobile testing unit(s), co-location of services, and community and local partners to reach clients in areas who have less access to testing and treatment centers.

3b. Encourage providers to routinely test all individuals who report being sexually active on an annual basis (i.e. annual physical) for STDs and HIV.

3c. Encourage extra genital site testing (urethra, rectal and pharyngeal) for chlamydia and gonorrhea every 3 months for individual who are engaging in those sexual behaviors. Encourage PrEP uptake for individuals with reactive STD screens.

3d. Utilize Disease Intervention Specialists (DIS) to locate individuals who have fallen out of HIV care, need STD treatment or tested positive for HIV and/or chlamydia, gonorrhea and syphilis and did not return for teatment and care.

3e. Expand access to condoms within the City of Long Beach through educational institutions and community-based partners.

3f. Provide effective behavioral interventions such as client-centered counseling and group level interventions.

GOAL 2: STRENGTHEN CAPACITY TO ADDRESS HIV AND STDs IN LONG BEACH

The overall capacity of the Long Beach Health and Human Services Department, community medical providers and non-profit organizations is limited and is unable to address the scope and scale of the epidemic when current available services are considered. Significant funding as well as increased proficiency among the city's medical providers and non-profit organizations is essential.

Objective 1: Identify additional $2 million to strengthen the size and capacity of the HIV/STD system to meet the needs across the city to reduce infections.

Strategies

1a. Identify additional $2 million in funding opportunities in partnership with federal, state, county and local agencies to increase staffing and support across the city to allow for increased education, surveillance, disease investigation, testing, treatment, linkage to care and overall system coordination.

1b. Utilize surveillance data to track trends, identify communities who are experiencing the highest rates of infection, and build service capacity to meet the needs of the community.

1c. Develop a comprehensive tool outlining all STD and HIV resources available in Long Beach to establish awareness of services among providers.

1d. Design and implement a coordinated service model across the many service providers (e.g., non-profit agencies, people with lived experience, medical providers, hospitals and academic institutions) building on the strengths of each partner to create an effective patient centered care model.

Objective 2: Educate 100 providers each year in the standards of care for STDs and HIV to support a robust STD and HIV continuum of care.

Strategies

2a. Develop training for medical providers on STD and HIV standards of care and reporting requirements.

2b. Develop trainings to improve capacity and cultural humility of providers and programs that deliver services to the most disproportionately affected populations.

2c. Train providers on signs and symptoms of STDs and HIV, who should be tested and how often, treatment guidelines, and reporting requirements for STDs and HIV.

2d. Train providers on PrEP and PEP as HIV biomedical prevention.

2e. Promote California Department of Public Health Screening and Treatment Recommendations.

2f. Provide a comprehensive toolkit outlining STD and HIV resources within Long Beach.

GOAL 3: EDUCATE COMMUNITIES ON HIV/STD PREVENTION, TESTING AND TREATMENT

An understanding of the ways in which HIV/STDS are transmitted, how to prevent transmission, and importance of and access to testing and treatment is essential to reducing infections across the City. Different populations in the city will require different messages and formats to ensure they have access to the information and they are willing to take necessary precautions.

Objective 1: Conduct STD and HIV workshops to 4,000 adolescents and young adults (ages 15-29) per year.

Strategies

1a. Develop a sexual health curriculum that is medically accurate for Long Beach Unified School District (LBUSD) which includes information on the following: STDs, HIV, PrEP, PEP, contraceptives, consent, and a hands-on demonstration on how to use a condom.

1b. Partner with higher education institutions such as Long Beach City College (LBCC) and California State University Long Beach (CSULB) to enhance sexual health curricula.

1c. Partner with Long Beach Unified School District, private schools and post-secondary institutions to deliver HIV/STD curricula.

Objective 2: Provide HIV and STD education at 30 community events per year.

Strategies

2a. Participate in community events including health fairs that focus on adolescents and young adults (ages 15-29), African-American, Latino and LGTBQ communities to promote awareness of HIV testing and STD screening and treatment locations.

2b. Distribute informational pamphlets on HIV and STDs, information on testing and treatment sites and information on PrEP/PEP sites in Long Beach.

2c. Provide HIV Rapid Testing at community events utilizing mobile testing units and partnered agencies.

Objective 3: Leverage and expand existing educational Campaigns to increase awareness of HIV and STDs among populations who are disproportionately impacted.

1a. Identify non-traditional settings (i.e. local markets, barber and beauty shops, churches, medical marijuana dispensaries, etc.) to expand presence of existing educational campaign materials in communities with highest infection rates.

1b. Utilize social media platforms (i.e. Facebook, Instagram, Twitter etc.) to advertise existing educational campaigns in the city.

GOAL 4: INCREASE ACCESS AND ENGAGEMENT IN CARE FOR HIV AND STD TREATMENT IN LONG BEACH

Effective treatment of STDs and HIV medical care effectively reduces the number of people carrying transmissible infections. STDs can be treated by antibiotics. Essential Access Health provides free patient delivered partner therapy (PDPT) for individuals who have been diagnosed with chlamydia and gonorrhea. PDPT allows a medical provider to provide treatment medications to sexual partners without being seen by the medical provider. This streamlines access to treatment medication. This has been a successful way of reducing reinfection rates of chlamydia and gonorrhea.

Engaging in HIV care and adhering to medical protocols can achieve full viral suppression, otherwise referred to as undetectable viral load. Research has found that an Undetectable viral load means that HIV is Untransmittable (U=U). Reengaging people who are not adhering to HIV medication and ensuring those who are diagnosed as positive engage in care is important to stemming new HIV infections.

Objective 1: Increase the percentage of newly HIV diagnosed persons in Long Beach who access HIV medical care within 30 days of their HIV diagnosis to at least 85%.

Strategies

1a. Improve reporting of newly diagnosed HIV cases to the Health Department.

1b. Strengthen coordination across medical providers and non-profit organizations who provide testing to ensure linkage to HIV care and treatment within 30 days of new HIV diagnosis.

1c. Utilize and increase the number of Disease Intervention Specialists (DIS) to identify and link individuals into care and treatment.

1d. Provide every person newly diagnosed HIV information about HIV Support Groups in Long Beach.

Objective 2: Increase viral suppression of persons living with HIV (PLWH) to at least 90%.

Strategies

2a. Create and provide effective interventions for medical providers who engage with individuals who are non-adherent to HIV medication to support in re-engaging individual back into care.

2b. Deliver consistent and routine messaging that an undetectable viral load means that HIV is untransmittable (U=U) to all patients living with HIV utilizing medical providers and support systems.

2c. Utilize DIS to locate individuals who have fallen out of HIV care and re-engage them to care.

2d. Empower people living with HIV/AIDS to help themselves and others around issues related to prevention and care.

Objective 3: Ensure an additional 10 high burden clinics carry/ administer treatment for chlamydia, gonorrhea and syphilis.

Strategies

Strategy 3a. Assist in acquiring syphilis medication for providers.

Strategy 3b. Promote patient delivered partner therapy (PDPT) among providers and help connect providers with Essential Access Health to deliver FREE PDPT for chlamydia and gonorrhea.

GOAL 5: EXPAND PrEP AND PEP ACCESS IN LONG BEACH

PrEP and PEP are effective tools in the prevention of HIV. Pre-Exposure Prophylaxis (PrEP) is taking a daily medication called Truvada, to prevent the acquisition of HIV among HIV negative individuals. PrEP is taken before an HIV exposure and can reduce the risk of getting HIV from sex by more than 90% and from injection drug use by more than 70%. PrEP services include quarterly STD screening and treatment if necessary, which works to support the plan's goal of increased testing. Post-Exposure Prophylaxis (PEP), a medication regimen for 28 days, is taken within 72 hours after possible exposure to HIV. PEP is effective in preventing HIV infection when taken correctly, but is not 100% effective. A high-risk HIV exposure and PEP can be an effective way of engaging higher-risk individuals in PrEP services.

Objective 1. Increase PrEP enrollment among HIV negative individuals to 4,550 individuals.

Strategies

1a. Provide education and promote benefits of PrEP among Latino and African-American MSM, intravenous drug users, transwomen and sex workers when testing for HIV and/or STD screening.

1b. Provide linkages to PrEP for injection drug users (IDU).

1c. Promote PrEP/PEP clinics throughout Long Beach with direct contact information on social media, social networks, email lists, city websites, and the Health Department website.

1d. Collaborate with local Emergency Departments to assist them in linking individuals who obtain PEP to PrEP services.

Objective 2. Train 500 service and medical providers on PrEP and PEP.

Strategies

2a. Equip providers with the CDC PrEP Clinical Practice Guidelines to reduce the risk of acquiring HIV infection in high risk individuals (MSM, youth ages 15-29, transgender women and men).

2b. Promote CDC's Guide to Taking a Sexual History for providers to assess a patient's risk to HIV and encourage PrEP for those that qualify.

2c. Utilize Pleaseprepme.org to gain access to information and several tools to guide providers in prescribing PrEP and PEP.

2d. Provide information on health insurances that cover PrEP and PEP and the enrollment process.

City of Long Beach
333 W. Ocean Blvd.
Long Beach, CA 90802

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Rev 1. 05.02.19

MEMBERSHIP APPLICATIONS ON FILE

- Alexander Luckie Fuller
- Damontae Hack
- Ernest Walker
- Guadalupe Velazquez

SUMMARY - RWP EXPENDITURE REPORT
As of November 5, 2020

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HIV AND STD PROGRAMS
RYAN WHITE PART A, MAI YEAR 30 AND PART B YR 2 (2020) EXPENDITURES BY SERVICE CATEGORIES

1	2	3	4	5	6
SERVICE CATEGORY	TOTAL FULL YEAR ESTIMATED EXPENDITURES PART A AND MAI	TOTAL FULL YEAR ESTIMATED EXPENDITURES PART B	TOTAL FULL YEAR ESTIMATED EXPENDITURES (Total Columns 2+3)	COH 2020 ALLOCATION PERCENTAGE APPLIED TO GRANT AWARD DIRECT SRVC PLUS PART B DIRECT SRVC	VARIANCE BETWEEN ALLOCATED BUDGETS AND TOTAL FULL YEAR ESTIMATED EXPENDITURES (Columns 5 - 4)
OUTPATIENT/ AMBULATORY MEDICAL CARE (AOM)	$ 7,771,456	$ -	$ 7,771,456	$ 9,584,184	$ 1,812,728
MEDICAL CASE MGMT (Medical Care Coordination)	$ 12,239,257	$ -	$ 12,239,257	$ 10,513,048	$ (1,726,209)
ORAL HEALTH CARE	$ 4,864,791	$ -	$ 4,864,791	$ 4,960,976	$ 96,185
MENTAL HEALTH	$ 363,459	$ -	$ 363,459	$ 211,105	$ (152,354)
HOME AND COMMUNITY BASED HEALTH SERVICES	$ 2,799,923	$ -	$ 2,799,923	$ 2,346,788	$ (453,135)
EARLY INTERVENTION SERVICES (HIV Testing Services)	$0	$ -	$ -	$ 207,587	$ 207,587
NON-MEDICAL CASE MANAGEMENT (Benefits Specialty Services and Transitional Case Management)	$ 1,916,408	$ -	$ 1,916,408	$ 2,291,134	$ 374,726
HOUSING (RCFCI, TRCF, and Permanent Supportive)	$ 3,172,138	$ 3,659,279	$ 6,831,417	$ 7,397,513	$ 566,096
OUTREACH (Linkage and Re-engagement Program and Partner Services)	$ 751,855	$ -	$ 751,855	$ 1,959,762	$ 1,207,907
SUBSTANCE ABUSE TREATMENT - RESIDENTIAL	$ -	$ 1,013,850	$ 1,013,850	$ 785,200	$ (228,650)
MEDICAL TRANSPORTATION	$ 503,260	$ -	$ 503,260	$ 664,982	$ 161,722
FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT	$ 3,026,341	$ -	$ 3,026,341	$ 2,093,462	$ (932,879)
LEGAL	$ 115,197	$ -	$ 115,197	$ 56,295	$ (58,902)
SUB-TOTAL DIRECT SERVICES	$ 37,524,085	$ 4,673,129	$ 42,197,214	$ 43,072,036	$ 874,822
QUALITY MANAGEMENT	767,163	-	767,163	$ 1,330,192	$ -
ADMINISTRATIVE SERVICES	4,433,910	500,000	4,933,910	$ 4,933,971	$ (61)
GRAND TOTAL	**$ 42,725,158**	**$ 5,173,129**	**$ 47,898,287**	**$ 49,336,199**	**$ 1,437,912**
GRAND TOTAL PLUS $285,908 MAI YR 29 Carryover	**$ 42,725,158**	**$ 5,173,129**	**$ 47,898,287**	**$ 49,622,107**	**$ 1,723,820**

RYAN WHITE PART A SUMMARY

DRAFT

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HIV AND STD PROGRAMS
SUMMARY REPORT
GRANT YEAR 30 RYAN WHITE PART A FUNDING EXPENDITURES THROUGH FEBRUARY 2021 (as of Nov 5, 2020 and invoicing up to September 2020)

1	2	3	4	5	6
PRIORITY RANKING	SERVICE CATEGORY	PART A COH ALLOCATIONS	PART A TOTAL YTD EXPENDITURES	PART A FULL YEAR EXPENDITURES	VARIANCE BETWEEN COH ALLOCATIONS AND TOTAL FULL YEAR ESTIMATED EXPENDITURES (Columns 3-5)
1	OUTPATIENT/AMBULATORY MEDICAL CARE	27.24%	4,207,919	7,771,456	$ 1,812,728
4	MEDICAL CASE MGMT (Medical Care Coordination)	29.88%	6,145,911	12,239,257	$ (1,726,209)
11	ORAL HEALTH CARE	14.10%	2,402,627	4,864,791	$ 96,185
3	MENTAL HEALTH	0.60%	206,184	363,459	$ (152,354)
16	HOME AND COMMUNITY BASED HEALTH SERVICES	6.67%	1,398,938	2,799,923	$ (453,135)
7	EARLY INTERVENTION SERVICES (HIV Testing Services)	0.59%	0	0	$ 207,587
10	NON-MEDICAL CASE MANAGEMENT (Benefits Specialty Services)	5.92%	759,535	1,280,587	$ 802,319
2	HOUSING (RCFCI, TRCF)	1.42%	398,871	468,871	$ 30,745
5	OUTREACH SERVICES (Linkage and Re-engagement Program and Partner Services)	5.57%	252,870	751,855	$ 1,207,907
15	SUBSTANCE ABUSE TREATMENT - RESIDENTIAL	0.00%	0	0	$ -
9	MEDICAL TRANSPORTATION	1.89%	191,382	503,260	$ 161,722
13	FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT	5.95%	1,689,905	3,026,341	$ (932,879)
21	LEGAL	0.16%	976	115,197	$ (58,902)
	SUB-TOTAL DIRECT SERVICES	**100%**	**17,655,118**	**34,184,997**	**$ 995,715**
	QUALITY MANAGEMENT	1,330,192	275,643	767,163	$ 563,029
	ADMINISTRATION (Includes COH Budget) (10% of Part A award)	4,057,158	2,787,071	4,057,097	$ 61
	GRAND TOTAL	**$ 40,571,580**	**$ 20,717,832**	**$ 39,009,257**	**$ 1,562,323**

Year 30 Grant funding for Part A is $40,571,580

* Early Intervention Services - PHI staff salary transfers updated through Sept. 2019

RYAN WHITE MAI SUMMARY

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH

DIVISION OF HIV AND STD PROGRAMS

GRANT YEAR 30 RYAN WHITE MAI FUNDING EXPENDITURES THROUGH FEBRUARY 2021 (as of Nov 5, 2020 and invoicing up to September 2020)

1	2	3	4	5	6
PRIORITY RANKING	SERVICE CATEGORY	TOTAL ALLOCATION MAI FY 30	MAI FISCAL YEAR 30 TOTAL YTD EXPENDITURES	MAI FISCAL YEAR 30 FULL YEAR EXPENDITURES	VARIANCE BETWEEN COH ALLOCATIONS AND TOTAL FULL YEAR ESTIMATED EXPENDITURES (Columns 3-5)
1	OUTPATIENT/AMBULATORY MEDICAL CARE	0.00%			$ -
4	MEDICAL CASE MGMT (Medical Care Coordination)	0.00%			$ -
11	ORAL HEALTH CARE	0.00%			$ -
3	MENTAL HEALTH	0.00%			$ -
16	HOME AND COMMUNITY BASED HEALTH SERVICES	0.00%			$ -
7	EARLY INTERVENTION SERVICES (HIV Testing Services)	0.00%			$ -
10	NON-MEDICAL CASE MANAGEMENT (Transitional Case Management)	6.14%	366,739	635,821	$ (427,594)
2	HOUSING (Permanent Supportive Housing/Housing for Health Program)	93.86%	1,351,633	2,703,267	$ 479,830
5	OUTREACH (Linkage and Re-engagement Program and Partner Services)	0.00%			$ -
15	SUBSTANCE ABUSE TREATMENT - RESIDENTIAL	0.00%			$ -
9	MEDICAL TRANSPORTATION	0.00%			$ -
13	FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT	0.00%			$ -
21	LEGAL	0.00%			$ -
	SUB-TOTAL DIRECT SERVICES	100%	**1,718,372**	**3,339,088**	**$ 52,236**
	ADMINISTRATION (10% of MAI Year 30 award)	376,813	188,629	376,813	$ -
	GRAND TOTAL	**$ 3,768,137**	**$ 1,907,001**	**$ 3,715,901**	**$ 52,236**

The total MAI funding for Year 30 is $3,768,137 plus $285,908 from Year 29 approved roll over funding. However, this table only reflects the base award without the carryover funds

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HIV AND STD PROGRAMS
GRANT YEAR 30 RYAN WHITE PART B FUNDING EXPENDITURES THROUGH MARCH 2021 (as of Nov 5, 2020 and invoicing up to September 2020)

1	2	3	4	5	6
PRIORITY RANKING	SERVICE CATEGORY	PART B BUDGET	PART B TOTAL YTD EXPENDITURES	PART B FULL YEAR ESTIMTED EXPENDITURES	VARIANCE TOTAL BUDGET VS. FULL YR. ESTIMATED EXPENDITURES (Columns 3-5)
1	OUTPATIENT/AMBULATORY MEDICAL CARE				$ -
4	MEDICAL CASE MGMT SVCS (Medical Care Coordination)				$ -
11	ORAL HEALTH CARE				$ -
3	MENTAL HEALTH				$ -
16	HOME AND COMMUNITY BASED HEALTH SERVICES				$ -
7	EARLY INTERVENTION SERVICES (HIV Testing Services)				$ -
10	NON-MEDICAL CASE MANAGEMENT (Benefits Specialty Services and Transitional Case Management)				$ -
2	HOUSING (RCFCI, TRCF)	3,714,800	1,829,640	3,659,279	$ 55,521
5	OUTREACH (Linkage and Re-engagement Program and Partner Services)				$ -
15	SUBSTANCE ABUSE TREATMENT- RESIDENTIAL	785,200	506,925	1,013,850	$ (228,650)
9	MEDICAL TRANSPORTATION				$ -
13	FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT				$ -
21	LEGAL				$ -
	SUB-TOTAL DIRECT SERVICES	**$ 4,500,000**	**$ 2,336,565**	**$ 4,673,129**	$ (173,129)
	QUALITY MANAGEMENT	$ -	$ -	$ -	$ -
	ADMINISTRATION (10% of Part B award)	$ 500,000	$ 202,386	$ 500,000	$ -
	GRAND TOTAL	**$ 5,000,000**	**$ 2,538,951**	**$ 5,173,129**	**$ (173,129)**

Year 2 State allocation for Part B is $5,000,000.

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COMMISSION ON HIV

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

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

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

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

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

Full Council:

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

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

- Consider adding the word "Prevention" in PP&A Committee's name.

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

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

Child Care Services Consumer Listening Session
Notes/Summary

Overview

The Division of HIV and STD Programs (DHSP) in collaboration with HIV Resources Service Administration (HRSA) Part D Recipients (UCLA and Los Angeles County + USC/Maternal Child, and Adolescent/Adult Center (MCA)), the Commission on HIV (COH), and the COH Women's Task Force conducted virtual listening sessions with community consumers to further determine their need for Child Care Services while attending medical and support service appointments.

Purpose

The purpose of these listening sessions was to further determine consumer Child Care needs to inform the Commission on HIV (COH) Child Care Services Standards of Care.

Below are the notes from these listening sessions submitted on behalf of DHSP, UCLA, MCA, COH, and the COH Women's Task Force.

Method/Process

Three online Zoom sessions were held with a total of 24 cis-gender women (women). An English-only session was held on October 18, 2020 with eight (8) participants, a Spanish-only session was held on October 23, 2020 with eight (8) participants, and a bilingual (English/Spanish) session on October 25, 2020 with eight (8) participants. Demographic information was not formally collected. However, the 24 women who participated were either African American and/or Latina.

The women had children whose ages ranged from four (4) to 15 years old. There was a subset of women who no longer had dependent children but had experienced accessing Child Care Services in the past.

The sessions were facilitated through Zoom. UCLA and MCA staff were the primary recruiters for the listening session participants. Promotion of the listening sessions was done via email and social media.

The sessions were co-facilitated by staff from UCLA, MCA and DHSP.

Listening Sessions Questions

1. Is childcare a barrier to attending your medical, dental, mental health, support service appointments? Please explain and tell me some more about that.

2. Please tell me more about the child-watch services that are currently offered by your medical, dental, mental health, support service provider.

3. For those of you that have received child-watch services during one of your appointments, please tell me how happy you were with the service? Did it work for you? Did it not work for you and why?

4. Who do you usually rely on now for childcare services to attend your medical, dental, mental health appointments? Are you happy with this option and please tell us more about it?

5. Please tell us what ideally this service should look like to best serve you?

6. Is there anything else we should know about your childcare needs to help you get to your medical, dental, mental health, case management, other support services appointments?

Main Themes

Access to Care

- For the participants who access their medical care at MCA, childcare services were not a significant barrier for them to attend medical appointments. Before the COVID-19 pandemic and Safer at Home Orders were released, MCA offered childcare services. These same participants noted that lack of childcare was a barrier to for accessing other medical services outside of the MCA clinic, such as dental appointments, labs/x-rays. They noted that e on-site child care offered by MCA was not available for these types of appointments. The participants described that childcare services had not been as accessible as in previous years (pre-COVID). (MCA had reported that the staff assigned to provide childcare had been on medical leave.)
- Participants who were not part of the MCA, noted the lack of on-site childcare was a significant barrier to them keeping their medical appointments.
- Participants in all focus groups noted they are usually forced to bring their children with them and try to occupy them with things (such as their cell phone) during their appointments. This was also noted by MCA-clients given the interruption/lack of continuous on-site childcare at that clinic.
- Participants noted that many times they did not feel comfortable asking the doctor questions or they were not able to pay full attention to what the doctor was telling them because their children were a distraction.
    - The number of children per participant ranged from 1 to 4.
    - Traveling with children on the bus was also mentioned as a challenge to traveling to appointments as, many participants only could travel by bus.
- All participants shared that if they were not able to take their children with them and if they did not have childcare at home, they would cancel their appointment.
    - During remote schooling (as a result of the COVID-19 pandemic), some noted that they would rather cancel the appointment, so their child would not miss school.

Current Services

- All focus group participants noted they would like a childcare/child watch program to have the following components:
    - do their homework/attend school while they are in the clinic
    - Provide food for the children (and clients) given that for many, attending a doctor's appointment is an all-day endeavor
    - Ensure that childcare staff are trained to address the needs of children with special needs.
- Participants receiving their HIV medical care at MCA noted they would like to be able to access the childcare/child watch program for non-MCA medical appointments

Outside Sources of Support

- Most focus group participants reported that they did not have trusted or reliable outside support to use as an option to watch their children.

- Some participants noted they could sometimes rely on family and friends--but not all the time. Participants with multiple children found it more difficult to rely on family and friends for childcare/watch.
- Some noted not trusting others, including family or ex-spouses, with the care of their children because of potential harmful situations (e.g., abuse/neglect).

Components recommended in a Child Care Services program:

Staffing:

- Core training requirements to handle children with special needs for staff
- CPR-certified staff
- Staff with childcare education background
  Staffed with enough people to provide appropriate one-on-one oversight of the children

Environment

- Internet access
- Computers for the kids to use during school hours
- Age appropriate educational supplies
- Food/snacks
- Masks for the kids and PPE
- Kid-friendly space with lots of seating, visually nice and kid-friendly videos available to watch
- Open 5 days a week

Gift Cards

- Many of the participants agreed gift cards would be useful to pay others (neighbors, family members) to watch their children during their appointments. They shared that they currently pay someone between $25 or $50 per child for a few hours. For multiple children and multiple appointments, this can become expensive and unsustainable.
- Visa gift card were most preferred as they “are like cash”.

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FOR COMMISSION ON HIV REVIEW 12/10/20

AGING TASK FORCE RECOMMENDATIONS
(Updated 12/07/20)

Background: The Aging Task Force (ATF) was formed in February 2019 to address the broad health needs of those over 50 years living with HIV and long-term survivors. According the Health Resources and Service Administration (HRSA), the RWHAP client population is aging. Of the more than half a million clients served by RWHAP, 46.1 percent are aged 50 years and older and this continues to grow. While Ryan White clients in Los Angeles County show higher engagement and retention in care, and viral suppression rates, within the 50+ population there exists disparities by racial/ethnic, socioeconomic, geographic, and age groups stratification.

The ATF developed the following recommendations to the Commission on HIV, Division of HIV and STD Programs (DHSP) and other County and City partners to address the unique needs of this population. The term older adults refer to individuals who are age 50 and older.

This is a living document and the recommendations will be refined as key papers such the State of California Master Plan on Aging and APLA's HIV and Aging Townhall Forums are finalized in the next few weeks.

Ongoing Research and Needs Assessment:

- Encourage the Division of HIV and STD Programs (DHSP) to collaborate with universities, municipalities, and other agencies that may have existing studies on PLWH over 50 to establish a better understanding of the following issues:
    - Conduct additional analysis to understand why approximately 27% of new diagnoses among persons aged 50-59 and 36% of new diagnoses among person aged 60 and older were late diagnoses (Stage 3 – AIDS) suggesting long-time infection. This may reflect a missed opportunity for earlier testing as it seems likely that persons aged 50 and older may engage in more regular health care than younger persons. (Data Source: http://www.publichealth.lacounty.gov/dhsp/Reports/HIV/2019Annual_HIV_Surveillance_Report_08202020_Final_revised_Sept2020.pdf)
    - Gather data on PLWH over 50 who are out of care or those who have dropped out of care to further understand barriers and service needs.
    - Conduct studies on the prevention and care needs of older adults.

- Understand disparities in health outcomes within the 50+ population by key demographic data points such as race/ethnicity, gender, geographic area, sexual orientation, and socioeconomic status.
- Gather data on the impact of the aging process as PLWH over 50 reach older age brackets. Articulate distinct differences in older age groups.
- Conduct deeper analysis on mental health, depression, isolation, polypharmacy and other co-morbidities that impact the quality of life of older adults living with HIV.
- Conduct analysis of best practices on serving older adults in non-HIV settings and adapt key strategies for a comprehensive and integrated model of care the population. Examples of best practices to explore are National Association of Area Offices on Aging (https://www.n4a.org/bestpractices) and Substance Abuse and Mental Health Services Administration and Health Resources and Services Administration, Growing Older: Providing Integrated Care for an Aging Population. HHS Publication No. (SMA) 16-4982. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016.
- Request DHSP to develop a data collection and reporting plan with a timeline on an annual report to the community.

Workforce and Community Education and Awareness:

- Educate the Commission on HIV, Department of Public Health, HIV workforce and community at large on ageism, stigma, and build a common understanding of definitions of older adults, elders, aging process and long-term survivors.
- Address ageism on the Commission on HIV and the community at large through trainings and by convening panels composed of Ryan White and prevention services clients and subject experts.
- Openly discuss and examine as part and parcel of HIV planning and implementation, the impediments to HIV prevention and care among aging populations posed by the historically embedded discrimination and bigotry institutionalized in mainstream US culture and society, as well as embedded in subcultural (ethnic, racial, social, religious, etc.) cultures and institutions that often goes unacknowledged: that is the interconnected/overlapping linkages between ageism (or what is expressed in ageism) and societal heteronormativity/homophobia (internalized and cultural), sexism, misogyny, racism, xenophobia, ableisms, and all forms of discrimination and bigotry targeting "The Other."
- Educate the HIV workforce on HIV and aging, including but not limited to how to work with the non-profit sector to link seniors to health, social services, and HIV prevention and treatment services.
- Train the HIV workforce on diseases of aging, such as cardiovascular disease and osteoporosis and dementia, and equip staff with the knowledge and skills to properly assess and treat conditions that impact older adults.
- Train older adults on how to adapt to the new realities of seeking care as they progress in the age spectrum. Train the HIV workforce on how to develop and deliver classes to older adults with respect, compassion, and patience.
- Expand opportunities for employment among those over 50 who are able and willing to work.

- Provide training on the use of technology in managing and navigating their care among older adults.
- Collaborate with the AIDS Education Centers to train HIV service providers on becoming experts and specialists on caring for older adults with HIV.
- Collaborate with local resources and experts in providing implicit bias training to HIV service providers.

Expand HIV/STD Prevention and Care Services for Older Adults:

- Expand and develop service models that are tailored for the unique needs of PLWH over 50. Specifically, community members representing older adults living with HIV have identified ambulatory/outpatient medical, medical care coordination, and mental health as key services they need. Unify and coordinate care within a medical home and reduce referrals to specialty care, if appropriate.
- Integrate an annual patient medical records review by gerontologist for PLWH over 50 in the Medical Care Coordination and Ambulatory/Outpatient Medical programs. The annual medical records review should review care needs for mental health, polypharmacy, social support, mobility, and other markers of overall health and quality of life. Ensure that MCC teams monitor and assist patients affected by cognitive decline in navigating their care.
- Customize food/nutrition and physical activity and mobility services for the aging population. Remedial exercise and rehabilitation to maintain or regain muscle mass may be needed for some older adults to help them remain in care and virally suppressed.
- Enhance the payment structure for services rendered to older adults living with HIV as they may require more frequent, longer, and more intensive and individualized medical visits and routine care to maintain their overall health as they progress in the age continuum.
- Expand supportive services, such as financial assistance, as incomes become more fixed in older age. As frailty increases with age, services should be customized by specific age groups.
- Address social isolation by supporting psychosocial and peer support groups designed for older adults. Leverage the work of agencies that already provide support groups for older adults and encourage the community to join or start a support group.
- Address technological support for older adults living with HIV as medical service modalities rely more and more electronic, virtual, and telehealth formats.
- Dedicate at least 15% of prevention funds to programming specifically tailored for individuals over 50. According to the California HIV Surveillance Report, persons over 50 accounted for 15% of all new infections. A similar trend is observed for Los Angeles County with about 13-14% of new HIV diagnoses occurring among persons aged 50 and older
- Address the lack of sexual health programs and social marketing efforts geared for older adults. Social marketing and educational campaigns on PrEP and Undetectable=Untransmittable (U=U) should include messages and images with older adults.

- Integrate programming for older adults in the use of Ending the HIV Epidemic funds in Los Angeles County. Schedule annual reports from the Division of HIV and STD Programs (DHSP) on how they are addressing HIV and aging.

General Recommendations:

- Collaborate with traditional senior services or physicians, or other providers who specialize in geriatrics and leverage their skills and expertise of those outside the HIV provider world.
- Ensure access to transportation and customize transportation services to the unique needs of older adults.
- Benefits specialists should be well versed in Medicare eligibility and services to assist those individuals who are aging with HIV
- Direct DHSP to start working with agencies that serve older adults such as the Los Angeles County Workforce Development, Aging and Community Services, City of Los Angeles Department of Aging, and DPH Office of Senior Health to coordinate and leverage services.
- Ensure robust and meaningful input from older adults living with HIV in Commission deliberations on HIV, STD and other health services.

LOS ANGELES COUNTY COMMISSION ON HIV

Adopted by BAAC Task Force 10.26.20

Black African American Community Task Force
Commitment Statement

The Black African American Community Task Force (BAAC) convened on April 30, 2019 to develop a progressive and inclusive agenda to address and provide recommendations to the Los Angeles County (LAC) Commission on HIV (COH) and Division of HIV and STD Programs (DHSP), on how to reduce and ultimately eliminate the disproportionate impact of HIV/AIDS and STIs[i] in all subsets of the Black/African-American (Black/AA) community by utilizing a community-wide mobilization effort.

With the full understanding that among **preventable, curable and medically manageable health conditions, Black/AA populations continue experience worse outcomes when compared with all other demographics across LAC, the BAAC aims to:**

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

Who we are:

The BAAC 'Village' is comprised of community advocates, leaders and health care professionals. The diversity of both professional and life experience provides a unique opportunity to advise DHSP; and other bodies who serve Black/AA people, on process that ensures equitable allocation of funding and resources that will impact our people currently living with or at risk for HIV.

The BAAC actively focuses its efforts on equity, justice, and equality[ii] as the historical disparities in HIV morbidity and mortality is a direct reflection of unequal access to HIV prevention and treatment services. We believe equality requires the allocation of resources be proportionate to HIV incidence and prevalence. Equity considers the harmful impact of systemic racism, genderism, classism and misogyny[iii] and recognizes resource distribution will not by itself close the historic health gap between Black/AAs and non-Black/AAs.

Nothing about us without us!

The BAAC will continue to operate from a position of solidarity and strength. The BAAC recognizes that it is comprised of individuals who share a common bond being vested within the Black/AA HIV community. We fully recognize that member diversity may lead to differences in problem solving approaches, opinions and communication; which if unresolved, not celebrated, and unappreciated, can and will lead to a malfunctioning body. To remedy this, all members of the BAAC agree to a code of conduct exemplifying excellence, respect for self and other taskforce members and constructive methods of communication that honor and support our variety of viewpoints and opinions.

The BAAC is united in ensuring that the COH and DHSP is actively aware of disproportionate HIV/STI related outcomes by race, sex/gender, and class. We remain proactive in providing solutions that are constructed and discussed through an antiracist and antimisogynistic lens. The BAAC is unwilling to accept the current status quo that perpetuates continued lack of adequate medical care, support and well-being.

As a testament to our commitment to the betterment of the sexual health of Black/AA in Los Angeles County, the BAAC offered 14 general/overall recommendations and 9 population-specific recommendations for consideration by the COH and DHSP. We invite all caucuses, committees, and working group of the COH, and leadership of DHSP to embrace these comprehensive recommendations to guide the development and allocation of resources that impact the most marginalized communities of Black/AA people.

We consider these our truths and intentions respectfully submitted on behalf of the COH BAAC.

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[i] At year-end 2019, there were 52,004 persons living with diagnosed HIV (PLWH) in LAC. **Twenty percent (20%) of those individuals diagnosed with HIV were Black/AAs, while representing only 8% of the population in LAC**. (LAC HIV Surveillance Annual Report (2019), Division of HIV and STD Programs, LAC Department of Public Health.)

According to the LAC HIV Surveillance Annual Report (2019), there are continued disparities in HIV diagnosis by population. **Black men and women had higher rate of HIV diagnosis** compared with other race/ethnicity groups. **Populations with lowest achievements in linkage to care included Blacks/AAs. Treatment coverage was lowest for Blacks/AAs** while the **greatest disparities in viral suppression also included the Black/AA population.**

Acquired Immunodeficiency Syndrome (AIDS) is now called "stage 3" per the World Health Organization's 2010 disease progression classification, (https://journalofethics.ama-assn.org/article/who-clinical-staging-system-hivaids/2010-03). **In Los Angeles County, the highest rate of stage 3 (AIDS) diagnoses was among African Americans (18 per 100,000).** The rate of stage 3 diagnoses for **African American females (6 per 100,000)** was 9 times higher than the rate for white females (<1 per 100,000) and 3 times higher than the rate for Latinas (2 per 100,000). Among **males**, the rate of stage 3 diagnoses for **African Americans (32 per 100,000)** was 4 times higher than the rate for whites (9 per 100,000) and 3 times higher than the rate for Latinos (13 per 100,000).

[ii] **Equity** (defined as the quality of being fair and impartial. "equity of treatment"). **Equality** is defined as the condition of being equal, or the same in quality, measure, esteem or value. **Disparities** - a noticeable and usually significant difference. (https://www.merriam-webster.com/)

[iii] **Systemic racism** – Institutional racism, also known as systemic racism, is a form of racism that is embedded as normal practice within society or an organization. It can lead to such issues as discrimination in criminal justice, employment, housing, health care, political power, and education, among other issues. These systems can include laws and regulations, but also unquestioned social systems. Systemic racism can stem from education, hiring practices or access. (https://theconversation.com/explainer-what-is-systemic-racism-and-institutional-racism-131152)

Genderism – Genderism may refer to: Gender binary, the classification of gender into two distinct, opposite, and disconnected forms of masculine and feminine. Gender essentialism, the theory that universal features in social gender are at the root of all differences between men and women. The belief that gender is a binary, comprising male and female, and that the aspects of a person's gender are inherently linked to their sex at birth. (https://psychology.wikia.org/wiki/Genderism)

Classism – prejudice or discrimination based on social class or a biased or discriminatory attitude based on distinctions made between social or economic classes; the viewing of society as being composed of distinct classes. (https://www.nccj.org/classism-0)

Misogyny – hatred, dislike, or mistrust of women, manifested in various forms such as physical intimidation and abuse, sexual harassment and rape, social shunning and ostracism, etc. *The underlying misogyny in slut-shaming; historically witch hunts were an embodiment of the misogyny of the time.* Ingrained and institutionalized prejudice against women; sexism. (https://www.merriam-webster.com/dictionary/misogyny)