LOS ANGELES COUNTY
COMMISSION ON HIV

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Get in touch: hivcomm@lachiv.org

EXECUTIVE COMMITTEE
Virtual Meeting

Thursday, October 22, 2020
1:00PM-3:00PM (PST)

Agenda + Meeting Packet will be available on the Commission's website at:
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LOS ANGELES COUNTY
COMMISSION ON HIV

AGENDA FOR THE **VIRTUAL** MEETING OF THE
LOS ANGELES COUNTY COMMISSION ON HIV (COH)
EXECUTIVE COMMITTEE

Thursday, October 22, 1:00 P.M.–3:00 P.M.

To Join by Computer, Please Register at:
https://tinyurl.com/y28qjfs6
**link is for non-Committee members + members of the public only*

To Join by Phone: +1-415-655-0001
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Executive Committee Members:			
Al Ballesteros, MBA, Co-Chair	*Bridget Gordon, Co-Chair*	Raquel Cataldo	Michele Daniels (Exec At-Large)
Erika Davies	Joseph Green	Lee Kochems, MA	Katja Nelson, MPP
Mario Perez, MPH	Juan Preciado	Kevin Stalter	Justin Valero (Exec, At-Large)
QUORUM*:	**7**		

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

AGENDA POSTED: October 16, 2020

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

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

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

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

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

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

Call to Order, Introductions, and Conflict of Interest Statements 1:00 P.M. – 1:03 P.M.

I. ADMINISTRATIVE MATTERS

1. Approval of Agenda **MOTION # 1** 1:03 P.M. – 1:05 P.M.

2. Approval of Meeting Minutes **MOTION # 2** 1:05 P.M. – 1:07 P.M.

II. PUBLIC COMMENT 1:07 P.M. – 1:10 P.M.

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

III. COMMITTEE NEW BUSINESS ITEMS 1:10 P.M. – 1:13 P.M.

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

IV. REPORTS

5. Executive Director's/Staff Report 1:13 P.M. – 1:30 P.M.

A. Commission/County Operational Updates
B. Virtual Lunch & Learn Series
C. Ending the HIV Epidemic and Commission Activities
D. November 12, 2020 Annual Meeting Preparation

6. Co-Chair's Report 1:30 P.M. – 1:50 P.M.

A. Congratulations to Exec At Large Member, Justin Valero and 2021 COH Co-Chair, David Lee
B. Holiday Meeting Schedule for November & December 2020
C. October 8, 2020 COH Meeting Feedback
D. Board Letter Regarding Contractual Process | UPDATE
E. 2021 Committee Open Nomination + Elections Preparation
F. At Large Executive Committee Member Open Nominations | REMINDER+ONGOING

7. Division of HIV and STD Programs (DHSP) Report 1:50 P.M. – 2:05 P.M.

A. Fiscal, Programmatic and Procurement Updates
B. Ending the HIV Epidemic (EHE) Activities + Updates

8. **Standing Committee Reports:** 2:05 P.M. – 2:45 P.M.

A. Operations Committee
   (1) Membership Management
      - New Member Applicant Interviews
      - New Member Application: Damontae Hack | **MOTION #3**
      - Danielle Campbell, MPH | Seat Change to Board Rep, D2
      - Stephanie Cipres, MPH | Change to Membership
   (2) Youth/Young Adult Engagement and Outreach Strategies
   (3) Peer Collaborator/Buddy Program aka Mentorship Program Implementation
   (4) 2020 Training Schedule | REMINDER

B. Planning, Priorities and Allocations (PP&A) Committee

C. Standards and Best Practices (SBP) Committee
   (1) Child Care Standards of Care | UPDATE
   (2) Universal Standards of Care | UPDATE

D. Public Policy Committee
   (1) 2020-2021 Legislative Docket | UPDATE
   (2) Ballot Initiatives
   (3) HOPWA Request for Proposal (RFP)

9. **Caucus, Task Force, and Work Group Reports:** 2:45 P.M. – 2:50 P.M.

A. Aging Task Force | October 26, 2020 @ 9am-1pm
B. Black/African-American Community (BAAC) Task Force | October 26, 2020 @ 1pm-3pm
C. Consumer Caucus | October 8, 2020 @ 3pm-5pm
D. Women's Caucus | November 16, 2020 @ 2pm-4pm
E. Transgender Caucus | October 27, 2020 @ 10am-12pm

V. <u>NEXT STEPS</u>

10. Task/Assignments Recap 2:50 P.M. – 2:53 P.M.

11. Agenda development for the next meeting 2:53 P.M. – 2:55 P.M.

VI. <u>ANNOUNCEMENTS</u> 2:55 P.M. – 3:00 P.M.

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

VII. <u>ADJOURNMENT</u>

13. Adjournment for the meeting of October 22, 2020. 3:00 P.M.

PROPOSED MOTION(s)/ACTION(s):	
MOTION #1:	Approve the Agenda Order, as presented or revised.
MOTION #2:	Approve the Executive Committee minutes, as presented or revised.
MOTION #3:	Approve New Member Applicant, Damontae Hack and elevate to November 12, 2020 COH meeting for approval, as presented or revised.

LOS ANGELES COUNTY
COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-6748
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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.

VIRTUAL LUNCH & LEARN SERIES:

SHARE, LEARN, AND SUSTAIN OUR HIV MOVEMENT

WOMEN+ HIV
A Special 4-Part Conversation

Spanish interpretation will be provided. See second page for instructions.

Please join the **Los Angeles County Commission on HIV Women's Caucus** for a special 4-part conversation as we center our movement around women and HIV in addressing four key social determinants of health that disproportionately impact women affected by HIV/AIDS and STDs in Los Angeles County.

Let's continue to work together as we rebuild our HIV movement amid the COVID pandemic by promoting and advancing the health and wellness of women and families impacted by HIV and STDs.

November 10, 2020 | 12-1:30pm
WOMEN+HIV: THE IMPACT OF TRAUMA
Susie Baldwin, MD, MPH, Medical Director
Nicolle Perras, MPH, LMFT, Health Program Analyst
Office of Women's Health, Los Angeles County Department of Public Health
Register Now: https://tinyurl.com/y2mkvum9

November 10, 2020
12:00-1:30pm

WOMEN+HIV:
THE IMPACT OF TRAUMA

GUEST SPEAKERS:
Susie Baldwin, MD, MPH
Nicolle Perras, MPH, LMFT
Office of Women's Health
LA County Department of Public Health

FACILITATORS:
Shary Alonzo &
Dr. LaShonda Spencer
Women's Caucus Co-Chairs

REGISTER NOW:
https://tinyurl.com/y2mkvum9

TO JOIN BY PHONE:
+1-415-655-0001
Access code: 145 404 2611

GRAB YOUR LUNCH, INVITE A FRIEND AND LET'S SHARE, LEARN & BREAK BREAD TOGETHER

#STRONGERTOGETHER

LOS ANGELES COUNTY COMMISSION ON HIV
3530 Wilshire Blvd., Suite 1140 Los Angeles, CA 90010

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LOS ANGELES COUNTY COMMISSION ON HIV

UPATED EVENT CODE

SE PROPORCIONARÁ TRADUCCIÓN SIMULTÁNEA DURANTE EL EVENTO.

SIMULTANEOUS SPANISH LANGUAGE INTEPRETATION WILL BE PROVIDED DURING THIS EVENT.

Español
Se proporcionará traducción simultánea durante el evento.

Canales de traducción disponibles:

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At the event, launch the Ablioaudience app and enter the following event code:

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October 16, 2020

To: EHEInitiative@ph.lacounty.gov

From: Los Angeles County Commission on HIV

Re: Comments on Ending the HIV Epidemic (EHE) Draft Plan

With medical advances and federal attention to ending the HIV epidemic, Los Angeles County is more than ever, closer to fulfilling the dream of an AIDS/HIV free generation in our lifetime. The Commission on HIV (Commission) commends and thanks the Los Angeles County (LAC) Department of Public Health (DPH), Division of HIV and STD Programs (DHSP) in drafting the local Ending the HIV (EHE) Plan. Listed below are comments and suggestions for enhancing the draft plan.

General Overarching Comments:

- Given the undeniable burden of HIV, STDs, and other public health and social issues on Black communities, the plan could be strengthened by declaring upfront and outright, the County's commitment to dismantling racism and inequities. Center the plan around Black lives and incorporate the recommendations from the Black/African American Community Task Force in all strategies, activities, in year 1 and beyond, as appropriate. (Attachment A)
- Develop specific HIV continuum and social determinants outcomes for the priority populations identified in the "Data in Action" sections of the plan.
- Provide a brief explanation of "Data in Action" sections. Why are these specific data points being highlighted for the reader's attention?
- Address how the three County health agencies (Public Health, Mental Health, and Health Services) will address service integration and coordination.
- Instead of using the phrase "Key Target Populations", consider using "Priority Populations".
- The plan could be strengthened by adding specific activities that are geared for the youth. How will this plan work for younger populations?
- Under Section IV, consider adding specific ongoing opportunities for community involvement and feedback. Examples include but not limited to, online comment card on the DHSP or lacounty.hiv websites; annual or bi-annual progress reports with public comment periods; and a performance dashboard that tracks if LAC is meeting its EHE leading indicators by geographic locations and priority populations. The performance dashboard should leverage the federal America's HIV Epidemic Analysis Dashboard (AHEAD).

- Clarify if the strategies and activities described in the plan are for year 1 only. Consider providing a timeline for activities beyond year 1 and a brief statement indicating which strategies and activities are ongoing.
- Consider developing a logic model to clarify the justification for selecting the proposed outcomes under all pillars and test assumptions behind each outcome.
- On July 21, 2020, the LAC Board of Supervisors adopted an anti-racist agenda that will guide, govern and increase the County's ongoing commitment to fighting racism in all its dimensions, especially racism that systemically and systematically affects Black residents. How does the plan respond to the Board's anti-racist agenda? Consider adding specific anti-racist strategies or activities that lead to outcomes of improved access to care and quality of life for the Black community.
- How will DHSP work with the Commission to synchronize and align the EHE activities and strategies with the Commission's planning, priority setting, and allocation process?
- How will the implementation of the activities and strategies be impacted by COVID, assuming that the County will likely be in some level of a pandemic response mode into 2021?
- Leverage other programs within DPH to increase HIV awareness, promote testing, and link individuals to prevention and treatment services. For example, collaborate with the Maternal, Child, Adolescent/Black Infant Health Programs, Office of Women's Health to ensure that Black women and mothers receive HIV/STD education, testing, and linkage to services they need. Since DPH programs tend to serve the same populations, the plan should include collaborative activities across the Department to promote individual and community wellness.

Capacity Building and HIV Workforce:

- Train the HIV workforce on trauma informed care, stigma reduction, implicit bias, and medical mistrust.
- Support agencies to establish organizational policies and practices that embody trauma informed care, reduce stigma, and rectify implicit bias and medical mistrust.
- Work with medical associations to increase comfort level with sexual health and knowledge of HIV services in the County.
- Promote racial equality in the HIV workforce and support agencies to hire more youth and people of color.

Pillar 1: Diagnose

- Consider adding specific strategies and activities that address how to scale up testing for highly impacted populations identified in the "Data in Action" section (youth ages 13-24, persons who inject drugs (PWID), and early HIV diagnosis among Latinx cisgender men).
- Consider including an activity aimed at increasing the capacity of Syringe Services Programs (SSPs) in LAC to conduct HIV testing and/or create a mechanism to formally partner with DHSP-funded HIV testing providers.
- The situational analysis section describes the importance of enrolling the support of private medical providers and health plans in making HIV testing routine and easily accessible. Consider adding an activity that seeks to establish an HIV testing partnership program with

one health plan per year. Consider pilot testing such a program in a health district considered a hotspot for HIV.
- DHSP is to be commended for taking the necessary steps to implement and expand access to home test kits.
- County health agencies must implement protocols that make HIV testing common and as part of a standard set of wellness checks for all patients.

Key Partners:
- Consider adding youth groups in both HIV and non-HIV sectors, Latino health and social service agencies, and immigrant rights advocacy groups such as Coalition for Humane Immigrant Rights (CHIRLA) and Esperanza Immigrant Rights Project.
- Consider partnering with the California Department of Public Health, Office of AIDS to encourage qualified entities to participate in the Syringe Exchange Certification Program.
- Consider developing partnerships and/or contracts with high school, college and university student health centers to promote HIV testing among youth and destigmatize HIV with educational campaigns on PrEP and Undetectable = Untransmittable (U=U).
- Consider adding the Cities of West Hollywood and Los Angeles, along with other municipalities in the County.

Pillar 2: Treat
- Consider adding specific strategies and activities that address how to improve outcomes along the HIV continuum for highly impacted populations identified in the "Data in Action" section (people who are unhoused at the time of HIV diagnosis, cisgender women, people with IDU transmission risk, and Black/African American persons living with HIV).
- Clarify and ensure that the pilot program for incentives apply to providers and all patients, not just those who are deemed high risk.
- Consider integrating mental wellness services for PLWH who may not meet acuity levels required for mental health treatment services.
- Consider adding a specific activity around working with private healthcare providers to link PLWH to care. Bridge the gap in knowledge about HIV prevention and care services among private providers/non-HIV specialists in the County.
- Work with State of CA partners to require health plans to deliver a certain level of HIV prevention, testing and education for their clients.

Key Partners:
- Consider adding the Cities of West Hollywood and Los Angeles, along with other municipalities in the County.
- Consider adding the LAC Development Authority as a key partner and resource in addressing homelessness and affordable housing for PLWH.

Pillar 3: Prevent
- Consider including long acting injectable PrEP and making it available to those who would benefit from it.

- Support the capacity of the local network of HIV prevention providers to use digital forms of communication and care to reach younger age groups.
- Develop Countywide activities that promote treatment as prevention such as U= U awareness campaigns, especially among non-Ryan White providers.
- Leverage the influence and combined capacities of the County's health agencies to train providers and staff on promoting HIV testing, PrEP, and treatment services as part of basic care for all safety net patients. Community members report dealing with providers who are unaware of PrEP and some have faced difficulties in getting a prescription for PrEP.

Key Partners:

- Consider including family planning clinics and Planned Parenthood as PrEP partners and access points.

Local Community Partners

- Provide clarification that the Commission Executive Director participated in the EHE Steering Committee applications review process (page 21).
- Add the Aging Task Force to the list of Commission task forces (page 22).
- As a key partner in ending the HIV epidemic, we welcome the ongoing dialogue on how the Commission can best support DHSP in implementing the plan.

Thank you for the opportunity to provide comments. Commission staff will work with the DHSP team to answer questions you may have about these suggestions. We remain committed to working with DHSP to ensure that we meet our shared vision of ending the HIV epidemic, once and for all.

(REVISED) Black/African American Community (BAAC) Task Force Recommendations

October 10, 2019

Introduction

The BAAC Task Force was formed in response to the Commission on HIV's (COH) February 14, 2019 National Black HIV/AIDS Awareness Day (NBHAAD) Panel discussion in an effort to address the disproportionate impact of HIV/AIDS in the Black/African American (AA) communities of Los Angeles County.

The BAAC Task Force convened on April 30, 2019 to develop a progressive and inclusive agenda to address and provide recommendations to the COH on how to reduce and ultimately eliminate the disproportionate impact of HIV/AIDS and STIs in all subsets of the Black/AA community utilizing a community-wide mobilization effort.

Healthcare Disparities in the Black/AA Community

The United States Census Bureau estimates Black/AA living in Los Angeles County (LAC) at 9% or approximately 909,500 as of 2018.(1) In 2017, there were 51,438 persons living with diagnosed HIV (PLWH) in LAC. **Twenty percent (20%) were Black/AA.**(2)

In 2016, **the highest overall rate of HIV diagnoses was among African Americans (56 per 100,000)**, followed by Latinos (19 per 100,000), whites (12 per 100,000), and Asians (6 per 100,000). These differences in rates were also observed by sex, most notably among **African American females (17 per 100,000) where the rate of HIV diagnoses** was 8 times higher than that of white females (2 per 100,000) and 5 times higher than the rate for Latinas (3 per 100,000). Among **males**, the rate of HIV diagnoses among **African Americans (101 per 100,000)** was 5 times higher than among whites (22 per 100,000) and 3 times higher than the rate for Latinos (34 per 100,000).(2)

The highest rate of stage 3 diagnoses (Acquired Immunodeficiency Syndrome) (AIDS) **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).(2)

Black/AA Care Continuum as of 2016[3]

Demographic Characteristics	Diagnosed/Living with HIV	Linked to Care ≤30 days	Engaged in Care	Retained in Care	New Unmet Need (Not Retained)	Virally Suppressed
Race/Ethnicity						
African American	**9,962**	**54.2%**	**65.9%**	**49.7%**	**50.3%**	**53.0%**
Latino	21,095	65.4%	68.3%	55.7%	44.3%	59.7%
Asian/Pacific Islander	1,710	80.5%	74.6%	60.5%	39.5%	68.5%
American Indian/Alaskan Native	294	75.0%	70.1%	54.10%	45.9%	52.4%
White	14,778	75.2%	71.6%	54.5%	45.5%	64.9%

The Ryan White (RW) program in LAC served 15,747 individuals between March 1, 2018 and February 28, 2019. Three-thousand three-hundred sixty (3,360) were Black/AA during the same period.[4]

Objectives:

- **Identify** strategies on how the COH can support Black/AA leaders and community stakeholders in an effort 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

General/Overall Recommendations:

1. Provide on-site cultural sensitivity and education training – to include addressing implicit bias and medical mistrust within the Black/AA community – for all County-contracted providers and adopt cultural humility into the local HIV provider framework. *Decision makers must realize their own power, privilege and prejudices and be willing to accept that acquired education and credentials alone are insufficient to address the HIV epidemic in the Black/AA community.*

2. Revise messaging County-wide around HIV to be more inclusive, i.e., "If you engage in sexual activity . . . you're at risk of HIV" in an effort to reduce stigma.

3. Incorporate universal marketing strategies for HIV prevention that appeal to all subsets of the Black/AA community in an effort to reduce stigma and increase awareness.

4. Provide resources to Community-Based Organizations (CBOs) to develop, implement and evaluate primary prevention interventions which are culturally appropriate and relevant.

5. Support young people's right to the provision of confidential sexual health care services.

6. Increase Pre-exposure Prophylaxis (PrEP) advertising within the Black/AA community to increase awareness. Marketing materials must depict the very community it is attempting to reach - specifically, Black/AA youth, women, transgender individuals, and gender nonconforming populations.

7. Initiate or partner in culturally informed research that aims to address the needs of the Black/AA communities. Researchers, whenever possible, must mirror the affected community it purports to study. Community reflectiveness in academic and CBO partnerships should include training in instrument development, data interpretation, presentations and publications.

8. Increase use of local statistics regarding new infections and disparities to educate and plan for the community; request Department of Public Health data be organized by Health Districts and zip codes to better target and identify communities in need.

9. Provide technical assistance to aid Black/AA agencies in obtaining funds for culturally sensitive services.

10. Proactively reach out to engage CBOs that are connected to the local Black/AA community.

11. End the practice of releasing Request for Proposals (RFPs) that have narrowly defined "Proposer's Minimum Mandatory Requirements." *This discriminatory practice purposely disqualifies existing relevant CBOs and other agencies that provide intersection health and human services.* When issuing RFAs, RFPs, or RFSQs, establish a demonstration/data pilot by creating a 15% funding carve-out for CBO's/ASO's, whose qualifications are below the "Minimum Mandatory Requirements", but at an agreed upon standard, to identify the proven and effective grassroots/community empowerment efforts that reach specified Black/AA audiences. This will allow DHSP in collaboration with the Commission to determine the efficacy of methodologies for outreach, linkages to care, retention in care, and other sensitive treatment and prevention interventions that are effective in reducing new HIV cases.

12. Continue to evaluate for effectiveness and increase the investment in Vulnerable Populations Grants that target subset populations of the Black/AA community (i.e. Trans men/women, women & girls, MSM) to address barriers and social determinates of health.

13. Engage agencies already funded as well as those not currently funded to focus on a Countywide PrEP Education and Outreach mini-grant process that will target all various subset populations of the Black/AA community, i.e. Trans community, women & girls, MSM.

14. Increase mobilization of community efforts to include:
    a. Increase community awareness fairs and social media campaigns intended to promote health and wellness in the Black/AA community, with concentration in high incidence areas;
    b. Condom distribution in spaces where adults congregate;
    c. HIV education and access to prevention tools in schools, spiritual communities, social clubs, neighborhood associations, etc.;
    d. Fund one social marketing campaign that addresses stigma and internalized homophobia as it relates to health and wellness around HIV;
    e. Support efforts that will ensure additional research and evaluation support be made available to agencies that provide services to the Black/AA community and to increase their capacity to link and collaborate with research institutions; and
    f. Provide training and incentives for CBOs within high incidence areas to prescribe PreP and nPep.

Population-Specific Recommendations:

Black/African American Trans Men:

The Ryan White (RW) program in LAC served 96 Black/AA Transgender persons during the period of March 1, 2018 to February 28, 2019. This was approximately .6% of the total PLWH/A in LAC.(4)

1. Conduct a Countywide needs assessment of the Trans masculine community that focuses on sexual risk behaviors.
2. Use Williams Institutes' research/data using Sexual Orientation Gender identity (SOGI) (method agencies use to collect patient/client data on sexual orientation and gender identity) to develop Trans male-specific programming.
3. Include Trans men in program decision making.
4. Develop a Trans masculine-specific PrEP campaign which will resonate with and reach Trans men in such a way that the message is not convoluted and therefore lost within the overall PrEP messaging. Messaging should include language around safety and gender affirmation - a campaign that says "Trans masculine individuals . . . this is for YOU." Perhaps include a myth buster around the notion that all Trans men are straight and only date and are sexually involved with cis men; a message that says we know sexual appetites are fluid for Trans men and that is why PrEP is important.
5. Educate/train medical and mental health providers to be more inclusive of Trans masculine bodies and its many different nuances.

6. Create a pilot/demonstration project using the information obtained from the various data sources listed above.

Black/African American Trans Women:

The Ryan White (RW) program in LAC served 96 Black/AA Transgender persons during the period of March 1, 2018 to February 28, 2019. This was approximately .6% of the total PLWH/A in LAC.(4)

1. Conduct a Countywide needs assessment of the Trans women community to address barriers and social determinants of health to better provide more targeted programming.
2. Increase efforts in collecting epidemiological data through surveillance on Trans women for purposes of planning more targeted programming.
3. Use William's Institutes' research/data using SOGI (method agencies use to collect patient/client data on sexual orientation and gender identity) to develop Trans women-specific programming.
4. Include and prioritize Trans women in program decision making.
5. Address stigma and the increasing violence against Trans women.

Black/African American Women and Girls: *(DHSP defined Black/AA women and girls as either childbearing women between the ages of 15-44 and those 50 Years and Older)*

The Ryan White (RW) program in LAC served 501 Black/AA women during the period of March 1, 2018 to February 28, 2019. This is approximately 31.82% of those receiving RW services.(4)

1. Evaluate existing PrEP and prevention access and messaging for impact on intervention groups and community health; assess dissemination methodologies and refine outreach and engagement strategies.
2. Allocate resources to create a PrEP Center for Excellence targeting women and their families, sexual and social networks.
3. Conduct an inventory of County-wide HIV/STD interventions and initiatives that target African American women at risk of and living with HIV that focus on education, employment services, empowerment, co-infections, treatment as prevention (TAsP), sexual reproductive health, intimate partner violence, and mental health.
4. Obtain data for all populations of women, especially those who are pregnant or such age groups affected by the high rates of STIs; include women-specific data in summits, reports, and community forums.

5. Reorganize and adopt educational approaches to care and prevention that incorporate information and knowledge on how preventative methods can benefit the woman within the context of her life. Such approaches include but should not be limited to:
   a. Integrate train-the-trainer models for community health outreach workers and testing staff that use motivational and empowerment strategies as a tool for risk reduction. Generating collective approaches and solutions that promote honesty and integrity within self and relationships with others is paramount. Hold agencies accountable to host honest adult conversations and have the courage to meet people where they are and build on what they know.
   b. Generate collective approaches and solutions that promote honesty and integrity of self and relationships with others is paramount; and
   c. Train community health outreach workers in all HIV Testing Sites to have conversations that validate the experience and power dynamics women confront within their relationships. Most often partners are missing from engagement, enrollment, and retention strategies. Include sexual and social networks in education, outreach, testing and other interventions that support family sustainability as a method of retention.

6. Allocate money to partner with institutions to support three demonstration projects at $250,000 each led and facilitated by and for Black women:
   a. Ensure agencies have tools available to demonstrate accountability and cultural competence. Staff should be linguistically and culturally representatives of the community and any intervention include a navigation component to address barriers to recruitment, uptake and retention of prevention and care based programming.
   b. All protocols should explicitly embrace the experience of women who have sex with men of known or unknown status as well as those diagnosed with HIV/AIDS. Further, qualitative interviews or Audio Computer-Assisted Self-Interview (ACASI) instruments should include an assessment of historical care and prevention participation as well as barriers to continuous engagement and participation.

7. Strategically reflect the needs of women in the jurisdictional stigma reduction efforts by funding projects that reduce stigma and increase access to female controlled HIV preventive tools such as Pre-Exposure Prophylaxis (PrEP), Post Exposure Prophylaxis (PEP), and the Female Condom 2 (FC2). Support agencies to integrate comprehensive opportunities for education, research and a complement to other strategies that give women the power to take control of their lives and situations in which have historically had little to no influence.

8. Expand the availability of community-based mental health services as a part of a continuous effort to treat women holistically: HIV and mental health education and awareness should accompany a range of holistic services that recognize that a woman may have multiple traumas that inform her choices. Increased collaborations between community and the private sector which is necessary to build awareness and reduce cultural and social based stigmas associated with mental health care. Increased education and training of non-HIV/AIDS service providers in hopes of offering a full circle of multidisciplinary services to those in need.

9. Develop a standard requiring all contracted organizations offer living wages as an incentive to hiring persons with lived experience. Initiating programming for Black women enables organizations to invest in their peers. Further, increased access to professional development opportunities and resources (ex. Income) enables them to self-sustain and decrease the impact that social correlates of health such as poverty have on informed sexual decision making.

<u>Black/African American Men Who Have Sex with Men (MSM):</u>

The Ryan White (RW) program in LAC served 2,093 Black/AA MSM during the period of March 1, 2018 to February 28, 2019. This was approximately 13.3% of those receiving RW services. (4)

1. Continue to increase the investment in innovative layered interventions that target young MSM and address barriers and social determinates of health like the Vulnerable Populations Grant.

2. Develop and release of Request for Application/Request for Proposal (RFA/RFP) that focuses on HIV positive MSM of all ages who are sexually active and at risk of co-infections.

3. Increase funding and resources in treatment as prevention, social support efforts, housing and mental health services.

4. Address Chemsex within the Black/AA MSM community through CBO led group sessions, evidence-based medicine directed intervention and medication assisted treatment.

Conclusion

Only by genuinely addressing the recommendations as provided above can the Los Angeles County HIV/AID Strategy (LACHAS) goals be met. Many of the recommendations provided are in alignment with the LACHAS and the County's Comprehensive HIV Plan (CHP), however, there must be very intentional and targeted efforts made to address social determinants, primarily stigma and racism, in the Black/AA communities. It is not enough to implore the same strategies of old; we must modernize methodologies in our marketing strategies to reach subpopulations within the Black/AA communities who do not identify according to current messaging. Messaging must be *truly* inclusive – "if you are sexually active, you are at risk".

The adage is true – "to reach them, you have to meet them where they are" - HIV and sexual health education along with HIV prevention interventions must be accessible in schools, jails, churches, barber/beauty shops, and social venues where Black/AA communities gather; while providers must be trained and educated to understand the various cultural nuances that can either stigmatize and subsequently discourage or create a culturally welcoming environment for Black/AA communities to access HIV prevention, care and treatment services.

On behalf of the BAAC Task Force, we thank the Executive Committee for its consideration of the above recommendations and look forward to its plan of action in response.

Special thanks to the following BAAC Task Force members and community stakeholders who volunteered their time and contributed to the development of recommendations: Greg Wilson (COH), Traci Bivens-Davis (COH), Bridget Gordon (COH), Dr. LaShonda Spencer (COH), Danielle Campbell (COH), Yolanda Sumpter (COH), Dr. William King (COH), Cynthia Davis (AHF), Luckie Fuller (COH), Jeffrey King (ITMT), Louis Smith III, Stevie Cole, Ivan Daniel III, Carl Highshaw (AMAAD Institute), Charles McWells (LACADA), Dr. Derrick Butler (THE Clinic), David Lee (CDU), Rev Russell Thornhill (MAPP), Terry Smith (APLA), Doris Reed (COH), Carolyn Echols-Watson (COH) and Dawn Mc Clendon (COH).

Endnotes

1. Census.gov/quickfacts/fact/table/losangelescountycalifornia; RH1225218
2. 2017 Annual HIV Surveillance Report; Ryan White program Clients Living with HIV YR 28 (03/01/2018 – 02/28/19)[i]
3. Los Angeles County HIV/AIDS Strategy (LACHAS) – P26; Table 5
4. Ryan White Program Clients YR 28 (3/1/18-2/28/19) Los Angeles County; Utilization by Service Category among Ryan White Priority Populations in Year 28

LOS ANGELES COUNTY COMMISSION ON HIV

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Continuing the Commitment to Ending HIV, Once and For All

2020 Virtual Annual Meeting Agenda
November 12, 2019
9:00AM-1:15PM
TENTATIVE/DRAFT

Meeting Objectives:

1. Continue community discussion and engagement around the Ending the HIV Epidemic (EHE)
2. Hear federal and local updates about the status and future of the EHE
3. Identify strategies for creating meaningful spaces for meaningful and inclusive intergenerational HIV movement

TIME	TOPIC
8:30-9:00AM	Virtual Check-In
9:00-9:30	• Call to order (Commission Co-Chairs) • Roll call • Welcome, Opening Remarks and Meeting Objectives • Welcome speakers • Recognition of Service and Leadership for Al Ballesteros
9:30 -10:15	**Ending the HIV Epidemic: What to Expect in 2021 and Insights on Building an Inclusive HIV Movement** **Speaker (CONFIRMED): Harold Phillips,** Senior HIV Advisor and Chief Operating Officer of *Ending the HIV Epidemic: A Plan for America*. US Department of Health and Human Services, Office of Infectious Disease and HIV/AIDS Policy (OIDP) • Questions and Answers 15 mins/10:00-10:15
10:15-11:30	Division of HIV and STD Programs (DHSP) Mario Perez **(CONFIRMED)** Title to be determined
11:30-11:40	BREAK
11:40-12:30	**What's next for the HIV movement and How Planning Councils Can Do Equity Work** **Speaker (INVITED/WAITING TO CONFIRM): Naina Khanna,** Executive Director, Positive Women's Network, USA **OR Venita Ray**, Deputy Director, Positive Women's Network, USA
12:30- 1PM	**Community Speak Out** Time for Commissioners to hear testimonies from the community.
1:00-1:15	**Closing Remarks and Inspiration for 2021 (Bridget Gordon, Co-Chair & David Lee, Co-Chair Elect)** Roll Call

LOS ANGELES COUNTY
COMMISSION ON HIV

DUTY STATEMENT

COMMITTEE CO-CHAIR

(APPROVED 3-28-17)

In order to provide effective direction and guidance for the Commission on HIV, Committee Co-Chairs must meet the following demands of their office, representation and leadership:

COMMITTEE LEADERSHIP:

① Serves as Co-Chair of a standing Commission Committee, and leads those monthly meetings
② Leads Committee decision-making processes, as needed
③ Meets monthly with Executive Director, or his/her designee, to prepare the Committee meeting agendas, course of action and assists Commission staff in the preparation of motions, backup materials and information for meetings, as necessary and appropriate
④ Assigns and delegates work to Subcommittees, task forces and work groups
⑤ Serves as a member of the Commission's **Executive Committee**

MEETING MANAGEMENT:

① Serves as the Presiding Officer at the Committee meetings
② In consultation with other Co-Chair and senior Commission staff member(s), leads the Committee meetings,
- conducting business in accordance with Commission actions/interests
- recognizing speakers, stakeholders and the public for comment at the appropriate times
- controlling decorum during discussion and debate and at all times in the meeting;
- imposing meeting rules, requirements and limitations
- calling meetings to order, for recesses and adjournment in a timely fashion and according to schedule, or extending meetings as needed
- determining consensus, objections, votes, and announcing roll call vote results
- ensuring fluid and smooth meeting logistics and progress
- finding resolution when other alternatives are not apparent
- ruling on issues requiring settlement and/or conclusion

③ Ability to put aside personal advocacy interests, when needed, in deference to role as the Committee's Presiding Officer.

REPRESENTATION:

In consultation with the Executive Director, Committee Co-Chairs:

① May ONLY serve as Committee spokesperson at various events/gatherings, in the public, with public officials and to the media if approved by the Commission Co-Chairs and Executive Director
② Take action on behalf of the Committee, when necessary

③ Generates, signs and submits official documentation and communication on behalf of the Committee
③ Present Committee findings, reports and other information to the full Commission, Executive Committee, and, as appropriate, other entities
⑤ Represent the Committee to the Commission, on the Executive Committee, and to other entities
⑥ Support and promote decisions resolved and made by the Committee when representing it, regardless of personal views

KNOWLEDGE:
① CDC HIV Prevention Program, Ryan White Program (RWP), and HIV/AIDS and STI policy and information
② LA County Comprehensive HIV Plan and Comprehensive HIV Continuum
③ LA County's HIV/AIDS and STI, and other service delivery systems
④ County policies, practices and stakeholders
⑤ Ryan White Program legislation, State Brown Act, applicable conflict of interest laws
⑥ County Ordinance and practices, and Commission Bylaws
⑦ Topical and subject area of Committee's purview
⑧ **Minimum of one year active Committee membership prior to Co-Chair role**

SKILLS/ATTITUDES:
① Sensitivity to the diversity of audiences and able to address varying needs at their levels
② Life and professional background reflecting a commitment to HIV/AIDS and STI-related issues
③ Ability to demonstrate parity, inclusion and representation
④ Take-charge, "doer", action-oriented; ability to recruit involvement and interest
⑤ Unintimidated by conflict/confrontation, but striving for consensus whenever possible
⑥ Firm, decisive and fair decision-making practices

COMMITMENT AND ACCOUNTABILITY TO THE OFFICE:
① Put personal agenda aside and advocate for what's in the best interest of the Commission
② Devote adequate time and availability to the Commission and its business
③ Assure that members' and stakeholders' rights are not abridged
④ Advocate strongly and consistently on behalf of Commission's and people living with and at risk for HIV, interests
⑤ Always consider the views of others with an open mind
⑥ Actively and regularly participate in and lead ongoing, transparent decision-making processes
⑦ Respect the views of other regardless of their race, ethnicity, sexual orientation, HIV status or other factors

2020 MEMBERSHIP ROSTER| UPDATED 10.2.20

SEAT NO.	MEMBERSHIP SEAT	Commissioners Seated	Committee Assignment	COMMISSIONER	AFFILIATION (IF ANY)	TERM BEGIN	TERM ENDS	ALTERNATE
1	Medi-Cal representative			***Vacant***		July 1, 2019	June 30, 2021	
2	City of Pasadena representative	1	EXC|SBP	Erika Davies	City of Pasadena Department of Public Health	July 1, 2018	June 30, 2022	
3	City of Long Beach representative			***Vacant***		July 1, 2019	June 30, 2021	
4	City of Los Angeles representative	1	PP	Ricky Rosales	AIDS Coordinator's Office, City of Los Angeles	July 1, 2018	June 30, 2022	
5	City of West Hollywood representative	1	PP&A	Derek Murray	City of West Hollywood	July 1, 2019	June 30, 2021	
6	Director, DHSP	1	EXC|PP&A	Mario Pérez, MPH	DHSP, LA County Department of Public Health	July 1, 2018	June 30, 2022	
7	Part B representative	1	PP&A	Karl Halfman, MA	California Department of Public Health	July 1, 2018	June 30, 2022	
8	Part C representative	1	PP	Aaron Fox, MPM	Los Angeles LGBT Center	July 1, 2018	June 30, 2022	
9	Part D representative	1	PP&A	Stephanie Cipres, MPH	LASC+USC Maternal, Child Adolescent Clinic	July 1, 2019	June 30, 2021	
10	Part F representative	1	PP	Jerry D. Gates, PhD	Keck School of Medicine of USC	July 1, 2018	June 30, 2022	
11	Provider representative #1	1	OPS	Carlos Moreno	Children's Hospital Los Angeles	July 1, 2019	June 30, 2021	
12	Provider representative #2	1	SBP	David Lee, MPH, LCSW	Charles Drew University	July 1, 2018	June 30, 2022	
13	Provider representative #3	1	SBP	Harold Glenn San Agustin	JWCH Institute, Inc.	July 1, 2019	June 30, 2021	
14	Provider representative #4	1	PP&A	LaShonda Spencer, MD	Charles Drew University	July 1, 2018	June 30, 2022	
15	Provider representative #5			***Vacant***		July 1, 2019	June 30, 2021	
16	Provider representative #6	1	PP&A	Anthony Mills, MD	Southern CA Men's Medical Group	July 1, 2018	June 30, 2022	
17	Provider representative #7	1	PP&A	Frankie Darling-Palacios	Los Angeles LGBT Center	July 1, 2019	June 30, 2021	
18	Provider representative #8	1	PP	Martin Sattah, MD	Rand Shrader Clinic, LA County Department of Health Services	July 1, 2018	June 30, 2022	
19	Unaffiliated consumer, SPA 1	1	EXC|OPS	Michele Daniels	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	
20	Unaffiliated consumer, SPA 2			***Vacant***		July 1, 2018	June 30, 2022	
21	Unaffiliated consumer, SPA 3			***Vacant***		July 1, 2019	June 30, 2021	
22	Unaffiliated consumer, SPA 4	1	EXC|SBP	Kevin Stalter	*Unaffiliated Consumer*	July 1, 2018	June 30, 2022	
23	Unaffiliated consumer, SPA 5					July 1, 2019	June 30, 2021	
24	Unaffiliated consumer, SPA 6	1	PP	Pamela Coffey	*Unaffiliated Consumer*	July 1, 2018	June 30, 2022	Alasdair Burton (PP)
25	Unaffiliated consumer, SPA 7			***Vacant***		July 1, 2019	June 30, 2021	Thomas Green (SBP)
26	Unaffiliated consumer, SPA 8	1	PP&A	Kevin Donnelly	*Unaffiliated Consumer*	July 1, 2018	June 30, 2022	
27	Unaffiliated consumer, Supervisorial District 1			***Vacant***		July 1, 2019	June 30, 2021	
28	Unaffiliated consumer, Supervisorial District 2			***Vacant***		July 1, 2018	June 30, 2022	Nestor Rogel (PP)
29	Unaffiliated consumer, Supervisorial District 3	1	SBP	Joshua Ray	*Unaffilated Consumer*	July 1, 2019	June 30, 2021	Eduardo Martinez (SBP/PP)
30	Unaffiliated consumer, Supervisorial District 4			***Vacant***		July 1, 2018	June 30, 2022	
31	Unaffiliated consumer, Supervisorial District 5	1	PP&A	Diamante Johnson	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	Kayla Walker-Heltzel (PP&A/OPS)
32	Unaffiliated consumer, at-large #1			***Vacant***		July 1, 2018	June 30, 2022	Tony Spears
33	Unaffiliated consumer, at-large #2	1	OPS|PP&A	Joseph Green	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	
34	Unaffiliated consumer, at-large #3	1	SBP	Felipe Gonzalez	*Unaffiliated Consumer*	July 1, 2018	June 30, 2022	
35	Unaffiliated consumer, at-large #4	1	EXC	Bridget Gordon	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	
36	Representative, Board Office 1	1	EXC|PP&A	Al Ballesteros, MBA	JWCH Institute, Inc.	July 1, 2018	June 30, 2022	
37	Representative, Board Office 2			***Vacant***		July 1, 2019	June 30, 2021	
38	Representative, Board Office 3	1	EXC|PP|SBP	Katja Nelson, MPP	APLA	July 1, 2018	June 30, 2022	
39	Representative, Board Office 4	1	SBP	Justin Valero, MA	Unaffilated Consumer	July 1, 2019	June 30, 2021	
40	Representative, Board Office 5	1	PP&A|EXC	Raquel Cataldo	Tarzana Treatment Center	July 1, 2018	June 30, 2022	
41	Representative, HOPWA	1	PP&A	Maribel Ulloa	City of Los Angeles, HOPWA	July 1, 2019	June 30, 2021	
42	Behavioral/social scientist	1	EXC|PP	Lee Kochems	*Unaffiliated Consumer*	July 1, 2018	June 30, 2022	
43	Local health/hospital planning agency representative			***Vacant***		July 1, 2019	June 30, 2021	
44	HIV stakeholder representative #1	1	EXC	Grissel Granados, MSW	Children's Hospital Los Angeles	July 1, 2018	June 30, 2022	
45	HIV stakeholder representative #2	1	SBP	Paul Nash, CPsychol AFBPsS FHEA	University of Southern California	July 1, 2019	June 30, 2021	
46	HIV stakeholder representative #3	1	EXC|OPS	Juan Preciado	Northeast Valley Health Corporation	July 1, 2018	June 30, 2022	
47	HIV stakeholder representative #4			***Vacant***		July 1, 2019	June 30, 2021	
48	HIV stakeholder representative #5	1	OPS	Danielle Campbell, MPH	UCLA/MLKCH	July 1, 2018	June 30, 2022	
49	HIV stakeholder representative #6	1	SBP	Amiya Wilson	Unaffiliated Consumer	July 1, 2019	June 30, 2021	
50	HIV stakeholder representative #7	1	PP&A	William D. King, MD, JD, AAHIVS	W. King Health Care Group	July 1, 2018	June 30, 2022	
51	HIV stakeholder representative #8			***Vacant***		July 1, 2018	June 30, 2022	Miguel Alvarez (OPS/SBP)
	TOTAL:	**36**						

LEGEND: EXC=EXECUTIVE COMM | OPS=OPERATIONS COMM | PP&A=PLANNING, PRIORITIES & ALLOCATIONS COMM | PPC=PUBLIC POLICY COMM | SBP=STANDARDS & BEST PRACTICES COMM

LOA: Leave of Absence

and it can be mailed, e-mailed or picked up at the office. Similarly, the application and is available online from the Commission's website at http://hiv.lacounty.gov. Submit your application by mailing it to or dropping it off at: 3530 Wilshire Blvd, Suite 1140, Los Angeles, CA 90010.
Applications may be emailed to hivcomm@lachiv.org. Staff will verify receipt of all applications via email. After receiving the application, staff will review it for accuracy and completeness, and contact the applicant if there are any possible errors, sections needing clarification, and/or if there are any questions that emerge from the application. Once the application has been deemed to be "complete" (either after revisions have been made, if necessary, or none are needed), staff will contact the applicants to schedule an interview with members of the Operations Committee. If you have questions or need assistance with the application, please contact the Commission office at (213) 738-2816.

PART II: MEMBERSHIP APPLICATION FORM
Section 1: Contact Information

1. Name: DAMONTAE HACK
   (Please print name as you would like it to appear in communications)
2. Organization: (if applicable) N/A
3. Job Title: N/A
4. Mailing Address: 1717 N. VERDUGO RD. APT. #263
5. City: GLENDALE State: CA Zip Code: 91208
6. Provide address of office and where services are provided (if different from above):
   Mailing Address:
   City: State: Zip Code:

7. Tel.: Fax:
8. Email: DAMONTAEHACK0@GMAIL.COM
   (Most Commission communications are conducted through email)
9. Mobile Phone #: (optional): (443) 536-8036

My signature below indicates that I will make every effort to attend all of the meetings and activities of the Commission, the committee to which I am assigned and related caucuses, task forces and working groups that I have joined voluntarily or that I have been asked to support. I will comply with the Commission's expectations, rules and regulations, conflict of interest guidelines and its code of conduct, consistent with all relevant policies and procedures. As the undersigned, I understand that governing legislation and/or guidance may be altered in the future, necessitating revision, modification, or elimination of specific Commission processes or practices—necessitating change with which I will be expected to comply as well. I further understand that sections of this application will be distributed publicly, as required by the Commission's Open Nominations Process and consistent with California's Ralph M. Brown Act. I affirm that the information herein is accurate to the best of my knowledge.

08/27/2020
Date

Signature:

Print Name

Section 2: Demographic Information

1. **Can you commit to the Commission's minimum expectations of active participation, regular attendance and sustained involvement?** ■ **Yes** ☐ **No**

2. **In which Supervisorial District and SPA do you work?** Check all that apply.

District 1 ❑	SPA 1 ❑	SPA 5 ❑
District 2 ❑	SPA 2 ❑	SPA 6 ❑
District 3 ❑	SPA 3 ❑	SPA 7 ❑
District 4 ❑	SPA 4 ❑	SPA 8 ❑
District 5 ❑		

3. **In which Supervisorial District and SPA do you live?**

District 1 ❑	SPA 1 ❑	SPA 5 ❑
District 2 ■	SPA 2 ■	SPA 6 ❑
District 3 ❑	SPA 3 ❑	SPA 7 ❑
District 4 ❑	SPA 4 ❑	SPA 8 ❑
District 5 ■		

4. **In which Supervisorial District and SPA do you receive HIV (care or prevention) services?** Check all that apply.

District 1 ❑	SPA 1 ❑	SPA 5 ❑
District 2 ❑	SPA 2 ■	SPA 6 ❑
District 3 ■	SPA 3 ❑	SPA 7 ❑
District 4 ❑	SPA 4 ❑	SPA 8 ❑
District 5 ❑		

5. **Demographic Reflectiveness and Representation:**
Federal funders require that the Commission report the following demographic information annually to ensure its conformity with reflection/representation rules.

5a. **Gender:** ■ Male ❑ Female ❑ Trans (Male to Female) ❑ Trans (Female to Male) ❑ Unknown

5b. **Race/Ethnicity:** (Check all that apply)

■ African- American/Black,not Hispanic	❑ Hispanic
❑ American Indian/Alaska Native	❑ Multi-Race
❑ Anglo/White, not Hispanic	❑ Other :_____
❑ Asian/ Pacific Islander	❑ Decline to State/Not Specified

5c. **Are you a parent/guardian/direct caregiver to a child with HIV under 19?** ❑ Yes ■ No

6. **FOR APPLICANTS LIVING WITH HIV:**

6a. **Are you willing to publicly disclose your HIV status?** ❑ Yes* ■ No
***DO NOT CHECK YES HERE if you do not want your HIV status known publicly. There is NO requirement that someone with HIV must disclose his/her status to the Commission or publicly.**

6b. **Age:**

❑ 13 – 19 years old	❑ 20 – 29 years old	
❑ 30 – 39 years old	■ 40 – 49 years old	❑ 50-59 years old
❑ 60+ years old	❑ Unknown	

6c. **Are you a "consumer" (patient/client) of Ryan White Part A services?** ■ Yes ❑ No

6d. **Are you "affiliated" with a Ryan White Part A-funded agency?** ■ Yes ❑ No

By indicating "affiliated," you are a: ❑ board member, ❑ employee, or ❑ consultant at the agency. A volunteer at an agency is considered an unaffiliated consumer.

Section 3: Experience/Knowledge

7. **Recommending Entities/Constituency(ies):** "Recommending Entities" are the individuals/ organizations who may have suggested or asked you to represent them on the Commission.

7a. **What organization/Who, if any/anyone, recommended you to the Commission?**

NORTHEAST VALLEY HEALTH CORP JUAN PRECIADO

7b. **If recommended, what seat, if any, did he/she/they recommend you fill?**

COMMISSIONER/ALTERNATE

8. **Please check all of the boxes that apply to you:**

1 ❑ I am willing to publicly disclose that I have Hepatitis B or C.
2 ❑ I am an HIV-negative user of HIV prevention services and who is a member of an identified high-risk, special or highly impacted population.
3 ❑ I am a member of a federally-recognized American Indian tribe or Native Alaskan village.
4 ❑ I am a behavioral or social scientist who is active in research from my respective field.
5 ❑ I am involved in HIV-related research in the following capacity(ies) (Check all that apply):
❑ scientist, lead researcher or PI, ❑ staff member, ❑ study participant, or ❑ IRB member.
6 ❑ A health or hospital planning agency has recommended that I fill that seat on the Commission.
7 ❑ I am an HIV specialty physician or an Infectious Disease (ID) doctor with HIV- positive patients.
8 ❑ The agency where I am employed provides mental health services.
9 ❑ The agency where I am employed provides substance abuse services.
10 ❑ The agency where I am employed is a provider of HIV care/treatment services.
11 ❑ The agency where I am employed is a provider of HIV prevention services.
12 ❑ The agency where I am employed is provider of ❑ housing and/or ❑ homeless services.
13 ❑ The agency where I am employed has HIV programs funded by Federal sources (other than Ryan White).
14 ❑ I work for or am otherwise affiliated with a health care provider that is a Federally Qualified Health Center (FQHC) or a Community Health Clinic (CHC).
15 ❑ As someone who is employed as an advocate for incarcerated PWLH and/or as a PWLH who has been incarcerated in the past three years, I can represent the interests of incarcerated PWLH.
16 ❑ I am able to represent the interests of Ryan White Part C grantees.
17 ❑ I am able to represent the interests of Ryan White Part D grantees.
18 ❑ I am able to represent the interests of Ryan White Part F grantees given my affiliation with:
❑ one of LA County's AETC grantees/sub-grantees ❑ a HRSA SPNS grantee
❑ Part F dental reimbursement provider ❑ HRSA-contracted TA vendor
19 ❑ As an HIV community stakeholder, I have experience and knowledge given my affiliation with: (Check all that apply)
❑ union or labor interests
❑ provider of employment or training services
❑ faith-based entity providing HIV services
❑ organization providing harm reduction services
❑ an organization engaged in HIV-related research
❑ the business community
❑ local elementary-/secondary-level education agency
❑ youth-serving agency, or as a youth.

9. **Training Requirements:** The Commission requires all members to complete the following trainings, which can be fulfilled if the trainings were provided by other institutions. Applicants will not be penalized for no prior training, but must take it once appointed.

9a. **Have you completed an "Introduction to HIV/STI,""HIV/STI 101," or a related basic informational HIV/STI training before? (If so, include Certificate of Completion; if not, the Commission provides the training)** ☐ Yes ■ No

9b. **Have you completed a Health Insurance Portability and Accountability Act (HIPAA) training before?** (If so, please include Certificate of Completion; if not, the Commission will provide the training) ☐ Yes ■ No

9c. **Have you completed a "Protection of Human Research Subjects" training before?** (If so, please include Certificate of Completion; if not, the Commission will provide the training) ☐ Yes ■ No

Section 4: Biographical Information

10. **Personal Statement:** The "personal statement" is a snapshot of your goals of your Commission participation, against which you can measure your effectiveness as a Commission member. This statement may be included on the Commission's website in the member section. Provide a short (50-word maximum) statement expressing why you want to be a Commission member:

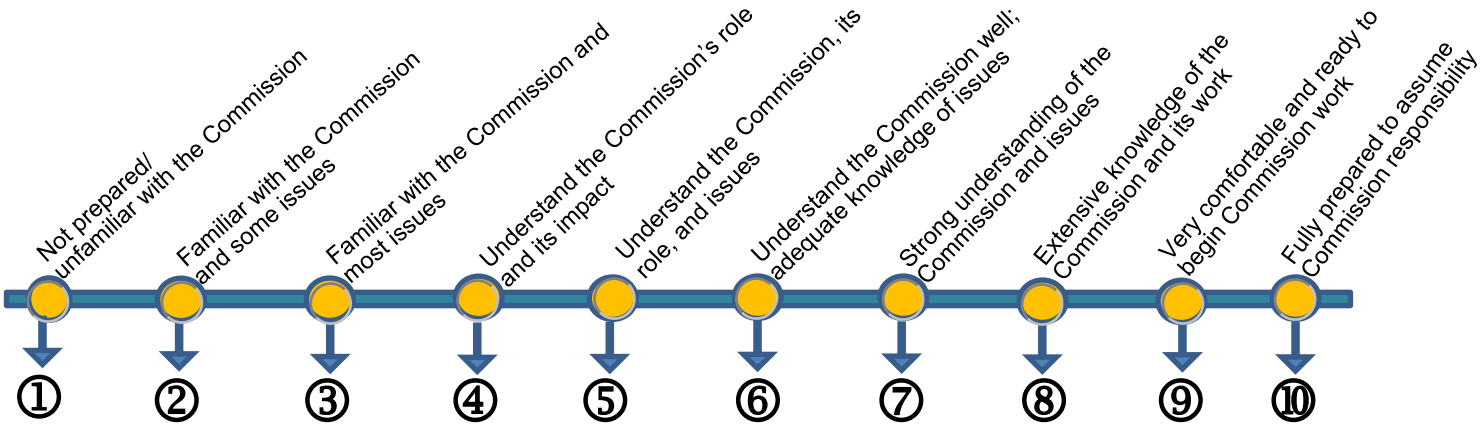
Damontae Hack, newly diagnosed. Class of 2020, Theater & Arts. I am familiarizing myself with this diagnosis, services and support. I am interested in becoming a planner and providing change. I would like to for our experience to be reflected in leadership positions- appeal & engage younger adults.

11. **Biography/Resume**: If you would like, you can indicate below that you are updating this section from your original or renewal application, or simply write a new paragraph. You may—but it is not required —attach a new/updated resume. You may continue on an additional page, if necessary. As you feel appropriate, please provide a short biography detailing your background, and how it has prepared you for service on the Commission:

12. **Additional Information**: In this section, please provide any additional information about yourself—or update information from your original or renewal application—that you feel will enhance the application review. If you choose not to include any additional information, indicate it here with "N/A". Your additional information may continue on an additional page, if necessary:

Section 5: New Member Applicant (Only to be completed by new member applicant)

13. **How prepared do you feel you are to serve as a member of the Commission, if appointed?** A candidate's "preparedness" for Commission service is assessed—for this response—according to the 10-point scale located on the next page, which indicates that those who are the "least" prepared ("1" on the scale) are "not familiar" with the Commission and the issues that it reviews. The more prepared a candidate is—as indicated on the scale (moving towards "10" from "1")—s/he should demonstrate increased familiarity with the Commission and its content, evolving into "understanding" and "comfort" with the role of the Commission and its practices, and "limited" to "extensive" knowledge about the topics it addresses. Mark the circle that represents where you feel you fall on this scale of "preparedness" ("1" is "not prepared" ➡ "10," "fully prepared")



14. **Describe any personal/professional experience that you believe has prepared you to perform effectively as a member of the Commission. Continue on an additional page if necessary.**

15. **What do you anticipate your greatest hurdles will be acclimating to your new role on the Commission? How do you think you will overcome them? Continue on an additional page if necessary.**

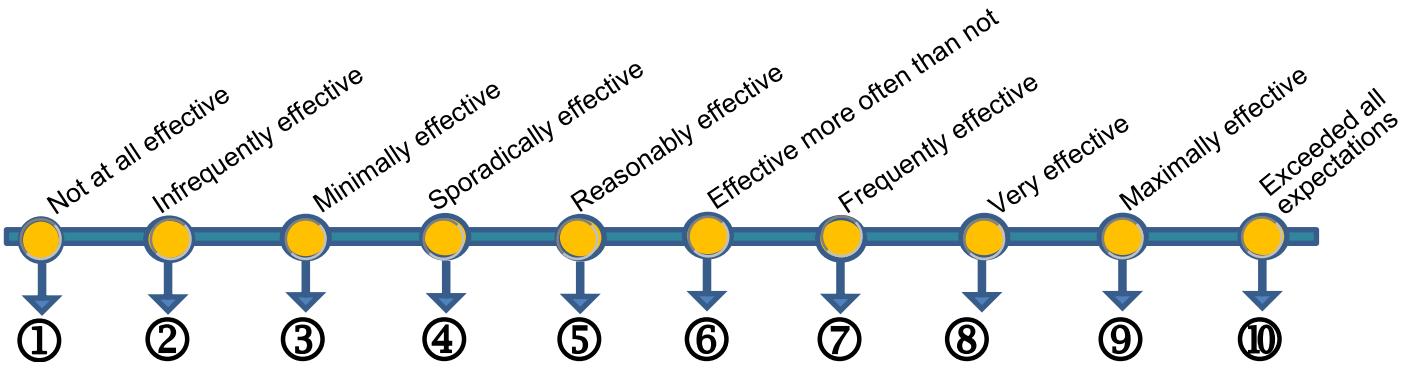
16. **How will your Commission membership benefit the lives of LA County residents with HIV/STDs and/or who are at high-risk of HIV-/STD-infection? Continue on an additional page if necessary.**

17. **Which of your strengths do you feel will enhance your Commission performance? What skills will you need to develop further for optimal Commission performance? Continue on an additional page if necessary.**

18. **Candidates are also nominated to fill Alternate seats as well: if you were nominated for an Alternate seat, would you be willing to serve in that capacity?** ❑ Yes ❑ No

Section 6: Renewal Applicant (Only to be completed by renewal applicant)

19. **How effective do you feel you were during your most recent term on the Commission?** Mark the circle that you feel is the best assessment of your Commission participation and engagement in the last term (1 is least effective ➡ 10 is most effective)



20. **Explain why you rated yourself the way you did in Question #16. Continue on an additional page, if necessary.**

21. **In your last term, what would you have done differently and what would you have improved, if anything (e.g., quality, communication skills, participation)?** Continue on an additional page, if necessary..

22. **In your last term, what, if any, barriers and/or obstacles prevented you from fully carrying out your Commission responsibilities as you would have liked?** Continue on an additional page, if necessary.

23. **What can the Commission do to help improve your effectiveness and/or level of contribution/accomplishment in your next term?** Continue on an additional page, if necessary.

24. **Candidates are also nominated to fill Alternate seats as well: if you were nominated for an Alternate seat, would you be willing to serve in that capacity?**

CLICK HERE TO PRINT FORM

CLICK HERE TO CLEAR FORM

LOS ANGELES COUNTY
COMMISSION ON HIV

Visit us online: http://hiv.lacounty.gov
Get in touch: hivcomm@lachiv.org

Virtual Training Schedule for Commissioners and Community Members

These trainings are **highly recommended.** The Ryan White HIV/AIDS Program Part A Manual stipulates the provision of a thorough orientation to new and returning planning council members and ongoing formal training to attain skills necessary to perform their duties.

September 2 @ 2pm to 3:30pm REGISTER HERE: https://tinyurl.com/y4rdbl6u	**Commission on HIV (COH) Overview** | Learn about the purpose of the COH, its ordinance and bylaws, and structure. Learn about integrated HIV prevention and care community planning.
September 14 @ 10am to 11:30am REGISTER HERE: https://tinyurl.com/yxnnleq5	**Ryan White CARE Act Legislation Overview** | Learn about the landmark law that establishes lifesaving care for people living with HIV in the United States.
October 1 @ 10am to 11:30am REGISTER HERE: https://tinyurl.com/yyl8gu9r	**Membership Structure and Responsibilities |** Learn about the duties of a Commissioner, the 51 seats on the body, and the functions of the Operations Committee. Learn how different member perspectives help facilitate a sound integrated HIV/STD prevention and care planning process. Understand the concepts of Parity, Inclusion, Reflectiveness, and Representation.
October 29 @ 10am to 11:30am REGISTER HERE: https://tinyurl.com/yyhgv8sb	**Priority Setting and Resource Allocation (PSRA) Process |** Ryan White HIV/AIDS Program resources are limited and need is severe. Learn about the responsibility of planning councils to use sound information and a rational decision-making process when deciding which services and other program categories are priorities (priority setting) and how much to fund them (resource allocation).
November 5 @ 10am to 11:30am REGISTER HERE: https://tinyurl.com/y3c7f632	**Service Standards Development Process** | Learn why the COH develops service standards for HIV services, the functions of the Standards and Best Practices Committee, and how community members help shape standards of care in Los Angeles County.
November 19 @ 10am to 11:30am REGISTER HERE: https://tinyurl.com/yyh64om6	**Policy Priorities and Legislative Docket Development Process** | Learn about the functions of the Public Policy Committee and how the COH's policy priorities and legislative positions are developed. Learn about the Board of Supervisors guidance for Commissions on taking positions on legislative bills.

Setting the Standard: A Comprehensive Overview of Service Standards for Part A Planning Councils/Planning Bodies Webinar

Join Planning CHATT on Wednesday, November 4th, from 3pm to 4:30pm ET to learn about the value of service standards in ensuring quality care for people with HIV.

Setting the Standard: A Comprehensive Overview of Service Standards for Part A Planning Councils/Planning Bodies

Wednesday, November 4th | 3 p.m. to 4:30pm ET

Participants will hear from St. Louis TGA and Los Angeles EMA about their successes and challenges with developing, reviewing, and updating services standards during the COVID-19 pandemic. Presenters will also share resources to support the development of service standards.

Register for the November 4th webinar

COUNTY OF LOS ANGELES
Public Health

LOS ANGELES COUNTY
HEALTH AGENCY

BARBARA FERRER, Ph.D., M.P.H., M.Ed.
Director

MUNTU DAVIS, M.D., M.P.H.
Health Officer

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www.publichealth.lacounty.gov

Submitted via email to STDplan@hhs.gov

June 3, 2019

Admiral Brett P. Giroir
United States Assistant Secretary for Health
200 Independence Avenue, SW
Room 716G
Washington, DC 20201

SUBJECT: Request for Information: Developing an STI Federal Action Plan

Dear Admiral Giroir:

On behalf of the Los Angeles County Department of Public Health, Division of HIV and STD Programs, thank you for your ongoing leadership and commitment to significantly decrease the rates of Sexually Transmitted Infections (STI) among and improve the sexual health of the residents of the United States.

We are pleased that under your leadership and the leadership of both Tammy R. Beckham, Director of the Office of HIV/AIDS and Infectious Disease Policy (OHAIDP) and Carol S. Jimenez, Deputy Director for Strategic Initiatives at OHAIDP, our federal partners at the Department of Health and Human Services (HHS) are actively seeking input on the development of the first ever Federal STI Action Plan.

As you know all too well, STI rates continue to rise and have a significant impact in all corners of our Nation, and certainly in Los Angeles County (LAC). In 2018 and among LAC residents, we reported more than 95,000 cases of STIs, including more than 61,000 cases of chlamydia, over 25,000 cases of gonorrhea, nearly 8,000 cases of syphilis, and 54 cases of congenital syphilis.

As one of the largest counties in the United States, we maintain that strong federal leadership, a set of shared and universally embraced STI-related performance metrics, an unprecedented level of public-sector and private-sector partnership on STIs and sexual health promotion, strong cross-federal agency collaboration, and the marshalling of both human and financial resources is critical to stem the tide of STIs over the next several years.

As our partners at HHS develop the first ever Federal STI Action Plan, we respectfully ask that the team consider the following structural and programmatic recommendations:

Structural Recommendations

- **Create the first ever STI.gov website** to serve a similar function to HIV.gov. This site should be used as a central national repository of information on STIs, including general information about STIs, educational resources for professionals, testing and treatment information, and federal guidance on reducing STI disease burden. This site would reinforce the importance of focusing on STIs domestically
- Consider including STI in the title of the Office of HIV/AIDS and Infectious Disease Policy. One consideration may be the **Office of HIV, STI and Infectious Disease Policy** to also signal a stronger national commitment to addressing the STI epidemic
- Form a **Secretary's Advisory Council on STIs and Sexual Health** to advise HHS on the federal government's response to the growing national STI epidemic and as a complement to the Presidential Advisory Council on HIV and AIDS or PACHA

Programmatic Recommendations

- Modernize STI service provision through an investment in full scale, high through-put STI express clinics in the most impacted areas in the US, with an initial anchor public sector investment that could be followed by a more robust public-sector/private-sector financing strategy. This is critical to significantly increasing patient screening, diagnosis and treatment volume as well as enhancing and normalizing the patient experience tied to frequent STI testing. The development and support of STI Express Clinics across the United States is important to counter the significant erosion of dedicated and specialty STI Clinic access points in the United States over the last two decades
- Enhanced Congenital Syphilis (CS) programing including:
  - Providing stronger national leadership to set CS best practices and ensure compliance among different professional organizations (e.g. American College of Obstetricians and Gynecologists)
  - Increased support and technical assistance to clinics serving priority populations related to syphilis best practices (updated staging and treatment guidelines, the importance of increased screening of all women of reproductive age regardless of risk characteristics)
  - Establishment of a syphilis pregnancy registry to track pregnancy complications and outcomes related to syphilitic infection during pregnancy in high morbidity jurisdictions
  - Address a range of current policy issues that impact broad access to Bicillin, including cost levels and health insurance coverage requirements
  - Increased support of programs that address common syphilis and CS co-epidemics, including HIV, injection and non-injection drug use (e.g. methamphetamine and opiates), mental illness and homelessness
- Support pharmacy-based programs that simultaneously and more holistically support Patient Delivered Partner Therapy (PDPT), HIV Pre-exposure prophylaxis (PrEP), and Human Papillomavirus (HPV) vaccinations
- Through a combination of HEDIS measure changes and public health plan (e.g. Medicaid) performance metrics, improve HPV vaccination rates among recommended populations as well as syphilis and extra-genital gonorrhea screening rates among highly impacted sub-populations, including, but not limited to, gay, bisexual and men who have sex with men, persons under 30 years of age, transgender persons and communities of color (particularly African-Americans, Latinos and American Indians/Alaskan Natives)

Programmatic Recommendations (continued)

- In partnership with the National Institutes of Health and other federal partners, significantly improve the domestic STI prevention research agenda and support STI intervention translational research efforts
- Describe successes, failures and lessons learned from previous national Syphilis Elimination efforts
- Consider developing a national Patient-Delivered Partner Therapy (PDPT) Strategy as a supplement to the Federal STI Action Plan with specific performance benchmarks based on level of STI burden

Thank you again for your leadership and for your commitment to improve the health of the residents of the United States. If you have any questions regarding this matter, please contact me at (213) 351-8001.

Very truly yours,

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

STD Strategic Plan Draft: Public Comment Feedback from Los Angeles County DPH

National STI Response Recommendations:

- Create an STD focused website to serve as a central national repository of information on STDs, including general information about STDs, educational resources for professionals, testing and treatment information, and federal guidance on reducing STI disease burden. The website should serve a similar function to HIV.gov. This site would reinforce the importance of focusing on STIs domestically
- Consider including STI/STD in the title of the Office of HIV/AIDS and Infectious Disease Policy. One consideration may be the Office of HIV, STI and Infectious Disease Policy to also signal a stronger national commitment to addressing the STI epidemic.
- Form a Secretary's Advisory Council on STDs and Sexual Health to advise HHS on the federal government's response to the growing national STD epidemic and as a complement to the Presidential Advisory Council on HIV and AIDS or PACHA
- Improve HPV vaccination rates among recommended populations as well as syphilis and extra-genital gonorrhea screening rates among highly impacted sub-populations, including, but not limited to, gay, bisexual and men who have sex with men, persons under 30 years of age, transgender persons and communities of color (particularly African-Americans, Latinos and American Indians/Alaskan Natives) through a combination of HEDIS measure changes and public health plan (e.g. Medicaid) performance metrics.

Overall Plan Feedback:

- The local approach is philosophically aligned with the national strategy. However, the national plan has a tempered goal of trying to prevent new infections, i.e., prevent further increase in trends. There is no expectation in the National Plan that we will decrease STD; this may differ from the expectations of our local DPH and County/Board leadership.
- There are various other plans-- National Vaccine Plan, national Viral Hepatitis Plan, EHE, etc. that are mentioned briefly. Only the EHE plan is really highlighted but, we feel there should be a place in this plan where the intersection of these plans is mentioned. There should be a way or an effort to align them.
- The plan is very comprehensive in terms of goals, but they read as a wish list not a feasible set of expectations as a result of insufficient funding and capacity.
- The plan should include a description of successes, failures and lessons learned from previous national Syphilis Elimination efforts

Structural/Formatting Feedback:

- The plan should be organized to flow from the highest STI priority vs. the most common.
- There are various authors and parts of the document where there you could see a difference in writing styles.
- We would suggest using plain language and simplified terms whenever possible.
- It is extremely long (88 pages).
- The 5 year and 10-year targets were useful, some like condom use were more realistic than CS for example.
- The executive summary should include infant death in the irreversible outcomes.

- The disparity and developmental indicators are really sub-indicators. We suggest numbering as such rather identifying as separate indicators.
    - For example:
        3. Reduce congenital syphilis rate by 15% by 2025 and 50% by 2030
            3.1 Reduce congenital syphilis rate among African American/Blacks
            3.2 Reduce congenital syphilis rate among AI/ANs
            3.3 Reduce congenital syphilis rate in the West

Subject Specific Feedback:

- Syphilis and Congenital Syphilis
    - The plan should place emphasis on enhanced Congenital Syphilis (CS) programing including:
        - Providing stronger national leadership to set CS best practices and ensure compliance among different professional organizations (e.g. American College of Obstetricians and Gynecologists)
        - Increased support and technical assistance to clinics serving priority populations related to syphilis best practices (updated staging and treatment guidelines, the importance of increased screening of all women of reproductive age regardless of risk characteristics)
        - Establishment of a syphilis pregnancy registry to track pregnancy complications and outcomes related to syphilitic infection during pregnancy in high morbidity jurisdictions
        - Address a range of current policy issues that impact broad access to Bicillin, including cost levels and health insurance coverage requirements
        - Increased support of programs that address common syphilis and CS co-epidemics, including HIV, injection and non-injection drug use (e.g. methamphetamine and opiates), mental illness and homelessness. The plan did not reference syphilis and meth use (MMWR).
    - Syphilis and CS have such a tremendous impact on LAC, and we see a significant difference in the populations that are impacted locally in comparison to what is mentioned in the national plan. We acknowledge that there are differences between US regions, however these differences can be better explained by States rather than US Regions which are too broad and do not clearly represent the critical situation.
- Surveillance
    - The plan should include more emphasis on building the capacity of surveillance. This could be achieved by partnering with institutions to building capacity within HDs or ensuring that that sufficient funds are set aside for surveillance activities
- Technology
    - It was great to see emphasis on technology advances (testing, vaccines, etc.). Without improvements in these areas, we will not be able to make significant impact.
    - Would appreciate placing more emphasis of testing and pharma.
    - Given the emphasis on technology, we would be curious to hear whether we have support from DPH leadership to assist with such studies/innovations.
        - Historically the legacy STD program was involved in some clinical trials related to testing, treatment and vaccines. During the past decade this has not been possible due to competing demands and a need to improve local programming. It is worth debating internally how we can help advance STI research.

    - Investment in full scale, high through-put STD express clinics in the most impacted areas in the US as a way to modernize STD service provision. This is critical to significantly increasing patient screening, diagnosis and treatment volume as well as enhancing and normalizing the patient experience tied to frequent STD testing.
        - The development and support of STD Express Clinics across the United States is important to counter the significant erosion of dedicated and specialty STI Clinic access points in the United States over the last two decades.
- Priority populations
    - Based on case rates for specific STD's, more attention should be focused on certain priority populations (i.e. youth, correctional health). There is no real mention of incarceration and STIs. We would suggest they add more on the importance of screening and treatment in incarcerated settings.
    - HIV specialty services offer a continuum of care model and structure to address social determinants of health. It would be helpful to include similar information about the expectations of STD service providers/general clinicians to address these areas of client concerns/needs.
    - Aside from partnerships with substance use treatment partners, it would be helpful to see bold policy and federal support around syringe exchange.
- Capacity Building and Training
    - The plan should include more details on how they will invest in capacity building and create initial certification trainings (mentorships, skills building, etc.) and ongoing updates for medical providers to reduce missed opportunities to test, diagnose, and treatment. Trained providers will rely less on secondary case reviews by DIS to confirm diagnosis and treatment.
    - The plan should detail workforce support for DIS to address training and staff development needs of this profession. Offer career paths for DIS and expand professional training opportunities and mentorship structures.
- Treatment
    - We appreciate that they included indicators on proportion appropriately treated
    - Consider developing a national Patient-Delivered Partner Therapy (PDPT) Strategy as a supplement to the Federal STI Action Plan with specific performance benchmarks based on level of STI burden
    - Support pharmacy-based programs that simultaneously and more holistically support Patient Delivered Partner Therapy (PDPT), HIV Pre-exposure prophylaxis (PrEP), and Human Papillomavirus (HPV) vaccinations

Policy Feedback:

- The plan is lacking in their policy recommendations. Although there are policy suggestions throughout the document, there should be a dedicated policy statement or section. Typically, when there is lack of funding for prevention, policy initiatives tend to be very effective (e.g., tobacco control).

Funding, Resources and Prioritizations:

- We appreciate that there is a section on program capacity challenges and the acknowledgment that there is a lack of State and local funds. There should be guidance or recommendations as to how Public Health Departments can prioritize efforts.
- There is significant recognition in the plan of insufficient STI funding and capacity. Locally, we have been discouraged to message this when discussing our approach to STI control. For

example, we were instructed by DPH leadership to remove any mention of the need for new staff or resources (ex: need for more DIS and improved data/surveillance capacity) from our CS Elimination Plan.

- We would recommend that the CDC include more discussion regarding the realities of Public Health Departments and how prioritizations should occur. Even if they provide a tool or suggestions on how to determine what to focus on would be very helpful. To only mention the capacity issue but, not provide how to address them is not terribly useful.
- It would be helpful to see the expectations and plans for integrating public and private partnerships to address STDs and other co-occurring disorders across the system of providers and how will they restructure reimbursements to support coordinated approach. Additionally, how will the use of technology enhancements support coordinated efforts across care providers to improve treatment opportunities.
- Although this is not a grant announcement, it would be helpful to understand if funding will be commensurate with levels of STD's within jurisdictions to begin to implement strategies with a workforce based on the local data. Will there be directives and new funding for targeted outbreak responses to immediate reduce the high rates of prioritized infections within jurisdictions?